Client Values and Satisfaction with Occupational Therapy

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Understanding clients’ perspectives about occupational therapy services they experience is essential for enhancing the client-centered practice of occupational therapy and for designing evaluations that are relevant to both clients and service providers. This study aimed to identify clients’ views about their occupational therapy services, and to explore congruence of these views with principles of enabling occupation in client-centered practice. Dimensions of client satisfaction and dissatisfaction relevant to future research were also examined. A cross-sectional survey research design, utilizing closed and open-ended questions within a structured telephone interview protocol, was used to collect data relevant to study goals. A purposive sample of 107 adults who had accessed occupational therapy services from one health region in Alberta, Canada were interviewed. Ratings of the accessibility, quality, and outcomes attributed to OT services were generally positive. Content analyses of responses to open-ended questions underlined the importance placed on quality of client-therapist interactions, communication, client education, and competency of therapists. Dislikes concerned limited accessibility of regional occupational therapy services. It is concluded that outcome evaluations should include indicators of client views in these domains. Support for the principles of client-centered practice was also found. Key words: client-centered practice, client values, outcomes research, rehabilitation.

INTRODUCTION

Understanding and respecting clients’ values, needs, and perspectives are guiding principles for enabling occupation in client-centered practice [1]. Engaging clients in decision-making, fostering open, clear communication, and actively facilitating client participation in the planning, implementation, and evaluation of the process and outcomes of occupational therapy are also fundamental to client-centered practice [1–4]. Involving clients in evaluation and research is advocated as a way to ensure that occupational therapy remains meaningful to clients and to their treatment, and as necessary for providing client-centered service [5, 6]. Law [7], upon reviewing the health and social sciences literature, concludes that the “research evidence supports that a client-centered occupational therapy practice will lead to improved client satisfaction and outcomes” (p. 25).

However, a search of the CINAHL, EMBASE, and MED-LINE electronic databases between the years 1966 and 2000 yielded no reported studies that explicitly measured client satisfaction with occupational therapy services. Indeed, there is very limited research and writing on client satisfaction within the broader field of rehabilitation [8, 9]. Support is evident, however, for the argument that client involvement in the planning and conduct of studies of client satisfaction in rehabilitation increases the likelihood that the dimensions of client satisfaction assessed represent those areas of service experience important to consumers, as defined by consumers [5, 10, 11]. To do so, it is imperative that a greater understanding be developed of what clients do (not) value about their experiences as consumers of occupational therapy services, and how these values may influence their satisfaction with these services.

Further, more research is needed to determine if taking a “client-centered approach” to how occupational therapy services are provided makes a difference to client satisfaction. What evidence to support or refute a client-centered approach to service delivery can be gleaned from clients themselves? Again, there are few empirical studies of the meaning of client-centered practice as interpreted by clients, or of what clients’ value in their occupational therapy experiences. One exception is a qualitative study by Corring and Cook [6] who explored the meaning and characteristics of client-centered care from the perspectives of 17 individuals experienced with mental health services. The central message that emerged from this study was “the need for individuals with mental illness to be viewed as valuable human beings by service providers and by society” (p. 71). Two in-depth interviews conducted with clients of mental health services about their experiences with a hospital-based occupational therapy service were recently reported by Rebeiro [12]. These clients described their experiences as “prescriptive, and as less than client-centered” (p. 7).

Clearly, there is much to be learned of relevance to the knowledge base of occupational therapy by asking clients about what they like and dislike about their experiences as occupational therapy clients. A primary purpose of this study was, therefore, to
identify clients’ likes and dislikes about the occupational therapy services they had received, and to explore the congruence of these findings with the principles of enabling occupation in client-centered practice. The study also aimed to identify domains of practice meaningful to clients that could be included in client evaluations of satisfaction with the process and outcomes of occupational therapy services.

