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OCCUPATIONAL THERAPISTS AS CASE MANAGERS WITHIN THE MEDICO-LEGAL FIELD: PERCEPTIONS OF OCCUPATIONAL THERAPISTS WORKING AS CASE MANAGERS

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DECLARATION

I, Emma Perridge, declare that this research report is my own work. It is being submitted for the degree of Master of Science in Occupational Therapy at the University of Witwatersrand, Johannesburg. It has not been submitted before for any degree or examination at this, or any other, university.

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Signature of candidate

On the **31st** day of **March** 2020.

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ABSTRACT

The global private healthcare industry has shifted towards case management in order to ensure a smoother healthcare process is maintained from beginning to end. Case management is a role of occupational therapists that is performed in various contexts in South Africa e.g. the insurance sector, health consulting to manage long term incapacity and disability in the workplace, the Road Accident Fund to aid motor vehicle accident victims and within the vocational rehabilitation service (Govender, et al., 2018).

However, literature does not mention occupational therapists' involvement within the medico-legal field (unless employed or providing services directly to the Road Accident Fund) e.g. case managers performing consulting work for trusts or curators. The medico-legal context is a broad description used by occupational therapists to describe a field of practise where occupational therapists work with the legal fraternity to help them quantify or qualify a legal case. Occupational therapists are referred injured patients from the state or private attorneys and asked to evaluate their functional abilities and to write recommendations in medio-legal reports and testify as expert witness (van Biljon, 2013).

van Biljon (2013) notes that occupational therapists do not know if their recommendations in the medico-legal reports are ever implements and therefore highlights the need for case managers. These case managers may perform tasks specific to the context and not defined in traditional case management literature. This could include providing advice to the trust (e.g. on housing, vehicle purchasing and required care) or writing motivational reports to the Master of the High Court. This is a service being offered and, therefore, there is a need to explore the medico-legal context and the gap that exists in literature of describing the role of occupational therapists as case managers within the medico-legal context.

The intention of this study was to explore the perceptions of selected South African occupational therapists about their work and responsibilities as case manager in a medico-legal context. Three objectives guided the study, exploring the perceptions of

their roles and responsibilities, their skills and knowledge, and of their preparedness to perform their case management role.

A qualitative research approach and a cross sectional descriptive design were used to complete this study. Data were gathered through seven semi-structured interviews with open-ended questions, which yielded the qualitative data.

Results offered three themes (each answering one of the three objectives), namely a holistic role approach, integrated body of knowledge and skills as well as broad experience Occupational therapy participants perceive themselves as making use of a holistic approach to fulfil their roles and responsibilities as clinical case managers working in the medico-legal context. They perceive themselves to have an integrated body of knowledge and skills, which support their ability to perform their role. Some thought they were prepared for their role, while others perceived themselves to be unprepared.

The results of this study provide guidance as to the role and responsibilities of a case manager and will assist occupational therapists currently working as case managers to increase their understanding and knowledge of their role. It will therefore enhanced practice by making more appropriate recommendations for clients during and after medico-legal trials. The results will provide a reference to occupational therapists working in this field to better coordinate the care of clients, which would ultimately benefit the latter. It may also encourage more occupational therapists to undertake such roles, as they have a better understanding of what the role entails, what would be expected of them and to prepare accordingly.

Table of Contents

List of Tables

Nomenclature and Operational definitions

Activist or advocate role

The occupational therapist as *activist* or *advocate* is a campaigner who lobbies for the cause of government people with disabilities, marginalised groups and for the inclusive participation of individuals and groups in meaningful and dignified occupations (AOTA, 1993; Nestadt & Blesedell, 1998).

Case management

"A collaborative process that assesses, plans, implements, coordinates, monitors, and evaluates the options and services required to meet the client's health and human service needs. It is characterized by advocacy, communication, and resource management and promotes quality and cost-effective interventions and outcomes." (pg. 3) (CCMC, 2013).

Case management role

A role is the function or position that somebody has (Concise Oxford English Dictionary, 2012). The function of a case managers in the medico-legal context may differ from other case management roles, resulting in this specific role evolving into a job type or job designation. Case management in the medico-legal context is not recorded in fundamental occupational therapy literature as a traditional job of occupational therapists. For the purpose of this study, the case manager role was defined as a work title or work designation. Occupational therapists can be employed as case managers but so can other health professionals.

Clinical reasoning

Clinical reasoning skills are skills that clinicians such as occupational therapists have been taught, which forms the basis of their thinking approach (Flemming, 1991).

Clinician role

The occupational therapy *clinician* is a person that participates directly or indirectly in a patient's health care by applying the occupational therapy process in relation to the occupational function of an individual or group of people (AOTA, 1993; Nestadt & Blesedell, 1998).

Collaborator role

The *collaborator* is a person who interacts and works with other health care practitioners, members of the multi-disciplinary team and community members across various departments or sectors (AOTA, 1993; Nestadt & Blesedell, 1998).

Conditional reasoning

Conditional reasoning is combining all forms of reasoning to be flexible in responding to changing circumstances or situations (Boyt Schell, 2014).

Consultant role

A consultant is someone who advises groups of people, organisations, government, etc. on grounds of expertise (AOTA, 1993; Nestadt & Blesedell, 1998).

Coordination

Coordination for the purposes of this study was defined as the act of making parts of something, groups of people, etc. work together in an efficient and organised way (Concise Oxford English Dictionary, 2012).

Educator role

The occupational therapist *educator* facilitates learning by leading, guiding or instructing within practice contexts (AOTA, 1993; Nestadt & Blesedell, 1998).

Ethical reasoning

Ethical reasoning is used to analyse an ethical dilemma, provide suitable solutions and determine the appropriate action. It is described as a systematic approach to moral conflict (Boyt Schell, 2014).

Manager role

The occupational therapist *manager* is a person who plans, implements and evaluates the occupational therapy service (including staff and other resources), while leading and motivating the staff (AOTA, 1993; Nestadt & Blesedell, 1998).

Mentor role

A *mentor* is a person who is knowledgeable, who gives others advice or guidance (AOTA, 1993; Nestadt & Blesedell, 1998).

Narrative reasoning

Narrative reasoning is a technique used to comprehend a client's specific situation and/or circumstances. The process or narrative reasoning is used to predict the effect of the disability, illness or occupational performance problem on their everyday life (Boyt Schell, 2014).

Pragmatic reasoning

Pragmatic reasoning is used to fit different therapy options into the present realities of service delivery e.g. scheduling, payments, equipment availability, therapists' skills and the personal circumstances of the therapists (Boyt Schell, 2014).

Researcher or Scholar role

The *researcher* or *scholar* who researches current evidence for occupational therapy and develops ways to refine and enhance the service, by producing effective practice. A scholar engages in academic, intellectual and research practices with the aim of developing the profession (AOTA, 1993; Nestadt & Blesedell, 1998).

Scientific reasoning

Scientific reasoning is a logic process similar to scientific analysis and provides understanding related to the client's condition as well as the ability to decide on interventions that would benefit the client (Boyt Schell, 2014).

CHAPTER 1

1 INTRODUCTION

This chapter aims to describe the background of case management within the medico-legal context in South Africa so as to highlight the need for the study. The purpose, aim, objectives and justification of the study are presented, after which the chapter concludes with the chapter organisation of the research report.

1.1. Background

In recent years, the global private healthcare industry has shifted towards case management to ensure that a smoother healthcare process is maintained from beginning to end (Denysys, 2017). Case management is a practice within health care delivery which aims to improve the client's health and promote wellness through communication, education, facilitation of services, advocacy and lastly, service and resource identification (CCMC, 2019).

Any person can perform the role of a case manager however, clinical case managers are usually medical professionals whose role is dependent on the treatment needs of the client and consists of developing intervention plans, monitoring and evaluating progress by coordinating an interdisciplinary team approach. Case management is not a profession in itself, but rather an additional oversight or co-ordinating role for health care professionals (Lohman, 1998). Various clinical practitioners gain experience in the coordination of care as clinical case managers, in order to ensure quality care which meets the client's health needs and which is cost effective (CMASA, 2013).

Globally, clinical case managers work in various settings in the health care context, including the insurance industry, private practices and clinical settings such as hospitals, long term care centres, community settings and home-based care services (CMSA, 2010). Although the nature of care within for each of these settings may be different, the main focus of case managers is to coordinate quality care for clients (Lohman, 1998).

This includes sustaining the client's quality of life by considering the client's condition, personal goals, context and environmental situations through a holistic approach (Robinson, et al., 2016). These functions underpin the philosophy of occupational therapy (Hooper & Wood, 2013), which has at its core humanism, holism and client centredness (Mayers, 1990; Hagedorn, 1995; Hemphill-Pearson & Hunter, 1997). Occupational Therapy philosophy guides occupational therapists to perform the role as clinical case managers because of the holistic, client centred nature in which they interact with clients (Lohman, 1998). This is consistent with the principles of clinical case management, which also makes use of a holistic approach by considering the client's condition, context and environment (Robinson, et al., 2016). Thus, occupational therapists are well positioned to assume the role and responsibilities of being a case manager. They have a unique contribution in terms of their unique knowledge and skills training related to a person's occupational performance (Krupa & Clark, 1995), assisting clients to become actively engaged in their daily activities.

The practice of occupational therapy is diverse and it allows occupational therapists to work in various settings and fields of practice including emerging areas of practice, such as case management. Occupational therapy uses a variety of treatment techniques, making the practice diverse (Parker, 2001; RCOT, 2019). Although the role of occupational therapists is multifaceted and flexible, the main focus is on sustaining outcomes for clients in terms of health and participation in life through engagement in occupation (AOTA, 2008; Robinson, et al., 2016). Clinical case management is therefore one of the many roles an occupational therapist can assume to achieve these outcomes (Lohman, 1998). While some occupational therapists work as clinical case managers on a full-time basis, others perform this role as part of their holistic intervention on an ad-hoc basis (e.g. in private practice) while still being involved in other clinical and administrative roles.

The medico-legal context is a context in which case managers deliver services. Although any medical professional can perform this role, it was observed by the researcher that occupational therapists perform case management work in the medico-legal context. Medico-legal work is a broad description used by South

African occupational therapists to define the context where occupational therapists works in the legal field to assist in a legal case (van Biljon, 2013). The medico-legal context can include personal injury matters (such as civil claims, medical malpractice or the Road Accident Fund claims), family matters, labour law matters and contractual dispute matters (van Biljon, 2013). Due to the specific nature of the medico-legal context, referral source (usually a legal entity such as a lawyer or trust) and expectations of the referral source, case managers may perform tasks specific to the context and not defined in traditional case management literature. This could include coordinate and monitor therapies and other interventions, assisting in identifying and engaging therapists, doctors and other service providers, to help in sourcing equipment, homes, vehicles and to provide reports to the trust, to motivate and obtain approval for trust expenditure (AD v MEC for Health and Social Development, 2016).

As case management in this context is a relatively new field of practice in South Africa, there is no literature, either locally or internationally, on the role and no guidance has been documented. Despite this, the researcher is of the opinion that occupational therapists are well suited to perform this role based on their professional philosophy of people as occupational beings. The core occupational therapy philosophy enables occupational therapists to address the occupational needs of clients from a functional and holistic perspective. Therefore, there is opportunity for further role description within this specific field, which will be further explored during this research.

1.2. Statement of the problem

Although case management is a role that is defined in the private health care industry (CMASA, 2013), it is an emerging role for occupational therapists in the medico-legal context within South Africa. Occupational therapists are employed as clinical case managers, within the medico-legal context, but the literature does not clearly define the role expectations of case managers within this context, either globally or in South Africa.

Case management in the medico-legal context may be different to traditional clinical case management roles because of the legal system, referral source, expectations of the referral source and related tasks. Case managers are however limited to descriptions of case managers in contexts which might differ significantly from the South African medico-legal context. Due to a lack of literature on this matter, occupational therapists cannot inform themselves and it is unknown if they perceive themselves prepared for this role.

1.3. Research question

Accordingly, the following research question was developed:

How do South African occupational therapists working within the medico-legal context perceive their role and responsibilities as clinical case managers, and do they perceive themselves to be prepared for such roles and associated responsibilities?

1.4. Purpose of the study

The purpose of this study was to explore the perceptions of South African occupational therapists who work as clinical case managers in the medico-legal context about their work. The study further explored occupational therapists' perception of the responsibilities attached to the case management role in this context and whether they felt equipped to manage these responsibilities. Lastly, occupational therapists' perception about their preparedness to take on the role as case managers within the medico-legal context was also explored.

1.5. Aim of the study

The aim of the study was to explore the perceptions of selected South African occupational therapists, who work in the medico-legal context, as to their roles and responsibilities as clinical case managers, and their preparedness to execute this role and associated responsibilities. To achieve this, the following objectives were set:

The researcher explored South African occupational therapists who work as case managers perceptions of:

- Their roles and responsibilities as clinical case managers working within the medico-legal context.
- The professional knowledge and skills they possess which support their ability to perform the role as clinical case managers within the medico-legal context.
- Their perceived preparedness to work as clinical case managers within the medico-legal context.

1.6. Justification for the study

The need for more efficient and effective health care management across the different sectors where health care is delivered, has been identified by the Case Managers Association of South Africa (CMASA). Professional management of required health care of each client, co-ordinated by a clinical case manager, could contribute to more effective care (CMASA, 2013). This study focusses on the medico-legal context and will assist occupational therapists, who are currently working as case managers in this context to form a better understanding of their role and associated responsibilities. It will assist them in making appropriate recommendations for clients during and after medico-legal trials. It may also encourage more occupational therapists to undertake such roles.

Legal experts may gain more insight or knowledge as to why occupational therapist do case management work, why they would be effective in this role and what skills they possess in order to work effectively within this field.

Having a clear definition of the role of occupational therapists will provide a reference for occupational therapists working in this field to better coordinate the care of clients, which could ultimately benefit clients. Lastly, it could also guide occupational therapists in preparation for the role as case manager in the medico-legal context.

1.7. Organisation of chapters of this research report

In conclusion, the first chapter provided the background to case management. An in depth understanding of literature related to case management follows in Chapter 2. This highlights the research gap that this study covers. Chapter 3 provides detail related to the methods used to conduct this study. Thereafter, Chapter 4 covers the

results of the study, followed by a discussion of the results and the conclusion of the study in Chapters 5 and 6 respectively.

CHAPTER 2

2 LITERATURE REVIEW

This chapter introduces concepts related to case management and existing case management models, discovers what the literature has to offer about occupational therapists assuming the role as case managers, as well as the skills they could use to be fulfil their role as case managers. Lastly, case management of the medico-legal context, which is the specific context for this study is explored.

The purpose of this literature review is to highlight the lack of information or guidance available for occupational therapists who assume the role of case managers, specifically in the medico-legal context.

2.1. Clinical Case Management

Case management has been defined as:

> *"A collaborative process that assesses, plans, implements, coordinates, monitors, and evaluates the options and services required to meet the client's health and human service needs. It is characterized by advocacy, communication, and resource management and promotes quality and cost-effective interventions and outcomes." (pg. 3) (CCMC, 2013).*

To explore the concept of clinical case management, the definition of each individual word in this phrase was examined: Firstly, the word *clinical* is defined in the Oxford English Dictionary (2012) as considering real persons or patients rather than theoretical studies (Concise Oxford English Dictionary, 2012). From this definition it can be expected that in healthcare, jobs are seen as clinical when the healthcare provider treats patients or provides direct patient care of any type. Accordingly, the clinical case manager will have contact with real persons or patients rather than making decisions solely on recommendations in reports. As stated in the formal definition above, clinical case management is a collaborative process, which indicates that it requires input from stakeholders or the actual client (CCMC, 2013).

There are various definitions for the word c*ase* as defined by the Concise Oxford English Dictionary (2012), of which the following three add the most value to describe case management. Firstly, when specifically considering case management in the medico-legal context, *case* can be defined as a legal action, which is decided in a court of law. The fact that the specific cases are legal in nature and have been decided in a court of law, differentiates them from other types of case management e.g. within a hospital or home-based setting. Furthermore, a *case* can be defined as a specific instance or situation, which highlights the fact that each case is different and unique as the person or patient it considers. The concept of a *case* is also defined as an occurrence of disease, injury or problem, which emphasises that intervention or management is required (Concise Oxford English Dictionary, 2012). Again, when considering the formal definition above, a case would refer to a specific person whose health and human service needs will be addressed (CCMC, 2013).

Lastly, the concept of *management* is defined as a process of "dealing with or controlling" people or things (Concise Oxford English Dictionary, 2012). This definition describes how clinical case management involves coordination of people or things. Management would entail all the aspects listed in the formal definition of case management above, namely; assessment, planning, implementation, coordination, monitoring and evaluation (CCMC, 2013).

When considering the definitions of all the above concepts, a general idea of clinical case management can be formed: The coordination of people with specific problems by direct contact. As seen in the first definition of the concept *case* above, it can also be considered that a case can have a legal component, such as in the medico-legal context, when decisions about the cases were made in the court of law.

The Case Management Society of America (CMSA) confirms the above as they define case managers as professionals who are the main contributors in the care coordination team and who coordinate client's access to quality healthcare (CMSA, 2010). Similarly, the Case Managers Association of South Africa (CMASA) supports the above, by stating that case managers are specialist in the coordination of care, which results in quality care (CMASA, 2013).

Moore (1990) noted that the initial step in defining case management is to differentiate it from the administrative structure that forms the framework of practice. He described the two primary aspects of case management as enabling and facilitating (Moore, 1990). When further considering these two aspects, enable is defined as providing someone with the means to do something or to make it possible for them to do it themselves while facilitate is to make an action or process easier (Concise Oxford English Dictionary, 2012). A case manager would make use of these two primary aspects to perform the essential tasks of case management by facilitating interventions and/or processes which could lead to enabling the person or patient. Therefore, a case manager's primary role is typically not to perform therapy, but rather to facilitate the care process that could lead to enabling the patient.

When cases are managed by medical professionals, they are referred to as clinical case managers. Clinical case managers' roles are determined by assessing the treatment needs of the client, developing intervention plans, monitoring and evaluating progress by accommodating an interdisciplinary team approach (Lohman, 1998). Bidwell (2013) suggests that many, but not all, case managers have a previous clinical qualification and without this (and a clinical evidence base from which to work), they have an unclear vision of the intervention that a client requires. It should however be considered that case management is not a profession in itself but rather an additional role for health care professionals (Lohman, 1998). Various clinical practitioners become clinical case managers in order to ensure cost effective, quality care which meets the client's health needs (CMASA, 2013) in a variety of settings.

Within the South African context, case management has developed into an essential role within the health care and wellbeing industry (CMASA, 2013). Clinical practitioners are tasked with the coordination of care and are termed clinical case managers. The Case Managers Association of South Africa state that they recognise case management is a function used in hospitals, health schemes, managed health care organisations and in coordination of rehabilitation and vocational programmes (where work and also non-work related injuries or illness as well as injuries on duty impacts on an employee's ability to stay at or return to work).

However, there is no mention of case managers within the medico-legal context and therefore no guidance for practitioners fulfilling this role.

In order to highlight the uniqueness of this position and work that a case manager would be called on to do and for the purpose of reviewing the literature and critically examining its appropriateness to the medico-legal context, an example of a typical case in the medico-legal context should be described. This is, however, only one example among many. In the High Court of South Africa (Western Cape Division, Cape Town) Case No: 27428/10 in the matter between AD (plaintiff) and MEC for Health and Social Development Western Cape (defendant):

> "[2] The plaintiffs are the parents of IDT who was born at Mowbray Maternity Hospital on 12 January 2009. After mother and child were discharged following an uneventful birth, IDT began to exhibit signs of jaundice. He was readmitted to the hospital on 16 January 2009. By the time he was discharged on 22 January 2009 he had suffered irreversible brain damage, resulting in athetoid cerebral palsy ('CP').
>
> [3] In December 2010 his parents issued summons against the defendant alleging negligent failure to diagnose and treat the jaundice timeously. They claimed damages for themselves and on behalf of IDT. In July 2012 the defendant conceded the merits. The present judgment is concerned with quantum only.
>
> The trust
>
> [24] The parties agree that IDT's award should be paid to a trust to be administered for his benefit. The parties also agree that the amount in respect of future medical expenses should be ring-fenced ('the medical fund') and that in certain circumstances the defendant should be obliged to supplement the medical fund and that in certain circumstances the defendant should be entitled to a refund from the medical fund (I refer to these as the top-up and claw-back provisions). The terms of these provisions and certain other aspects of the trust deed are in dispute.

> [25] The trust issues were formally introduced by way of a conditional counterclaim by the defendant to which the plaintiffs replicated. They annexed to their respective pleadings the trust deeds they proposed.
>
> The case manager
>
> [26] The parties agree that a suitably qualified person should be appointed as IDT's case manager for life. The function of the case manager is to coordinate and monitor therapies and other interventions, to assist in identifying and engaging therapists, doctors and other service providers, to help in sourcing equipment, to provide reports to the trust, to motivate and obtain approval for trust expenditure and so forth. Although the case manager would typically be a health professional, she is not part of the treating team." (AD v MEC for Health and Social Development, 2016)

In the above extract, the court agreed that a trust should administer any money awarded to the plaintiff and that a case manager should be appointed to manage the case for life. The court lists some functions of the case manager, however the list is ended with "and so forth" indicating that the case manager could have more responsibilities. The court also indicated that the case manager should be a health professional, thereby recognising their clinical skills. From the above, it is evident that case management is a profession referred to and practised in the medico-legal context in South Africa, however, there is no mention of case managers within the medico-legal context on the Case Managers Association of South Africa website (CMASA, 2013) and therefore no guidance for practitioners fulfilling this role.

When further exploring the concept of case management, different case management models and contexts exist. The models serve as guidelines for performing case management duties or tasks in a variety of contexts and, therefore, these models should be reviewed to determine if they would be appropriate for the medico-legal context.

2.2. Case management models

There are various models that are used by case managers. These include the broker service model, the clinical case management model, the assertive community treatment model, the intensive case management model, the strengths model and

the rehabilitation model (Mueser et al., 1998). Vanderplasschen (2007) examines four of these (which include a combination of some of these models, i.e. the brokerage model, the assertive community treatment/intensive case management, the clinical/rehabilitation model, and strengths-based case management) and states that although these models have similar primary functions (assessment, planning, linking, monitoring, and advocacy), they can be distinguished based on their characteristics, level of service delivery, client contribution, and case manager participation (Vanderplasschen et al., 2007). Each of these models are described below, while considering differences and/or similarities between the models.

The broker or expanded-broker model

This model was the first to be used for management of persons with severe mental illness (Mueser et al., 1998) and has the discriminating characteristic of *coordination* (Vanderplasschen & Wolf, 2005). It is a brief approach to case management which emphasises the connection of the client to the required services and the coordination of service providers, which is the case managers' main responsibility. The case manager assists clients to identify their needs and brokers services for them all in one or two interactions (SAMHSA, 1998). Specific tasks of this model included assessing the patient's needs, planning, linking the patient to services by referral, monitoring and coordinating as well as advocacy (Intagliata, 1982; Mueser et al., 1998).

The broker or expanded-broker model has been shown to work best for clients who are not seriously marginalised and who receive adequate support from their communities (Vanderplasschen et al., 2007). It would therefore not be adequate for the medico-legal context as it lacks an ongoing and close relationship with the client whereas most cases in this context require life-long management. Another limitation is that it provides guiding concepts with regards to the management of persons with severe mental health illnesses but did not specify cases which would typically be associated with the medico-legal context such as cerebral palsy, traumatic brain injuries, vegetative states, etc. It also requires case managers to link patients with recommended clinical services without acting as clinicians themselves. Mueser et al. state that this presents a problem as it assumes clinical skills are not required to

perform effective case management as a provider can always be identified to provide necessary clinical services (Mueser et al., 1998). To overcome this limitation, the clinical case management model was developed.

The clinical case management model

This model was established as a result of case managers often acting as clinicians by providing direct services or intervention to patients (Lamb, 1980). The discriminating characteristic of this model is that the case manager is seen as a *role-model and therapist* (Vanderplasschen & Wolf, 2005) as the case manager delivers services typically associated with therapy such as psychotherapy and psychoeducation. Services are provided in four broad areas, including the initial phase (which consists of engagement, assessment and planning); the second, which consists of environmental interventions (linking the patient with resources in the community, meeting with families and caregivers, upkeep and development of social networks, collaboration with other multi-disciplinary team members and advocacy); thirdly patient intervention (which includes sporadic individual psychotherapy, education in independent living skills and patient psychoeducation which all require clinical skills) and lastly patient-environmental interventions (which include addressing crises and monitoring the patient's status) (Kanter, 1989).

When compared to broker or extended-broker model, the clinical case management model addresses the need for clinical skills (Lamb, 1980). Although it makes provision for interaction with the client and the client's environment, it does not make provision for interaction with the primary referral source in the medico-legal context, namely the legal entity. As seen in the above case (AD v MEC for Health and Social Development, 2016), the case manager is required to interact with the legal entities either through providing reports to the trust or to motivate and obtain approval for trust expenditure. Therefore, this model, which does not take into consideration the legal interactions, would not make provision for the medico-legal context.

The Assertive Community Treatment model (Stein & Test, 1980)

In the 1970's, a program, the "Program for Assertive Community Treatment" (PACT) was developed by Stein and Test (Stein & Test, 1980), which served as a community

based alternative to hospital admission, specifically for persons with severe mental illnesses, categorised by chronic psychosis or a pattern of high service use. It is frequently referred to as the Assertive Community Treatment (ACT) model and was designed to be an all-inclusive treatment method that went beyond the previous two models (Mueser et al., 1998). The ACT model's main differentiation is providing intervention to patients through practical support in daily living activities, such as transportation, shopping, laundry, etc. (Mueser et al., 1998). The ACT model makes use of a multidisciplinary approach, usually consisting of at least two case managers as well as a psychiatrist and a nurse. Typical characteristics of this model include a low patient-staff ratio, execution in the community rather than in a practice or office setting, sharing of caseloads by a team of case managers, 24-hour availability, service provision by the ACT team itself as well as being an indefinite service (Stein & Test, 1980; Test, 1992).

A limitation of this model when considered for the medico-legal context is that it, similarly to the broker or expanded-broker model, focusses on the care of persons with severe mental health illnesses, specifically in this case those with chronic psychosis or a pattern of high service use, and therefore also does not make provision for cases which would typically be associated with the medico-legal context. This model also does not make provision for the complexities of medico-legal cases as the ACT model has a preference for providing direct services rather than referring patients elsewhere (Mueser et al., 1998). This would not make provision for the various service providers or practitioners who are typically involved in medico-legal cases. As seen in the above case AD v MEC for Health and Social Development, the case manager in the medico-legal context typically assists in identifying and engaging therapists, doctors and other service providers to assist in the case.

