Introduction

Occupational therapists are experts in determining the level of assistance required to perform activities of daily life\(^1\). Occupational therapy services can be purchased to provide expert opinions to courts, tribunals, and other dispute resolution services regarding the amount of assistance a person requires to perform their pre-injury tasks. Arnold, Mackenzie, James and Millington (2017) identified that the differing opinions provided to the court by occupational therapists is an issue not only for the court but also the profession of occupational therapy. Occupational therapy reports are perceived as being inconsistent in methodology determining the amount and duration of care hours required particularly for those who sustain a compensable musculoskeletal injury.

Estimating care hours is a complex multi-dimensional process\(^2\). Occupational therapists have different clinical reasoning as a result of their previous experiences working with people who have a similar disorder\(^3\). Difference in opinion can also relate to the influence of report purchaser. In the medicolegal setting, therapists provide reports exclusively to plaintiffs (the person making the claim for damages) or the defendant (the party or company responding to the claim for damages) or to both parties\(^4\). Occupational therapists are encouraged to clearly articulate their reasons allowing the reader to understand how the conclusions were made\(^5,6\). However, for many the explanation of reasoning behind recommendations is difficult as there is no single method that records all of the factors that influence the recommendations made\(^6\).

The assessment process used by occupational therapists focuses on analysis of occupational performance, identifying specific skills or deficiencies impacting on the person’s ability to perform tasks\(^7\). This information is used to establish an individual treatment plan developed in consultation with the client\(^8\). The approach differs in the medicolegal area of practice where therapists are asked to identify limitations in the performance of domestic tasks and then identify the number of hours required to perform these tasks. The court uses this information to determine the amount of financial compensation payable to the claimant\(^9\). Occupational therapists use their intuitive process to retrieve information and knowledge gained through experience of similar situations and clients\(^6\) to assess clients and to develop recommendations of care. While there is literature examining the role of occupational therapists in the medicolegal area, only one article addresses how the information was gathered and translated into hours of domestic care\(^10\). This small qualitative focus group study of NSW therapists identified that the selection of tasks included as housework differed depending on whether the therapist provided reports for a plaintiff (a claimant who brings a case against another in a court of law) or defendant (one who responds to/defends a court action initiated by a plaintiff). Factors that influenced therapist’s decision-making included restrictions associated with the legal system; the medical management of the claimant; cultural and societal factors; residential location; access to services and chronic pain. Strategies to translate assessment data into hours of care were identified as including: use of the claimants stated times if perceived as reasonable, and time taken by the therapist to perform a similar task in their own home within the context of the judicial system.
The purpose of this national study is to identify how occupational therapists estimate domestic assistance requirements of claimants who have lodged a claim in an Australian court of dispute regardless of the legislation.

Method

The research questions were identified as 1a. How do occupational therapists conduct medico-legal assessments? 1b. Does the conduct of the medico-legal assessment differ based on location? 1c. Does the conduct of the medico-legal assessment differ based on whom the report is provided to? 2. How do occupational therapists translate their assessment data into hours of care? and 3. What factors do therapists identify as influencing their recommendations for domestic assistance?

Using a purposive sampling method, an online survey format was chosen to facilitate the collection of information. Surveys allow description of the characteristics of a large population, in this instance, occupational therapists. An online survey is a faster and more cost effective method of collecting data from respondents than pen and paper surveys. Surveys can be structured to minimise any loss of data by respondents missing a question. The use of a web-based survey allows respondents to remain anonymous with no data being collected that would allow their identification.

The online survey was informed by findings from previous qualitative research involving occupational therapy focus groups, stake holder feedback and existing occupational therapy texts regarding assessment details, tasks observed and possible strategies for translation of findings.

Survey development

The survey comprised 22 questions. Forced response was used to minimise missing data with each question having to be completed to progress onto the next question. In Australia, each state and territory have their own jurisdiction that has the potential of impacting on the decision making of therapists. Thus, an understanding of the applicable legislation and the purpose of the report. A knowledge of the respondents age group and clinical experience as well as experience in providing medicolegal reports was considered important given research that states a minimum number of years of clinical experience are required versus those who state years of experience does not make a therapist an expert. The age groups were Group 1 aged 25 to 30 years; Group 2 aged 31 – 40 years; Group 3 aged between 41-50 years; Group 4 aged between 51-60 years and Group 5 aged between 61-70 years.