MATERIALS AND METHODS

Context

The study was conducted in the context of a community-based occupational therapy service administered by a regional health authority situated in the primarily rural, east central region of Alberta, Canada. In 1997–1998, 2.5 full-time equivalents of occupational therapists provided services to residents of the region [13]. While client-centered practice is not yet embedded in standards of occupational therapy practice in Alberta, awareness of client-centered practice models, principles, and approaches is widespread among Canadian occupational therapists due to the dissemination of this knowledge in university curricula, professional publications, conferences, and other educational media. However, it was not known if occupational therapists practicing in this health region were implementing a client-centered model of practice at the time of data collection. Recent research indicates that although occupational therapists may be aware of client-centered approaches, actual implementation of client-centered practice is more limited and subject to many barriers [12, 14, 15].

Participants

A cross-sectional survey research design, including both quantitative and qualitative data collection methods, was used to address the research questions. The target population for the survey purposively included all community-dwelling adults who had been discharged from occupational therapy services in the East Central Regional Health Authority between January and April 1998. Additional inclusion criteria were the ability to understand and speak English, orientation to person, place, and time, and ability and willingness to verbalize ideas and opinions about their occupational therapy experiences. Among this population were all adults who had accessed occupational therapy services at home or as outpatients of a regional health care facility. Excluded from the target population were all those who had received occupational therapy as residents of long-term care facilities or as inpatients in acute care facilities, and all clients under 18 years of age.

From administrative records compiled by the regional health authority (RHA), a total of 150 clients were identified as meeting the eligibility criteria for inclusion in the study. All identifying information for these individuals was kept confidential by the RHA, except for the telephone number of the household in which each eligible individual resided. An electronic database containing these 150 unique telephone numbers was created and then formatted for a computer-assisted telephone interviewing system at the University of Alberta. Among the 150 telephone numbers in the original pool of potential respondents to the survey, 25 numbers were unusable due to telephone line trouble, discontinuation of telephone services, or inability to contact an eligible individual at that telephone number. Using the 125 remaining numbers, each potential participant in the study was informed of the purpose and importance of the study, and that his/her participation was entirely voluntary. He/she was also informed that he/she could decline to answer any question on the survey, that information provided would be kept anonymous, and that he/she could terminate the interview at any time. The names and contact telephone numbers of the principal investigator and the research coordinator in the health region were provided to individuals who had any questions about the study.

In total, 107 individuals consented to be interviewed, yielding an overall response rate of 85.6%. The sample was comprised of 27 (25.2%) men and 80 (74.8%) women. Classified by age group, 34.6% were between 50 and 64 years. Asked to rate their health compared to others their own age, 39.3% said that their health was good, while 37.3% rated their health as fair or poor. Physicians were the referral sources for about 55% of the sample. When asked, “Why did you need occupational therapy services?” remediation of physical and functional performance deficits related to health problems, followed by assessments for orthotic devices and assistive equipment, were most often mentioned. Over half of the respondents reported some type of medical condition as the reason why they had needed occupational therapy services, but did not explain how this condition had resulted in impairments, disabilities, or handicaps that led to a referral to an occupational therapist. None of the respondents mentioned mental health problems. Selected characteristics of the sample are shown in Table I.

Survey instrument

A telephone survey questionnaire was developed for the purposes of this study. During the development of this data collection instrument, occupational thera-
pists and healthcare managers in the health region were consulted about the content of the questionnaire so that it included items considered relevant and valid to these expert groups. A pretest of the survey instrument was conducted on July 7, 1998 with 20 recently discharged occupational therapy clients in the health region. The pretest obtained clients’ and interviewers’ perspectives on the content of questions, questionnaire flow, response categories, and interviewing instructions. Engaging clients in the process of identifying and communicating their perspectives about the content and format of the draft questionnaire was a way to facilitate a more client-centered approach to the research design. Following review of the pretest findings, changes were made to the survey instrument and to the computer programming of the survey so as to improve the content, validity, and format of the interview protocol.

The final version of the data collection instrument began with information about the study, ethical considerations, and a request for participation in the study by responding to the survey questionnaire. The next section of the survey contained questions about access and utilization of occupational therapy services in the health region. Then respondents were asked to rate the extent of agreement with a series of opinion statements, shown in Table II, that addressed the accessibility of occupational therapy services (four items), health outcomes attributed to receipt of occupational therapy (six items), and global satisfaction with occupational therapy services (two items). A five-point rating scale was used to indicate the extent to which each respondent agreed with each of these statements, with “1” indicating strongly agree and “5” indicating strongly disagree. Three open-ended questions followed in which clients were asked to describe what they liked and disliked about the occupational therapy services they had received, and what suggestions they had to improve these services. The final section of the survey instrument asked questions about the demographic characteristics and self-rated health of respondents.