The Intensive case management (ICM) model

Vanderplasschen & Wolf (2005) describe the ACT and ICM models together and note that their discriminating characteristic is that it is a *comprehensive* approach (Vanderplasschen & Wolf, 2005). The ICM model meets the requirements of service users who have severe psychiatric disorders and are unable to participate in

intervention by regular case management due to their complex needs. (Surles et al., 1992). Examples of these include stabilising the situations of drug abusers with serious and complex problems and to control their service utilisation. As can be expected, such patients consume a large portion of the costliest treatment services such as emergency room visits (Mueser et al., 1998). The model prescribes a smaller caseload with more frequent and intensive case management and suggests services in patients' environments and a focus on practical support in daily living activities (Vanderplasschen et al., 2007). Like the ACT, the ICM model prescribes daily living support in the client's own environment but differs from the former in not sharing the case load with another case manager (Mueser et al., 1998).

Considering all the models described, the ICM model would be considered most appropriate for the medico-legal context because of its low patient to staff ratio and intensive case management in the client's environment. However, similarly to the first two models that were discussed above, the ACT model and the ICM model would not be appropriate as they focus on management of a psychiatric client and not to cases typically encountered in the medico-legal context such as traumatic brain injuries, cerebral palsy and in some cases, vegetative states. This model also does not make provision for interactions with the legal entities and the responsibilities associated with this such as providing reports to the trust or to motivate and obtain approval for trust expenditure.

A weakness of this and the other models described above, is that there is no focus on the client's strengths; instead, they focus on the clients' limitations associated with the diagnosis (Mueser et al., 1998).

The Strengths model

The discriminating characteristic of the strengths model is that focus is placed on *strength and empowerment of the client* (Vanderplasschen & Wolf, 2005). Concerns arose over the previous case management models as they overlooked the clients' strengths that they can use in order to achieve personal goals. A further criticism was the lack of use of community support that can be used to facilitate community integration (Mueser et al., 1998). The Strengths model was developed to address

these and included the following principles: focussing on the client's assets instead of the limitations or pathology; the relationship between the case manager and the patient is key; intervention is grounded on the patient's self-determination; the client's community is regarded as resourceful; consultations occur in the community; client's suffering from severe mental illnesses can learn, grow and change. (Sullivan, 1992; Rapp, 1993).

Although the Strengths model has valuable attributes, it is considered to be most applicable to high functioning patients who have the ability to make decisions for themselves. Typical cases in the medico-legal context are people with severe disabilities, who have been declared incapable of managing their own affairs and therefore require an administrator to be appointed by the court. Clients would therefore not be able to self-determine their interventions and this model would not be suitable for medico-legal cases.

The Rehabilitation model

The Rehabilitation model, like the Strengths model, also focuses on case management services that highlight the clients' goals rather than those set by the mental health system (Anthony et al., 1993). A distinct feature of the Rehabilitation model is the importance of evaluating and remediating instrumental skills that may enhance community cohesion as well as reaching the patient's own personal goals (Mueser et al., 1998). Therefore, when a patient's unique skills or strengths are identified, special intervention is given to these skills to enhance them.

However, the Rehabilitation model has similar shortcomings as the Strength model and the other models described above. Based on the descriptions of the above models, it is evident that the coordination and monitoring of care are common to all the models and explicit. Although each of these models have a valuable contribution to case management, they will not provide adequate guidelines for case management in the medico-legal context as they do not describe cases typically encountered in the medico-legal context (as the case described above AD v MEC for Health and Social Development (2016) where clients are usually declared incapable of managing their own affairs and therefore require a curator or trust to be appointed

by the court. They do not make provision for interactions with the legal entities who are appointed by the court as administrators of the case. They also do not consider that the client will require life-long case management and it is only the clinical case management model that requires of a case manager to have clinical skills and as seen in the case above, a case manager appointed for a medico-legal case would typically be a health professional.

2.3. Case management process

Since the above models were developed, various case management associations or societies e.g. the Case Managers Association of South Africa (CMASA) have been formed to govern case management practise. The Case Management Society of America (CMSA) released a Standard of Practice for Case Management, which describes the functions typically performed by case managers. These include comprehensive evaluation to develop a care plan, to plan with the client and service provider or referral source to ensure optimisation of the treatment, facilitating communication and coordination between the role players to reduce fragmentation in services, educating or empowering clients or the health care team on treatment options, using community resources and benefits, encouraging appropriate use of health care services or benefits to improve quality of care and maintaining cost effectiveness, assisting in client transition back into the home, community or work environment, advocating for clients and the referral source to facilitate positive outcomes (CMSA, 2010).

Although the second function described above includes planning with the referral source and the last function includes advocating for the referral source, it does not specify the legal entity which would typically be the referral source in the medico-legal context. With the medico-legal context comes specific responsibilities not mentioned above e.g. attending trust meetings or advising the legal entity. The legal entity will also have specific expectations e.g. writing motivations for the Master of the High Court on trust expenditure.

From the functions described above by the CMSA (2010), it is evident that case managers require a range of skills such as assessment, planning, facilitation and

interpersonal skills such as communication. They also need to work effectively by making use of available resources, empowering and advocating for/or with clients, and being aware of various facilitators and inhibitors for successful reintegration into their communities. Although many of these are professional skills, one could argue that many e.g. reintegration into the community and being aware of the factors that could contribute or inhibit the transition into the community, could be considered as clinical skills (which occupational therapists would typically possess of) as they require knowledge about the person, their condition and their environment (Robinson, et al., 2016). Therefore, the suitability or potential of occupational therapists as case managers will be further explored.

2.4. Occupational therapists as case mangers

The case manager role is one of the many professional roles of an occupational therapist. However, it is also important to consider other roles which can typically be assumed by an occupational therapist in order to distinguish the difference in roles. Some roles assumed by occupational therapists include a clinician, manager, educator, researcher or scholar, collaborator, activist or advocate, mentor and consultant (AOTA, 1993; Nestadt & Blesedell, 1998).

The case manager does not typically assume the role of a *clinician* as seen above in AD v MEC for Health in Social Development (2016) where it states that although the case manager would typically be a health professional, they are not part of the treating team. However, as seen in the clinical case management model, the case manager sometimes acts as a clinician when delivering services such as psychotherapy or psychoeducation (Kanter, 1989), and it should be established if the case manager in the medico-legal context assumes this clinician role.

The occupational therapist *manager*'s functions echo many of the functions listed in the definition of case management by CCMC which states that case management is a process that assesses, plans, implements, coordinates, monitors and evaluates *(CCMC, 2013).* Based on this, it can be assumed that the occupational therapy manager has many of the required skills to perform case management.

The occupational therapist can also assume the role of an *educator*. The clinical case management model reflects on the case manager as acting as a clinician by providing direct services or intervention to patients through e.g. psychoeducation (Lamb, 1980). This model highlights that clinical case managers sometimes provide direct services to their clients and that this could include educating the client. The Case Management Society of America Standard of Practice for Case Management also includes educating or empowering client or the health care team on treatment options (CMSA, 2010) and therefore the occupational therapy educator would be a role associated with case management.

At the other end is the *researcher* or *scholar* role. At the time of conducting the research, CMASA stated that it was part of a process to consolidate formal training for case managers practising in South Africa (CMASA, 2013). However, it did not make mention of case management in the medico-legal context and therefore it could be considered that there was no formal training for case managers within the medico-legal context in South Africa. There is thus no opportunity for case managers to assume the scholar role within this context, however it is possible for them to assume the researcher role by their own means.

The occupational therapist as *collaborator* interacts and works with other health care practitioners, members of the multi-disciplinary team and community members across various departments or sectors (AOTA, 1993; Nestadt & Blesedell, 1998). The definition of case management describes it as a collaborative process *(CCMC, 2013),* however in a typical medico-legal case in the South African case management context, the case manager's function is rather described as coordinating therapies and interventions (AD v MEC for Health and Social Development, 2016). Similarly, the case management models as discussed above refer to coordination of services i.e. the broker or expanded-broker model has coordination as its discriminating characteristic (Vanderplasschen & Wolf, 2005). Therefore, it would be required to distinguish between collaboration and coordination to also determine if the case manager within the medico-legal context collaborates or coordinates.

Coordination is defined as the act of making parts of something, groups of people, etc. work together in an efficient and organised way while collaboration is defined as the act of working with another person or groups of people to produce something (Concise Oxford English Dictionary, 2012). The notable difference of these two terms is the actual involvement of the case manager. Coordination would include making the team to work together to reach a goal, while collaboration would be working with the team to reach a goal. It should be confirmed if the case manager within the medico-legal context in South Africa is a collaborator or a coordinator.

The case management definition states that case management is characterised by advocacy *(CCMC, 2013)* and the CMSA Standards of Practice for case management confirms this by stating that a case manager is to advocate for the clients as well as the referral source to facilitate positive outcomes (CMSA, 2010). Based on this, it can be assumed that the occupational therapy *activist* or *advocate* will be equipped to case manage. What is however not clear, is in which way the case manager advocates for the referral source, which is usually a legal entity within the medico-legal context.

The *mentor* role is not typically associated with case management as there are no clear links to case managements' typical function or models. The researcher is however of the opinion that this role could have valuable importance in case management within the medico-legal context in South Africa, specifically as there are no guiding concepts to this specific context.

A *consultant* role is not typically associated with case management as there are no clear links to case managements' typical function or models, however when considering the functions as stated in a typical medico-legal case, the case manager should provide reports to the trust to motivate and obtain approval for trust expenditure. This could be considered advising the trust on grounds of their expertise as health professional. Therefore, it should be considered if this role is unique to case management within the medico-legal context.

The above professional roles of an occupational therapist make many contributions to case management, as discussed previously. When focussing on the role of a case manager again (which is also a professional role of the occupational therapist) it should be noted that many typical functions of case managers overlap or parallel those of occupational therapy e.g. assessing, monitoring, advocacy and meeting with families and/or caregivers. Such sentiments are echoed by the Case Management Certification requirements of the United States of America, whereby health workers must demonstrate the ability to apply six essential tasks to practise as a certified clinical case manager: assessment, planning, implementation, coordination, monitoring and evaluation (CCMC, 2013). According to Lohman (1998), these tasks parallel some categories of the minimum requirements of occupational therapy practise as set out by the American Occupational Therapy Association (AOTA), such as screening, evaluation and re-evaluation, intervention including planning and implantation, transition, discharge and outcome measurement (AOTA, 2015). The Health Professions Counsel of South Africa (HPCSA) aligns with these categories, as set out by AOTA, on Form 265 named the "Professional board for occupational therapy, medical orthotics and prosthetics and arts therapy – standards of practice for occupational therapists – February 2006" (HPCSA, 2006). The HPCSA lists the occupational therapy standard of practice services as consultation or collaboration, screening, assessment, intervention planning, intervention, transition services, evaluation and discontinuation together with recommendations (HPCSA, 2006).

The above roles of an occupational therapist also align with case management functions and to further highlight this, Lohman (1998) identifies various skills which occupational therapists possess that enable them to work as case managers. These include clinical reasoning, communication skills, leadership abilities and flexibility (Lohman, 1998). When further exploring the first skill, namely clinical reasoning, it can be considered that to determine client impairments, goals and treatment aims, occupational therapists obtain, categorise and analyse information about their client's abilities and individual life situation. The fundamental method involved in this process is clinical reasoning (Chapparo & Ranka, 2008).

Flemming (1991) describes how occupational therapists appeared to use multiple thinking approaches, depending on the nature of the clinical problem they address. Occupational therapists make use of numerous reasoning processes throughout the various phases of client management, namely; scientific -, narrative -, pragmatic –, ethical - and conditional reasoning (Boyt Schell, 2014). The types of clinical reasoning are described as below.

Scientific reasoning would assist the occupational therapist to comprehensively and logically evaluate the client to develop a care plan which would benefit the client, which is typical function of the case manager (CMSA, 2010).

Narrative reasoning would assist the occupational therapist to comprehend a client's specific situations and/or circumstances and would assist the occupational therapist to ensure optimisation of treatment which is specific to the client's needs. It would also give the occupational therapist the understanding of which community resources and benefits are available in the client's specific situation and how to assist them to transition back into their specific community, which are all typical functions performed by the case manager (CMSA, 2010).

Although *pragmatic reasoning* is not directly linked to case management, this reasoning is required for any type of service delivery including case management in the medico-legal context as this is considered a life-long management (AD v MEC for Health and Social Development, 2016). The occupational therapist should not therefore, take on a case to manage if it does not suit the therapists' current realities.

Ethical reasoning is not directly linked to case management, but should be considered necessary whenever any type of moral dilemma arises and is therefore an important skill.

Finally, *conditional reasoning* would be required to combine all the different types of clinical reasoning skills as describe above. This would be useful to case management and would enable the occupational therapist to combine the above types in a specific situation as required.

Other than the skills which occupational therapists possess that enable them to work as case managers, Lohman (1998) argues they also have in-depth knowledge of functional aspects of patient care and a holistic perspective which further enables them to work as clinical case managers. Occupational therapists have knowledge about activity analysis, psychological interventions, illnesses, disability, daily activities as well as routines and therefore, have the ability to identify clients' needs in terms of their health, occupational participation and quality of life (Robinson, et al., 2016). These aspects echo some of the case management functions proposed by the Case Management Society of America such as educating clients and the health care team on treatment options, assisting the client to transition back into the home, community or work environment, all of which are required to holistically monitor and coordinate the care of various patients (CMSA, 2010). Occupational therapists already reason in case management terms if they embrace the principal philosophies of occupational therapy (Kornblau and Hafez, 2007). One of these is that humans are occupational beings, infused with a distinctive, biological necessity for occupation and, when so engaged, they meet needs for survival, growth, development, health and well-being (Wilcock, 1993). The core occupational therapy philosophy enables occupational therapists to address the occupational needs of clients from a functional and holistic perspective, which would enable them to fulfil the role of case manager.

Although there is international literature available on occupational therapists as case managers, little is recorded in the South African context. Govender et al., (2018) assessed the role of the occupational therapist in case management in South Africa, noting that their work was the first of its kind in in the South African context. They confirmed what the international literature stated, that occupational therapists offer unique skills to case management, addressing the clients' needs holistically with the focus on maintaining or improving their functioning to engage in meaningful occupation. They also noted that, in South Africa, it appears as if occupational therapists practice case management in the disability management or vocational rehabilitation contexts either internally (through vocational rehabilitation service) or externally, within the insurance sector (Govender et al., 2018). However, case management within the medico-legal context is not described and, as this is an

emerging field where services are delivered, it requires further investigation so as to provide case managers with guidance.

As described above, the literature supports that occupational therapists have unique skills and knowledge to enable them to be case managers. Kornblau and Hafez (2007) noted that the vital activities of case management have various correlations with the Occupational Therapy Practice Framework: Domain and Process (AOTA, 2014; Kornblau and Hafez, 2007), which can be further explored by means of considering the occupational therapy process as suggested by the Occupational Therapy Practice Framework and how it correlates with case management.

2.5. Occupational therapy process

According to the Occupational Therapy Practise Framework: Domain and Process (3rd edition), many professionals use a similar treatment process, namely: evaluating, intervention and monitoring outcomes. Occupational therapists, however, are the only clinicians who use occupations as their primary treatment modality to enhance health, well-being and participation in meaningful activities (AOTA, 2014). Because of this, occupational therapists working as case managers have the skills to enable their clients to improve or recover occupational participation and performance.

The first step of the occupational therapy process, common to most case management models, consists of *evaluation,* which happens during the first and all other interactions with the client (AOTA, 2014). Occupational therapists establish which occupations clients want to, and/or need to, perform, identify what activities they can perform or have performed in the past, and then determine enablers or disablers to participation in occupations. The occupational profile of a person and occupational performance analysis assist occupational therapists in evaluating a client (AOTA, 2014). All of these skills enable the case manager to ensure optimisation of treatment through a holistic picture of the clients by establishing their interests and strengths.

The *intervention* step consists of the services that are provided by occupational therapists, together with clients, to enable engagement in occupations that are

related to health and well-being (AOTA, 2014). Occupational therapists use evaluation information and theoretical principles to determine occupation-based interventions. These depend on the client (an individual, group or population) and the context where the service will be delivered (Moyers & Dale, 2007). The intervention process is divided into three phases, namely intervention plan, intervention implementation and intervention review. During all of these phases, theory, practice models, frames of references and evidence are combined with the information gathered during the evaluation. This guides the occupational therapist's clinical reasoning (AOTA, 2014). Kornblau and Hafez (2007) noted that case managers are involved in client interactions, but usually do not treat clients in the typical sense, although some models (e.g. clinical case management model) makes provision for clinical interactions. Typically, occupational therapists who work as case managers usually do not assume the clinician role, however they manage what occurs outside the clinic or hospital setting and therefore experience case management as a community-based expansion of the medical model (Hafez, 2007). The above occupational therapy intervention phases could guide the case manager's reasoning as it includes intervention planning and review thereof.

Outcomes define what clients have realised. The emphasis on outcomes is entwined throughout the occupational therapy process. Outcomes are linked to the intervention provided as well as to the occupations, client factors, performance skills, performance patterns, contexts and environments targeted and the transactional relationship among the areas of the domain, which enables the client's ability to engage in occupations (AOTA, 2014). Outcomes may also relate to client's subjective experience when goals are reached e.g. improved self-confidence, hope, resilience, subjective experience of well-being and should not only be limited to the individual but can also be described for groups, populations and other collectives (Adams, 2016). Outcomes and the documentation therefore will be dependent on the practise setting and expectations of the stakeholders (AOTA, 2014). This phase of the occupational therapy process can add value to case management as many of the models described above also include some form of monitoring, but do not include a review or type of outcome measure to evaluate the progress of the management

intervention. Such a phase can give feedback to the stakeholders on what outcomes or targets have been reached during the case management process.

When considering the value that outcomes and the measurement thereof can add to the case management process, another management methodology in which there is a definite outcome, time scale and budget, should be explored. Therefore, project management was considered to contribute to the case management process:

2.6. Project management

A project is defined as *"Any planned, temporary endeavour undertaken to create a unique product, service or other complete and definite outcome (deliverable) within a limited time scale and with limited resources - a limited budget" (Steyn et al., 2008).*

Steyn et. al. (2008) proceeds to further break down each aspect of the above definition, which will be discussed below. Additionally, some of the aspects' contribution to case management will be considered by comparing it to the typical functions employed by case managers as set out by the Case Management Society of America. Lastly, it will be linked with the occupational therapy process.

Planned: Projects are planned, carried out and controlled by stakeholders to reach pre-set desires of the clients (Steyn et al., 2008). Similarly, case management is a planned process, which consists of a comprehensive evaluation to develop a care plan with the client and service provider or referral source to ensure optimisation of treatment (CMSA, 2010). Occupational therapists use the information obtained during the first step of the occupational therapy process, namely evaluation, during the initial phase of the intervention phase, namely intervention planning in order to successfully implement and review their interventions (AOTA, 2014).

Temporary: This implies that a project has a start and a finish. Important project aspects are the initiation and closure, and the end is reached when the project objectives have been achieved or when the project is concluded for any other reason (Steyn et al., 2008). When considering how this could contribute to case management, a case could either be short-term case management where a clear

end is evident, or it could require long term intervention and input from the case manager. Similarly, in occupational therapy, a client can be consulted on a short-term basis e.g. in a primary health care facility or on a long-term basis e.g. in school settings.

Unique: This suggests that each project is different from another and has a single, definable determination. However, with the uniqueness comes risk and ambiguity (Steyn et al., 2008). As can be expected in case management, each case is unique and should be handled as such when educating or empowering clients or the health care team on treatment options, community resources and benefits (CMSA, 2010) based on the clients, their context and environment. Similarly, in occupational therapy, each client is seen as unique and is handled as such during all stages of the occupational therapy process.

Complete and definite outcome: Every project leads to deliverables, which should meet the needs of the stakeholders (Steyn et al., 2008). When considering case management, each case could have its own set of deliverables and outcomes which would contribute to the goal of the case. This could include assisting in client transition back into the home, community or work environment and while advocating for clients and the referral source to facilitate positive outcomes (CMSA, 2010). The final stage of the occupational therapy process is outcome, which defines what the client has realised and will be dependent on the practise setting and expectations of the stakeholders (AOTA, 2014).

Limited time scale and budget: A project must always end within a specific time, implicit within a target date. The budget must also be taken into consideration (Steyn et al., 2008). In case management, the referral source will usually inform the case manager of timeframes and budgets associated and the case manager will encourage appropriate use of resources to ensure cost effective quality care (CMSA, 2010). This aspect will typically be covered during the pragmatic reasoning of an occupational therapists clinical reasoning (Boyt Schell, 2014).

Project management is performed by a project manager, who requires working knowledge in various disciplines, which is altered to the specific project environment

in order to manage a project. There are various skills which the project manager require to manage a project. These include “hard skills,” such as scheduling and risk analysis, as well as “soft skills” e.g. interpersonal, communication, teambuilding, people-managing and negotiating skills (Steyn et al., 2008). Many of these skills echo those required by a case manager as described above such as assessment, planning, facilitation and interpersonal skills such as communication. Again, these skills are closely parallel the minimum requirements of occupational therapy as set out by AOTA and can therefore be associated with occupational therapy skills (AOTA, 2015).

As seen above, most of the information related to case management is found in international literature. It is however necessary to understand what information is available in the medico-legal context in South Africa.

2.7. Case management in the medico-legal context in South Africa

In South Africa, occupational therapists are employed as case managers in different contexts e.g. the insurance sector, health consulting to manage long term incapacity and disability in the workplace, the Road Accident Fund to aid motor vehicle accident victims and within the vocational rehabilitation service (Govender, et al., 2018). However, the literature does not mention occupational therapists’ involvement within the medico-legal field (unless employed or providing services directly to the Road Accident Fund) e.g. case managers performing consulting work for trusts or curators. This is a service being offered and, therefore, there is a need to explore the medico-legal context and the gap that exists in literature of describing the role of occupational therapists as case managers within the medico-legal context.

A medico-legal case is defined as an instance of injury or illness where the attending health care professional, after gaining background and assessing the patient, concludes that investigation by law enforcement agencies is necessary to determine a responsibility for the case in accordance with the law of the country (Dogra & Rudra, 2005; Meera, 2016). In the medico-legal field of practice, clients who are declared incapable of managing their own affairs require a curator or trust to be appointed by the court, as an administrator. The curator appointed to administer the

estate of such a person is known as the *curator bonis* (The Department of Justice and Constitutional Development, 2003). According to the Mental Health Care Act 17 of 2002, section 59; *"A master of a High Court may appoint an administrator to care for and administer the property of a mentally ill person or person with severe or profound intellectual disability…"* (Government Gazette No. 24024, 2002). According to South African Common Law, the High Court may appoint such a curator to a person who is declared incapable of managing their own affairs. The application procedure is defined in Rule 57 of the Rules of the High Court and can apply to persons who are mentally ill or mentally deficient, who cannot manage their own affairs due to physical infirmity and/or are declared prodigals who are unable to manage their finances (The Department of Justice and Constitutional Development, 2003).

The *curator bonis* may appoint a case manager if recommended by experts in the medico-legal reports, either while the case is ongoing or after it has been finalised. The case manager is appointed to ensure the wellness of a client is maintained by coordinating appropriate and/or recommended interventions. Bidwell (2013) recorded that case managers should intervene autonomously of the legal process with the best interest of the client, who would be the claimant involved in litigation for personal injury damages (CMSUK, 2009), in mind. This also supports the notion that case managers are usually not the treating therapists nor the therapist who conduct the medico-legal assessment, in order to prevent bias and to continue intervening for the best interest of the client.

Medico-legal work is a broad description used by South African occupational therapists to define a field of practice where the occupational therapists works in the legal field to assist in quantifying or qualifying a legal case. These occupational therapists usually assist in personal injury matters (such as Medical Malpractice, Road Accident Fund Claims or Civil Claims), family matters (such as child custody and divorce with spouse maintenance), contractual dispute matters (such as insurance policies or claims) and labour law matters (van Biljon, 2013).

Many occupational therapists in the medico-legal field consult clients for a few hours of concentrated evaluation, after which a report is written, and future medical rehabilitation and therapeutic intervention is recommended. Other recommendations might also include reasonable accommodation or workplace adaptations and assistive devices. The report also includes prices and details of service providers. On occasion, the occupational therapist conducts a work or home visit, but in most practices no follow up is performed (van Biljon, 2013).

In a study (van Biljon, 2013), a participant with six years' experience in the medico-legal view, noted the following: *"I feel frustrated when I am unable to assist a client in a practical way when it is clearly needed and I wonder if the recommendations I made are ever implemented. There is no follow up. If feels un-therapeutic*." This statement highlights the need for case managers within the medico-legal context. Van Biljon (2013) suggested that failure by involved parties, to determine if the client has any understanding regarding the recommendations that were made in the medico-legal report, is unethical. Further, no handover is provided to another therapist to implement the recommendations that were made or to offer therapeutic assistance once the trial is over. Money from the cases is usually available for rehabilitation, reasonable accommodation and assistive devices purposes, but there is no follow up to ensure that these funds are spent as recommended in the medico-legal reports (van Biljon, 2013). From the court case extract above, it is seen that a case manager will solve many of these ethical issues (AD v MEC for Health and Social Development, 2016) and therefore the need for this role and its associated responsibilities should be described in such a way that it supports the case managers' practice.

Case management in the medico-legal context seems to be the field of practice in which occupational therapists in South Africa have identified the opportunity to deliver services and they have therefore assumed a role as clinical case managers in this context. There is no international or local research available about their specific role in medico-legal practice, however, through personal experience in clinical private practice, it has been observed that the medico-legal context is a practice setting where clinical case managers play a key role.

Case managers are required to identify and engage with therapists, doctors and other service providers (AD v MEC for Health and Social Development, 2016) and from personal experience, it was identified that clinical case managers work closely with the multi-disciplinary team and are the direct link between the curators or trust and other health care team members, to ultimately ensure optimal benefit to the client form a health care perspective. This indicates that the role of a case manager in the medico-legal context is similar to the role of a case manager in various other contexts. However, the medico-legal context has some unique aspects.

From the above typical case (AD v MEC for Health and Social Development, 2016) it is noted that the case manager in the medico-legal context provides reports to the trust to motivate and obtain approval for trust expenditure, which is a unique contribution by the case manager in the medico-legal field. However, the case managers' responsibilities conclude with "and so forth" indicating that there could be many more associated responsibilities. Some unique aspects, based on personal experience and relevant to case managers within the medico-legal context, include that the case manager provides advice to the trust or curator regarding the suitability and appropriateness of new assistive devices, interventions or routine medical care. These recommendations will help to ensure that the client's estate is effectively managed from a health professional's point of view (Groenewald, 2013). Although personal experience has identified some unique aspects about occupational therapists working as case managers but, there could be many other responsibilities. There is however no supporting literature to confirm this or provide guidance. It is also unknown if occupational therapists perceive themselves to be prepared to take on this role. These uncertainties provide the rationale and basis for this study.