The next five questions asked respondents to rank descriptors regarding assessment methods they used and whether reports from various medical and therapy professions were provided as part of the legal evidence. The rating scales varied depending on the question, but were generally associated with the frequency of performance ranging from “always”, “if needed”, “rarely” and “never”. No definition of the ratings was provided, rather each therapist was required to self-determine the frequency the task was performed. This information was followed by four open-ended questions regarding assessment tools they used and the impact of culture on their decision making. The final four questions focused on clinical reasoning used by therapists plus two open-ended questions on how the therapist translated their assessment data into the number of hours of care.
The survey was trialled with seven respondents who had been involved in the occupational therapy focus group study and were known to the primary author to ensure the intended information was collected. The trial respondents indicated that the questionnaire took less than 10 minutes to complete. This trialling process resulted in refining of the open-ended questions and the layout of the questionnaire prior to submission for ethics approval through University of Sydney, Australia (2015/058).

**Participants recruitment**

In Australia, it is compulsory for occupational therapists to be registered with the Australian Health Practitioners Regulatory Agency (AHPRA) in order to practice. However, AHPRA does not collect data indicating areas of service provision. Occupational Therapy Australia, the elective association of registered therapists, provides data on the various areas of specialist work undertaken by the individual therapist. Their database identified 180 occupational therapists who indicated providing medicolegal reports. The ethics committee approved email invitation to participate in the on-line study was disseminated to members of the Medicolegal Interest Group and Association members who provide medicolegal reports. This included those who had been involved in the trial questionnaire. The email contained information about the study aims, the researchers and their contact details plus an explanation that no identifying data would be collected to ensure confidentiality. The web address for the survey was included allowing access via a hyperlink to the website. Dissemination of the email occurred four times to this group (being two weeks apart) until no additional participants responded. Members were also invited to share the email with other therapists within their network.

To access medicolegal therapists who did not belong to Occupational Therapy Australia, a search of public data bases was undertaken. The email inviting participation in the survey was forwarded to an additional 34 interstate therapists. Four repeat emails were sent out until no additional participants responded. A final email was sent out to all above sources in October 2018 and the survey closed at the end of December 2018. Emails were sent to 242 members and, as respondents were asked to pass the email to other therapists, the total number of potential respondents could not be determined.

**Data Collection**

The survey data was collected and managed using the REDCap (Research Electronic Data Capture) tool hosted at the University of Sydney. REDCap is a secure, web-based application designed to support data capture for research studies.

**Data Analysis**

Data was analysed using IBM SPSS Statistical software package and Excel™ for statistical analysis. Analysis included percentages, frequencies, and Pearson correlation analysis to identify relevant relationships between the three therapist groups, age group and years of experience. Kruskal-Wallis test was used to identify any statistically significant associations between the unmatched ordinal variables of legislation, assessment content, tasks observed, documents provided to the therapist and factors influencing estimation.

Text analysis of the open-ended question was completed using Qualitative Solutions and Research Program NVivo to facilitate analysis. Inductive thematic analysis was undertaken by reading all the comments for the overall meaning, and then coding paragraphs or sentences according to their content. A consensus coding process was used with the primary author coding all data and the remaining three authors coding sections of the data.
Following collaborative discussion, a final coding tree was developed and used to recode the data. All authors were involved in grouping the codes into themes. To ensure consistency, suitable quotes that exemplified the category for each theme were identified.

**Results**

*Participant demographics.*

In total 58 participants completed the online survey with most of the respondents’ practicing in New South Wales (NSW) (64%, n=37). All states and territories of Australia were represented in the survey (Figure 1). The Occupational Therapy Association data was compared to the survey results.