### Data collection

Experienced interviewers of the Population Research Laboratory administered the structured telephone interview protocol from a central location at the University of Alberta. Use of these interviewers was advantageous as they were independent of the health region, not service providers, and skilled in computer-assisted telephone interviewing. These interviewers and their supervisors had received training on the study background, the content of the survey instrument, and how to administer the structured interview protocol so as to collect high quality data. Interviewing took place between August 10, 1998 and August 18, 1998. Each interview took approximately 20 min to complete. Reliability checks conducted with 10% of the survey sample revealed no statistically significant differences in responses between the first and second interviews.

### Data analyses

The computer-assisted telephone interviewing (CATI) system permitted direct entry of responses into an electronic format. Quantitative data collected were automatically tabulated using the features of the CATI system and then imported into the SPSS for Windows Version 8.0 statistical computing program [16]. Descriptive analyses of frequencies, percentages, measures of central tendency (mode, median), and of dispersion (range) were conducted for all quantitative variables in the survey instrument.

Verbatim responses to the open-ended questions about clients’ likes, dislikes, and suggestions to improve occupational therapy services were compiled across all interviews, downloaded from the CATI system, formatted, and printed. Any identifying information was removed from the text so as to ensure the anonymity of individuals concerned. To understand more fully respondents’ experiences and values influencing their reported satisfaction and dissatisfac-

### Table I. Selected characteristics of study sample (n = 107)

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>% (n)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sex</td>
<td></td>
</tr>
<tr>
<td>Males</td>
<td>25.2 (27)</td>
</tr>
<tr>
<td>Females</td>
<td>74.8 (80)</td>
</tr>
<tr>
<td>Age group (years)</td>
<td></td>
</tr>
<tr>
<td>18–49</td>
<td>34.6 (37)</td>
</tr>
<tr>
<td>50–64</td>
<td>34.6 (37)</td>
</tr>
<tr>
<td>65+</td>
<td>30.9 (33)</td>
</tr>
<tr>
<td>Self-rated health</td>
<td></td>
</tr>
<tr>
<td>Excellent</td>
<td>23.4 (25)</td>
</tr>
<tr>
<td>Good</td>
<td>39.3 (42)</td>
</tr>
<tr>
<td>Fair</td>
<td>25.2 (27)</td>
</tr>
<tr>
<td>Poor</td>
<td>12.1 (13)</td>
</tr>
<tr>
<td>Referral source</td>
<td></td>
</tr>
<tr>
<td>Physician</td>
<td>54.8 (57)</td>
</tr>
<tr>
<td>Other provider</td>
<td>18.3 (19)</td>
</tr>
<tr>
<td>Self</td>
<td>16.3 (17)</td>
</tr>
<tr>
<td>Family &amp; friends</td>
<td>10.6 (11)</td>
</tr>
<tr>
<td>Total occupational therapy sessions</td>
<td></td>
</tr>
<tr>
<td>1–2</td>
<td>28.9 (30)</td>
</tr>
<tr>
<td>3–4</td>
<td>20.2 (21)</td>
</tr>
<tr>
<td>5–10</td>
<td>20.2 (21)</td>
</tr>
<tr>
<td>More than 10</td>
<td>30.8 (32)</td>
</tr>
</tbody>
</table>
Table II. Ratings of client satisfaction with occupational therapy services (n = 107)