2.8. Conclusion

There are various contexts in which a case manager assumes his or her role. However, research in the South African context has highlighted an ethical dilemma in the medico-legal context as there is uncertainty if recommendations made in medico-legal cases are ever implemented (van Biljon, 2013). Case management in the medico-legal context seems to be the field of practice in which occupational

therapists in South Africa have identified the opportunity to deliver services and they have therefore assumed a role of as clinical case managers in this context.

The purpose of this literature review was to highlight the lack of information or guidance available for occupational therapists who assume the role of case managers, specifically in the medico-legal context.

Based on the literature perused, it is evident that case management is not new in the medico-legal process, nor is case management unknown in occupational therapy. However, there is no information available to occupational therapists who perform the role as case managers in the medico-legal context.

There is a need for information related to the roles and responsibilities, required knowledge and skills and to determine if occupational therapists perceive themselves to be prepared for this role.

CHAPTER 3

3 METHODOLOGY

This chapter describes the methodology used in this research. It explores the research design and the selection of participants, and then progresses to describes the data collection techniques which were used during the research. This chapter also gives an overview of the research procedure and data analysis process that was followed. Furthermore, it considers the techniques that were used to ensure the rigor and trustworthiness and concludes with the ethical considerations that were considered in the study.

3.1. Research design

A qualitative research approach, which falls into the interpretive paradigm, was chosen for this study. A qualitative approach was used, which aimed to explore concepts that assist in the understanding of the participant's lived experiences and views regarding a certain phenomenon (Al-Busaidi, 2008). By using a qualitative approach, the researcher explored the participant's perception of their role and responsibilities as case managers within a medico-legal context, gaining insight into their experiences and opinions regarding the topic.

Lambert & Lambert (2012) noted that a basic qualitative descriptive design is a valuable method as it draws from naturalistic inquiry, which supported the notion of studying something in its natural state where possible. The qualitative descriptive research design used therefore had no pre-selection of study variables, no manipulation of variables and no previous commitment to a theoretical view of a target phenomenon (Lambert & Lambert, 2012).

A cross sectional descriptive design was used for this study. The cross sectional design was carried out at one point in time over a short period and provided a 'snapshot' of participants' perceptions about their role as case manager within the medico-legal context (Levin, 2014). It should therefore be considered that the outcome of the research was related to participants' perceptions at a specific point in time.

3.2. Selection of participants

The study sample of participants was selected from the population of South African occupational therapists working as clinical case managers in the medico-legal context.

Lambert & Lambert (2012) suggested that the ultimate goal of a qualitative descriptive research design, as in any other qualitative research design, was to find participants who were considered to be rich in information to reach data saturation (Lambert & Lambert, 2012). In order to obtain participants who were deemed rich in information, firstly a purposive sampling method (Tongco, 2007) was used by targeting a known participant who fitted the inclusion criteria. Thereafter, a snowball sampling method was used by asking the initial research participant to identify another participant (Noy, 2008) and then asking the second round of participants to identify additional participants who meet the inclusion criteria and so forth.

Inclusion criteria:

- Occupational therapists who are employed as clinical case managers by legal entities within the medico-legal field.
- Occupational therapists who have more than one year's experience as case managers and have managed more than ten cases. The researcher was guided by Benner's definition that qualify such participants as advanced beginners, who have working knowledge of key concepts in practice (Benner, 1982). These participants would therefore have sufficient experience in the specific work to be able to provide the required data.

The sample size was determined by data saturation. Data saturation was reached by the 7th interview, when no additional information was attained and information was repeated by the participants (Guest et al., 2006).

3.3. Data collection techniques

Data collection was done through in-depth, one-on-one interviews. These interviews were semi-structured, which is suitable for data collection in qualitative studies where

the researcher is not testing a specific hypothesis (David & Sutton, 2004), but rather wanting to gain insight into the participants' perception. The researcher had an interview schedule of key open-ended questions and probes (Appendix A). The development of the questions and probes were guided by the objectives of the study. However, the direction of the conversation i.e. answers by the participants determined if additional questions were asked (Bhamani, 2012) in order to gain a deeper understanding and insight into the participant's perception regarding the research topic. The questions and probes were reviewed after each interview to determine if they required amending.

Although the questions did not require amending, additional questions were also formulated, based on participant's answers, in order to explore if participants shared common perceptions and ideas regarding their role as clinical case managers within the medico-legal context.

3.4. Research procedure

Once ethical permission was gained to conduct the research, the first participant was contacted via email. The potential participant was informed about the study by means of the approved information sheet (Appendix B) and given the choice to participate in the study. When the occupational therapist agreed, informed consent (Appendix B) was obtained. A meeting was set up at the occupational therapists' practice (the choice of venue ensured that the participants were comfortable and in a familiar environment) and at a time convenient for the participant. The interview was recorded (consent to be audiotaped in Appendix B) and the researcher took field notes during and after each interview.

After completion of the interview, the participant was asked to put the researcher into contact with other potential participants: occupational therapists who meet the inclusion criteria. Interviews with other participants were conducted in the same manner as above, by means of snowball sampling. A total of 8 interviews were conducted, after which no further participants, who met the inclusion criteria, were identified by research participants who partook in the study. The interviews were conducted until data saturation was achieved. Results were obtained from seven

interviews as one participant did not meet the research criteria, despite indicating that they did. The recorded interviews were transcribed by a professional transcriber and then the transcriptions were cleaned by the researcher. While cleaning and correcting the transcript familiarised the researcher with the data.

3.5. Data analysis

Thematic content analysis steps as suggested by Creswell (2003) were used:

1. *Organising and preparing* the data for the purpose of analysis. This included having interviews transcribed, typing field notes and organising the data into types according to the source.
2. The researcher obtained a general sense of the data while reading through the transcriptions to check for its correctness. While reading through all of the data, the researcher determined the overall meaning.
3. Once the researcher obtained a general sense of the data, the *coding* process was started by organising the data into chunks of information by labelling the information with a term. Deductive coding, which is coding with a theoretical framework as background (Pope, van Rooyen & Baker, 2002) was used for coding Objective 1 and part of Objective 2. Deductive coding was used as there are known professional roles of occupational therapists described in the literature (AOTA, 1993; Nestadt & Blesedell, 1998) as well as known clinical reasoning types (Boyt Schell, 2014). Inductive coding, which consists of obtaining data gradually from the data (Pope, van Rooyen & Baker, 2002) was used when coding the remaining part of Objective 2 and Objective 3. This was because there was no known theoretical background to guide this part of the coding and data emerged gradually from the transcripts. A software system for the analysis of qualitative and mixed methods research, MAXQDA, was used to assist with organising and analysing the data (MAXQDA, 2019). MAXQDA was chosen as it has automatic search and coding tools which saves time with the basic coding process.
4. Generating a *description* from the codes to generate a smaller number of subcategories. Sub-categories were then grouped into categories and categories into themes.
5. The researcher determined how the categories were to be *represented*.

6. *Interpreting* the meaning of the data by capturing the essence of the information.

3.6. Rigor / trustworthiness

Lincoln and Guba (1985) were the original, seminal authors on this topic and substituted the quantitative rigor terms of reliability and validity with the concept of trustworthiness in qualitative studies. Trustworthiness is obtained through four aspects namely: Credibility, transferability, dependability and confirmability. Within these aspects there are specific methodological strategies to demonstrate qualitative rigor, which will be discussed below (Guba & Lincoln, 1985; Morse et al., 2002).

Trustworthiness was maintained through:

1. *Credibility*:

   Credibility is the most essential principle to develop trustworthiness as it endorses the truthfulness of the findings of the research (Lincoln & Guba, 1985). Credibility was ensured by the researcher through interviewing appropriate participants, with selection based on the inclusion criteria. The researcher had confidence in their experiences, the truth of the data and the interpretations of the data. Techniques used to ensure credibility included:

   - *Peer debriefing*: This is defined as a process of divulging oneself to a peer who is disinterested in the research topic, in a similar way as one would in an analysis session. By doing so, aspects of the inquiry are explored and debated (Lincoln & Guba, 1985). Peer debriefing was done monthly during this project, as the research was discussed with a fellow MSc student doing research within another field of occupational therapy practice.
   - *Accurate transcription of information:* The data were transcribed by a professional transcriber and thereafter transcriptions were cleaned by the researcher to ensure that the audiotapes were transcribed correctly. This ensured that the transcribed information was accurate and contributed to the credibility of the information.
   - *Member-checking:* This is defined as the process of checking the data that arose from the research to verify its correctness (Lincoln & Guba,

1985). After the analysis was finalised, all participants were asked to review the to determine if what has been transcribed is true and has come across accurately. Responses indicated that participants felt that selected codes, categories and sub-categories reflected that their interviews had been accurately analysed.

- *Bracketing*: The researcher obtained distance from preconceived ideas or beliefs about the study. This was done by writing down what was believed about the phenomenon in this case management in the medico-legal context (refer to Appendix C), before the research commenced, and through bracketing, those thoughts were brought into consciousness to attempt to control subjectivity.

2. *Transferability*

   Transferability is the ability of findings to be transferred from a study to different contexts (Krefting, 2017). The researcher presented a thick/dense description of the research process, research context and participants (as seen in Chapter 4), so that the findings can be transferred to other occupational therapists who are interested in working within this specific field. To ensure transferability, a detailed report of the methodology used, is provided.

3. *Dependability:*

   Dependability is based on the consistency of the findings of the research project (Guba & Lincoln, 1981). Lincoln and Guba (1985) describes that there are resemblances between methods for ensuring dependability and those for guaranteeing credibility. Dependability was ensured by:

   - *Obtaining data saturation*: Data was gathered until no new data emerged. By the seventh interview, data saturation was reached, however the eighth interview was already scheduled and therefore also conducted.
   - *Audit trail:* A clear description of the method, process notes, interview questions, interview recordings and transcribed interviews will be stored

for six years per the requirements of the University of Witwatersrand's requirements.

4. *Confirmability*

Confirmability is associated with neutrality and objectivity (Lincoln & Guba, 1985). To ensure these, data analysis commenced with the assistance of an external auditor (co-coder) who assisted the researcher with the coding process, including first round and second round analysis. This ensured that the researcher's biases did not influence the findings. The co-coder was a senior lecturer in the occupational therapy department at the Witwatersrand University, who was not the researcher's supervisor and therefore also unbiased to the research study. To further contribute to the neutrality and objectivity of the research, the researcher only reported consistent and stable findings which was derived from the participants and not from own biases.

3.7. Ethical considerations

Ethical clearance was applied for and granted by the Human Research Ethics Committee of the Faculty of Health Sciences at the University of the Witwatersrand. The research's ethics number is M170910 (Appendix D).

The participants were provided with the approved information sheet and informed consent sheet and were asked to sign consent to be recorded as described in 3.4 (Appendix B). The participants were informed that their participation held no direct benefits, that they were free to withdraw from the study at any time without consequences and that anonymity would be maintained throughout the study. Anonymity of the participants, the legal entities who employed the participants and the clients whose cases the participants managed were not recorded and no personal identifying information obtained during the interview, including any names, will be shared. Participants were asked about their perceptions and experiences and this information was reported on anonymously by giving each participant a number rather than using any personal identifying information.

3.8. Conclusion

A qualitative research approach was used to enable the researcher to explore the participant's perception of their role as case managers within a medico-legal context, giving insight to their experiences and opinions regarding the topic. Interviews were used to gain information and the research procedure was described. Strategies to ensure trustworthiness included credibility, member checking, peer debriefing, accurate transcription of the information, transferability, dependability, obtaining data saturation, audit trail, confirmability and bracketing.

Ethical clearance for this study was obtained from the Human Research Ethics Committee of the Faculty of Health Sciences of the University of Witwatersrand. Informed consent was obtained from each participant.

CHAPTER 4

4 RESULTS

This study aims to describe South African occupational therapists who work in the medico-legal context's perception of their role. In order to answer this question, three objectives guided the study. These were to explore South African occupational therapists who work in the medico-legal context's perception of:

- Their roles and responsibilities as clinical case managers working within the medico-legal context.
- The skills and knowledge they possess which support their ability to perform this role.
- Their perceived preparedness to work as case managers within this role.

This chapter reports on the results of the study and is presented according to the three objectives.

4.1. Demographic information on participants for this study

Data was collected through one-on-one, semi structured interviews with eight occupational therapists from South Africa. All participants were white and female. Only seven recording were transcribed as one participant did not meet the inclusion criteria, despite indicating that she did. From the remaining seven participants, three of the participants obtained their Bachelor in Occupational Therapy at the University of Pretoria (UP), three a Bachelor of Science at the University of Witwatersrand (Wits), one a Bachelor of Science at the University of Cape Town (UCT) and one a Bachelor in Occupational Therapy at the University of the Free State (UFS). Participants reported having between eight and 27 years of experience at the time of the interview in 2018. Three participants had 20 or more years of experience in occupational therapy, three had ten or more and one had more than five years. Three participants had post-graduate qualifications including one Master of Science (MSc) obtained at Wits and two diplomas obtained at UP, one in Vocational Rehabilitation (DVR) and one in Hand Therapy (DHT).

Table 4:1 Demographic information on Participants for the study

Participants	Code	Basic qualification	Year of qualification	Training institute	Postgraduate qualifications	Years of OT experience
Participant 1	P1	B Occ Ther	2006	UP	DVR (2008)	12
Participant 2	P2	BSc OT	2010	Wits	MSc OT (2016)	8
Participant 3	P3	BSc OT	1992	Wits		26
Participant 4	P4	B Occ Ther	2001	UP	DHT (2002)	17
Participant 5	P5	B Occ Ther	1998	UFS		20
Participant 6	P6	B Occ Ther	2000	UP		18
Participant 7	P7	BSc OT	1991	UCT		27

4.2. Themes, categories, subcategories and codes

Three themes emerged from the thematic content analysis of the qualitative data. Each theme that emerged answered a research objective.

The first theme, *Holistic role approach,* is linked to the first objective, indicating that case managers working within the medico-legal context make use of a holistic role approach to fulfil their roles and responsibilities as clinical case manager.

The second theme, *Integrated body of knowledge and skills,* linked to the second objective, indicates that case managers working with the medico-legal context, make use of an integrated body of knowledge and skills to perform their role.

Lastly, the third theme, *Broad experience,* is linked to the third objective, indicating that broad experience prepared the case managers to work within the medico-legal context.

The above themes will be reported on by exploring the categories, subcategories and codes. Codes will be substantiated by quotes form participants.

4.2.1. Objective 1:

*The researcher explored South African occupational therapists who work in the medico-legal context's perception of their **roles and responsibilities** as clinical case managers.*

Participants shared their perceptions in open ended questions. The theme that arose from the data analysis, was ***Holistic Role Approach.*** The theme highlighted the participants reported perception that case managers within the medico-legal context assume various roles and therefore make use of a holistic role approach. This theme emerged as participants did not relate to only responsibilities associated with one role but rather with multiple roles.

As there are known professional roles of occupational therapists in literature (AOTA, 1993; Nestadt & Blesedell, 1998), as defined in the nomenclature and operational definitions and described in Chapter 2, the definitions of these roles were used as a theoretical framework for a deductive coding process of Theme 1 (Pope, van Rooyen & Baker, 2002). A new role, the coordinator, which is not described in occupational therapy literature emerged and will be discussed below. Each category represents the various roles to which participants related and, as the case managers combined them, their approach can be viewed as a holistic one. The sub-categories are responsibilities related to each role as defined in literature and the codes are the tasks related to each responsibility as reported by the participants.

Table 4:2 Theme 1 - Holistic role approach

Category	Subcategory	Code
Manager role	Managing finances	- Finding the necessary quotes from service providers or suppliers. - Organising medical aids. - Managing monthly allowances. - Making arrangements in terms of the accounts.
	Managing the team	- Overseeing an admin person. - Contracting the medical team.
Collaborator role	Being the liaison between the client and the legal entity	- Running decisions via the family and via the trust. - Being the link between the family and the trust.
	Facilitating participation in daily activities	- Facilitating community integration such as leisure and social activities. - Directing them to work opportunities.
Coordinator role	Coordinating appropriate care and interventions	- Making the necessary medical and rehabilitation appointments - Making the necessary transport arrangements. - Sorting out admissions. - Sourcing caregivers, school facilitators and au pairs when needed. - Sourcing and managing consumables. - Follow up and monitoring of the case process.

	Ensuring that the environment is suited for the client	- Procurement of recommended equipment and/or assistive devices. - Coordinating housing and the required adaptations. - Ensuring that an adequate vehicle is purchased. - Getting clients into the right schools. - Finding the right placement facilities.
	Facilitating appropriate support for the family	- Connecting parents to other parents of special needs children in the community. - Sending parents to psychologists.
Advocacy role	Managing the family's expectations	- Ensuring that the money is spent for the benefit of the client. - Reminding family that the money is not going to last forever.
	Creating opportunity for the family to empower themselves	- Give family the resources to take on as much as they can on their own. - Reduce the ongoing need and the dependency of the family on the case manager.
Clinician role	Client intervention	- Helping the client to put down boundaries. - Training the client on equipment. - Doing home visits. - Doing work visits. - Identify other needs which emerge. - Being available 24/7 for emergencies.
	Family and/or caregiver intervention	- Advising the family. - Educating the family. - Caregiver and parent training.
Consultant role	Consulting the legal entity	- Advising and guiding the curators or the trust involved on the management of the case post-trial - Writing motivational reports for the court, trusts and curators. - Facilitating meetings with the trusts.
	Consulting the team and/or stakeholders	- Consulting on home accessibility and adaptations. - Commenting on appropriateness of properties.

The results pertain to participants' perceptions. They identified that they require a holistic role approach and related to five known roles; manager, collaborator, clinician, consultant and advocacy role.

4.2.1.1 Manager role

Occupational therapy literature identifies that the manager leads staff and resources (AOTA, 1993; Nestadt & Blesedell, 1998). Participants identified that managing finances (which would relate to managing resources) and managing the team (which would be related to management and/or leading the multi-disciplinary and multi-sectorial staff) are typical responsibilities associated with case management.

Managing finances

Participants indicated that they had many responsibilities which required them to manage finances. For example, the legal entity might request them to find the necessary quotes from service providers or suppliers, such as a vehicle, driving lessons, equipment, etc.

P3: ***"[…] the Trustee was then asking me to find quotes…"***

Another financial management responsibility was to organise medical aids for the clients who did not have such support and would benefit of having medical aid in order to better utilise the available funds. Organising medical aids was considered a way of managing the client's finances and therefore part of the manager role.

P2: ***"[…] organising medical aids if it's the best route to take to try and help save funds".***

Participants reported that it is also their responsibility to manage the monthly allowances of the clients, especially for those who cannot manage their own finances. In the medico-legal field, clients who are declared incapable of managing their own affairs require a curator or trust to be appointed by the court, as an administrator (The Department of Justice and Constitutional Development, 2003). The appointee may then appoint a case manager who would then manage the monthly allowance of the client.

P5: ***"[…], is just putting things into place, so I will get him online shopping for his groceries put into place, pre paying for contract for his phone and they pay him for his rent, for his unit directly to the owner of the place that he is staying in…"***

Lastly, the participants reported that it is the responsibility of the case manager to make arrangements to settle the client's accounts, including during hospital

admission, therapy appointments, all contributing to the management of the client finances.

P1: ***"[…] make arrangements in terms of their accounts because often there is difficulty having the accounts paid immediately..."***

Managing the team

Managing or leading the team was a typical responsibility of the manager. Participants indicated that they had many responsibilities as case manager which requires of them to manage the team.

Their first responsibility related to overseeing an administrative person. From participants' reports it is evident that there was great benefit in having an administrative person to do many of the administrative tasks e.g. making the necessary medical appointments, but that this person still required supervision from the case manager, which requires effort and time.

P3: ***"You know so you've got your very admin intense [intense admin while managing the case]. Have a really good PA to do all the admin stuff, make the following appointments she comes back to you,' no, we can't have Dr [confidential name] making please move it because you've only got the splint appointment there' that's why you can't just have an admin person doing it you need to still oversee it…"***

It was also the responsibility of the case manager to contract the multidisciplinary team, who form part of managing the overall team (including members of the inter-sectorial team) who is involved in the case.

P5: ***"[…], I will identify where it is needed to bring in a social worker as well or work in connection with a social worker or when it is needed to as I said employ an occupational therapy to do something or employ a physio to do something or an occupational therapy that specialises in a certain area…"***

This role included being able to identify needs which required clinical reasoning skills, which can be considered a required skill to fulfil the role of clinical case manager within the medico-legal context, which will be discussed in Theme 2.

4.2.1.2 Collaborator role

Participants stated that they were responsible for tasks such as interacting and working with others, which were typically be associated with the collaborator role. They reported that being the liaison between the client and the legal entity and facilitating participation in daily activities formed part of their responsibilities as clinical case manager within the medico-legal context.

<u>Being the liaison between the client and the legal entity</u>

Being the liaison between the client and the legal entity was considered a responsibility of the collaborator, as this required interaction and working across sectors with the legal team and the client and their family towards a common goal.

Participants reported that it was their responsibility to run decisions (related to the best possible outcomes for the client such as therapy, consumables, etc.) via the family and the trust, which required them to interact with both the legal entity and the family to ensure that all stakeholders had a common goal in mind.

P7: ***"It has to be run via the family and via the trust and just to keep within those parameters…"***

Participants reported that it was their responsibility to be the link between the client and the legal entity. They made sure to interact with both important stakeholders in the case to ensure that there were common goals, while being mindful of certain obligations towards the legal aspects of case.

P7: ***"I truly believe that we are very well placed to be that person, to be the go between the trust and family, to be mindful of the needs as well as having cognisance of what are the rules, regulations of a trust…"***

In the above quote, the participant highlighted the fact that she believed that occupational therapists were well suited to be that person who ensured the collaboration. This was likely due to occupational therapists understanding of the holistic, bigger picture.

P2: ***"[…] oh gosh I think clinically, clinical skills we definitely use as understanding the holistic picture."***

P2: ***"I think we're taught to look at everyone in a holistic approach from undergrad… we consider all areas always that's part of our training and we understand disability as a whole looking at the social context… the physical context, psychological, behavioural, cognitive. So, with… and when you look at that you're looking at the family and the extended boundaries of a human and an individual. So, I think that in itself helps you to look at a picture fully and understand all limitations that the family are, are going through."***

These skills and knowledge as described in the above two quotes will be discussed in more detail in Theme 2.

<u>Facilitating participation in community based daily activities</u>

Facilitating participation in community based daily activities was be considered a responsibility of the collaborator, as this required interaction and working with other health care practitioners, members of the multi-disciplinary team, community members and other stakeholders.

Participants stated that they were responsible for facilitating the client's participation in daily activities by facilitating community integration in leisure and social activities. This required case managers to collaborate with community members or stakeholders who had or knew of opportunities available in their communities. The case manager worked with these people and the client to ensure the client engaged in the appropriate occupations such as leisure and social activities.

P6: ***"Okay so that is basically ADL's and work and then leisure, obviously also it would be nice to get them involved in community participation which is refer again not actually doing the physical therapy or whatever, getting them involved for example in wheelchair basketball or whatever, it is more a network of information that's supplied."***

P7: ***"[…] connecting parents to other parents of special needs children for example in the community as well as integrating or assisting them to actually reach out to the abled bodied neighbours and friends and not to just box these kids in either."***

The first quote highlights community reintegration through means of leisure activities while the second highlights community reintegration through social activities, both were considered components of daily activities.

Participants indicated that they facilitated clients' participation in daily activities by directing them towards work opportunities. Case managers facilitated this by interacting with stakeholders or community members who had or knew of opportunities available for the clients to achieve a common goal of securing work for the client.

P4: ***"Future placement of supportive or what you call it, sheltered employment if you get to that point…"***

4.2.1.3 Coordinator role

The definition of case management described a collaborative process *(CCMC, 2013),* however in a typical medico-legal case in the South African case management context, the case manager's function was rather described as coordinating therapies and interventions *(AD v MEC for Health and Social Development)*. Therefore, it was important to distinguish between collaboration and coordination.

From the interviews with participants it is evident that they identify with responsibilities associated with coordination. Therefore, a role, which is not described in occupational therapy literature, emerged.

Participants reported that coordinating appropriate care and interventions, ensuring that the environment was suited for the client and facilitating appropriate support for the family all forms part of their responsibilities as clinical case managers.

Coordinating appropriate care and interventions

Coordinating appropriate care and intervention was considered a responsibility of the coordinator as this required encouraging groups of people such as health care professionals, members of the multi-disciplinary team and community members to work together.

P7: ***"[…] to assist the families in putting the whole package of care and rehabilitation together to ensure that all is recommended actually happens and as effectively and as age appropriately as possible."***

Participants expressed that it was their responsibility to make the necessary medical and rehabilitation appointments with members of the multi-disciplinary team in order to ensure the client received the appropriate care.

P6: ***"[…] then I start arranging whatever they need, either therapy or medical appointments..."***

A further responsibility of the case manager included making the necessary transport arrangements for the client to get to the appropriate appointments. Participants reported that they do this by working with transport companies, taxi services, etc. which required coordination of the service.

P5: ***"[…] or transport, so they really, you know, came up with a lot of things that I have to assist with."***

P7: ***"[…] I think our abilities as OT's to truly look at family dynamics, to housing aspect, to transport issues to all the layers that come with raising or living with a disabled adult or child.***

From the above quotes it can be seen that case managers were required to coordinate transport, but that it is not merely transport, it is arranging transport for people with disabilities who cannot do this for themselves. This could include various complexities that need to be considered e.g. if the disabled person has a wheelchair or other types of assistive devices that are also requires transportation.

In addition, the case manager is responsible for sorting out various types of admission such as to hospital or a rehabilitation centre. The case manager coordinates the necessary service providers and/or administrative staff to ensure that the client receives the appropriate care and interventions.

P6: ***"[…] in terms of like medical admissions, hospital admissions, medical care…"***

P2: ***"In terms of RAF cases we've dealt with patients having to be put into rehab facilities, landing up as drug addicts that we've had to sort out".***

The second quote highlights the severity and complexity of the medico-legal cases which therefore could require more complex management e.g. admitting a client to a rehabilitation centre for drug addiction but then also considering the complex management of the case after discharge and coordinating the necessary precautions.