![Survey respondents in relation to association medicolegal members by state/territory](image)

Most of the respondents were between the ages of 40 to 60 (Table 1) with only one respondent being under 30 years of age. Respondents mean years of clinical experience was 22.34 years (SD 9.2, range 4 to 48 years) with a mean of 10.63 years of experience providing medicolegal reports (SD 7.4, range 1 to 30 years). The average number of assessments conducted during 2017/2018 was 23.17 (SD 28.6, range 0 to 150 assessments). The response of the two outliers on this item were reviewed. The person with a zero-count indicated she had been on maternity leave during the preceding year, while the person who reported performing 150 assessments was in full-time medicolegal practice and conducted three assessments per week for both defendant and plaintiff solicitors (Table 1).

**Descriptive Statistics**

<table>
<thead>
<tr>
<th></th>
<th>N</th>
<th>Minimum years</th>
<th>Maximum years</th>
<th>Mean years</th>
<th>Std. Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical experience</td>
<td>58</td>
<td>4</td>
<td>45</td>
<td>22.34</td>
<td>9.201</td>
</tr>
<tr>
<td>Years doing medicolegal assessments</td>
<td>58</td>
<td>1.0</td>
<td>30.0</td>
<td>10.629</td>
<td>7.4130</td>
</tr>
<tr>
<td>Number of assessments in the previous 12 months</td>
<td>1344</td>
<td>0</td>
<td>150</td>
<td>23.17</td>
<td>28.661</td>
</tr>
</tbody>
</table>
A positive correlation was found between the years of clinical experience and the years providing medicolegal assessments ($r^2=.730$, $n=58$, $p=.000$). There was a low correlation between the years of experience performing medicolegal assessments and the number of assessments conducted ($r^2=.264$, $n=58$, $p=.05$) but none between the years of clinical experience and the number of medicolegal assessments performed.

Previous research using focus groups with occupational therapists and motor vehicle insurers revealed therapists were perceived as providing different options on domestic care needs based on who was funding the report. To assist in determining if this is a correct assumption, an analysis using categories of plaintiff work only, defendant work only or to both was determined alongside the legislation within which therapists worked (Table 2). The majority of plaintiff only therapists were aged between 30 to 40 years, while for the defendant group it was 40 to 50 years and those who provided both defendant and plaintiff reports were aged 50 to 60 years.

<table>
<thead>
<tr>
<th>Age Grouping</th>
<th>Group 1 25 – 30</th>
<th>Group 2 31 – 40</th>
<th>Group 3 41 – 50</th>
<th>Group 4 51 – 60</th>
<th>Group 5 61 – 70</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage</td>
<td>1.7%</td>
<td>27.6%</td>
<td>32.8%</td>
<td>31%</td>
<td>6.9%</td>
</tr>
<tr>
<td>Number</td>
<td>1</td>
<td>16</td>
<td>19</td>
<td>18</td>
<td>4</td>
</tr>
</tbody>
</table>

Table 1: Participant characteristics.

A positive correlation ($r^2=.760$, $n=30$, $p=.000$) was noted between clinical years of experience and medicolegal experience for the group that provided reports to both plaintiff and defendant sources. For plaintiff only therapists, a correlation between the number of medicolegal assessments and their years of performing medicolegal assessments was identified ($r^2=.64$, $n=12$, $p=.000$). Therapists who provide reports to both plaintiff and defendants had more years of clinical experience and had provided medicolegal assessments for more years than the other groups. On average defendant only therapists conducted more medicolegal assessments during the preceding year.

All respondents indicated they provided reports under at least two judicial systems. The majority of respondents provided reports under the motor vehicle accident legislations
(87.9%, n=51), followed by medical negligence claims (63.8%, n=37), claims against public liability policies of companies (60.3%, n=35), workers compensation legislation (48.3%, n=28) and finally superannuation/total permanent disability (19%, n=11) (Table 2). A further nine indicated that they also provided reports for other courts such as the Dust and Diseases court, within asbestos legislation and the National Disability Insurance Scheme.

Therapists who provided both defendant and plaintiff reports or plaintiff only reports mainly did so within the motor vehicle schemes known as Compulsory Third Party legislation (CTP), followed by medical negligence claims. Those who only did defendant work provided reports within the motor vehicle legislation followed by public liability. There was no significant relationship between the various legislations and whether therapists did plaintiff or defendant only or both.

Areas interviewed/assessed.