<table>
<thead>
<tr>
<th>Opinion statement</th>
<th>SD %</th>
<th>DS %</th>
<th>N %</th>
<th>AS %</th>
<th>SA %</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Domain: satisfaction with accessibility of OT services</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>“It is easy to access information on where to access occupational therapy services in the health region.”</td>
<td>3.8</td>
<td>10.5</td>
<td>16.2</td>
<td>17.1</td>
<td>52.4</td>
</tr>
<tr>
<td>“The place where I received occupational therapy services is conveniently located.”</td>
<td>3.7</td>
<td>1.9</td>
<td>3.7</td>
<td>7.5</td>
<td>83.2</td>
</tr>
<tr>
<td>“The waiting time to access occupational therapy services was too long.”</td>
<td>37.7</td>
<td>21.7</td>
<td>12.3</td>
<td>15.1</td>
<td>13.2</td>
</tr>
<tr>
<td>“Overall, I am satisfied with the accessibility of occupational therapy services in the health region.”</td>
<td>5.6</td>
<td>6.5</td>
<td>6.5</td>
<td>24.3</td>
<td>57.0</td>
</tr>
<tr>
<td><strong>Domain: health outcomes attributed to OT services</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>“The occupational therapy services I received improved my ability to look after myself and my home.”</td>
<td>5.2</td>
<td>3.1</td>
<td>17.5</td>
<td>19.6</td>
<td>54.6</td>
</tr>
<tr>
<td>“The occupational therapy services I received improved my ability to work.”</td>
<td>13.3</td>
<td>4.1</td>
<td>13.3</td>
<td>19.4</td>
<td>50.0</td>
</tr>
<tr>
<td>“The occupational therapy services I received improved my ability to do leisure activities.”</td>
<td>8.1</td>
<td>5.1</td>
<td>12.1</td>
<td>23.2</td>
<td>51.5</td>
</tr>
<tr>
<td>“The occupational therapist educated me on how to prevent problems due to my health condition.”</td>
<td>8.7</td>
<td>1.9</td>
<td>7.7</td>
<td>25.0</td>
<td>56.7</td>
</tr>
<tr>
<td>“The occupational therapist taught me how to effectively manage my health condition.”</td>
<td>7.8</td>
<td>2.0</td>
<td>7.8</td>
<td>27.5</td>
<td>54.9</td>
</tr>
<tr>
<td>“The occupational therapy services I received were effective in improving my health.”</td>
<td>4.7</td>
<td>5.7</td>
<td>8.5</td>
<td>17.9</td>
<td>63.2</td>
</tr>
<tr>
<td><strong>Domain: global satisfaction with OT services</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>“Overall, I am satisfied with the quality of occupational therapy services in the health region.”</td>
<td>3.7</td>
<td>3.7</td>
<td>3.7</td>
<td>14.0</td>
<td>74.8</td>
</tr>
<tr>
<td>“I would recommend to others the occupational therapy services of this health region.”</td>
<td>1.9</td>
<td>0.9</td>
<td>5.7</td>
<td>8.5</td>
<td>83.0</td>
</tr>
</tbody>
</table>

SD = strongly disagree; DS = disagree somewhat; N = neutral; AS = agree somewhat; SA = strongly agree; OT = occupational therapy.

Data triangulation was used as a strategy to assess the credibility, dependability, and confirmability of results [19, 20]. That is, the qualitative data were compared with the quantitative data to assess the extent to which findings using different types of questionnaire items (open and closed questions) yielded convergent results. Trustworthiness of the data was also assessed by obtaining feedback from the occupational therapists in the health region who reviewed aggregated results of the survey, and commented on the validity of the interpretations and conclusions. Regional healthcare managers responsible for administration of occupational therapy services validated findings related to the accessibility of occupational therapy services in this health authority. Unfortunately, however, permission had not been obtained from individual respondents to contact them after the data collection phase for the purpose of validating the results of the survey, and so they were not involved in this phase of the study.

RESULTS

**Ratings of occupational therapy services**

High levels of client satisfaction with the accessibility of occupational therapy services, with health out-
comes attributed to receipt of occupational therapy, and with the overall quality of these services were evident in the aggregated ratings in response to the opinion statements in the survey instrument. As Table II shows, three-quarters of the sample strongly agreed with the statement, “Overall, I am satisfied with the quality of occupational therapy services in the East Central health region”, and 83% strongly agreed that they would recommend to others the occupational therapy services administered by this regional health authority. Still, about 28% of the respondents agreed to some extent with the statement, “The waiting time to access occupational therapy services was too long”, and about 12% expressed dissatisfaction with the accessibility of occupational therapy services in the health region. Between 8% and 17% of respondents were dissatisfied to some extent with the health outcomes attributed to receiving occupational therapy services.