Another task that case managers reported was sourcing caregivers, school facilitators and *au pairs* when needed, again requiring contacting and coordinating the necessary service providers to ensure the client receives the appropriate care.

P4: ***"Specifically, with the cerebral palsy children, it's an overall view from making sure that they get the right therapy, the right schooling, sourcing caregivers, facilitators or au pairs when needed…"***

The above quote highlights that it is the case manager's responsibility to coordinate these people but also to ensure that the most appropriate people are identified to deliver these services. This also requires clinical reasoning skills (such as scientific reasoning and narrative reasoning) and knowledge about the condition, support the client would require, etc., which are discussed in Theme 2 below.

Similarly, sourcing and managing consumables would be considered a role of the case manager. This would require coordinating service providers to ensure the necessary consumables are available for the case care.

P6: ***"[…] arranging for consumables, like nappies, linen savers, you know the KY jellies, those kind of things, catheters…"***

Lastly, in terms of coordinating appropriate care and interventions, participants reported the case manager was responsible for follow up and monitoring the case process, which included working closely with, and coordinating everyone who was involved in the case.

P3: ***"[…] make sure that all of that is coordinated you know your different therapies your different medical interventions and in what order it should happen and how it should happen because you can't get the wheelchair and a seating right until you've had some of the surgery and you shouldn't have this splint made until you've had Botox to have it released and you shouldn't have that in place and have the Botox without having your six months of post surgery's physio in place. You know so its coordinating that whole team…"***

It was noted that from the above quote, that case managers within the medico-legal context, made use of various skills (such as clinical reasoning, prioritisation, etc.), in order to coordinate appropriate care and interventions, which would also all be considered required skills.

Ensuring that the environment is suited for the client

Ensuring that the environment is suitable for the client could be considered a responsibility of the coordinator. This would require encouraging groups of people such as health care professionals, members of the community and/or other stakeholders/professionals in various sectors to work together to ensure that the client has the required equipment and/or assistive devices, housing, vehicle, schools or placement facilities.

Participants conveyed that it is their responsibility to procure the recommended equipment and/or assistive devices, which requires coordinating the suppliers within the community to ensure the equipment and/or assistive devices would contribute to providing a suitable environment for the client.

P6: ***"[…] ordering equipment, making sure it has been put in place, you know firstly assessing for the right stuff, and then measuring, seeing what they're needing, ordering it online or telephonically or whatever and then getting it put in place and see that they actually able to use it."***

From the above quote it is evident that participants rely on their clinical skills e.g. assessment skills to determine what type of equipment and/or assistive devices would be needed. This is further discussed in Theme 2.

Participants also reported that their role included housing and the required adaptations, which involved coordinating with estate agents to obtain the appropriate housing and with builders or architects to ensure the required adaptations are implemented. This would all ensure the client's environment is suited for their needs.

P3: ***"So that's where you know I see my role and its very much looking at you know housing, accommodation and make sure that all of that is coordinated…"***

P2: ***"[…] moving people into houses that are more adequate or adapting the house that they're in if the house is good enough."***

Participants stated that it is their responsibility to ensure an adequate vehicle is purchased for the client, involving coordinating with the relevant vehicle experts and vehicle dealer to ensure the vehicle is appropriate for the client to ensure that the client's environment is suited for them.

P2: ***"Looking at vehicles that are adequate for the child and the family and wheelchairs…"***

Gaining access to the right schools for clients is also a responsibility of the case manager requiring interaction with the schools in the community to find the most suitable school and thereby ensuring the environment is most suitable for them.

P2: ***"[…] you manage their entire life pretty much, so you're looking at finding schools..."***

The above quote reports on the responsibility of the case manager to find the clients a school if that is required, but it also reflects on them managing the client's entire life, which would require knowledge of a person as a whole. This is knowledge that occupational therapists possess, which will be discussed in more detail in Theme 2.

Above, it was reported that the case manager is responsible for sourcing the appropriate caregivers, school facilitators and *au pairs*, which contributes to the coordination of appropriate care for the client, whereas coordination of appropriate schooling rather focuses on ensuring that the client's environment is suited for their needs.

Lastly, participants reported that it is their responsibility as case managers to find the right placement facilities for clients. This requires them to coordinate with the treatment facilities in the community to ensure the placement is suited for the client.

P7: ***"I am actually also assisting an adult male who is prematurely in a more of a kind of a retirement home because he is had a, he has got slight hemiplegia and also traumatic brain injury, subtle stuff going on and he was unable to live independently, so just to find the right placement for him not an old age home, somewhere which where he would be safe yet still have all his other needs met and social, that sort of peripheral supervision and that was quite a challenging case as well so it is not just children, it is the ability to work across the board age-wise."***

From the quote above it is seen that the participant relies on clinical reasoning skills as well as on medical knowledge to perform this role, which will further be discussed in Theme 2.

Facilitating appropriate support for the family

Facilitating appropriate support for the family could be considered a responsibility of the coordinator as this requires encouraging the family to access other health care professionals, multi-disciplinary team members and community members to get the support they require.

Participants indicated that a role they perform as case managers is to connect parents to other parents of special needs children in the community. This would require the case manager to coordinate with people in the community to find out where the family could access the appropriate support and to coordinate their meeting.

P7: ***"[…] this particular mom was quite anxious, and she met with a mom in a similar community to discuss and in terms of ADL and care and what that means for this child."***

P7: ***"[…] connecting parents to other parents of special needs children for example in the community as well as integrating or assisting them to actually reach out to the abled bodied neighbours and friends and not to just box these kids in either."***

The second quote highlighted that the participant also saw value in connecting the client and their families with abled bodied peers for further support for the families.

Participants reported that sending parents to psychologists in order to support them is a role they performed as case manager. This required the case manager to coordinate with the psychologist to find the adequate support for the family.

P2: ***"[…] sending the parents to psychologists sometimes because they've been through so much themselves…"***

4.2.1.4 Advocacy role

P1: ***"[…] to stand up and kind of put myself out there as an advocate for this client…"***

Occupational therapists advocate on behalf of, or in collaboration, with their clients. However, considering that many of these clients do not have the capacity to administer their own affairs, case manager must advocate on behalf of the child or disempowered individual.

Participants perceived that they were responsible for tasks which would typically be associated with the advocacy role, such as managing the family's expectations and empowering the family to take care of the client, both promoting the interest of the client.

<u>Managing the family's expectations</u>

Managing the family's expectations (i.e. regarding the intention of what the medico-legal payout money) was considered a responsibility of an advocate as it promoted the interest of the client who were not able to speak for themselves and promoted change in the family's attitude toward the case, client and money.

Participants stated that they were responsible for managing the client's needs versus the perceived needs of the family by ensuring that the money was spent for the benefit of the client (and not the family). Managing the family's expectations in such a way was considered advocating for the client as it promoted both the interest of the disempowered client and change in the family's attitude.

P4: ***"[…] effectively making sure that the money is spent on the child and not on other stuff what is meant to be spent on.'***

The quote below explained that the case manager reminded the family that the money should be managed in a sustainable manner and through doing so, the case manager changed the family's attitude.

P1: ***"[…] asking for random things for themselves or the houses is not in the benefit of the child and the money is not going to last forever."***

Creating opportunity for the family to empower themselves

Creating opportunities for the family to empower themselves was also considered a responsibility of the advocate as it promoted both the interest of the client and changes in the family's attitude towards their own abilities. The case manager created opportunities for empowerment by giving choices to the family so that they could make informed choices in order to have more control in their situation.

P7: ***"[…] what the more radical orthopaedic surgeons might be recommending in terms of radical orthopaedic surgery for the CP kids, really assisting the parents in terms of gathering information, so sometimes I have even sourced books on a particular topic for example when the parents may be reluctant to… with the pegs [percutaneous endoscopic gastrostomy] and CP kids, some parents really just need time, the right specialists and literature and just to aid them in decision making processes definitely I see that as the case manager role…"***

P1: ***"[…] we do try and give them the resources to take on as much as they can on their own…"***

Participants expressed that they were responsible for giving the family the resources to take on as much as they can on their own so that it reduced the ongoing need and the dependency of the family on the case manager.

P7: ***"[…] through the process this mom has become quite empowered, in fact very empowered and she actually still sometimes doubts herself and will bounce things off me, but my involvement has drastically reduced."***

4.2.1.5 Clinician role

Although the clinician role was not typical of case managers, the participants reflected on responsibilities which would routinely be associated with the clinician role, when functioning as a case manager within the medico-legal context. The participants identified that the role was assumed as they had responsibilities in terms of client, family and/or caregiver intervention (which all form part of the intervention phase of the occupational therapy process). It was argued these tasks come naturally to the occupational therapists, who had and utilised these skills.

<u>Client intervention</u>

Providing client intervention was also a responsibility of the clinician as it forms part of the occupational therapy process (AOTA, 2014). Participants reported on a few responsibilities which would be considered client intervention, which are discussed below.

Boundary setting was considered a typical interpersonal relationship skill which can be addressed in occupational therapy and thus helping clients establish boundaries would form part of occupational therapists' client intervention, and thus form part of the clinician role.

P5: ***"[…] previous family members that they stayed with but now wants a part of the pie in terms of the money that is available, so just trying to help the client to put down boundaries for that…"***

Participants reported that the case manager within the medico-legal context would at times train the client to use equipment, which formed part of the client intervention phase of the occupational therapy process and therefore part of the clinician role. This required the case manager to have knowledge of equipment, which will be further explored in Theme 2.

P5: ***"[…] in terms of equipment as well, procurement of equipment and training the client on it."***

Participants reported that the case manager was required to do home and work visits and this assisted in identifying other needs that emerge, which all formed part of clinical intervention or evaluation phases of the occupational therapy process. These responsibilities are considered a role of the clinician.

P6: ***"[…] I always do a home visit, well basically I do continuously home visits, or several home visits…"***

P5: ***"[…] but as a case manager if I go in and I do a work visit and see…"***

P7: ***"[…] so just to take cognisance of what is being recommended to obviously make it current and now and then to further identify other needs which emerge, which often include things which perhaps haven't been identified by the medical experts in the process…"***

P6: ***"[…] firstly assessing for the right stuff, and then measuring, seeing what they're needing…"***

From the quote above by P7, it was evident that the participant noted that the needs of the case might change, or new needs might emerge, and therefore she required

the skills to be able to identify these needs. From the last quote it was seen that the participant has the skills required to assess, measure and identify needs. All of the above formed part of the clinician role and as the case manager participants were all occupational therapists, it was assumed that they had the required skills to perform the clinical role, which will further be discussed in Theme 2 and Theme 3.

The participants reported that being available 24/7 for emergencies to assist the clients or their families with whatever problem might arise was part of their role as clinical case managers within the medico-legal context.

P1: ***"Then I'm also on beck and call 24/7 for emergencies… so should something happen to a client during the night families are ill equipped and even though we do try and give them the resources to take on as much as they can on their own they often don't have the ability to contact the Trust, the Trustees or Curators often don't want to give their personal numbers so if something happens outside of office hours it becomes quite difficult to get the, the money needed to get the person admitted to hospital. And often they don't know whether this is an emergency that warrants going to hospital… they don't always understand what's going on. So, then I would often get phone calls where I would need to explain what, what needs to happen. I often need to phone an ambulance, contact doctors, make arrangements in terms of the accounts because often there is difficulty having the accounts paid immediately and we need to try and negotiate to get the children or adults the care that they require."***

From this, it was seen that the case manager was required to be available to the client at all times, in order to support the client in whatever situation that arose. It was also seen that these situations were often complex and required a lot of input from the case manager.

Family and/or caregiver intervention

Providing family and/or caregiver intervention was another responsibility of the clinician that formed part of the occupational therapy process (AOTA, 2014) and was considered as intervention for a group of people.

Participants conveyed that they advised and educated the family on any aspects which they are unfamiliar with, which formed part of the family and/or caregiver intervention phase of the occupational therapy process and therefore was consistent with the clinician role.

P1: ***"[…] I need to advise the families on the procedures that are going to be done so I need to make sure that the families really understand what the doctors have said…"***

The participants reported that they performed caregiver and parent training, which was considered part of family and/or caregiver intervention, which is included in the occupational therapy process and therefore a role of the clinician.

P4: ***"[…] we also sourced a Hiday system for communication purposes, trained the caregiver in that as well as the parents..."***

From the above quotes it was seen that the case manager advised and educated the families and also provided training to caregivers and parents. These were typical responsibilities associated with the clinician role, however, it appeared form the above that the occupational therapists who were case managers within the medico-legal context had the required skills to do these tasks and therefore were likely to perform these tasks, as it came naturally to them, rather than referring to a member of the multi-disciplinary team.

4.2.1.6 Consultant role

P5: ***"It's, it differs with the different trust companies that I consult for so they see me as a consultant and they have different needs…"***

Participants reported they were responsible for tasks which would typically be associated with the consultant role and believed that they assumed this role as they consult the legal entity as well as the team and/or stakeholders through providing advice based on expertise. The participants in this study were all occupational therapists and therefore it can be assumed that the aspects that they consulted on were within their expertise as occupational therapists.

Consulting the legal entity

Consulting the legal entity was considered a responsibility of the consultant, who advised the curators or trust involved on the management of the case post-trial, either through attending meetings or by means of a report. Here, the case manager advised, based on their expertise as occupational therapists, which formed part of the consultant role:

P5: ***"[…] with the post RAF [Road Accident Fund] funds you are consulting for the trust and the trust is actually your client, not the client, and it is quite a mind-set change because they are ultimately responsible for the client's funds so you can advise them and guide them…"***

P2: ***"[…] the Trust sees you as the medical expert that helps to implement the medical needs and social needs in accordance with what was recommended in the medico-legal reports."***

P1: ***"I need to write motivations to the Master of the Court and sometimes to the Trust or Curator related to anything out of the ordinary that the children or clients may need."***

Participants reported that they used their group facilitation skills during meetings with the trusts, to benefit the process.

P3: ***"[…] being able to run groups and facilitate groups because often you are doing that when you're meeting with Trusts."***

Consulting the team and/or stakeholders

Consulting the team and/or stakeholders was considered a responsibility of the consultant as the consultant advised them based on their expertise as occupational therapists.

The team members and/ stakeholders that participants referred to included professionals such as architects who advised on home accessibility and adaptations, based on their expertise.

P4: ***"Then the next step as soon as the trust has approved, has approved the purchase will be to sit with an architect and draw up the plans to ensure that the house is accessible for him [the client] in the future."***

The participants further noted that the case manager would also advise on home accessibility and appropriateness of properties and would consult the real estate agents as well as the legal entities, based on their expertise as occupational therapists.

P1: ***"When houses need to be organised for the clients either to purchase or to rent then I consult on accessibility and changes or adaptations that may be needed in the home to allow the client's wheelchair for example to fit through or a hoist system to be appropriately installed so it comments on the appropriateness of properties."***

From the stated perceptions of the participants it can be concluded that participants made use of a holistic role approach when performing the role of a case manager within the medico-legal context thus addressing objective 1.

4.2.2. Objective 2:

The researcher explored South African occupational therapists who work in the medico-legal context's perceived ***knowledge and skills*** *which support their ability to perform the role as clinical case managers.*

Participants shared their perceptions, through open-ended questions, about their knowledge and skills that support their ability to perform the role as clinical case manager within the medico-legal context.

The theme that arose from the data analysis of the interviews, was ***Integrated body of knowledge and skills.*** This second theme highlights the participants' reported perception that case managers within the medico-legal context require a broad range of knowledge and various skills. This theme emerged as participants did not relate to one specific skill but rather to various skills and an integrated body of knowledge of humans as occupational beings that would be required to perform their role.

During analysis, three categories of skills were evident, namely clinical reasoning, professional skills and administrative skills. Participants also reflected that they used a broad knowledge of a client as an occupational being to perform their role.

When considering the first category of skills, namely, clinical reasoning, there are known types of clinical reasoning types described in literature (Boyt Schell, 2014). These known clinical reasoning types' definitions were used as a theoretical framework for the coding process (Pope, van Rooyen & Baker, 2002) of clinical reasoning skills. Therefore, deductive coding was used for clinical reasoning skills. For the remaining skills (professional and administrative) and the body of knowledge, inductive reasoning was used (Pope, van Rooyen & Baker, 2002). This is presented in tabular form below.

Table 4:3 Theme 2 - Integrated body of knowledge and skills

Category	Sub-category	Codes
Clinical reasoning skills	Ethical reasoning	- Rather refer the client to an occupational therapist who then does the treatment. - Not fulfilling the role of expert witness and case manager.
	Narrative reasoning	- Culturally that is what is appropriate (particularly in our African cultures). - It depends on the client's circumstances. - To understand where their needs are coming from.
	Pragmatic reasoning	- It is being aware of the pace at which the client can go. - Not having space in my practice.
	Scientific reasoning	- I then need to be the voice of reason. - Having the knowledge and skills.
	Conditional or Interactive reasoning	- Put all skills together and use them all. – - Deciding which skills to use.
Professional skills	Interpersonal skills	- Negotiation skills - Assertiveness skills - Mediation skills and diplomacy - Networking skills - Conflict management skills - Communication skills
	Conduct skills/ Professionalism	- Setting boundaries. - Thinking and questioning your own prejudices. - Keep yourself personally distant
	Project management skills	- Planning and organising skills - Problem solving skills - Time-management skills - Multi-tasking skills - Critical thinking and analytical skills - Crisis management skills - Prioritising skills - "Moving skills" - Ability to think out of the box - Adaptability and flexibility
Administrative skills	Implementing systems to keep track of change	- Put systems into place so your admin staff can help implement the system. - We've got excel sheets for everything.
	Report and other writing skills	- Record keeping skills - Taking notes. - To write motivations to the Master of the Court - Your written ability in terms of justifying, calculating and motivating.
Integration of knowledge of a client as an occupational	Knowledge of a person as a whole	- Holistic approach to the client. - Being suited for the multi-faceted cases. - Having general knowledge about medical conditions as well as functional.

being	Knowledge of a client functioning as part of a collective	- If you can see where your whole family is functioning, then you know how to approach. - You need to look at the family as a whole. - OTs have the ability to look at that the family dynamics.
	Knowledge of optimal occupational functioning	- We've got an understanding of the client's ability and functioning. - Knowledge of functional implications and equipment. - OTs work with patients though activities of daily living. - Occupational therapists have a wide variety of skills.

The results pertain to participants' perceptions. They perceived themselves to have suffice/adequate knowledge and skills to support their ability to perform their role as case managers within the medico-legal context. They identified three categories of skills, namely, clinical reasoning, professional and administrative skills as critical within case management. Participants reported making use of clinical reasoning skills, which were skills that clinicial occupational therapists have been taught and which form the basis of their thinking approach (Flemming, 1991). Participants also reported using professional skills, which are skills that a person who is engaged or qualified in a profession would use and administrative skills, which are skills typically required to complete tasks related to managing a business or practise. Lastly, participants reported making use of an integration of knowledge on the various aspects related to humans as occupational beings. Participants reflected on their integration of this knowledge and the above skills which all contribute to their ability to perform the role of clinical case manager within the medico-legal context. This will be discussed below.

4.2.2.1 Clinical reasoning

During the interview, participants described that they use clinical reasoning skills to perform their role of clinical case manager. They identified that all types of clinical reasoning skills are required, including ethical reasoning, narrative reasoning, pragmatic reasoning, scientific reasoning and conditional/interactive reasoning (Boyt Schell, 2014).

Ethical reasoning

P1: ***"It makes it very difficult because you need to know what you need to present how so you need to try and keep your objectivity while seeing the human side of things because otherwise these families become numbers to the Trust. Ja, so a lot of ethical reasoning as well related to these aspects…"***

As seen from the above quote by P1, case managers require ethical reasoning skills to ensure that clients are seen as humans and not merely as numbers. They were required during the course of their work to analyse ethical dilemmas and to provide suitable solutions and appropriate action (Boyt Schell, 2014) when working with these complex cases.

Participants reported that as case managers they do not fulfil the role of expert witness as this would be considered unethical, as seen in the quote below by P7. Should an expert witness recommend case management for the case, it could be questioned if the expert witness is making this recommendation for their own financial gain. By choosing not to perform both roles, the case manager is following an appropriate approach to an ethical dilemma.

P7: ***"So, then [confidential name] knew my experience and asked if I would take over from case manager point of view because obviously she could not continue being the assessor in terms of expert witness and case manager…"***

Participants also reported on ethical dilemmas they have faced as case managers and how they responded as a consequence of their ethical reasoning skills. Participants indicated they would rather refer the client to another occupational therapist for treatment than being questioned if the request for treatment could be construed as for their own financial gain. This however contradicts what participants reported as recorded in Theme 1 – Clinician role. It appears that although the clinician role is not typical of case management, participants sometimes assumes these responsibilities. It was argued these tasks come naturally to the occupational therapists, who had and utilised these skills.

P3: ***"Here's a good treating therapist, I can't treat you because I did your original medico-legal assessment…"***

Narrative reasoning

In order to understand a client's experience, occupational therapist would make use of narrative reasoning. Participants reported that it is important to be aware of clients and their families and their experiences in order to understand certain decisions they make, as seen in the quote by P1 below.

P1: ***"And sometimes it's not always that it's with a bad intent sometimes it is just because culturally that's what appropriate particularly in our African cultures where families look after each other and if one person has money then they care for everyone in the family and that is a strong cultural thing…"***

P3: ***"But we've got a funeral next week and he doesn't… he can't wear a white shirt and we have to wear white because that tradition that's the only thing to worry about nobody listens to that because everybody's too busy worrying about everything else and they ask you but that's their bigger stress is that he's not going to look the same at the funeral…"***

In the quote above by P3, the participant described a situation where a client required a specific piece of clothing for a funeral as this was culturally appropriate. The case manager requires narrative reasoning to understand that, for this client, a white shirt was needed at that time. Obtaining the appropriate white shirt was that client's priority because of his culture and the case manager would require an understanding of this immediate need. Participants reported that as case managers they would have to be aware that the management of the case would depend on the client's circumstances. Understanding the client's circumstances would be enhanced by narrative reasoning so that case managers can comprehend a client's specific situation and/or circumstances, which would guide their management.

From the quote below by P7, it can be seen that circumstances that should be considered can include (but are not limited to) location, literacy, language, support structure, family structure, etc.. Narrative reasoning skills will assist the case manager to be able to comprehend the client's specific situation (based on these aspects) and manage the case based on these circumstances.

P7: ***"[…] it depends entirely on the location of the patient, if they are in a rural or more urban and literacy, language level for example with the Mafikeng family they are brand new to Cape Town, their support structure is very limited. Mom has recently lost her husband as well, so it is also identifying she hits an incredible dip so her emotional needs is something that I am also addressing, which wasn't identified at medical expert stage because she was still married and in a secure supportive structure."***

The same participant, P7, further highlighted the importance of also understanding the experience and the circumstances of the family, in understanding the circumstances of the client.

P7: "***With moms needs and mom's desperate needs she returned to work which wasn't a need then but now it is, so the evolution of the case and being very mindful as the case manager as to what is the current context and, in the process, as well."***

This understanding of the family circumstances forms part of the case managers' narrative reasoning skills, but also requires the case manager to have knowledge on the client as part of a collective, which in turn, forms part of their knowledge of humans as occupational beings. This will be further discussed below. This contributes to the theme which highlights that participants perceive case managers working in the medico-legal context to require an integrated body of knowledge and skills in order to perform their role.

P1 further confirmed this, as seen in the quote below, as she reported that it would be required of a case manager to understand the basis of the client and their family's

needs, which in turn requires understanding the client's specific experience, situation and/or circumstances (that will require narrative reasoning skills).

P1: ***"[…] you really need to understand where their needs are coming from and you can't even though you sometimes feel like you want to just tell them to just kind of get with it and realise that asking for random things for themselves or the houses is not in the benefit of the child and the money's not going to last forever. You can't go there and you need to really try and figure out what is below this and a lot of the times with some of the moms that I have worked with the problem is that they feel they're owed because they've gone through this trauma and they've had to give up their lives to care for this disabled child and you need to work with that when you address these things…"***

Pragmatic reasoning

Participants voiced that case managers should be aware of the pace at which the client can go, which would be considered pragmatic reasoning as it considers the client's realities.

P7: ***"Often the needs are so great, you can't go in there and address every need; it is about doing it at the pace of the family, at the pace of the child…"***

From the above quote, it can be seen that the participants perceived that case managers deduced, through pragmatic reasoning, the pace that the family and the client can accept. They deduced this by considering the various factors that form a part of the client's realities, which could include facilitators, barriers, prognostic indicators, etc. The case manager was perceived to have the ability to adapt the pace of their service to each unique case, as each client's realities are different and unique.

Participants reported that case managers needed to keep the status of their own clinical practice in mind, which would be considered pragmatic reasoning as the realities of the practice could influence service delivery. One such example is where there is no space available at the case manager's practice; this could literally be i.e.

physical space for client's with various disabilities or operationally i.e. therapists' availability based on their caseload. Participant 3 reported, as seen below, that she referred the client to a treating therapist, because she did not have the capacity at her practice.

P3: ***"Here's a good treating therapist I can't treat you because I did your original medico-legal assessment, or I don't have space in my practice at that stage."***

Scientific reasoning

Participants perceived that scientific clinical reasoning skills enabled them to be the voice of reason. To be able to "be the voice of reason", the case manager required a specific skill set or knowledge foundation to form the "reasoning", which provided understanding to the client's condition (including symptoms, prognosis, etc.) as well as the required intervention. This "reasoning" is their scientific reasoning.

P1: ***"For example, is it reasonable to have to buy a wheelchair this year if I've bought a wheelchair last year because they don't know they've never worked with this. So… and I then need to be the voice of reason that kind of comes back and says no traditionally you would only need a wheelchair once every five years… let's look at this specific case yes, the child had a growth spurt now the chair really isn't suitable, or something happened and then to make recommendations in terms of that."***

From the above quote, it can be seen that the participant has clinical knowledge about assistive devices such as wheelchairs, knowing the typical life span of a wheelchair but also understanding the client's condition. Based on their understanding of these, the participant reasons that that a new wheelchair would be required. This is considered scientific reasoning.

Participants perceived that that they had the correct knowledge and skill set to perform their role as case managers. As seen in the quote below, P4 perceived that

occupational therapists have the knowledge and skills to perform the role of case managers. These form the basis of their scientific analysis (as part of their scientific reasoning), understanding the client's condition and being able to decide on interventions that benefit the client.

P4: ***"I think we as OT's have the knowledge and the skills, it is just realising which skills you need to use and if you're able to adapt…"***

From the above quote, it was seen that the participant not only emphasised that occupational therapists have the knowledge and skills, but also that they are required to adapt to the changing needs of the client, which highlights the uniqueness of each case.