All respondents identified they always reviewed ‘how many people live in the house at the time of the assessment’ (Figure 2). In descending order, the next most frequently examined area was ‘instrumental activities of daily living (IADL) at the time of assessment’ (98.3% = always). ‘Who aided the injured person’ (94.7% = always) and ‘how long had they been providing this assistance for’ (94.7% = always). The area least likely to be assessed was ‘employment status’.
Therapists indicated that they used observation of the claimant performing functional tasks rather than using a goniometer to measure range of movement or a dynamometer to measure grip strength. Lifting and carrying capacity was based on observation of the person lifting items such as a bottle of milk or a basket of washing and this was supported through photographs (29.3%, n=17).

Formal or standardised assessment tools were used when addressing a specific requirement such as cognitive function, hand function or quality of life instruments.

**Functional tasks examined.**

No single activity was indicated by all therapist as routinely observed. The majority (94.8%, n=55) indicated the selection of activities was based on tasks the claimant reported as problematic. Respondents were asked to rank six common everyday domestic activities, previously identified in the focus group study, with 43.1% (n=25) ranking retrieval of items from an overhead cupboard as the most common task they observed.\(^{10}\)
Respondents indicated they would ask the claimant to perform tasks that did not aggravate their symptoms using this information to determine what tasks could be performed pain free.

“Pick the task that they can do and one that they can’t do and compare the difference”. Participant 12 (22 years clinical experience, 16 years medicolegal experience, both plaintiff and defendant reports)

Task analysis identified the steps required to complete the task and included not only the physical requirements of the task but also the decision and cognitive processes, environmental enablers and restrictors impacting on performance. An understanding of the relevance of the task to the person’s life was also seen as important by therapists. Examples of tasks reviewed by respondents included retrieving items from a washing machine, hanging clothes on a line, and making the bed. This information was then further clarified by asking the claimant to perform other tasks that had similar requirements to those identified as being able or unable to perform.

“Depending on their performance during range of movement testing, I will get them to attempt functional activities to see if the range actually limits function” Participant 29 (15 years clinical experience, 2 years medicolegal experience, providing defendant reports only).

A tour of the house was perceived by all respondents as an opportunity to gather evidence of consistency with information provided during the interview plus an understanding of environmental constraints experienced by the claimant. Judgements were made regarding cleanliness of the house, the number of people who lived in the house and any adaptive equipment used.

“[the house tour] helps to understand what the person is required to do. I look for consistency of information with observation, as people relax and do tasks habitually which may allow better understanding of their function.” Participant 1 (45 years clinical experience, 30 years medicolegal experience, both plaintiff and defendant reports).
**Resource documentation.**

Therapists report they were not consistently provided with medical documents that assisted in understanding the claimant’s progress/recovery over time. The most frequently provided documents were the general practitioner treatment notes (31%, n=18 always and 56.1%, n=32 sometimes) revealing a moderate associate (h²=8.887, df 1, p=.003) regardless of whether the request was for a report provided on behalf of the defendant or plaintiff. Therapists indicated reports from orthopaedic surgeons, physiotherapist, occupational therapists, psychologists, and rehabilitation specialist were only occasionally provided.

**Influences on care determination.**

Respondents were asked to identify factors that influenced their decision on care hours (Figure 4). Therapists own clinical experience had the most influence on decision making (91.4%. n=53) followed by the claimant’s statement of time taken to perform tasks (50%, n=29). Over 50% of the respondents indicated that they did not take into consideration whether the report was being provided for the defendant or plaintiff lawyers.

<table>
<thead>
<tr>
<th>Factors influencing domestic assistance estimation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Claimants cultural or religious background</td>
</tr>
<tr>
<td>Own clinical experience</td>
</tr>
<tr>
<td>Claimants statement</td>
</tr>
<tr>
<td>Defendant report</td>
</tr>
<tr>
<td>Plaintiff report</td>
</tr>
<tr>
<td>Solicitor requirements</td>
</tr>
<tr>
<td>Legislation restrictions</td>
</tr>
</tbody>
</table>

![Figure 4 Impacts on therapists clinical reasoning.](image)

**Translation of information into care hours**

Therapists were asked to comment on how they translated the information gained from the assessment into the number of care hours required. Thematic analysis revealed three major themes emerging from the data. These were (1) confirming the claimant’s statement of their pre-injury performance, (2) the influence of the claimant’s environment and (3) triangulation of information.