**Qualitative findings**

Consistent with the pattern of quantitative results, the frequency of comments expressing “likes” (n = 102) about the occupational therapy services far exceeded the frequency of “dislikes” voiced (n = 34), while 46 people made suggestions for improvement. Specific findings are reported under the thematic categories of therapist characteristics and service characteristics. Notably, while the likes expressed by clients emphasized therapist characteristics, dislikes identified by the study sample mainly related to service characteristics. Further, all suggestions made by clients on how to improve occupational therapy services in this health region were related to service characteristics.

**Therapist characteristics.** Sub-themes emerging from the content analyses of comments on therapist characteristics included quality of client–therapist interactions, communication, therapist sensitivity to client needs, helpfulness, usefulness of information given, and perceived competency of therapists in professional practice. Reflecting on interactions with the occupational therapist, one client said, “I liked the one on one, personal caring nature of the therapist. The person was very professional.” Another said, “The lady was very nice, easy to talk to, and she was a wealth of information. She helped me organize my lifestyle easier [pause], and she has helped me a lot.”

Themes of communication and sensitivity to client needs were further evidenced by the remark, “She was very accessible, she listened and responded to my needs.”

Showing concern and respect for the client’s abilities were therapist characteristics valued by clients. To quote another client, “I think that she was very concerned about my abilities, and she was definitely impressed with my improvement and ingenuity. [Pause] Sometimes I am ahead of them on what to do. She thinks I was creative in figuring out what to do with the disability I have, and to determine how to use my right hand.” Information-sharing and education related to activities of daily living were also valued, as this comment illustrates, “The best thing about it was the way it was handled, the one on one and the explanations were excellent for every day living. In our case, she was very good about explaining the do’s and don’ts of what to do every day. We have an excellent therapist.”

The perceived competency of the occupational therapists clearly influenced clients’ opinions. To quote one respondent, “I liked the competent knowledge of the person that administered the service . . .” Another stated, “The occupational therapists are very considerate, kind, and also they know what they are doing.” In contrast, perceived lack of competency and lack of confidence surfaced in comments about characteristics that clients disliked about therapists. Describing this view a client said, “I suppose that this therapist didn’t seem to care like a whole lot. She is unsure of what she is doing. [Pause]. She doesn’t seem confident of what she’s doing.”

**Service characteristics.** Service characteristics, particularly the availability and accessibility of services, influenced clients’ views about what they liked, disliked, and suggested for improvement of occupational therapy services. Clients expressed appreciation that occupational therapy services were available in the health region in view of health benefits that they attributed to receipt of these services. The fact that occupational therapists provided services in client’s homes, as well as through regional healthcare facilities, was seen as positive by clients with limited mobility and needs for environmental assessments and home adaptations. Prompt access to services with minimal wait times was also identified as what clients liked about their occupational therapy services. To summarize, one client, “[I liked] their availability, and they certainly did their best to make things easier for me, whether it was a wheelchair, or grab bars, or a chair in the shower.”

Dislikes about services primarily focussed on difficulties in accessing occupational therapy services within the health region. Here, clients identified problems in contacting therapists, too long waiting times to access services, distances that had to be traveled to access services in a health facility many kilometers from home, and lack of information on where and how to access occupational therapy. Illustrative comments are as follows, “[I disliked] . . . the fact that it
took so long to get in here at the beginning. She was hard to track down at the beginning because she was in all different areas. If I had gone in earlier, I would be improving a lot more than right now. Even though I am improving a lot now, I would be that much better.”

Another respondent explained, “Too many times, the therapists, they have to share their time with so many people that they can’t monitor you close enough, and sometimes they just get tired like ordinary people. Sometimes I have to wait for answers to my questions.” Reinforcing this theme was the comment, “The waiting time to get an appointment is too long.”

Suggestions made on how to improve occupational therapy services in this health region were consistent with problems attributed by clients to the limited availability and accessibility of occupational therapy services in this health region. For example one client suggested, “I think we need someone in the area with more hours. Full-time would be nice. We need more money in our area put into occupational therapy than the physical therapy. There is more of a demand for occupational therapy. They should also do some advertising so more people are aware of the service provided for them.” Another person suggested, “They [the health region] could have more literature on it, on where you can get help if there are any problems.”