Conditional or Interactive reasoning

Occupational therapists attribute their knowledge, competence and experience to contribute to their continuously developing clinical reasoning skills (Shafaroodi, et al., 2014) and similarly participants expressed that they put together all types of knowledge and skills in order to respond to changing circumstances.

P2: ***"Ja so for example wheelchair fittings is like post… a postgraduate training courses you go on to specialise in wheelchairs. Motor vehicle adaptions is something people specialise in later… like we've got the general, but we don't fully know it from the start. Paediatrics is a field people specialise in after having studied OT. You often get OT's specialising… well most of the time they either go paeds or psyche or adults whereas case management you could land up on any of the above and you've got to manage them as best you can. So, I think we've got the baseline skills and obviously have been taught a wide range of possible areas which we could go into and then for case management we actually have to put it all together and use it all so, you land up learning a lot all of it as and when you go."***

The quote above described how occupational therapists have a wide range of knowledge and skills, which contributes to their clinical reasoning, used when performing the role of case manager within the medico-legal context. Participants reported that, although they have all the skills described above, it is also crucial that the case manager is able to decide which skills to use at the right time, which would form part of their conditional or interactive reasoning skills. This enables them to be flexible in responding to changing circumstances or situations as seen in the quote below by P4, who highlights that case managers have to know which skills to use.

P4: ***"I think we as OT's have the knowledge and the skills, it is just realising which skills you need to use…"***

P4: ***"[…] we have the skills to case manage it is just making sure you use the right skills set…"***

4.2.2.2 Professional skills

One definition of professional is being connected with a job that requires specific training or skills (Concise Oxford English Dictionary, 2012). Professional skills are the skills that a person who is engaged or qualified in a profession, would use. Professional skills often include soft skills and hard skills, which enable professionals to engage in their profession. Hard skills are teachable/technical skills which are usually easy to quantify, such as project management skills. Soft skills are those that relate to the way a person interacts with other people, which could include interpersonal skills and conduct/professionalism (Laker & Powell, 2011). During the interview, participants reflected on hard and soft skills used by professionals. When considering *professional skills*, participants identified that interpersonal skills, conduct skills/professionalism and project management skills were required to support their ability to perform the role as clinical case manager within the medico-legal context.

Interpersonal skills

One professional skill referred to by participants was interpersonal skills, which are considered soft skills (Laker & Powell, 2011). Specific interpersonal skills which participants referred to were negotiation, assertiveness, mediation and diplomacy, networking, conflict management and communication skills . All of these are these are also considered to be an interpersonal skill and contribute to the case manager's professional skill set. Participants perceived that they used these interpersonal skills in their role as clinical case managers within the medico-legal context.

Participants reported that they negotiated on behalf of the clients who often did not have the skills or capacity to negotiate their own matters.

P1: ***"[…] make arrangements in terms of the accounts because often there is difficulty having the accounts paid immediately and we need to try and negotiate to get the children or adults the care that they require."***

In the above quote, the case manager negotiated with service providers in terms of outstanding accounts to ensure the clients continued to receive the care they required. They would therefore require negotiation skills.

Another interpersonal skill that case managers reportedly make use of is assertiveness skills. Participants reported they required these to stand up to families or the legal entities, as seen by the quote below by P1. The quote by P7 below described how case managers were also required to justify their decisions, which are based on their clinical expertise and clinical reasoning (as described in detail above) as occupational therapists, which could be considered an attribute to assertiveness.

P1: ***"Assertiveness, to be able to stand up to the families but also to the Trust and the Curators because often they don't understand why you're asking for specific things and they might get difficult about it."***

P7: ***"I think also to preserve the role so we are not perceived as just running with situations and spending and then possibly justifying after, if asked it should be justified every step of the way even if you are not specifically asked."***

When asked about skills that they required to perform their role, participants perceived they required mediation skills and diplomacy to address matters with stakeholders, families, legal entities, etc.

P3: ***"[…] really good can I say interpersonal contradict management and mediation skills."***

P1: ***"I remember the first trust meeting that I had with a company who was newly doing trusts and they've never worked with children with Cerebral Palsy before and we'd ask for Botox and the one trustee literally sit up and said: "No really I cannot take this anymore now they want Botox seriously why do these moms want to look young and use their children's money for that?" so they really don't understand and you need to very diplomatically address that.."***

Participants reported that they often network with colleagues or other role-players; accordingly, networking skills were important for as case managers.

P3: ***"I'm just basically trying to help them find resources, telling them where to go to try and get wheelchair, try and arrange wheelchair seating clinics…"***

Participants reported they were often required to manage conflict and therefore are required to have conflict management skills.

P2: ***"Ja managing conflict is a huge one because the parents fight with you and so do the Trust…"***

Case managers also perceived that they required the ability to communicate in a way that was appropriate for the intended audience.

P5: ***"You need very good communication skills and interpersonal skills. I don't think if you are not a people's person you definitely can't do this but to also need to be, you need to know how to be firm as well and I think I can't see how someone can't do it without being an OT, that is my personal opinion because there is so much involved in it."***

P7: ***"[…] and communication, excellent communication is the ability to listen and to be able to facilitate sometimes quite tricky meetings…"***

From the above two quotes it can also be seen that participants acknowledge that to be able to communicate effectively, they require the ability to express themselves in a way that they are understood, but to also have good listening skills in order to understand what the other person is saying.

Conduct skills/Professionalism

P7: ***"[…] you have to have the ability to work with these teams in a very professional, empathetic, really understanding their role, acknowledging their role with an aim of truly working collaboratively for the well-being of this child not an us and a them scenario."***

Participants reported that conduct skills/professionalism was another professional skill they used to perform their role. They ensure their professionalism by setting boundaries, thinking and questioning their own prejudices and keeping themselves personally distant from the cases. All of these are these are also considered to be conduct skills/professionalism and contribute to the case manager's professional skill set.

Participants reported that they required the ability to set boundaries with their cases. From the quote below it was evident that case managers perceived it important to set up boundaries with their clients as a strategy to maintain their own work-life balance.

P4: ***"[…] there are various pitfalls that you can fall into and you need to be careful of and boundaries you need to set, set up with these case management cases otherwise it does consume your whole life."***

Participants reported that they needed to be able to think and question their own pre-conceived ideas about cases. From the quote below, questioning your own prejudices was linked to narrative reasoning skills as it required the case manager to consider the client's circumstances and needs rather than what they may perceive to be the needs of the family.

P7: ***"[…] the way you think and question your own prejudices and what you may perceive as a need may not be the need of the parents…"***

Participants reported that they need to keep themselves personally distant from the case. Although these cases are complex and require a holistic role approach as mentioned in Theme one, the case manager should be able to distinguish their role as professionals and not become personally involved.

P4: ***"[…] keep yourself personally distant from it otherwise it can consume you, it is not your child, it is not your family to worry about…"***

Project management skills

Another professional skill that participants referred to was typically associated with project management. They reported making use of the following skills: planning and organising, problem solving, time-management, multi-tasking, critical thinking and analytical, prioritising, "moving skills", ability to think out of the box, adaptability and flexibility, and the ability to manage crises. All of these are these are also considered to be project management skills and contribute to the case manager's professional skill set.

P1: ***"[…] but planning and organisational skills are a huge factor. You really need to keep a hundred things in mind at once…"***

From the above quote it was also evident that performing the role of case manager within the medico-legal context required complex planning and organisational skills as there are various things to plan and organise all at once.

Participants reported they required problem solving skills, which in this work context were skills required to manage a project. However, from the quote below by P1, it was evident that the participant attributes the problem-solving skills to her occupational therapy training and was therefore also referring to her clinical reasoning skills, as described in detail above. Clinical reasoning skills (as described above) enabled this case manager to analyse and solve problems which arose in the case.

P1: ***"So… and analysing problems the problem-solving process which I also think we as OT's have been very much equipped with during our studies, so I think that definitely helped."***

Time management skills and multi-tasking skills were two more skills reported by participants. The previous quotes referred to many aspects ("hundred things") needing planning and organising all at once, and time management and multi-tasking skills were required to be able to manage them all at once.

P3: ***"Excellent time management skills… excellent multitasking skills [are needed]…"***

Participants reported to perform the role of clinical case manager within the medico-legal context, they required critical thinking, analytical skills as well as the ability to crises manage.

P6: ***"[…] critical thinking, crisis management and multi-tasking definitely, so yes I would definitely agree with that, that is a good description [of skills needed by a case manager that are associated with project management]."***

P5: ***"…there is definitely a step by step and analysis and kind of like a tick off and monitoring process…"***

Participants reported they required oversight of the entire case, again highlighting the complexity of case management in the medico-legal context and the holistic role approach that case managers required. However, they also reported they should be able to bring all aspects of the whole case together and to prioritise the needs, requiring prioritising skills.

P7: ***"[…] it's like being the bird's eye view and about absolutely having and knowing every pocket and facet and trying to pull it together, where possible in prioritising."***

A participant reported that case managers required "moving skills". Though "moving skills", the participant meant being aware of everything, keeping track of everything and to be hands on.

P3: ***"[…] I know it sounds weird but good moving skills because you actually need to be able to keep track of everything. You don't always have a pen or paper with you or but you need to know after you've had your hands on and you're aware of everything."***

Participants reported they required a certain amount of creativity and the ability to think out of the box. This could also be linked to problem solving, which was described earlier.

P7: ***"I would say skills is very much the ability to think out of the box, to be flexible…"***

One participant reported that case managers require the ability to be flexible, while another used the word adaptability. These skills are closely linked and are those typically required by a project manager. However, as seen in the quote below by P4, the participant attributed her adaptability skill to her occupational therapy training. As

reported above, clinicians have conditional or interactive reasoning skills, which requires the ability to combine all forms of reasoning, to be flexible in responding to changing circumstances or situations (Boyt Schell, 2014). These contribute to the participants' sentiment that occupational therapists have the ability to be adaptable.

P4: ***"I think your basic, you know, occupational therapy degree enables you to be quite adaptable and that is one thing. My husband says it as well, he can spot an occupational therapy a mile away, they just adapt to various situations and never reading people so our skill to adapt and read situations…"***

4.2.2.3 Administrative skills

Another skill which the participants reported on *administrative skills*, which they used in their role as clinical case managers within the medico-legal context. Participants identified that implementing systems to keep track of change, reporting and other writing skills are necessary administrative skills.

Implementing systems to keep track of change

Participants perceived that one of the keys to being a successful clinical case manager was to put systems into place to be easily used by administrative staff.

P3: ***"[…]be able to put systems in place so your admin staff can help implement the systems, but you need to be visually in implementing systems… let's try this. We need this. We need this kind of excel sheet. You need to sort of be the vision behind it and see the bigger picture of how you can manage each patient and then manage all your patients. So that you don't drop the ball and miss something or lose track of something."***

From the quote above, it is evident that the case managers developed systems to have oversight of all cases in which they were involved, to keep track of all of it at once. This links to the previously discussed on the "moving skill" as it requires being aware of, and keeping track of, everything and being hands on.

Participants also stated that they use Excel sheets to keep track of everything, thus demonstrating their administrative skill:

P3: ***"[…] we have a very detailed sheet with which she writes two boxes of Oats, one tube of toothpaste so we've got excel sheets for everything that's part of our market management company, so we've got excel sheets for everything."***

From the above quote, the participant described how they use Excel sheets for managing items such as consumables. Creating the excel sheet and keeping it up to date on the sheet can be considered an administrative skill which can either be done by the case manager or an administrative person.

Report and other writing skills

Participants reported they required report and other writing skills, which could be considered administrative skills to be able to perform their role as case manager within the medico-legal context.

One such example is record keeping which is a writing skill which contributes to case managers' administrative skill set.

P5: ***"[…] you don't always have your files with you so you need to be very disciplined in setting time for yourself that you are actually sitting down and you make notes on what has happened during the week because a lot of it is done as you said before telephonically. You can manage a lot of it telephonically but you not always have all your files with you so you have to be disciplined in sitting down and making the notes ..."***

The quote by P5 above highlights that the case manager are to be disciplined in their record keeping, which would be important in any case, but even more so in medico-legal cases where case managers are required to report to the court.

Participants reported they require the ability to keep notes. This aids the case manager to keep track of the case and possible changes. The quote below illustrates that the participant finds this task challenging as things happen throughout the day. Again, this is emphasising the need to be disciplined in taking notes in order to keep track of the changes.

P1: ***"And then keeping fairly rigorous notes, which I find is often a challenge because people phone you whenever during the day and it's a quick email here and it's a quick note there and it's really quite difficult to keep track of the time spent and to make nice detailed notes on telephone conversations as you might be taking the call while driving or quickly in-between other clients so that does become a complication."***

P7: ***"Your note taking has to be absolutely [right], your ability to take notes and keep records is very important and especially for example this case that came from Mafeking to Cape Town. It must be hand over-able…"***

The participants reported a case manager in the medico-legal context required the ability to write motivational reports to the Master of the Court. However, based on the content of the report, it would also be considered a clinical skill and the ability to justify their clinical reasoning as occupational therapists in a written format.

P1: ***"I need to write motivations to the Master of the Court and sometimes to the Trust or Curator related to anything out of the ordinary that the children or clients may need."***

As these motivational reports were considered legal documents, participants reported they require the ability to justify, calculate costs and motivate their clinical reasoning through their written ability. Again, the content of the report would be considered a clinical skill.

P7: ***"[…] communication in all forms but very much your written ability in terms of justifying, calculating and motivating and not just going off on a whim and doing it every step of the way…"***

4.2.2.4 Integration of knowledge of a person as an occupational being

P3: ***"[…] you're not just looking at one aspect of that person and I think that's what you know makes us unique that we look at the bigger picture and how they function in the bigger picture."***

P1: ***"[…] OT's looking at the whole person makes us uniquely equipped to really do the clinical reasoning that is needed for these clients keeping in mind the limited funds and weighing up what we do more or less important."***

P4: ***"All the medical knowledge, knowing the diagnosis and the needs of the diagnosis, the long-term prognosis of the diagnoses and what will be needed to prevent complications such as contractures etcetera and also to know what can be done therapeutic, medically, adaptive equipment you name it, to enhance functional ability, ja just daily life."***

Participants voiced that they made use of their knowledge of humans as occupational beings when performing their role as case manager within the medico-legal context. Participants however made it clear that they make use of an *integration of knowledge of a person as an occupational being*. This includes various concepts, including the knowledge of a person as a whole, knowledge about the client functioning as part of a collective, and knowledge on optimal occupational functioning. These are some of the core philosophies of occupational therapy.

<u>Knowledge of a person as a whole</u>

P2: ***"Whereas as an occupational therapist we've got the full scope to cover all the aspects that are required to help a person holistically and fill all fields that are needed to be covered."***

P2: ***"Because ultimately as a case manager I think we're dealing with people and dealing with their lives as opposed to needing to just treat one aspect and helping them live better fully and personally I feel like that's the point of OT."***

From the above two quotes the participants perceived that occupational therapists were well equipped professionally to perform the role as case managers because of their knowledge of a person as a whole.

Participants expressed that they have a holistic approach to the client, which consists of various aspect related to the client, includes the physical as well as social side, while looking at factors such as independence, activities of daily living and work. It is evident that occupational therapists have different lenses through which they work, which enable them to manage the case as a whole, covering all of the occupational needs of the client.

P2: ***"Ja so I think the holistic picture makes a massive difference. I think the fact that we're taught all the different areas makes a massive difference because most people are only taught psychologist's only do psych and physiotherapists only do physical aspects whereas we look at the whole picture and I don't think there's many other professions that that actually do that."***

P2: ***"I think we're taught to look at everyone in a holistic approach from undergrad… we consider all areas always that's part of our training and we understand disability as a whole looking at the social context… the physical context, psychological, behavioural, cognitive. So, with… and when you look at that you're looking at the family and the extended boundaries of a human and an individual. So, I think that in itself helps you to look at a picture fully and understand all limitations that the family are, are going through"***

From the above quote, it is seen that participants refer to a person as a whole when considering all of their aspects (i.e. physical, emotional, cognitive, behavioural), but also being part of a bigger whole e.g. being a member of their family or community.

Participants stated that they are suited for multi-faceted cases as they look at family dynamics, housing, transport and all the layers that come with a disabled person. As the occupational therapist is trained to consider all of these occupational matters, they have the ability to look at the client as a whole, which contributes to their integrated knowledge of the client as an occupational being.

P3: ***"Especially in the clinical field of medico-legal is that OT's have by virtue of our training we have a global picture, so we have had to look at that person as a whole from the beginning even our assessments it's the whole person you know physio is very much more physical, speech is very much more language. yes, they asked about activities of daily living and obviously doctor/dentist and that are very specific. But we even our reports are very global, and it looks at accommodation it looks at you know your work your social your recreation and activities of daily living, survival skills so you've looked at all that already and that exactly what case management is, it's actually the management of an entire person's life."***

When looking at the above quote, the participant refered to various areas of occupation including activities of daily living, instrumental activities of daily living (such as survival skills), leisure and social. These areas of occupation form part of occupational therapists' scope of practice and therefore they perceived they were are able to look at a person as a whole and are competent to perform the role of case manager which entails managing the person's entire life.

Participants reported they had general knowledge about medical conditions as well as functional implication, equipment and social aspects. This contributed to their knowledge of a person as a whole, specifically when considering that the case manager's client has serious medical conditions and/or disabilities that lead to functional limitations. As a result of this medical knowledge and its effect on functional implications, certain conclusions can be made about the client's occupational profile as an occupational being.

P4: ***"All the medical knowledge, knowing the diagnosis and the needs of the diagnosis, the long-term prognosis of the diagnoses and what will be needed to prevent complications such as contractures etcetera and also to know what can be done therapeutic, medically, adaptive equipment you name it, to enhance functional ability, ja just daily life."***

Knowledge of a client functioning as part of a collective

Participants voiced that their knowledge of a client functioning as part of a collective assisted them to perform the role of case manager within the medico-legal context. This knowledge contributes to their knowledge of the client as an occupational being as part of collective.

Participants reported that they considered how the whole family was functioning and therefore knew how to approach the case.

P3: ***"So I know where they functioning. I made this hierarchy of needs, the whole family, their entire support structure. In my head I level them and go ha okay this family we're going to have to case manage like this because we've got the fast majority of this family only functioning on self-pres [self-presentation] and maybe level 2 of Maslow's hierarchy of needs so we need to address all of this stuff first."***

The case manager has to take various aspects of the whole family (including language, ability, schooling for the other children, etc.) into consideration. These aspects guide the case manger's decisions and actions that would influence the whole family, who also therefore need to be considered.

P3: ***"[…] you need to look at the family as a whole. We've now… the Trust buys a wheelchair friendly house in Sandton however this is Soweto based family you have seven other children who are all Shangaan speaking no one's speaks English and now the Trust doesn't pay for those other seven children to go to school, a Model C School in Sandton. But it was close to the doctors and that [was] for the cerebral palsy child. Yes but what about the other seven children***

who the family now can't afford to send to school anywhere. And they were under the impression that the trust is going to pay for all those children and the increased water and lights and the increased burden in a house that's in Sandton where your rates and taxes water and lights size of the yard maintenance of the pool are all suddenly… where does that money come from?"

Participants perceived that occupational therapists have the ability to look at family dynamics, which contribute to their understanding of a client functioning within a collective. Again, the family dynamics were perceived to influence the case manger's approach to the case as case management of a client would influence the whole family dynamic and therefore the family would also need to be considered.

P7: ***"And it is not just about the patient, the client, the child, very much not in case management is my experienced thus far, you are really dealing with a whole scenario and I think our abilities as OT's to truly look at family dynamics, to housing aspect, to transport issues to all the layers that come with raising or living with a disabled adult or child."***

Knowledge of optimal occupational functioning

From participants reports it was evident that they had knowledge of optimal occupational functioning which contributed to their integration of knowledge of a client as an occupational being. They reported that they had an understanding of their client's ability and functioning which contributed to their knowledge of optimal occupational functioning which empowered them to perform the role of case manager within the medico-legal context.

P6: ***"[…] I would say from an occupational therapy perspective I normally start with basic personal hygiene ADL's, putting those needs you know getting those needs sorted first, like your seating positioning kind of thing, mobility devices, incontinence care, those kind of things. So it, my priority would be get the medical, basic medical needs, getting that sorted as quickly as possible and then go from there getting the ADL's sorted. So basically, working for the***

quality of life within their home environment, training of care givers, etcetera, those kind of things. To basically sort of maintain the quality of life and preserve life function"

From the above quote, it was also evident that occupational therapists who performed the role as case managers used their knowledge about a client's ability and occupational functioning to guide them in terms of case management, to decide where to start and to prioritise care.

Participants perceived their knowledge on functional implications and equipment, enabled them to predict their client's optimal occupational functioning.

P5: ***"[…] I do a work visit and see okay we just need a new chair and a laptop stand or something…"***

P6: ***"[…] accessibility training, the seating, the postural, you know observations and stuff that we have and then also the psychiatric background that OT's have…***

As seen from the first quote above, occupational therapists used their knowledge of functional implications and equipment to identify needs and make recommendations. They were able to make recommendations (which would typically be a part of the occupational therapy process' evaluation stage) because of their training. However, it would not typically be the role of the case manager to evaluate (it would rather be the role of the clinician occupational therapist) but because of their training, it is second nature for them to make these observations and identify these needs.

Participants reported that they work with patients through activities of daily living; this enables them to have knowledge of their client's optimal occupational functioning.

P4: ***"I think that is our unique skills. I think it differs us from physio because occupational therapy look, occupational therapy treats a person in whole from you know where, I have always believed that's what defines us, we work***

through, with the patients through activities of daily living, it was effectively what I would define as different from physiotherapy."

From the above quote the participant believed that working with clients on a functional and occupational level are an occupational therapist's unique skill. This enabled the case manager to consider all aspects related to the client's daily live, which is what makes occupational therapists suited to be case managers.

Lastly, participants reported that they have a wide variety of skills which all contributes to their knowledge of their client's optimal occupational functioning.

P2: ***"So, I think we've got the baseline skills and obviously have been taught a wide range of possible areas…"***

Some of these skills were reported to include knowledge of psychology and interpersonal skills, Maslow's hierarchy and Vona du Toit's model of Creative Ability. These were perceived to all contribute to their understanding of a client as an occupational being which enabled them to perform their role as case manager within the medico-legal context.

P4: ***"I think we have the best skills set to do that, doctors will only look at the client's medical treatment and well-being, you know is he getting the right medicine, is his surgery scheduled, things like that. Physios may be able to look at wheelchairs and things like that and therapy being offered, however I do not think they have the skill set for accommodation, caregivers, schooling, things like that. Future placement of supportive or what you call it, sheltered employment if you get to that point and they have the recommendation of the assistive devices are definitely not in their scope and they are definitely not skilled because they do not do psychology, they do not do interpersonal skills…"***

P4: ***"So, it is a lot of your medical knowledge of the condition and the disease and then your therapeutic knowledge and your knowledge of assistive devices***

and how to improve independence that is the right word, improve the independence in life…typical OT."

P4: ***"[…] it is all the knowledge of accessibility of independence of what is required for a wheelchair for a turning circle in the house for a wheelchair. The recommended incline of a ramp, it is second nature for me but it is an occupational therapy skill."***

P6: ***"I think OT's are really the best suited medical professional or supplementary professional for the role, if you look at your nursing care they would obviously look at a person's, you know, basically nursing kind of needs okay but they might not have accessibility training, the seating, the postural, you know observations and stuff that we have and then also the psychiatric background that OT's have, it brings a unique set of skills to the table. Physio's they would obviously look a lot or focus a lot on the physical side of things also getting a person as functional as possible from a physio point of view you know working on physical ability but again the accessibility stuff and psyche stuff is mainly based in the occupational therapy field, so I feel we are actually best suited because we have a really wide variety of skills that we can work on…"***

The above finalises the results obtained for Objective 2. It can be concluded that participants who assume the role of case manager within the medico-legal context, make se of an integrated body of knowledge and skills, as stated above, to perform their role.

4.2.3. Objective 3:

The researcher explored South African occupational therapists who work in the medico-legal context's perception of their ***preparedness*** *to work as clinical case managers.*

The theme that arose from the data analysis of the interview, was ***Broad experience***.

Participants shared their perceptions about their preparedness to work as clinical case mangers within the medico-legal context. Through inductive reasoning, three categories emerged from the data (Pope, van Rooyen & Baker, 2002), one indicating the participants felt unprepared for the role and two indicating their perceived preparedness. Although some participants reported a few reasons as to why they felt unprepared for the role, most participants highlighted various reasons (related to their experiences) why they felt prepared for the role as clinical case managers within the medico-legal context. Based on this there was more evidence for participants perceiving themselves to be prepared (through broad experience) than unprepared. These reasons were organised into the sub-categories and codes as can be seen in table 4.4

Table 4:4 Theme 3 - Broad experience

Category	Sub-category	Codes
Unprepared for the role	Inexperienced in case management in the medico-legal context	- I haven't done case management before. - I had never written a pure medico-legal report before. - When I started, I thought it was a lot more casual than it was. - You cost the trust tons of money if you make mistakes.
	Insecurities in the role	- I'm still growing and still don't always feel things are in place. - Having to fight my own anxiety.
	Need for additional training	- Either post-grad courses or pre-grad courses should address case management. - Guidelines/protocols might be valuable. - It needs to be brought into our scope of practice and we need to focus on training. - To be further equipped in e.g. facilitation skills.
Academically prepared	Occupational therapy training assisted to prepare for the role	- In second and third year you are taught group therapy and interpersonal skills. - OTs have, by virtue of our training, a global picture so we look at the person as a whole. - We've got the baseline skills and have been taught a wide range of possible areas. - We were taught to clinically reason and to look at the whole person. - Medical background and knowledge.

	Research prepares for the role	- Research to make sure you 've made the best decision. - I keep reading and researching.
	Courses assisted in preparation for the role	- Counselling, bereavement and marriage guidance courses. - Staying abreast with your continuous professional development.
Practically prepared	Vast clinical (OT) experience in various fields and contexts	- My work experience in terms of working with families and doing caregiver training for clients. - A broad network of information and access to various suppliers. - My background with knowing how the medico-legal system works. - Work experience after you qualified that teaches you how to adapt, adjust and assist people with disabilities.
	Received mentorship to prepare for the role	- Coaching in terms of what would be my role - Being put me into contact with other occupational therapists who did case management. - Mentoring from the attorney - Mentors and people in different industries which helped to equip me.
	Personal experience assisted in preparing for the role	- Raising a child with a disability and managing his needs - It's essential to have life experience to draw on.

The results relate to participants' perceptions. They perceived themselves to be prepared for the role as clinical case managers within the medico-legal context by either academic preparation or having clinical experience. Some other occupational therapists perceived themselves to be unprepared. This will be discussed below.