**Theme 1: Confirming the claimant’s statement of pre-injury performance**

Therapists talk about obtaining information from the claimant on their performance of housework tasks pre-and post-accident. This narrative included an understanding of not only the initial accident but also the impact that it has had on their life over time. The claimant’s statements of domestic tasks performed prior to and following the incident was an important consideration for therapists.
“I look at what tasks they are having problems with, why it is a problem, then give consideration to the person’s frequency of task performance and how long it took” Participant 14, (43 years of clinical experience, 18 years medicolegal providing both plaintiff and defendant reports).

This narrative was then followed up by observation of the person performing problematic tasks to clarify if the claimant’s statement was an accurate recall of time needed for a task as well as an accurate understanding of restrictions. Some therapists used this information to discuss with the claimant what is a reasonable amount of time spent on tasks while other therapists used the observation of performance to determine consistency of effort. “I find if their estimate of time is exaggerated, it also goes hand in hand with inconsistent ROM [range of movement] and functional tasks”. Participant 27 (25 years of clinical experience, 2 years medicolegal providing defendant only report).

**Theme 2: The influence of the claimant’s environment**

The physical size of the house and property were important influences on the allocation of domestic assistance time. This included being aware of how clean the house was, the impact of geographical location, access to support services as well as who was available to assist at home and in the community.

“I consider the size of the dwelling and the frequency with which these tasks are commonly performed in the community. This is based on my own anecdotal experience as well as Bureau of Statistics information”. Participant 23 (30 years clinical experience, 20 years medicolegal providing both defendant and plaintiff reports).

Cultural influences were perceived by respondents as influential on time estimates. For example, a Lebanese person cooking in an outside kitchen increased the time frame not only for meal preparation but also clean up. This not only applies to those from other countries but also to indigenous Australians.

“When I assessed an Aboriginal man…it was important to note cultural issues such as living with various family members and the different accessibility in remote areas, where there was no running water nor electricity in the open style house”. Participant 13 (14 years clinical experience, 4 years medicolegal experience providing both defendant and plaintiff reports).

In contrast, some of the respondents held the view that regardless of the cultural expectations it is the person’s capacity to perform the task that should be considered, not how they do it and why.

“Whilst culture may affect whether someone performs a task, we are operating in an Australian legal system and thus the capacity to perform a task is more important than if it was culturally relevant to the person”. Participant 4 (35 years clinical experience, 15 years medicolegal providing defendant reports only).

An understanding of the claimant’s family situation, including others who resided in the house and the care responsibilities required was also identified as impacting on therapist decision making about domestic care.

“Reasonable levels of assistance post-injury is considered depending on the ages of those living in the household. For example, a 30-year-old primary carer of two
children under 5 years of age has different care requirements to a single 50-year-old with no dependants”. Participant 13 (14 years clinical experience, 4 years medicolegal experience providing both defendant and plaintiff reports).

**Theme 3: Triangulation of information in care hours estimations.**

A moderate correlation was noted between the use of the claimant’s statement of time taken to perform domestic tasks influencing therapist’s decision-making regarding care ($h^2=5.58$, $p=.018$). This occurred regardless of what legislation the report was provided under. For the majority, the medical diagnosis was then combined with the claimant’s estimation of time if the tasks identified by the claimant as problematic were consistent with the therapists understanding of restrictions associated with the diagnosis (69.6%, n=39). Another strategy cited was to obtain a quote from a local cleaning services who were provided with information about the size of the house and the specific tasks to be performed (41.3%, n=23).

“I ascribed commercial hours based on advice received from such agencies as to how much time would be needed to complete the domestic chores on a weekly basis. This is almost always significantly less than the hours being provided on a gratuitous basis. Participant 52 (25 years clinical experience, 11 years medicolegal, both defendant and plaintiff reports).

Just over half of the respondents indicated they used their own performance time when estimating the claimant’s hours of care (51.8%, n=29). One group of 5 therapists reported they kept personal diaries for a specified time period and then combined the data to determine an average time to perform the task. Other respondents indicated they asked the client to complete a chart recording their pre and post injury division of housework. This information was then analysed/evaluated by the therapist using their clinical experience with the client who had similar injuries.