Other clients indicated the value they placed on occupational therapy services by recommending that more physicians refer patients to occupational therapy, and by advocating that occupational therapy services be marketed more widely so as to increase public awareness. This theme is captured in the comment, “Get more doctors using occupational therapists. Referring them more to the therapists would be great. In my case the therapist helped me out a lot. They need more advertising, but I don’t know how they would go about it because they do so much; . . . they could inform people of the extent of their services as they have so much to offer”.

DISCUSSION

By listening, recording, and analyzing the opinions and ideas expressed by these clients, it was possible to develop more understanding of the values influencing clients’ satisfaction and dissatisfaction with their occupational therapy services. The high response rate for this survey (85.6%), and the richly detailed comments provided by many respondents, supports the practice of including client perspectives in evaluations of occupational therapy services, for both theoretical and methodological reasons.

Results of this study are consistent with previous studies of patient satisfaction with healthcare, specifically in the importance placed by clients on the interpersonal manners, communication skills, and competence of service providers, the availability and accessibility of services, and the outcomes attributed to interventions [9, 11, 21, 22]. These domains of concern, extending somewhat beyond existing guidelines for client-centered practice of occupational therapy [1, 21], should be included in future research and outcome evaluations of client satisfaction and dissatisfaction with occupational therapy.

Contrasting the empirical results of this study with the theoretical principles of client-centered practice provides evidence that applying specific principles of client-centered practice [23] makes a difference to client satisfaction. Among what these clients valued most were therapists’ practice characteristics demonstrating interest and respect for client views, open clear communication, and interventions that met individual needs for information, advice, and assistance with performance of every day occupations.

Competency of the occupational therapists in professional practice, as seen by these clients, was of central importance in evaluating their experiences, as was the effectiveness of therapists’ interventions with them. These findings demonstrate the importance of continuing competency as a requirement for active clinical practice of occupational therapy, and of public expectations that professionals are accountable for their practice.

A limitation of this study is that the findings may be context-specific, and not reproducible with occupational therapy clients in different geographical locations and with different occupational therapy experiences. Further comparative research is needed with client groups drawn from diverse settings to determine the reproducibility of these results. It is possible that alternative study designs and analytical techniques may yield conflicting or consistent results with those reported here.

Studies using multiple research methods, particularly those drawn from qualitative research traditions, would yield more insights as to the reasons why clients are more or less satisfied with occupational therapy services they experience. Guided interactive interviews combined with open-ended questions, invitations to clients to “tell their stories”, and use of hypothetical scenarios can yield useful information about the meaning and determinants of client satisfaction [24]. To present client perspectives in the evaluation of rehabilitation programs, it is essential to use methods that can express their experience as it occurs in the natural setting, complete with the variability and lack of control over client characteristics [25].

Involvement of clients in all phases of the research process, from planning the goals of the study to
validation of the interpretations and conclusions reached, would strengthen future studies based on principles of client-centered practice. Client satisfaction studies must include domains of interest to clients, as well as to healthcare planners and providers, in order to improve services and appropriate service utilization. Additional benefits of a focus on client satisfaction are accounting for the effectiveness of services provided, successfully marketing services, and for increasing responsiveness of services to client needs and expectations [8, 26].

Further research on factors contributing to dissatisfaction with occupational therapy services, and on barriers to client-centered practice, would facilitate needed changes in practice patterns and service characteristics that mitigate against achievement of positive outcomes and improved satisfaction. Conceptual frameworks that include the broader determinants of health, and that go beyond biomedical frameworks of practice, may be useful in understanding and reducing these barriers.

This study has shown that the quality of client—therapist interactions, communication, client education, and competency of therapists make a difference to client satisfaction with occupational therapy services. To this extent, these findings lend support to the principles of client-centered practice for enabling occupation, and reinforce the importance of continuing competency. This study also indicates that service characteristics, specifically the availability and accessibility of occupational therapy services, influence satisfaction and dissatisfaction. Future evaluations of the process and outcomes of occupational therapy services should include these service characteristics in view of their apparent importance to clients.

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