4.2.3.1 Being unprepared for the role

Some participants reported on their perception of being unprepared for their role as clinical case mangers within the medico-legal context. They attributed their unpreparedness to being inexperienced, having insecurities within the role and having a need for additional training.

P5: ***"I was not prepared at all, there was no training, I have been doing it for about six years now and I have learned along the line, made a couple of mistakes in the beginning, that is ja, there is no training for it…"***

P1: ***"So, I think that those, those skills I wasn't completely prepared although I knew intellectually what would be expected of me doing it is something else. And then I also think emotionally I wasn't really prepared for the commitment and the emotional drain that this places on you because you don't realise before you start this that you will be getting a hundred phone calls a day."***

Inexperienced in case management in the medico-legal context

Some participants reported that they had not done case management before, which indicated they were inexperienced and therefore unprepared for the role.

P1: ***"So, I went, and I had an appointment with the attorneys and I explained that I haven't done this before but that I understood what it is that they want me do…"***

From the above quote it can be seen that although the participant has not performed the role before, she understood what was expected of her, through interaction with the attorney.

Participants reported they had not written pure medico-legal reports before and from skills and knowledge required as described above in Theme 2, participants reported that case managers require the ability to write medico-legal reports e.g. motivational reports for the court. Not having written a pure medico-legal report before (being inexperienced), added to the participants' perception of being unprepared.

P1: ***"And I think that was the first thing that really hit me was that I, I had never written a pure medico-legal report before and even after getting opinions and help and mentoring from other therapists and from the attorneys after they'd read it and pointed out things that left me vulnerable that I could change. When… after I had handed in my first report and the opposing side had read it and responded to that report there was so many things that I just thought afterwards how did I not include that how did I… Yeah so, I think in that***

respect I wasn't equipped well and I've kind of kept that lesson with me in terms of my notes and my preparation for cases because they can come back any time…"

The participant who stated the above, described an instance where she had to write a report motivating to the court why a case manager would be required for a certain client so that the court would include case management fees to the pay-out. This would be considered a unique task performed by occupational therapists who works within the medico-legal field.

Participants reported they thought that the position was more casual than it was, which emphasises their inexperience and lack of preparedness for the complexities related to case management in this challenging field.

P1: ***"And then something that I unfortunately had to learn the hard way is that you need to before getting into any of this your communication channels just it's so important to establish exactly how those channels are going to be working. So initially when I started I, I thought it was a lot more casual than it was and there was some unnecessary misunderstandings and assumptions made which led to some difficult situations and complications and a few embarrassing moments."***

From the quote above, it was seen that one such complexity was related to the communication channels involved in case management in the medico-legal context. Gaining the appropriate approval form the legal entity, prior to making decisions with the family was essential, because if it was not approved, the case manager would have to explain to the family why this decision was declined by the legal entity.

Participants reported that mistakes they made costs the trusts money. Inexperience could therefore lead to negative financial consequences the trust money. These serious events contributed to the case manager feeling unprepared for their position.

P2: **"*So, for example if you, if you go and order a car for a patient and it's not the ideal car you're going to cost that family a lot of money and in the long run have to sell the car. There's also been cases of people buying the wrong houses that weren't able to be adjusted and then you're costing the Trust tons of money because you bought a house…"***

Insecurities in the role

Some participants voiced having insecurities in the position including that they are still developing skills required for this job.

P1: ***"So, I think… and it's [report writing] something that I'm still growing in that I still don't always feel is in place."***

Here, the participant expressed a level of insecurity in her own report writing abilities and this personal insecurity contributed to the experience of being unprepared for the position.

Participants stated they have to fight their own anxiety which could be seen as an insecurity that contributed to their perception of being unprepared.

P1: ***"And then the assertiveness, having to fight my own anxiety, to stand up and kind of put myself out there as an advocate for this client without becoming too aggressive or a rescuer which is often difficult for me."***

The above quote explained how the participant fought her own anxiety by being assertive and finding a balance between being aggressive and a rescuer. This could also relate to the conduct skills described in Theme 2 of being able to set boundaries and the ability of the participants to keep themselves personally distant from the cases they manage.

Need for additional training

Participants noted they have a need for additional training to perform the role of case manager within the medico-legal context, which could indicate that they perceive

themselves to be unprepared for the role. Participants indicated that additional training should either be included in post-graduate or undergraduate courses.

P4: ***"[…] so it might be easier where there is a specific protocol though I don't think you can put out a protocol for case management because it is an ever changing thing, it changes per client through case managing but there might be some guidance on tricky situations and what to be aware of and things like that, that either post grad course should address it or pre grad, I am not sure, I think that should be more post grad course like your Voc rehab and your hand therapy course because there are various pitfalls that you can fall into and you need to be careful of and boundaries you need to set, set up with these case management cases…"***

Here the participant acknowledged that any training was unlikely to cover all the complexities associated with case management as each case will be unique, but that providing some guidelines or protocols for case management may assist them. As guidelines or protocols were not available to the participants, it can be assumed that they have a need for additional training and therefore they were not fully prepared for the role.

P4: ***"[..] guidelines slash protocols might be valuable. No this is step one, this is step two, if this happens this can be done…"***

P4: ***"I mean a five hundred thousand Rand house can be accessible but a ten million house as well. But ja, to those are there is definite guidelines, not protocols, guidelines that can be given to case managers out there."***

Participants stated that the position as case managers within the medico-legal context needs to be brought into occupational therapy's scope of practice to focus on training. The participants made mention of the requirement to realign training therefore, which can be interpreted that some participants were unprepared for the role.

P5: ***"Maybe I can just add I think it is time for OT's to rise up and own it [case management] and not allow other people to sort of you know to take over the role. I think we need to really bring it into our scope of practice and own it really you know and focus on training and getting it going…"***

The above quote also highlights that the participant is of the opinion that occupational therapists need to add this specific role to their scope of practice of the profession and offer specific training in order to take ownership of the role.

Lastly, participants indicated they have a desire to learn other skills e.g. facilitation skills in order to perform this role. As they reported that they would require additional formal training, it can be assumed that they felt that this was a specific skill which was necessary to perform as a clinical case manager, which was not covered sufficiently in the existing occupational therapy training.

P7: ***"[…] to be further equipped in for example facilitation skills. I feel that is something which I would possibly do, something more formal perhaps. I really feel that is an essential skill to actually be able to facilitate and co-ordinate something of which is in some of us occupational therapist [and not in others]."***

The above concluded some participants perception of being unprepared for the role. The following covers why the participants perceived themselves to be prepared for the role.

4.2.3.2 Academic preparation

Some participants perceived themselves prepared for the role due to their academic training. This included their undergraduate and post graduate occupational therapy training, undertaking research and attending courses.

<u>Occupational therapy training assisted to prepare for the role</u>

P7: ***"[…] I do believe that we have that extra edge, extra insights, extra ability to see the layers of a situation based on our training under-grad…"***

"I think your basic, you know, occupational therapy degree enables you to be quite adaptable and that is one thing."

P3: ***"[…] by virtue of our training they would make good case managers especially in the medico-legal field."***

P6: ***"Well, obviously in terms of shaping your mind sets, forming your mind-set, I mean we come from an occupational therapy model that we have learned at varsity level…"***

Participants voiced that their occupational therapy undergraduate training assisted to prepare them for their role. They stated that in the second and third year of their occupational therapy training they are taught group therapy and interpersonal skills, which they use to be able to perform their role as case managers.

P4: ***"A lot of interpersonal skills come in, then you feel it second nature but you forget about what [we would learn in] second and third year group therapy and interpersonal skills and those things we did and ja so I think that is definitely ja comes into hand when dealing with all these people."***

Participants previously reported they were the liaison between the trust and the client and/or family and that they assumed the role of collaborator and coordinator. Based on the above quote, participants perceived themselves to be prepared for this role because they were taught group therapy and interpersonal skills in their occupational therapy training.

Participants reported that by virtue of their training, they were able to obtain a global picture, to look at the person as a whole, which contributed to their preparedness to take on the role.

P2: ***"I think the fact that we're taught all the different areas makes a massive difference because most people are only taught…psychologist's only do***

psych and physiotherapists only do physical aspects, whereas we look at the whole picture and I don't think there's many other professions that that actually do that."

P2: ***"I think we're taught to look at everyone in a holistic approach from undergrad… We consider all areas always that's part of our training and we understand disability as a whole looking at the social context… the physical context, psychological, behavioural, cognitive."***

As mentioned in Theme 2, participants' perceived that occupational therapists had the knowledge of humans as occupational beings as well as the ability to look at a person as a whole which contributes to their integrated body of knowledge, which in turn enables them to perform their role as clinical case manages. From the quotes above, participants perceived that their occupational therapy training taught them to look at a person as a whole.

They further believed that they had the baseline skills and had been taught a wide range of possible areas during their occupational therapy training, which further contributed to their preparedness.

P2: ***"So, I think we've got the baseline skills and obviously have been taught a wide range of possible areas which we could go into and then for case management we actually have to put it all together and use it all…"***

Participants reported in Theme 2 that case managers made use of a wide variety of skills and knowledge when performing the role of clinical case manager. The quote above supports this.

Participants voiced that they were taught to clinically reason and to look at the person as a whole through their occupational therapy training, which contributed to their preparedness:

P1: ***"I think my basic training as an occupational therapist really prepared me. I don't know how people in other professions can so easily walk into a role as a case manager…we have a very good understanding about the medical treatment aspect. We have a good understanding of the rehab that would be needed the multidisciplinary rehab that will be needed and [it's] easy for us to understand why this rehab needs to come through. We know… we have a fair idea of the types of equipment that is available as assistive devices out there. So, I think from that side I think very much my occupational therapy qualification assisted me. Also, together with that I think my… the way in which we were taught to clinically reason as OT's looking at the whole person makes us uniquely equipped to really do the clinical reasoning that is needed for these clients keeping in mind the limited funds and weighing up what we do [is] more or less important. So… and analysing problems the problem-solving process which I also think we as OT's have been very much equipped with during our studies, so I think that definitely helped…"***

From the above quote, it can be seen that the participant ascribed a lot of her preparation for the role as case manager to her academic training, specifically her ability to clinical reason.

Lastly, participants voiced that they have the required medical background and knowledge, which prepared them for their role. Occupational therapists are taught this in their studies and therefore they are academically prepared to take on the role.

P4: ***"All the medical knowledge, knowing the diagnosis and the needs of the diagnosis, the long-term prognosis of the diagnoses and what will be needed to prevent complications such as contractures etcetera and also to know what can be done therapeutic, medically, adaptive equipment you name it, to enhance functional ability…"***

The above quote highlights that clinical knowledge was required to perform the role, which occupational therapists were taught in their studies. However, some of the quotes above state the participants' opinions that occupational therapists are best

suited because of the core occupational therapy philosophies which they were taught such as humans are occupational, holistic beings.

Research prepares for the role

Some participants expressed that they did research to prepare for the role, which could be considered an academic means to preparedness. One participant reported that research enabled her to ensure that she had made the best decisions.

P2: ***"[…] I wouldn't walk into it blindly. I definitely think you need someone to guide you and has the experience or you need to research yourself broken to make sure that you've made the best decision possible in accordance with what you have…"***

To emphasise the importance of research one participant reported that she keeps on reading and researching to prepare herself for the role.

P3: ***"[…] I think that has equipped me a lot in being able to manage stuff. And I keep reading, reading, reading, researching, researching and researching…"***

The above quote emphasised the extent to which research was required to prepare for the role. From the repetition of reading and researching it can be assumed that it is a continuous process of research which prepares the participant as a case management.

Courses assisted in preparation for the role

Participants stated that attending courses had assisted them in carrying out the role; courses could be considered another academic/theoretical means of preparedness. Courses that the participants referred to include counselling, bereavement and marriage guidance courses.

P3: ***"[…] I've done courses through my church you know on counselling and bereavement and… so I think all of that plays a big role in where you're trying to handle these kind of people. Because the families are no longer functional***

like they were somewhere there's been an injury, and, in a way, it's been made worse by the legal process…"

P3: ***"And then I think that because I've done my, many years ago I did a counselling, my counselling course through UNISA as a marriage guidance counsellor…"***

The above quote explained that the clients and/or their families have likely been traumatised by the experience that led to the disability. The participant expressed that the trauma was also likely increased by the medico-legal process which is some cases takes years to finalise. The participant reported that additional courses such as counselling, bereavement and marriage guidance courses assisted her to work with these clients and/or families.

Participants also reported that staying abreast with their continuous professional development (which is likely through attending courses) prepared them for the role as clinical case manager within the medico-legal context. Continuous professional development could also be considered academic preparation for the role.

P6: ***"[…] but I mean most of my experience, actually, I think comes from the courses that I attended lots and lots of courses so obviously staying abreast with your CPD…"***

4.2.3.3 Practically prepared

Some participants perceived themselves prepared for the role due to practical experience in various areas which included vast clinical experience in various fields and contexts before becoming a clinical case manager, personal experience and receiving mentorship to prepare for the role of clinical case manager within the medico-legal context.

Vast clinical (OT) experience in various field and contexts

P7: ***"[…] working in various fields and context and having worked in community day hospital sector in the Western Cape, I worked, ja across the board, I think that is absolutely really has to prepare you because your case management can be in any context."***

P3: ***"[…] years and years of experience and I think that that makes a big difference. I worked in government. I worked in semi-private government. I worked in a mining hospital. I worked at the West Rand School which is a government cerebral palsy school and then started running my own practice part-time and then ultimately fulltime. So, I've had such a vast clinical experience I've ran, you know, from psychiatric then also working with life healthcare where they've got the… and where I did it in a rural area was a combination of life healthcare like they have with Esidimeni where you had a government and private working together… The mining hospital where I worked underground with miners, splints, you know work hardening and then getting kids from the West Rand school into work. So that is… gave me such a well rounding…"***

Participants conveyed that their experience in various fields and contexts prepared them for becoming clinical case managers within the medico-legal context. They perceived that their experience in working with families and doing caregiver training, assisted them as this is one of the responsibilities of the clinical case manager as reported above in Theme 2.

P1: ***"[…] I would be well equipped because of my psychiatric background and my work with families and… because of my work in the government I've had to work a lot with uneducated families that have had very little exposure to medical, Western medicine and medical procedures and things. So, I was experienced in dealing with that…"***

P1: ***"My work experience… I worked in psychiatry for a long time and my work experience in terms of that and working with families and doing caregiver training with families for… for families with clients with neurological and psychiatric conditions I think that really, that really helped, it helped to manage a lot of the, the situations that we were in."***

The first quote describes how working with families in government settings prepared the participant as she was exposed to working with families who were not exposed to Western medicine and through working with these families, she was able to prepare herself for the role as case manager where she would be required to explain various legal and/or clinical decisions to families.

Participants also expressed that the broad network of information and access to various suppliers all comes with experience in various fields and contexts. Working with a broad network and having access to suppliers, could be considered a means of being practically prepared.

P6: ***"[…] you actually need a broad network of information and access to various suppliers, you need to know what works and what doesn't. And I think that sort of comes through experience…"***

The above quote could also relate to the collaborator role as mentioned in Theme 1 as the collaborator is required to work with their network and suppliers towards a shared goal. It can therefore be considered that the collaborator would require experience which would give them a broad network of information and access to various suppliers.

One participant felt that she was prepared by her background knowledge on how the medico-legal system works. Working and having experience in the medico-legal field would therefore be a field that could contribute to her preparedness to fulfil the role.

P5: ***"I think what is actually more important to me is my background with knowing how the medico-legal system works. That has been more beneficial***

to me because I have found that I have appointed an occupational therapy to assist me with case management but she didn't have the background of medical legal work and she really struggled to understand because it's very difficult with post RAF case management, which I think is different to medical negligence…"

From the above quote it appeared that the participant felt that experience in specifically the medico-legal field prepared her for the role, in contrast another participant felt that work experience (in an unspecified field) taught her to adapt, adjust and assist people with disabilities. She therefore felt practically prepared due to her clinical experience.

P7: ***"[…] I really believe that it's something you should get into after many years of either occupational therapy experience and life experience. I feel strongly about that. Communication abilities and the fact and if one has, you have the confidence and the expertise that you have actually had to justify as a medic, as a medico-legal expert in the witness box that carry over if you have got that in the wings as part of your experiences I feel that is really important and relevant because case management is also about continuing in your head and not in a witness box, to justify is it necessary, how much is necessary ,why, where and how and to know that you can be and should be audited at any point about what you are doing…"***

Received mentorship to prepare for the role

P7: ***"It's not just pretending you know it all, it is reaching out to those who have experience and longer and tapping into their resources and be willing to learn and evolve and ja every case, every scenario, every day in case management can bring a new challenge…"***

Participants indicated that they felt prepared for the role of case manager within the medico-legal context by receiving mentorship. Coaching in terms of what the role would entail would contribute to the mentorship, which would practically prepare them for the role.

P2: ***"I started doing medico-legal work for [confidential name] and she's been doing case management for years. Ja and I got involved through her, so she got me into case management and taught me the ropes and showed me how to… how it works and what it all entails."***

P7: ***"I think I had guidance and meetings with other similar and the ability to bounce things off her and brainstorm…"***

Participants reported that they were put into contact with other occupational therapists who did case management who mentored them, and shared practical knowledge which prepared them for the role.

P1: ***"[…] she'll coach me through it and she put me into contact with another occupational therapist who did paediatric case management for another case of theirs. And when I got stuck I'd send her an email and just find out how did she handle situations like that and kind of took it from there."***

From this quote, it is evident that the participant could access the other occupational therapist who worked as a case manager within the medico-legal context, to assist her with practicalities such as how to handle a certain situation. Participants also reported accessing attorneys to help prepare for the role. Participants reported that they received mentoring from the attorneys to prepare them for the role as case manager.

P1: ***"[…] getting opinions and help and mentoring from other therapists and from the attorneys after they'd read it and pointed out things that left me vulnerable that I could change."***

Receiving mentorship from the attorneys would be considered a type of practical preparedness which would be specific to the role of case managers within the medico-legal context. Occupational therapists would not necessarily access the mentorship of attorneys in other roles.

Lastly, participants reported that they accessed mentorship from people in different industries, which practically prepared them for the role as clinical case manager within the medico-legal context.

P1: ***"My networking that I did over the years and my involvement in various occupational therapy based and multidisciplinary based organisations really helped me because I could fall back on those. I had mentors that I can talk to. I knew people in different industries, the devices and treatment centres and schools and that definitely helped to equip me…"***

Other than having the experience or accessing a mentor, some participants reported that they were prepared for their role due to their own personal experiences.

Personal experience assisted in preparing for the role

One participant said that she believed she was prepared for the role as a clinical case manager in the medico-legal context due to her personal experience. She stated that raising a child with a disability and managing his needs, prepared her for the role, which could be considered a practical preparedness to the role.

P3: ***"And then I have [as a single parent] a twenty-four adopted a disabled child whereas he did more management than anything under the sun where I had to try and manage his needs…"***

Other participants perceived it was essential to have life experience to draw on, which could also be considered as their own personal experienced in a practical manner, which prepared them for the role.

P7: ***"I think another skill, I think an essential skill is life experience, I think it's years of clinical experience very much life experiences is very necessary and… in this field. You really need to draw on a lot of non-sort of classical textbook kind of scenarios…"***

The above finalises the results obtained for Objective 3. It can be concluded that some participants felt unprepared for the role as clinical case manager within the medico-legal field, it was either due to not having experience in the field, their personal insecurities or due to their perceived need for additional training. However, there were various expressions of feeling prepared for the role, either by their academic training as occupational therapists, attending courses, doing research, or being prepared by practical means, through their experience, receiving mentorship or through their personal life experiences.

4.2.3.4 Conclusion

This chapter reported on the results obtained during this study by answering the three objectives that guided the study. Three themes emerged from the data including, *Holistic role approach*, *Integrated body of knowledge and skills* and *Broad experience.* Each theme was further divided into categories, which comprise of subcategories. Each sub-category consisted of various codes. Quotes from the interviews were used to further describe or support the results.

The results identified that the participants perceive themselves to made use of a holistic role approach to fulfil their roles and responsibilities as clinical case managers working in the medico-legal context. They made use of various occupational therapy roles as described in literature (AOTA, 1993; Nestadt & Blesedell, 1998) to fulfil their overall role as a case manager. These roles included: manager, collaborator, advocate, clinician and consultant. Participants also reported on responsibilities which would be associated with coordination. Therefore, a new role emerged which was named the coordinator. Participants further described the responsibilities related to each of these roles which is required to perform the role as clinical case manager within the medico-legal context. Some unique responsibilities of case managers in the medico-legal context include writing motivational reports to the court, giving account for all expenses and decisions to the legal entity, being the liaison between the client, the multi-disciplinary team and the legal entity and consulting the legal entity.

Occupational therapists perceive themselves to have had an integrated body of knowledge and skills which supported their ability to perform the role as clinical case managers within the medico-legal context. Participants identified three skills they perceived they used to perform their role as clinical case manager, namely: clinical reasoning, professional and administrative skills. They further described skills related to each sub-category. Participants reported that they have an integration of knowledge of a client as an occupational being which enables them to perform their role. They also described which areas of knowledge they integrate to understand their client as an occupational being.

Lastly, there were various expressions of participants who perceived themselves to be prepared for the role as clinical case manager within the medico-legal context by having broad experience, while some perceived themselves to be unprepared. These who felt prepared for the role, either felt prepared through academic preparation or by practical preparation. They further described what would consist of academic and practical preparation. Those who felt unprepared for the role described the factors which contributed to their feeling of unpreparedness.

CHAPTER 5
5 DISCUSSION

This chapter focusses on interpreting the results in the light of the objectives set for the study. The chapter will discuss the importance of the results and how they answer the objectives. The implications of the findings and limitations of the study will also be discussed.

5.1. Demographic characteristics

All seven participants were occupational therapists who studied at four universities across South Africa, including UP, Wits, UCT and UFS. These universities do however not represent the diversity of the occupational therapy education system in South Africa, as these are previously advantaged tertiary education facilities and only a few of the institutions that offer occupational therapy training.

Six of the seven participants had more than ten years of occupational therapy experience. Three had post-graduate diplomas/degrees. In a recent study titled *"The role of the occupational therapist in case management in South Africa",* 71% of the respondents (55 participants) had ten or more years of experience as occupational therapists, which the researchers deemed as a sample comprising a reasonably experienced group of occupational therapists (Govender et al., 2018). Similarly, the research deemed the experience of this sample group as experienced.

The inclusion criteria stated that participants should have more than one year's experience as case managers, qualifying them as advanced beginners (Benner, 1982) and all participants were deemed suitable, with adequate experience to participate in the study. At the time of the interviews in 2018, participants did not identify any other possible participants who met the inclusion criteria.

5.2. Holistic role approach

This research found that South African occupational therapists who participated in this research perceive themselves to make use of a **holistic role approach** when fulfilling the of role clinical case managers working in the medico-legal context.

The results of this study indicate that case management in the medico-legal context is a complex role, which requires a holistic role approach. Robinson et al. (2016) echoes this by highlighting the holistic nature of case management by stating that case managers sustain client's quality of life by considering a holistic approach, including the client's condition, personal goals, context and environmental situations. These functions underpin the philosophy of occupational therapy (Hooper & Wood, 2013), which at its core is humanism, holism and client centeredness (Mayers, 1990; Hagedorn, 1995; Hemphill-Pearson & Hunter, 1997). Occupational therapists are therefore well positioned to assume the role and responsibilities of a case manager.

The results generated one theme for Objective 1, namely Holistic *role approach.* During data analysis, it became evident that participants described roles, consistent with that defined in literature (AOTA, 1993; Nestadt & Blesedell, 1998). All the participants were experienced occupational therapists and therefore it could be expected that when they had to analyse the roles and responsibilities of a clinical case manager, they used their existing knowledge of the professional roles in occupational therapy, based on their education and training, to guide their thinking.

The data were interpreted in such a way that certain responsibilities were associated with specific roles, according to that role's definition. Therefore, the roles formed the categories and certain responsibilities typically associated with those roles formed the sub-categories, with the actual tasks described by the participants as codes. From this, it was found that case management is the umbrella term that encompasses various other known occupational therapy roles, which function together or in isolation, depending on the type of case and required responsibilities for that case.

Participants associated with responsibilities linked to five known occupational therapy roles. These roles include the manager, collaborator, advocate, clinician and consultant. There are however nine roles reported in occupational therapy literature (AOTA, 1993; Nestadt & Blesedell, 1998). Participants did not relate with responsibilities typically associated with the remaining occupational therapy roles

namely; educator, researcher/scholar and mentor themselves. Participant however reported that they have a need for further training or education related to this role, which would require an educator. They further reported performing their own personal research to prepare for the role, however this is informal research rather than aimed at developing the profession (AOTA, 1993; Nestadt & Blesedell, 1998). Participants reported they have mentors who prepare them for the role, but did not report on being mentors to others. The participants also reported on tasks that would typically be associated with coordination and therefore a new role emerged which was termed the coordinator role.

Extended Manager role

The manager role in occupational therapy literature (AOTA, 1993; Nestadt & Blesedell, 1998) relates to managing factors within their own setting or practice i.e. resources and staff. The results demonstrated that case managers within the medico-legal context perceived that they were responsible for managing resources such as finances, not necessarily related to their own setting, but rather related to the case e.g. finding quotes or making arrangements in terms of accounts. As these clients are declared incapable of managing their own affairs, management of their finances is an important responsibility of case managers. Participants reported that case managers are responsible for obtaining quotes, organising medical aids, managing the monthly allowances and making arrangements in terms of accounts. They are required to give account for all expenses and decisions to the legal entity, which is a unique responsibility of the case manager within the medico-legal context. However, it is important to note that this role is not unique to occupational therapists as any person with the required administrative skills (as will be discussed later in Theme 2) would be able to manage the clients' finances.

Managing staff, a typical function of the manager role, was reported by participants, who manage their own staff such as personal assistants. They also reported that involving or contracting other members of the multi-disciplinary team was part of their role. With the latter, the manager requires clinical skills such as clinical reasoning in order to determine which members of the multi-disciplinary team are best suited and

when to involve them in the case, therefore a clinical case manager is best suited for the role.

Participants also reported it is the responsibility of the case manager within the medico-legal context to follow up and monitor the case process, including different therapies and medical interventions. This correlates with the occupational therapy manager role, which is described in occupational therapy literature as a person who plans, implements and evaluates a service (AOTA, 1993; Nestadt & Blesedell, 1998). Participants reported they monitor the entire process of the case over a lifetime, which is associated with the responsibilities of a manager (planning, implementation and evaluation). This is consistent with the case management definition (CCMC, 2013*)*, that makes clear reference to these specific tasks i.e. planning, implementing, monitoring, evaluating and resource management. However, from the participant's views it is clear the case manager also requires the ability to know in which order these interventions (such as different therapies and different medical interventions) should occur, which require clinical reasoning skills (which will be discussed in Theme 2). A case manager in the medico-legal context will thus require clinical reasoning skills.