“I use a combination of the hours and frequency the client use to complete, the home environment, their functional capacity, whether they can perform in a modified way [such as using pacing strategies or equipment] and my years of experience in understanding how long it takes other people with/without an injury to complete a task”. Participant 22 (9 years clinical experience, 1 year medicolegal, defendant only reports).

When data were evaluated according to the sub-groups of defendant, plaintiff or both, 70% (n=21) of therapists who performed reports for both used the claimant’s statement of previous performance to estimate care hours. For the defendant only group 62.75% (n =11) used diagnosis closely followed by their own times to complete tasks. The plaintiff only group used diagnosis (75% n=9) followed closely by the claimant’s statements (66.6%, n=8).

“Firstly, I think about their functional results, what can they do vs what can’t they do? If they have difficulties bending, then that will translate into difficulty vacuuming. If they can’t reach overhead, then they can’t hang out washing. Next is have they exhausted all treatment options, or adaptive aides for example, using a lowered washing line. I think about core things the person needs: cooking, cleaning, washing etc and about what time per day that would take an individual based on lived experience, the size of their house, family needs etc. There are also some commonly accepted times for certain things for example 2 hours of cleaning per week will include bathrooms, floors etc but won’t include windows”. Participant 47 (14 years clinical experience, 3 years medicolegal, defendant only reports)
Discussion

The aim of the study was to understand how occupational therapists conduct medico-legal assessments and translate their assessment data into hours of care. The factors that were identified by therapists as influencing their recommendations for domestic assistance were also investigated.

This study revealed that those who undertake medicolegal assessments had extensive clinical experience of over 10 years confirming the commonly held view in Australia that therapists should have more than five years of clinical experience prior to providing expert opinions to the court\(^\text{15}\). The more clinical experience the therapist has, the more likely an insurer or solicitor will use their services as they meet the criteria for an expert witness under the current court legislation\(^\text{22,23}\). In this study, defendant only therapists undertook more assessments per person. This reflects the funder being insurers and their solicitors who have greater access to funds than the plaintiff sources. It could also reflect the fact that insurers often have a panel of providers they use for specific services\(^\text{4,24,25}\). However, the years of clinical experience alone does not always equate with expertise\(^\text{26}\). In the legal setting an expert has specialised knowledge that is based on the person’s training, study or experience\(^\text{9}\). They are expected to provide an unbiased opinion that does not advocate for either the claimant or defendant regardless of who funds the report. The court expects that the reports will contain objective unbiased information to assists in decision making regarding monetary payment of compensation associated with the inability to perform domestic tasks\(^\text{22}\). The Court Expert Witness code of conduct also require experts to document all the assumptions, facts, and investigations relied on to make the decision\(^\text{27}\). Therapists indicated difficulties in consistently recording the factors that influenced their decision. Research by Allen (2004) on functional capacity assessments and reports for court revealed guidelines are required to assist clear realistic interpretation of the assessment results\(^\text{28}\). This research on provision of domestic care opinions to court also supports their recommendation for the development of therapy guidelines on court reporting.

Occupational therapists evaluate the person’s occupational performance in everyday activities and tasks. The assessment method used by therapists in this study comprised an interview format where data was gathered regarding the claimant’s pre-injury function and involvement in housework and their perception of strengths and limitations in housework task performance. Interview data was then combined with observation of the claimant performing a range of tasks and activities, and an analysis of the environment factors influencing outcomes of performance. The method of assessment did not appear to differ regardless of who purchased the report. The assessment process reported by the respondents was consistent with occupational therapy philosophy regarding measurement of daily living skills\(^\text{16}\).