Collaborator role

Clinical case management is defined as a collaborative process (CCMC, 2013). This study indicated that participants have responsibilities associated with the occupational therapy collaborator role, being the liaison between the client and the legal entity and facilitating participation in daily activities.

During the interview, participants described that they frequently collaborate with other health care practitioners, members of the multi-disciplinary team and with community members across different sectors. The collaboration with other stakeholders is typical of the collaborator as described in occupational therapy literature (AOTA, 1993; Nestadt & Blesedell, 1998).

One aspect that distinguishes the medico-legal context from other contexts where case management is performed, is that case management within the former is strictly

governed. Participants reported that it is their responsibility to be the liaison between the client, the multi-disciplinary team and the legal entity. This responsibility could be considered a unique responsibility within the medico-legal context as participants reported that they are the link between the family and the trust, which is appointed as the administrator of the case.

Participants reported it is their responsibility to facilitate the client's participation in daily activities, which is clinical responsibility outsourced by the case manager to other health care practitioners, members of the multi-disciplinary team and community members across different sectors. Occupational therapists as case managers are likely to consider facilitating participation in daily activities as facilitating *occupational* participation as they are the only clinicians who use occupations as their primary treatment modality to enhance health, well-being and participation in meaningful activities (AOTA, 2014). Participants were all occupational therapists, who would have at their foreground facilitating participation in daily activities and occupational participation, which they are uniquely equipped to facilitate, based on their training. The case manager would, however, not be involved as a clinician in terms of occupational participation such as community integration (e.g. leisure and social activities) but would rather collaborate with the people who make this possible. Community integration could lead to an increase in participation in daily activities as the clients would have access to new facilities and/or people. It would be considered the role of the collaborator as it will require of the case manager to work with facilities in the communities and community members to include the client and their family.

Coordinator role

It was clear from this study that occupational therapists coordinate quality care for clients, a typical focus for case managers as indicated by Lohman (1998). Participants reported on responsibilities that would be associated with coordinating, which is consistent with a role termed the coordinator role. Although this role is not described for occupational therapists (e.g. AOTA, 1993; Nestadt & Blesedell, 1998), it is a prominent function in case management literature. The formal definition of case management describes coordination as one of its key elements (CCMC, 2013).

The Case Management Society of America states that case managers coordinate role players (CMSA, 2010). Similarly, the Case Managers Association of South Africa (CMASA; 2013) state that case managers are specialists in the coordination of care, which results in quality care. Participants reported that it is their responsibility to coordinate appropriate care and interventions, ensure the environment is suited for the client and to facilitate appropriate support for the family.

Participants reported that coordinating appropriate care and interventions requires the case manager in the medico-legal context to coordinate appointments, transport arrangements, admissions, sourcing caregivers, school facilitator and au pairs as well as managing consumables. Although these tasks are not specifically unique to occupational therapists, participants highlighted the complexities associated with these tasks e.g. making travel arrangements for people with severe disabilities who often have wheelchairs or other assistive devices and who cannot do these tasks for themselves. These cases often require complex coordination e.g. admitting a client to a rehabilitation centre for drug addiction but then also considering the complex management of the case after discharge and coordinating the necessary precautions e.g. coordinating that weekly groceries are delivered to the recovering addict, rather than them purchasing their groceries with their own money. At first glance these tasks may seem simple, however, when considering the actual cases with which the participants work and the complexity of these cases, clinical reasoning skills are required to perform them.

The tasks reported by participants to ensure the environment is suitable for the client include ensuring equipment, assistive devices, housing, vehicles, schools and facilities. Clinical skills (such as clinical reasoning), knowledge on their disability and assistive devices are required to ensure that these aspects are suited for the client. Ensuring these is typically the role of a primary health care occupational therapist and therefore it should be questioned why the primary health care occupational therapists are not ensuring that the client's environment is suited for the client, in these medico-legal cases. To answer this, two things should be considered. Either the client is a state patient and government resources are not available to support this client, or the client has a medical aid and can accesses private occupational

therapy services. However, medical aids have limitations in terms of what occupational therapists can charge, in accordance with medical aid tariffs and the number of occupational therapy sessions available for the patient. This responsibility has therefore become part of the clinical case managers' role, where the financial resources are made available through the medico-legal process and the funds awarded to the case.

An additional responsibility within the coordination role is facilitating appropriate support for the family by connecting parents to other parents of special needs children in the community and sending parents to psychologists. The case manager will require clinical reasoning skills to be able to identify that the family require support and making the appropriate referral.

Advocate role

In the medico-legal context, the clients are declared incapable of managing their own affairs and require a curator or trust, to be appointed by the court, as an administrator (The Department of Justice and Constitutional Development, 2003). This highlights these specific clients' vulnerability and the need for the clients' rights to be upheld, as they likely cannot uphold their own rights. Clients are usually persons who are mentally ill or mentally deficient, who cannot manage their own affairs due to physical infirmity and/or are declared prodigals who are unable to manage their finances (The Department of Justice and Constitutional Development, 2003). In addition to the loss of ability, medico-legal cases are often association with possible loss of income and purpose in life. These clients are often disempowered as their choices are limited. They look at the medico-legal process as a process that can give them choices again, these often being financial gain.

When again looking at the formal definition of case management, it states that case management is characterised by advocacy (CCMC, 2013) and a case manager is known to facilitate advocacy (CCMC, 2019). Advocacy is mentioned in various case management models (Intagliata, 1982; Kanter, 1989; Mueser et al., 1998) and is therefore explicit in case management. In the health and social development fields it is the responsibility of everyone involved to promote the interests of clients or

patients who are unable to uphold their own rights. However, in the medico-legal field, many of the clients do not have the capacity to administer their own affairs and therefore it is one of the main responsibilities of the case manager to advocate on behalf of the child or disempowered individual who cannot speak on behalf of themselves. Advocacy is thus is a key component of case management and the advocate role highly relevant in case management.

Participants noted they are responsible for tasks that promote the best interest of the client and therefore associated with advocacy. They do this by managing the family's expectations to promote the interest of the client and to create opportunities for the family to empower themselves.

Many of the responsibilities associated with the advocate role, as reported by participants, was with regard to the case resources and ensuring that money is spent on the client and not on the family. With high unemployment and poverty being on the rise in South Africa (Department of Statistics South Africa, 2017), many families may regard the money awarded during the legal case as a means of support for the family, leading to the neglect of the client. Participants reflected on preserving funds, to the benefit of the client, by ensuring the funds are spent on the client and reminding the family that the money should be spent in a sustainable manner. A further way of preserving funds is creating opportunities for the family to empower themselves, as this reduces the involvement of, and thus dependency on, the case manager, which further reduces case expenditure. Ethical clinical reasoning skills lead the case manager to identify that creating opportunities for the family to empower themselves would be the moral decision, so that the family require less input from the case manager leading to less funds being spent. The occupational therapist would have the ethical reasoning skills to make this moral decision.

Clinician role

Participants reported that they perform tasks that typically performed by the clinician such as client intervention and family or caregiver intervention. Although these tasks are the role of the clinician, the participants who are all occupational therapists reported that they perform many of these tasks as case manager as it is second

nature to them. It is likely to be a common occurrence for case managers as the clinical case management model was established as a result of case managers often acting as clinicians by providing direct services or intervention to clients (Lamb; 1980; Mueser et al., 1998). By performing these tasks as part of their role, clinical case manager would not need to refer the client to other clinicians such as occupational therapists for performing the tasks the participants reported on e.g. training on equipment.

One of the tasks which the participants reported was identifying medical needs as they change or arise. This requires clinical skills to be able to identify these needs and therefore a person without clinical skills would not be suited, as they will not be able to manage a dynamic case with changing or arising medical needs.

Consultant role

A consultant is an advisor to groups of people, organisations, governments, etc. on grounds of expertise (AOTA, 1993; Nestadt & Blesedell, 1998). The participants gave advice using their expertise as occupational therapists when performing the role of case manager. The participants reported that they consult to the legal entity, the client as well as to the team and/or other stakeholders.

Consulting the legal entity is a unique responsibility of the clinical case manager within the medico-legal context and would not be a responsibility of the case manager in other contexts. Some participants perceived that consulting to the legal entity required a mindshift as the legal entity was their client and not the person whose case is being managed. They also perceived that their role and responsibilities or involvement in the case depended on the instruction or mandate from the legal entity.

Participants perceived they have certain skills as occupational therapists such as group facilitation skills, which benefit the legal entities during meetings. An example of this is using their group facilitation skills during meetings in order to facilitate conversations during these meetings.

The participants also reported that the clinical case manager consults with the other members of the team or other stakeholders. As occupational therapists the participants believed that they have the relevant knowledge and skills (which will further be discussed in Objective 2) to give advice to the relevant team members on home accessibility and adaptations as well as on the appropriateness of properties, including considerations such as location to the relevant medical services and accessibility of the home. Occupational therapists share their expertise during consultations with the team and this again has the ability to save on the case funds. By performing these tasks, they save funds, as they do not need to refer the team members to other clinicians such as occupational therapists for consulting on home accessibility and adaptations as well as on the appropriateness of properties.

From the above it can be concluded that, although case management is the primary role of the case manager, it is a collaborative or rather holistic role approach which is used when managing cases in the medico-legal context. Based on the philosophy of occupational therapy and its holistic, client centered approach, it can be expected that more than just one role will be assumed as different aspects of managing the client might require different roles. Many of these responsibilities associated with the different roles require clinical skills, with some of them being unique to occupational therapists (such as facilitating occupational participation). Two of these roles also have responsibilities that are unique to the medico-legal context, namely the extended manager role (managing the client's finances who is declared incapable of managing their own affairs) and the consultant role (consulting the legal entity based on their expertise as occupational therapists).

Clinicians and, specifically, occupational therapists are well suited to perform the role of clinical case managers within the medico-legal context as many of the professional roles associated with occupational therapy form part of the holistic role approach required by case managers in this context.

The above discussion highlights that there are many similarities between the traditional occupational therapy roles (AOTA, 1993; Nestadt & Blesedell, 1998) and the role of the case manager. As participants were all experienced occupational

therapists it is expected that they associate with roles described in occupational therapy literature and that this forms the basis of their reasoning. There were, however, some tasks associated with each role, that are unique to the medico-legal context. These were mostly associated with the legal entity e.g. being the liaison between the client and the legal entity and consulting to the legal entity. During analysis a new role, which is not described in occupational therapy literature, also emerged which were all associated with coordination and therefore termed the coordinator role.

5.3. Integrated body of knowledge and skills

*This study found that South African occupational therapists who were employed as clinical case managers and participated in this research perceived themselves to have an **integrated body of knowledge and skills** which supported their ability to perform the role as clinical case managers within the medico-legal context.*

The results of this study indicated that case management in the medico-legal context is complex and requires an integrated body of knowledge and skills. Although the question which related to this objective asked specifically about skills that were used, it was evident that the participants also related their answers to the knowledge they have, which enables them to perform the role of case manager within the medico-legal context. During the analysis phase, it was evident that certain codes pertained to skills while others pertained to knowledge.

The results generated one theme for Objective 2, namely *Integrated body of knowledge and skills.* The integrated body of knowledge and skills which participants reported on included clinical reasoning skills, professional skills, administrative skills and integration of knowledge of a client as an occupational being.

<u>Clinical reasoning skills</u>

The first category or skill that participants reported on was clinical reasoning skills. Lohman (1998) identifies that clinical reasoning is one of the various skills that occupational therapists possess, which enables them to work as case managers.

Five known types of clinical reasoning types exist (Boyt Schell, 2014) and therefore the researcher used the definitions to guide the analysis of the clinical reasoning skills.

The participants in this study identified that they used all five types of clinical reasoning skills when performing their role. According to the World Federation of Occupational Therapists (WFOT) Minimum Standards for the Education of Occupational Therapists (2016), practitioners should demonstrate clinical and professional reasoning and behaviours. Occupational therapists are therefore taught this as part of the curricula and have the necessary reasoning skill to perform the role.

Participants reported when working with the client, they make use of narrative reasoning and cultural awareness as well as scientific reasoning. They typically had experience in working with various South African cultures and therefore have an understanding of different cultures and aspects related to understanding different personal and cultural situations. Participants reported that, when faced with certain moral decisions, they required the ability to ethically reason. This is usually an unconscious process but drives decision making at various points throughout the process (Jordens & Little, 2004). Participants reported they are required to make decisions based on the logistics or contexts of their own practices and therefore pragmatic reasoning skills are required. Literature describes that organizational constraints, resources, practice trends and reimbursement issues should all be considered (Chapparo & Ranka, 2008) which is similar aspects that participants reported.

Although these clinical reasoning skills are commonly used in occupational therapy practice, some of the decisions that are made based on clinical reasoning are unique to the medico-legal context e.g. participants reported that they do not fulfil the role of expert witness as well as case manager. This could be considered a moral decision, based on ethical reasoning, as it could be questioned if the expert witness recommends case management for their own financial gain, which would be immoral. Although this specific context is unique, it continues to honour occupational

therapy code of ethics which includes objectivity as a standard of practice (AOTA, 1994).

As seen in the discussion above, participants reported making use of clinical reasoning skills when performing the role of case manager within the medico-legal context. Therefore, the person fulfilling the role would benefit from having clinical background.

Professional skills

The next category or skill that participants referred to was professional skills. Participants reported interpersonal skills, project management and conduct skills/professionalism as those required to perform their role of case manager. These skills are similar to those that CMSA (2010) includes as functions typically performed by case managers. The CMSA includes a range of skills such as planning, facilitation and interpersonal skills such a communication. Lohman (1998) goes further identify that occupational therapists possess communication skills, leadership abilities and flexibility, which enables them to work as case managers (Lohman, 1998).

Based on the various professional skills reported by the participants, it can be concluded that a person performing the role as case manager within the medico-legal context would typically be a qualified person with professional skills. Most case management associations, such as CMSA (2010) recognises case managers as skilled professionals, indicating that the person fulfilling the role requires professional skills. In this study, participants indicated that professional skills would enable them to establish, maintain and manage the necessary interpersonal relationships, manage the project (case) in such a way that it has efficient and effective and conduct themselves in a professional manner.

As described in chapter two of this study, there are various links or associations to be made between the skills or processes used in project management (Steyn et al., 2008), the occupational therapy process (AOTA, 2014) and case management (CMSA, 2010). There are various skills that the project manager requires to manage

a project including “hard skills” which are aspects such as scheduling and risk analysis, as well as “soft skills” which consists of interpersonal, communication, teambuilding, people-managing and negotiating skills (Steyn et al., 2008). Many of these skills echo those required by a case manager as described by CMSA, such as assessment, planning, facilitation and interpersonal skills such as communication outcomes (CMSA, 2010). Again, these skills closely parallel Occupational Therapy Practice Framework: Domain and Process (3rd edition), which state the occupational therapy process consist of assessment, intervention (planning, implementation and review) and monitoring outcomes activities (AOTA, 2014). These activities are also closely related to categories of the minimum requirements of occupational therapy practice as set out by the American Occupational Therapy Association (AOTA), such as screening, evaluation and re-evaluation, intervention including planning and implantation, transition, discharge and outcome measurement (AOTA. 2015).

When considering conduct skills/professionalism, the researcher is of the opinion that the specific codes for this sub-category (setting boundaries, thinking and questioning your own prejudices and keeping yourself personally distant) relate to skills which can be associated with ethical considerations or responsibilities of a professional person and therefore are professional skills. Occupational therapists have objectivity as part of their code of ethics as a standard of practice (AOTA, 1994) which would these conduct skills. Furthermore, these professional skills will be required in any case management profession as all case managers are recognises as skilled professionals, regardless of the context (CMSA, 2010).

Administrative skills

Participants perceived they required administrative skills when performing the role of case manager within the medico-legal context. As discussed above in Objective 1, the participants assume the manager role when supervising administrative staff; however, it was also evident they require administrative skills such as the implementation of systems to keep track of change (which the admin staff then follow up on).

Participants reported on report and other writing skills, which included keeping records, taking notes and the written ability of justifying, calculating and motivating. These skills would not be considered unique to the medico-legal context, however writing motivations to the Master of the Court would be considered a unique responsibility in this context.

Literature such as Lohman (1998), Robinson et al. (2016) and descriptions by various case management associations, report on various required skills to perform case management, however it does not highlight administrative skills which participants reported on during this study. Although record keeping and reporting is not unique to case management in the medico-legal context, it could be considered that participants reported on administrative skills such as record keeping and reporting as case management in this context is governed by law and is required by the Master of the Court. It is therefore an integral part of their work as confirmed in the case of AD v MEC for Health and Social Development (2016) which states that the case manager is required to provide reports to the trust and to motivate and obtain approval for trust expenditure.

Integrated knowledge of a human as an occupational being

The final category reports on the knowledge the participants reported having, which enables them to perform their role as clinical case managers within the medico-legal context. From the sub-categories (knowledge of a person as a whole, knowledge of a client functioning as part of a collective and knowledge of optimal occupational functioning), it is evident that they use their occupational therapy knowledge to enable them to perform the role, as these aspects draw on occupational therapy philosophy, which at its core has humanism, holism and client centeredness (Mayers, 1990; Hagedorn, 1995; Hemphill-Pearson & Hunter, 1997). Occupational therapy programmes are guided by a unique philosophical understanding of occupation (WFOT, 2016) and occupational therapists are the only clinicians who use occupations as their primary treatment modality to enhance health, well-being and participation in meaningful activities (AOTA, 2014) From the participants perceptions, it was however evident that these bodies of knowledge do not occur in isolation, but rather that integrated knowledge is required to be able to look at a client

holistically. Therefore, the theme of integrated knowledge of a human as an occupational being arose. The WFOT outline the essential knowledge, skill and attitudes that occupational therapists require for competent practice and from the description, it is evident that occupational therapist are not required to have one body or knowledge but rather to have substantial knowledge, skills and attitudes in various areas, which should be integrated (WFOT, 2016). This highlights that knowledge does not occur in isolation but rather in an integrated manner, as described by participants.

Participants reported making use of their knowledge of a person as a whole to assist them. This includes looking at the client holistically, considering all aspects of the client's life, working with them through activities of daily living and having knowledge on the medical and functional aspects as well as the needs and interests identified by the client. This is consistent with the occupational therapy philosophy which urges occupational therapists to view clients in a holistic manner and as an occupational being (Wilcock, 1998). This echoes the principles of clinical case management, which also makes use of a holistic approach by considering the client's condition, context and environment. Occupational therapists however have a unique contribution in terms of their specialised level of academic and skills training related to occupational performance (Krupa & Clark, 1995; Hansen et al., 2007). Occupational therapists are the only clinicians who use occupations as their primary treatment modality to enhance health, well-being and participation in meaningful activities (AOTA, 2014). Because of this, occupational therapists working as case managers have the knowledge and skills to plan and implement effective intervention that could lead to improved occupational performance.

Participants perceived they have knowledge of their client functioning as part of a collective, which enables them to know where the whole family is functioning and gives insight to the family dynamics. This contributes to the notion of looking at the person as a whole and knowing that the client is a part of a collective. The occupational therapy process allows for considering outcomes not only in terms of individuals but also in terms of groups, populations and other collectives (AOTA, 2014; Adams, 2016). Participants reflected that their knowledge of a client

functioning as part of a collective, enables them to be case managers within the medico-legal context.

Lastly, participants reported having knowledge of optimal occupational functioning which enables them to perform their role as case managers within the medico-legal context. They reported that this knowledge of the transactional nature of occupational performance enables them to understand the client's ability, functioning and functional implications. They reported a variety of knowledge bases which they have, which contributes to their knowledge of optimal occupational functioning e.g. knowledge on models such as Vona du Toit's Level of Creative Ability and Maslow's Hierarchy of needs. This in turn contributes to their integrated knowledge of a client as an occupational being and enables case managers to identify the needs of the clients to further enable their occupational functioning. Lohman (1998) agrees that occupational therapists have in-depth knowledge of functional aspects of patient care. Functional aspects include daily living activities, independence, social activities, public transportation, and community reintegration, including work, and education (Turner et al., 2009). Occupational therapists have knowledge about activity analysis, psychological interventions, illnesses, disability, daily activities as well as routines and therefore have the ability to identify client's needs in terms of their health, occupational participation and quality of life (Robinson, et al., 2016). This all contributes to the case manager's focus, which is to coordinate quality care for clients (Lohman, 1998).

Kornblau and Hafez (2007) argue that occupational therapists already reason in case management terms if they embrace the principal philosophies of occupational therapy, which includes that humans are occupational beings, infused with a distinctive, biological necessity for occupation and, when so engaged, they meet needs for survival, growth, development, health and well-being (Wilcock, 1993). The core occupational therapy philosophy enables occupational therapists to address the occupational needs of clients from a functional and holistic perspective. This is confirmed in the South African context by Govender et al (2018), who state that occupational therapists offer unique skills to case management including addressing

the client's needs holistically with the focus on maintaining or improving their functioning to engage in meaningful occupation.

From the functions typically performed by case managers, as described by CMSA (2010), it is evident that case managers require a range of skills such as working effectively by making use of available resources, empowering and advocating for clients, and being aware of various facilitators and inhibitors for successful reintegration into their communities. The researcher is of the opinion that occupational therapists use this integrated knowledge of humans as occupational beings to be able to identify these facilitators and inhibitors for successful reintegration into their communities. This is confirmed by occupational science literature which focuses on the study of the human as an occupational being, who has a need to engage with their environment through daily occupations (Yerxa et al., 1989).

The above skills (clinical reasoning skills, professional skills and administrative skills) and integrated knowledge of a client as an occupational being cannot occur in isolation. Conversely, integrated skills and knowledge are required to be able to meet the responsibilities and overall role as case manager within the medico-legal context as described above in Objective 1.

Based on the above results, it is evident that a professional who has skills such as professional skills and administrative skills will be able to perform this role, but that they also require certain clinical skills such as clinical reasoning. Lastly, participants rely heavily on their occupational therapy knowledge of a personal as an occupational being, which enables them to perform their role and therefore it can be assumed that occupational therapists are suited well to perform the role of case manager within the medico-legal context.

5.4. Broad experience

This study found that South African occupational therapists who were clinical case managers and participated in this research perceived themselves to be prepared by

*their **broad experience** to work as clinical case managers within the medico-legal context.*

Although the participants reported some aspects which related to them feeling unprepared for the role, they also reported various reasons why they were indeed prepared, because of academic and practical preparedness.

Unprepared for the role

Some participants expressed feeling unprepared for the role of case manager within the medico-legal context. They reported this arose from being inexperienced, having their own personal insecurities and having the need for additional training.

As this is a new role within the South African context, with little literature or guiding concepts available for the medico-legal context, it can be expected that some participants did not feel prepared. Being inexperienced led to them feeling unprepared. They also reported having insecurities, however, they did not relate these insecurities to their lack of training, but rather to their own personal insecurities e.g. still growing or fighting their own anxiety and assertiveness. Insufficient preparation and unfamiliarity can bring to the forefront a person's own insecurities and anxiety. This is confirmed by a study in the field of communication that reveals that preparation and unfamiliarity are two reasons that could contribute to anxiety (Bippus & Daly, 1999).

The participants also stated they have a need for additional training, specifically directed towards this specific field, and mentioned possible avenues of training e.g. adding it to the curriculum in pre-graduate occupational training, availing postgraduate courses or training opportunities with guidelines and protocols. The researcher is of the opinion that, due to the complexity of case management in the medico-legal context, as described by participants, this training would be better suited in post-graduate training and courses. This will ensure that occupational therapists have the relevant practical experience (Benner, 1982). Participants noted that this should be added to the South African occupational therapy scope of practice so that there can be an additional focus placed on training.

Academic preparation

Participants reported they perceived themselves to be prepared for the role as case, managers by being academically prepared. As discussed in the results, they reported that their occupational therapy training, attending courses (as part of their continuous professional development as well as other type of course) and doing research prepared them.

As was described in the literature review and Theme 2, occupational therapists hold various skills that enable them to fulfil the role as case manager. The Case Management Certification requirements notes that health workers must demonstrate the ability to apply six essential activities to practise as a certified clinical case manager: assessment, planning, implementation, coordination, monitoring and evaluation (CCMC, 2013). According to Lohman (1998), these activities parallel some categories of the minimum requirements of occupational therapy practise as set out by the American Occupational Therapy Association, such as screening, evaluation and re-evaluation, intervention including planning and implantation, transition, discharge and outcome measurement (AOTA, 2015). Therefore, it can be concluded that occupational therapists are academically prepared to take on the role as case manager. It should, however, be considered that there are some unique roles in the medico-legal context, as reported in Theme 1. However, when considering the skills and knowledge described above in Theme 2, some of these e.g. clinical reasoning skills and the integrated knowledge of humans as occupational beings are taught in occupational therapy training.

Practically prepared

Participants reported they perceived themselves to be practically prepared by their past experiences as occupational therapists. Their substantial clinical experience in various fields and contexts, and the mentorship they received, prepared them for the role as clinical case manager within the medico-legal context.

As noted above, a clinical role of the case manager is to perform family training on equipment and therefore it can be expected that, due to their clinical occupational

therapy experience of working with families and suppliers, they will be well equipped to handle such a responsibility. Some participants also reported their experience and background of knowing how the medico-legal system works prepared them for the role. This is a unique contribution of working within the medico-legal field to prepare the case manager to work within this specific context.

Another useful method for preparation was mentorship by other occupational therapists working in the field. Some participants also mentioned that mentoring by members of the legal team e.g. the case attorney further assisted their preparation. Mentoring by a legal professional/team is a unique feature of the medico-legal context as legal entities would not typically mentor occupational therapists in other roles.

Lastly, one participant felt practically prepared for her role as case manager within the medico-legal context by her own personal experience of raising a disabled child and having to manage his needs. This was however a unique experience and not an experience of the entire participant population.

Overall, when considering the three categories above, the researcher is of the opinion that participants felt more prepared for the role than unprepared. They described instances of how they were prepared academically as well practically. When considering their perceptions of being unprepared one reason was due to personal insecurities and being inexperienced.

However, based on the results, the researcher opines that there is a definite need for adding this specific role of case manager within the medico-legal context to the scope of occupational therapy practice.

5.5. Implications for practice

The need for the health care sector to be more efficient and effective in terms of managed care, has been identified by the Case Managers Association of South Africa (CMASA, 2013). As the medico-legal context is a context where case management is practiced, having a clear role definition and skills and knowledge

requirements might enable more occupational therapists to take on this role and therefore add to the efficiency and effectiveness of the health care system. The resourceful coordination of these medico-legal cases can have financial benefits as case is managed effectively by an occupational therapist who has the ability to clinically reason and who has knowledge about the various functional implications for the disabled client.

Having a clear guidance of the roles and responsibilities will assist occupational therapists currently working in the case management field to increase their understanding and knowledge of their role and therefore also enhanced practice by making more appropriate recommendations for clients during and after medico-legal trials. It will provide a reference to occupational therapists working in this field to better coordinate the care of clients, which would ultimately benefit the latter. It may also encourage more occupational therapists to undertake such roles, as they have a better understanding of what the role entails, what would be expected of them and to prepare accordingly.

The results will be available to legal entities who employ clinical case managers, to gain more insight or knowledge as to why occupational therapist are well suited to perform the role. Knowing where the occupational therapist have certain insecurities might assist the legal entity to better mentor them for responsibilities that are unique to the medico-legal context

Understanding the occupational therapist's unpreparedness, insecurities and need for additional training may also provide guidance for training facilities in South Africa to better prepare their graduates or guide them in terms of what additional support the qualified occupational therapists may require in terms of post-graduate training.

5.6. Limitations of the study

Since this was a relatively new field within the South African context at the time of data collection, there was only a limited number of research participants who met the inclusion criteria, resulting in the results not being generalizable. Further, participants were all white and female, adding to the results not being generalizable.

Due to the nature of the qualitative study, results are related to participants' perceptions, opinions, feelings and views, again resulting in the results not being generalizable.

When the objectives were set and the research questions designed, the researcher used the terms roles and responsibilities as well knowledge and skills interchangeably. However, during the analysis phase of the study, it became evident that these concepts should rather have been termed individually and the questions rather have allowed for participants to respond to these terms individually.

Lastly, because of the specific nature of the study i.e. the medico-legal context in South Africa, the results will likely not be suitable to be generalised and implicated to other contexts or countries.

5.7. Recommendations and future research

Participants highlighted the need for the role of case manager within the medico-legal context to be added to the occupational therapy scope of practice. They further indicated that there is a need for training in this specific field. Further research may therefore be necessary regarding the inclusion of this role in the under-graduate and or post-graduate curricula.

As the field grows in South Africa, more occupational therapists may undertake this role. Future research can be conducted with an expanded sample size so that the results are more generalizable.

Additional research can also focus in depth on each of the identified roles and the accompanying responsibilities to gain deeper insights to the role of occupational therapists in the medico-legal context.

CHAPTER 6

6 CONCLUSION

The aim of the study was to explore South African occupational therapists who work in the medico-legal context's perception of their roles and responsibilities as clinical case managers and their preparedness to execute this role and associated responsibilities. To achieve this aim, the following objectives guided the study.

The researcher explored South African occupational therapists who work as case managers perceptions of:

- Their roles and responsibilities as clinical case managers working within the medico-legal context.
- The skills and knowledge they possess which support their ability to perform the role as clinical case managers within the medico-legal context.
- Their perceived preparedness to work as clinical case managers within the medico-legal context.

Literature was reviewed and revealed that there are various contexts in which a case manager assumes his or her role. Case management in the medico-legal context seems to be an area in which occupational therapists in South Africa have identified the opportunity to deliver services and have therefore assumed a role as clinical case managers in this context. Although personal experience has identified some unique aspects of occupational therapists working in this context, there is no supporting literature to confirm this and therefore the need for this study.

The study was guided by a qualitative research approach to enable the researcher to explore the participant's perception of their role, which provided insight into their experiences and opinions. Semi-structured interviews with open-ended questions were used to gain information. Strategies to ensure trustworthiness included credibility, member checking, peer debriefing, accurate transcription of the

information, transferability, dependability, obtaining data saturation, audit trail, confirmability and bracketing.

Three themes emerged from the data including, *Holistic role approach*, *Integrated body of knowledge and skills* and *Broad experience.* Each theme was further divided into categories, which comprise of sub-categories. Each sub-category consisted of various codes. Quotes from the interviews were used to further describe and support the results.

The results revealed that occupational therapists perceive themselves to use a holistic approach to fulfil their roles and responsibilities. They make use of various occupational therapy roles as described in literature (AOTA, 1993; Nestadt & Blesedell, 1998) to fulfil their overall role as a case manager. These roles include: manager, collaborator, advocate, clinician and consultant. Participants further reported on tasks that could be described as coordinating and therefore a new role emerged, referred to as the coordinator role. Participants described the responsibilities related to each of these roles which is required to perform the role as clinical case manager within the medico-legal context. It can be considered that these roles can be used at once or in isolation, depending on the type of case and required responsibilities of the specific type of case.

On deeper evaluation of the case manager role in the medico-legal context, it is apparent that this is no longer a role but rather a work title or work opportunity in its own right. This specific job type can be assumed by an occupational therapist, but also by many other medical professionals. Occupational therapists however have the integration of knowledge of a client as an occupational being that contribute to their thinking and management of the case and the money.

Occupational therapists perceive themselves to have an *integrated body of knoweldge and skills* which support their ability to perform their role. Participants identified three skills they use to perform their role as clinical case manager, namely: clinical reasoning, professional and administrative skills. They further described skills related to each sub-category. Participants reported they have an

integration of knowledge of a client as an occupational being which enables them to perform their role. They further described which areas of knowledge they integrate to understand their client as an occupational being.

Lastly, occupational therapists perceived themselves to be prepared for the role by *Broad experience.* Although the participants reported some aspects that related to them feeling unprepared, they reported various reasons why they were indeed prepared for such a role. Participants perceived themselves to be prepared because of academic purposes or because of practical purposes.

This study will assist occupational therapists currently working in the case management field, to increase their understanding and knowledge of their role so they can have increased application and therefore also enhanced practice by making more appropriate recommendations for clients during and after medico-legal trials. It may also encourage more occupational therapists to undertake such roles.

The results will be available to legal entities who employ clinical case managers, to gain more insight into why occupational therapists are well suited to perform the role of case managers in the medico-legal context. They will also have more insight to the skill and knowledge they possess and their preparedness to take on the role. Knowing where the occupational therapist might have certain insecurities might assist the legal entity to better mentor or prepare them for responsibilities that are unique to the medico-legal context.

Having a clear definition of the role and responsibilities of occupational therapists will provide a reference to occupational therapists working in this field to better coordinate the care of clients, which would ultimately benefit clients. Lastly, the results will also be available to guide occupational therapists to better understand what would be expected of them in such a role and to prepare accordingly.

REFERENCES

AD v MEC for Health and Social Development, Western Cape Provincial Government 2016 SA 27428/10 paras 2-3, 24-16.

Adams, F. (2016). *Development of descriptors for domains and items for collective participation in occupations*. A thesis submitted to the Faculty of Health Sciences, University of the Witwatersrand, Johannesburg.

Al-Busaidi, Z. Q. (2008). *Qualitative Research and its Uses in Health Care*. Sultan Qaboos University Medical Journal, 8(1), pg. 11-19.

Anthony, W.A., Forbess, R. & Cohen, M.R. (1993). *Rehabilitation oriented case management. Case Management for Mentally III Patients: Theory and Practice*. Chur, Switzerland: Harwood Academic Publishers, 1993. pg. 99-118.

American Occupational Therapy Association. (1993). *Occupational Therapy Roles*. American Journal of Occupational Therapy, 47(12), pg. 1087-1099.

American Occupational Therapy Association. (1994). *Occupational Therapy code of ethics*. America Journal of Occupational Therapy, 48. pg. 1037-1038.

American Occupational Therapy Association. (2008). Occupational therapy practice framework: Domain and process (2nd ed.). American Journal of Occupational Therapy, 62(7), pg. 625–683.

American Occupational Therapy Association. (2014). Occupational Therapy Practice Framework: Domain and Process (3rd Edition). American Journal of Occupational Therapy, 68(Supplement_1), S1–S48. https://doi.org/10.5014/ajot.2014.682006

American Occupational Therapy Association. (2015). Standards of Practice for Occupational Therapy. American Journal of Occupational Therapy, 69(3), pg.1-7.

Benner, P. (1982). From novice to expert. American Journal of Nursing, 82(3), pg. 402-407. https://doi.org/10.1080/0305764910210307

Bhamani, A. (2012). Using interviews as research instruments. Language Institute Chulalongkorn University.

Bidwell, S. A. E. (2013). What do Personal Injury solicitors expect of case managers?

Bippus, A.M. Daly, J.A. (1999) What do people think causes stage fright? Naïve attributions about the reasons for public speaking anxiety. Communication Education, 48:1, 63-72, DOI: 10.1080/03634529909379153

Boyt Schell, B.A. (2014). Professional Reasoning in Practice. In: Willard & Spackman's Occupational Therapy. Baltimore: Lippincott Williams & Wilkins, a Wolters Kluwer Business, p. 384.

Case Management Society of America [CMSA] (2010). Standards of practice for case management. Available at: www.cmsa.org/portals/0/pdf/memberonly/standardsofpractice [Accessed 15 April 2017].

Case Management Society UK [CMSUK]. (2009). Standards and Best Practice Guidelines (2nd Ed). CMSUK: London

CCMC. (2013). Definition and Philosophy of Case Management. [Online] Available at: https://ccmcertification.org/about-us/about-case-management/definitionand-philosophy-case-management [Accessed 4 April 2017].

CCMC. (2019). Introduction to the Case Management Body of Knowledge. [Online] Available at: https://www.cmbodyofknowledge.com/content/introduction-casemanagement-body-knowledge [Accessed 23 January 2019].

Chapparo, C. Ranka, J. (2008). Clinical reasoning in occupational therapy. In: Clinical reasoning in the health professions. Philadelphia: Elsevier, pp. 265-277.

CMASA. (2013). Case Manager Association of South Africa. [Online] Available at: http://www.casemanagement.co.za/ [Accessed 15 April 2017].

CMSA. (2010). CMSA San Francisco/East Bay Chapte. [Online] Available at: http://www.cmsa-sf-eb.org/index.php/what-is-a-case-manager [Accessed 8 May 2017].

Concise Oxford English Dictionary. (2012) 12th Ed. Emerald Group Publishing Limited 2012.

Cresswell, J.W. (2003). Research Design. Qualitative, Quantitative and Mixed Methods Approach. 2nd Edition. California: Sage Publications.

David, M., Sutton C.D. (2004). Social Research the Basics. London: SAGE Publications.

Denysys (2017). The Benefits of Case Management in Healthcare. [Online] Available at: https://www.denysys.com/blog/the-benefits-of-case-management-inhealthcare/ [Accessed 23 01 2019].

Department of Justice and Constitutional Development (no date) Legal position of persons incapable of managing their own affairs.

Department of Statistics South Africa. (2017). Poverty on the rise in South Africa. Retrieved from Stats SA: www.statssa.gov.za/?p=10334

Dogra, TD., Rudra, A. (2005). Lyon's Medical Jurisprudence & Toxicology. 11th ed. New Delhi:
Delhi Law House; p. 367.

Govender, K., Christopher, C. & Lingah, T. (2018) The role of the occupational therapist in case management in South Africa, 48(2), pg. 12–19.

Government Gazette No. 24024. (2002). Mental Health Care Act. [Online] Available at: http://www.gov.za/sites/www.gov.za/files/a17-02.pdf [Accessed 23 June 2017].

Guba, E., Lincoln, Y. (1981) Effective evaluation: Improving the usefulness of evaluation results through responsive and naturalistic approaches. San Francisco: Jossey-Bass.

Guest, G., Bunce, A., & Johnson, L. (2006). How many interviews are enough? An experiment with data saturation and variability. Field Methods, 18(1), 59-82. doi:10.1177/1525822X05279903

Hafez, A. K. B. (2007). Becoming a Case Manager: A “Next Step” for occupational therapy Professionals. pg. 11–12.

Hagedorn, R. (1995). Occupational therapy: Perspectives and processes. Edinburgh, UK: Churchill Livingstone.

Hemphill-Pearson, B., & Hunter, M. (1997). Holism in mental health practice. Occupational Therapy in Mental Health, 13(2), 35–49.

Hansen, R., Dirette, D.K., Atchison, B.J. (2007). Thinking like an OT. In: Conditions in Occupational Therapy: Effect of Occupational Performance. Philadelphia: Lippincott Williams & Williams, pp. 1-7.

Hooper, B. Wood, W. (2013). The Philosophy of Occupational Therapy, in Willard & Spackman’s Occupational Therapy, pg. 35–44.

HPCSA. (2006). Form 265 Professional board for Occupational Therapy, Medical Orthotics and Prosthetics and Art Therapy - Standards of Practice for Occupational Therapists.

Intagliata, J. (1982) Improving the quality of community care for the chronically mentally disabled: The role of case management. Schizophrenia Bulletin, 8(4):655-674.

Jordens, C.F.C., Little, M. (2004). In this scenario I do this, for these reasons': Narrative, genre and ethical reasoning in the clinic. Social Science and Medicine 58:1635-1645.

Kanter, J. (1989). Clinical case management: Definition, principles, components. Hospital and Community Psychiatry, 40:361-368,

Krefting, L. (2017). Rigor in Qualitative Research: The Assessment of Trustworthiness. 45(3), pg. 214–222.

Krupa, T. & Clark, C. C. (1995). Occupational therapists as case managers: responding to current approaches to community mental health service delivery. Canadian Journal of Occupational Therapy, 62(1), pg. 16-22.

Laker, D.R., Powell, J.L. (2011). The difference between hard and soft skills and their relative impact on training transfer. Human Resource Development Quarterly. 22(1): 111-122.

Lamb, H.R. (1980). Therapist-case managers: More than brokers of services. Hospital and Community Psychiatry. 31:762-764.

Lambert, V.A., Lambert, C.E. (2012). ‘Editorial: Qualitative Descriptive Research : An Acceptable Design. Pacific Rim J Nurs Res, 16(4), pg. 255–256.

Levin, K. A. (2014). ‘Study Design III : cross-sectional studies Study design III : Cross-sectional studies’, (February 2006). doi: 10.1038/sj.ebd.6400375.

Lincoln, Y., Guba, E. (1985). Naturalistic inquiry. Newbury Park: SAGE Publications Ltd.

Lohman, H. (1998). Occupational Therapists as Case Managers. Occupational Therapy in Health Care, 11(3), pg. 65–77.

Mayers, C. (1990). A philosophy unique to occupational therapy. British Journal of Occupational Therapy, 53, 379–380.

MAXQDA (2019). [Online] [cited 2017 April] Available at: https://www.maxqda.com/?utm_expid=.HYL6SEWUQaqlYvgzfnwOzA.0&utm_referrer=https%3A%2F%2Fwww.google.com%2F

Meera, T. (2016). Medico-legal cases: What every doctor should know. J Med Soc; 30: pg.1334.

Moore, S. (1990). A social work practice model of case management: The case management grid. Social Work, 35: pg. 444-448.

Morse, J. M., Barrett, M., Mayan, M., Olson, K., & Spiers, J. (2002). Verification Strategies for Establishing Reliability and Validity in Qualitative Research. International Journal of Qualitative Methods, 1(2): pg. 13–22. https://doi.org/10.1177/160940690200100202

Moyers, P. A., & Dale, L. M. (2007). The guide to occupational therapy practice (2nd ed.). Bethesda, MD: AOTA Press.

Mueser, K. T., Bond, G. R., Drake, R. E., & Resnick, S. G. (1998). Models of community care for severe mental illness: A review of research on case management. Schizophrenia Bulletin, 24: pg. 37-74

Neistadt, M. Blessedell, CE. (1998). Willard & Spackman's Occupational Therapy. Baltimore: Lippincott Williams & Wilkins.

Noy, C. (2008). Sampling knowledge: the hermeneutics of snowball sampling in qualitative research. International Journal of Social Research Methodology, 11(4): pg. 327-344.

Parker, H., (2001). The Role of Occupational Therapists in Community Mental Health Teams:
Generic or Specialist? The British Journal of Occupational Therapy, 64(12): pg. 609–611.

Pope, C. van Royen, P. Baker, R. (2002). Qualitative methods in research on healthcare quality. Quality Safety Health Care, 11:138-152.

Rapp, C.A. (1993) Theory, principles, and methods of the strengths model of case management. In: Harris, M., and Bergman, H.C., eds. Case Management for Mentally III Patients: Theory and Practice. Langhorne, PA: Harwood Academic Publishers: pg. 143164.

Robinson, M., Fisher, T. & Broussard, K. (2016). Role of occupational therapy in case management and care coordination for clients with complex conditions. American Journal of Occupational Therapy, 70(2): pg. 7002090010p1-7002090010p6.

Rozanne Groenewald Occupational Therapists. (2013). Centurion.

Shafaroodi, N., Kamali, M., Parvizy, S., Mehraban, A. H., & O'Toole, G. (2014). Factors affecting clinical reasoning of occupational therapists: a qualitative study. Medical journal of the Islamic Republic of Iran, 28, 8.

Stein, L.I., & Test, M.A. (1980). Alternative to mental hospital treatment: I. Conceptual model, treatment program, and clinical evaluation. Archives of General Psychiatry,37: pg. 392397.

Steyn H, et. al. (2008). Project Management: A Multi-Disciplinary Approach (second, revised edition).

Substance Abuse and Mental Health Administration (SAMHSA). (1998). Comprehensive case management for substance abuse treatment (TIP Series 27). Rockville: U.S. Department of health and human services, Public Health Service, Substance abuse and mental health services administration, Centre for substance abuse treatment.

Sullivan, W.P. (1992). Reclaiming the community: The strengths perspective and deinstitutionalization. Social Work, 37: pg. 204-209.

Surles, R.C., Blanch, A.K., Shern, D.L. & Donahue, S.A. (1992). Case management as a strategy for systems change. Health Affairs, 11: pg. 151-163.

Test, M.A. (1992). Training in community living. In: Liberman, R.P., ed. Handbook of Psychiatric Rehabilitation. New York, NY: Macmillan Press: pg. 153-170.

The Department of Justice and Constitutional Development. (2003). Legal position of persons incapable of managing their own affairs, Pretoria: The Department of Justice and Constitutional Development.

Tongco, D. (2007). Purposive Sampling as a Tool for Informant Selection. Ethnobotany journal, 5, pg. 147–158.

Turner, B., Ownsworth, T., Cornwell, P., & Fleming, J. (2009). Re-engagement in meaningful occupations during the transition from hospital to home for people with acquired brain injury and their family caregivers. American Journal of Occupational Therapy, 63, 609–620.

UCSLibraries. (2019). Organising Your Social Sciences Research Paper: Types of Research Designs. [Online] Available at: https://libguides.usc.edu/writingguide [Accessed 10 September 2019].

Wilcock, A. (1993). A theory of human need for occupation. Journal of Occupational Science: Australia, 1(1): pg. 17-24.

Wilcock, A. (1998). Reflections on doing, being and becoming. Australian Occupational Therapy Journal, 46(1): pg. 1–11.

Neistadt, M. E. Crepeau, E. B. (1998). Willard & Spackman's Occupational Therapy 9th edition,. Lippincott, Philadelphia.

van Biljon, H. (2013). Occupational Therapist in Medico-legal work - South African Experiences and Opinions. SA Journal of Occupational Therapy, 43(2): pg. 27–34.

Vanderplasschen, W. et al. (2007). Effectiveness of Different Models of Case Management for Substance-Abusing Populations. 39(1), pp. 81–95.

Vanderplasschen, W. Wolf, J. Rapp, RC. Broekaert, E. Is case management an effective and evidence-based intervention for helping substance abusing populations? In: Pedersen MU, Segraeus V, Hellman M, editors. Evidence Based Practice: Challenges in Substance Abuse Treatment. Helsinki: Nordic Council for Alcohol and Drug Research (NAD); 2005.

World Federation of Occupational Therapists (Revised 2016). Minimum Standards for the Education of Occupational Therapists.

Yerxa, E., Clark, F., Jackson, J., Parham, D., Pierce, D., Stein, C. et al. (1989). *An introduction to occupational science: a foundation for occupational therapy in the 21st century.* Occupational Therapy in Health Care 6(4): 1–17

Appendix A: Semi-structured interview questions and probes

1. How did you become involved in case management within the medico-legal context?

1. Explain your role and duties as a clinical case manager within a medico-legal context?
    a. Probe: Give me examples form your experience.
2. Tell me about the skills that you use to be a clinical case manager within a medico-legal context?
    a. Probe: Give me examples form your experience.
3. How were you prepared to take on this role as a clinical case manager within a medico-legal context?
    a. Probe: Do you think you are sufficiently prepared for this role? And give reasons for your answer.
4. What is your perception of occupational therapists fulfilling the role as clinical case manager within the medico-legal field?
    a. Probe: Do you think occupational therapists are suited to perform this role and explain your answer.

Appendix B: Information sheet and consent forms

Information sheet and consent form

Name of the researcher: Emma Perridge

Institution: University of Witwatersrand
Occupational therapy department

Title: SOUTH-AFRICAN OCCUPATIONAL THERAPISTS PERCEPTION OF THEIR ROLE AS CLINICAL CASE MANAGERS IN A MEDICO-LEGAL CONTEXT

Dear Occupational Therapist

Thank you for your consideration to participate in the above-mentioned research project.

I, Emma Perridge, am an MSc student in the Occupational Therapy Department of the University of Witwatersrand. I am current doing a research project that aims to: explore South African occupational therapists' perception of their role as clinical case managers and their preparedness to execute this role within the medico-legal context.

I would like to invite you to participate in this research. If you agree to participate, you will be asked to partake in a semi-structured interview with open-ended questions relating to your roles and duties as a clinical case manager within a medico-legal context, as well as the skills and abilities you use to work in this field and how prepared you were to take on this role. The interview will be recorded and is expected to last approximately 90 minutes.

With your permission, the interview will be audiotaped and these tapes will be kept in a MP3 format on a password protected computer by the researcher. The tapes will be stored and then destroyed after six years or after two years if the study is published, according to HPCSA regulations.

Participation is strictly confidential as no personal identifying information related to you or your clients will be shared. You can also withdraw from the study at any point without any prior warning or negative consequences.

Feedback on the study will be available on request.

For any ethical concerns please contact the chairperson of the Human Research Ethics Committee at the University of Witwatersrand, Prof P Cleaton-Jones at peter.cleaton-jones@wits.ac.za

Contact details for the administrative offices: Ms. Z Ndlovu/ Mr Rhulani Mkansi/ Mr Lebo Moeng, Tel: 011 717 2700/2656/1234/1252, or email: Zanele.ndlovu@wits.ac.za; Rhulani.mkansi@wits.ac.za; Lebo.moeng@wits.ac.za

If you have any further queries please do not hesitate contact me at emma.perridge@gmail.com.

I sincerely appreciate your participation.

Yours truly,

Emma Perridge

The researcher

Informed consent:

I, _____ hereby agree to participate in the research study and am willing to participate in an interview conducted by Miss Perridge. I have been informed about my right to withdraw at any time during the research without any negative consequences.

Signed at _____ on this day _____ of _____ year _____.

Printed name:	Witness name:
Signature:	Signature:
Date:	Date:

Consent to be audiotaped

I, _____ hereby agree to be audio taped in the research study and in an interview conducted for the study.

Signed at _____ on this day _____ of _____ year _____.

Printed name:	Witness name:
Signature:	Signature:
Date:	Date:

Appendix C: Researcher's assumptions of the study

There is no clear role definition or guiding concepts related to clinical case management for occupational therapist within the medico-legal context. The researcher is however of the opinion that occupational therapists are well suited to perform this role based on their professional philosophy of people as occupational beings (Wilcock, 1998), meaning they are able to address the occupational needs of clients from a functional and holistic perspective. There is opportunity for further role description within the specific field of clinical case management within the medico-legal context, which will be further explored during this research.

From personal experience in clinical practice it was determined that the medico-legal context has some unique aspects to other types of case management: The case manager can provide advice to the trust or curator regarding the suitability and appropriateness of new assistive devices, interventions or routine medical care. These recommendations will help to ensure that the client's estate is effectively managed from a health professional's point of view. The case manager also provides motivations and feedback reports to the Master of the High court.

The researcher further assumes that occupational therapists are well prepared for their role as a clinical case manager within the medico-legal context. From personal experience, the researcher observed that occupational therapists use many of the interpersonal - and managing skills taught at an undergraduate level of occupational therapy studies.

Appendix D: Ethics Clearance Certificate

UNIVERSITY OF THE WITWATERSRAND, JOHANNESBURG

R14/49 Ms E Perridge

HUMAN RESEARCH ETHICS COMMITTEE (MEDICAL)
CLEARANCE CERTIFICATE NO. M170910

NAME: (Principal Investigator)	Ms E Perridge
DEPARTMENT:	School of Therapeutic Sciences Department of Occupational Therapy Medical School
PROJECT TITLE:	South African occupational therapists' perception of their role as clinical case managers in a medico-legal context
DATE CONSIDERED:	29/09/2017
DECISION:	Approved unconditionally
CONDITIONS:	
SUPERVISOR:	Dr F Adams and Ms R Smith
APPROVED BY:	Professor PE Cleaton-Jones, Chairperson, HREC (Medical)
DATE OF APPROVAL:	06/12/2017

This clearance certificate is valid for 5 years from date of approval. Extension may be applied for.

DECLARATION OF INVESTIGATORS

To be completed in duplicate and **ONE COPY** returned to the Research Office Secretary on 3rd floor, Phillip V Tobias Building, Parktown, University of the Witwatersrand, Johannesburg.
I/We fully understand the conditions under which I am/we are authorised to carry out the above-mentioned research and I/we undertake to ensure compliance with these conditions. Should any departure be contemplated from the research protocol as approved, I/we undertake to resubmit to the Committee. **I agree to submit a yearly progress report**. The date for annual re-certification will be one year after the date of convened meeting where the study was initially reviewed. in this case, the study was initially reviewed in **September** and will therefore be due in the month of **September** each year. Unreported changes to the application may invalidate the clearance given by the HREC (Medical).

Principal Investigator Signature _____ Date _____

PLEASE QUOTE THE PROTOCOL NUMBER IN ALL ENQUIRIES

UNIVERSITY OF THE WITWATERSRAND, JOHANNESBURG

Appendix E: Turn it in report

SOUTH AFRICAN OCCUPATIONAL THERAPISTS' PERCEPTION OF THEIR ROLE AS CLINICAL CASE MANAGERS IN A MEDICO-LEGAL CONTEXT

ORIGINALITY REPORT

8%	3%	2%	6%
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MATCH ALL SOURCES (ONLY SELECTED SOURCE PRINTED)

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★ Submitted to University of Witwatersrand

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Exclude quotes	On	Exclude matches	Off
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