Clinical reasoning within occupational therapy is defined as “the use of multiple reasoning strategies throughout the various phases of client management” (pg. 274)\(^\text{29}\). It explains the way occupational therapists make ‘wise’ decisions\(^\text{30}\). Within the medicolegal context, occupational therapists collect data to be synthesised together to develop a well-reasoned opinion. This study identified that data about issues impacting on the performance of tasks in addition to the claimant’s perception of function were considered, however, lack of access to medical/specialists reports was identified as a limitation. The lack of medical information regarding the claimant’s recovery over time restricts the therapist’s access to objective information on the claimant’s recovery. Without this objective information, therapists scientific clinical reasoning is limited resulting in therapists being dependent on the
claimant’s report of function or extrapolating from their own clinical experiences of recovery with previous clients. The survey respondents indicated they used a range of strategies to identify how long it takes to clean the residence. Therapists indicated they combined the claimant’s reported function, diagnosis and its impact on movement and housework taking into consideration what is reasonable and necessary under the legislation. However, the most common strategy to calculate actual care hours was based on the therapist’s own performance time in their own home. This does not reflect a true understanding of the claimant’s situation. Research by Usdansky & Parker (2011) confirms that people with degree level education, such as occupational therapists, perform less housework than those with a high school education. This finding invalidates the use of therapist’s own time frames when estimating care requirements for claimants with a lower formal education level. Other strategies such as the use of information from commercial services limits the application to the individual as commercial services charge for their service often with a minimal period or cost for the task regardless of time taken. The presence of children in a household results in increased demands for domestic assistance for all residents in the household and in particular for the person who is the primary carer for the child. This reinforces the need to consider the individual within their own environment rather than apply an assumed number of hours for tasks.

The challenge for therapists is to process the multiple factors that impact on the injured person’s ability to perform their pre-injury housework roles and tasks. In this study, therapists were unable to articulate an algorithm that would translate the assessment data into care hours and duration of care. Rather they described making decisions within the context of legislation, integrating information from their own clinical experience with people who have similar physical restrictions; their knowledge about the person gained from the assessment; and from any provided medical reports; through the dual filters of occupational therapy and the therapists own clinical and personal experiences.

Strategies, such as those used to teach undergraduates therapists the skills exhibited by experienced therapists, could be an option allowing experienced therapists to actively think about their recommendations. These strategies include self-talk, practice with paper-based cases discussing the results with other experienced therapists, and the use of mind-maps to identify all influencing factors. The inclusion of the clinical reasoning areas of diagnostic, procedural, narrative, ethical, conditional, pragmatic, and interactive reasoning provides therapists with a method of documenting their clinical reasoning regarding domestic assistance requirements.

**Strengths and limitations**

The survey method allowed the exploration of concepts of how occupational therapists conduct medicolegal assessments translating findings into hours of domestic assistance. This study provides information on important factors to investigate when undertaking a medico-legal assessment in Australia and could be generalised to other countries that have similar legal systems. However, this survey may not have reached all those who are actively involved in the provision of medicolegal reports on domestic assistance requirements. Utilising data available through the occupational therapy association may have resulted in missing registered occupational therapists working in this area who are not members of the association. Attempts were made to expand the distribution of the survey using snowball sampling, however, as the Australian Health Practitioners Regulatory Agency
does not provide data regarding areas of specialist practice, there is no evidence that those who do not belong to the association but are registered and provide medicolegal reports, responded.

Another limitation of the survey format is the restrictions associated with obtaining opinions. Questions were developed based on the results of occupational therapy focus group findings on this topic¹⁰ and were trialled prior to distribution. This resulted in the inclusion of open-ended questions allowing detailed written responses, however, not all respondents provided written opinions.

The quality of the reports written by the therapists was not explored as this was beyond the remit of the study. However, evaluating reports would enable researchers to explore how therapists explain their clinical reasoning, and the consistency of recommendations. This should include an analysis of court decisions were comments were made regarding the occupational therapy recommendations. This information may also allow development of guidelines to assist in the writing of reports for the courts.

Conclusion:
Therapists use a range of strategies including discussion with other therapists, their own clinical experiences with clients having similar restrictions and injury as well as feedback from the claimant when estimating domestic assistance required. The translation of the assessment data into hours of assistance continues to be difficult to explain clearly due to individual therapist approaches. However, most of the surveyed therapists indicated that they were aware of this limitation and attempted to explain their clinical reasoning. Therapists providing reports to court require relevant expertise in the areas being investigated as well as skills in reporting and writing recommendations. Further investigation of the quality of reasoning contained in the reports is recommended for future study.

References


