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## Perspectives on content and delivery of the ABLE 1.0 intervention programme

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### ABSTRACT

**Background:** The occupational therapy intervention programme ABLE 1.0 was designed to enhance the ability to perform activities of daily living in persons living with chronic conditions. There is a need to determine if content and delivery of the ABLE 1.0 are acceptable among occupational therapists (OTs) and clients after having delivered or received the programme, respectively.

**Objectives:** The paper reports on evaluation of content and delivery of the ABLE 1.0 among OTs and clients. This, in terms of acceptability of intervention in principle, and perceived value, benefits, harms, or unintended consequences of the intervention.

**Material and methods:** Qualitative semi-structured interviews were conducted with OTs having delivered and clients having received ABLE 1.0 in a Danish municipality. Content analysis was performed.

**Findings:** Two OTs and three clients participated. Analyses revealed six categories related to content and delivery; 'Overall perception of the programme'; 'Potential for implementation'; 'Evaluation, goal setting and clarification of reasons for ADL task performance problems'; 'Intervention: compensatory solutions'; 'Format and duration' and 'Preconditions for delivery'.

**Conclusions and significance:** The findings provided valuable information used for further development of the ABLE programme.

### ARTICLE HISTORY

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### KEYWORDS

Activities of daily living; complex interventions; feasibility; occupational therapy



## Introduction

This study is a part of the 'A Better everyday Life' research programme. The overall purpose of the research programme is to develop and evaluate an occupational therapy intervention programme, named ABLE, aiming at enhancing the ability to perform activities of daily living (ADL) among persons living with various types of chronic conditions. An intervention programme aiming directly on enhancing ADL ability was needed, as existing research has revealed that exercises to enhance body functions do not necessarily result in enhanced ADL ability [1–6].

The first version of the ABLE intervention programme (ABLE 1.0) [7] is an eight-week intervention

programme building on a compensatory approach by teaching new ways of doing, using adaptive equipment/assistive technology, and modifying physical/social environments to enhance ADL ability. ABLE 1.0 was developed based on existing evidence [8, 9], occupational therapy theory [10, 11], clinical expertise of occupational therapists (OTs) and client preferences and needs [7, 12, 13].

The process of developing ABLE 1.0 was guided by the British Medical Research Council's (MRC) guidance on development and evaluation of complex interventions [14]. According to the MRC guidance [14], intervention development and evaluation comprise four phases: 1) development, 2) feasibility/piloting,

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3) evaluation, and 4) implementation. The process related to the development of ABLE 1.0 has previously been described [7]. Subsequently, a study evaluating the feasibility of ABLE 1.0 in terms of content and delivery was designed using the guidelines by O’Cathain et al. [15] and described in a published protocol paper [16]. As described in the protocol paper, the aims of the study were to evaluate seven aspects of feasibility; (1) intervention development, (2) intervention components, (3) mechanisms of action, (4) perceived value, benefits, harms, and unintended consequences, (5) acceptability of intervention in principle, (6) feasibility and acceptability in practice, and (7) fidelity, reach and dose [16]. In a previous paper [7, 17], results related to some of the aspects have been reported (aspects 1-3 and 6-7). For the previous part, data comprised registration forms, filled out immediately after having received or delivered each ABLE 1.0 session, by clients and occupational therapists (OTs) respectively. Hence, data were collected during delivery of the ABLE 1.0. The present paper reports on remaining feasibility aspects (aspects 4-5). For this part, data comprised interview data gathered after the participants had received or delivered the full version of ABLE 1.0 [16]. More specifically, the present paper reports on the evaluation of the acceptability of the intervention in principle (i.e. overall perception of content and delivery and the extent to which the intervention has the potential to be implemented in usual practice) and the perceived value, benefits, harms, or unintended consequences of the intervention. This from the perspectives of both OTs delivering and clients receiving ABLE 1.0.

## Materials and methods

### Design and procedures

The feasibility study was designed as a pre-test-post-test single group study recruiting 30 persons with chronic conditions and two occupational therapists [7, 16, 17]. Post-intervention qualitative interviews were conducted to explore how persons living with chronic conditions experienced receiving ABLE 1.0 and how OTs experienced delivering it.

### Setting

The feasibility study was conducted in the Department of Training and Health in a Danish municipality. Both OTs and physiotherapists were employed in the department.

## Participants

Potential participants to be interviewed were OTs having delivered ( $n=2$ ), and clients having received ABLE 1.0 (i.e. completed the intervention programme according to the manual) ( $n=20$ ) between September 1, 2017, and December 19, 2017. Clients, who had completed ABLE 1.0, were, at the final session, asked if they would agree to be contacted later to be interviewed about the content and delivery of the intervention programme. A total of 17 clients (17/20, 85%) accepted to be contacted. Only clients who were able to participate in a group interview were contacted.

### The ABLE 1.0 intervention programme

ABLE 1.0 is an 8-week occupational therapy intervention programme aiming at enhancing the ADL ability in persons with chronic conditions. The intervention programme is informed by two occupational therapy models: the Person-Environment-Occupation (PEO) model [10] representing occupational performance as being shaped by the interaction between a person, an environment, and a task perceived by the person as meaningful and/or purposeful to do (i.e. occupation) and; the Occupational Therapy Intervention Process Model (OTIPM) [11] describing a problem-solving process. ABLE 1.0 is generic i.e. using the same approach, when addressing ADL task performance problems across these persons’ ages, diagnoses, and sexes. Still, the intervention programme is individually tailored based on initial evaluations. The intervention programme is implemented where the clients typically perform ADL tasks (e.g. home or local area) with the tools and materials usually used [11].

ABLE 1.0 consists of session 1: evaluation of ADL ability based on self-report and observation, using the ADL-Interview (ADL-I) [18, 19] and Assessment of Motor and Process Skills (AMPS) respectively [20, 21]; session 2: goal setting using Goal Attainment Scaling (GAS) [22] and clarification of reasons for ADL task performance problems; sessions 3 to 7: interventions aiming at enhancing the ADL ability, based on the compensatory model of OTIPM [11] by teaching new ways of doing, using adaptive equipment/assistive technology, and/or modifying physical/social environments. During the intervention sessions, the OT employs one or more of nine optional intervention components [7, 17] organised in a ‘tool box’ according to the PEO model [10]. The final session includes re-evaluation including evaluation of goal

attainment and re-evaluation of ADL ability. Five sessions are mandatory: sessions 1 to 4 and the final session. Thus, while the number of intervention sessions may vary based on the client's needs, two intervention sessions are considered the minimum (session 3 and 4). Based on the OT's reasoning, sessions are carried out face-to-face or by telephone, with or without 'homework' between sessions (e.g. practising new ways of doing).

Prior to delivering the ABLE 1.0, OTs participated in a two-and-a-half-day workshop containing lectures, role-play, and video demonstrations of elements of the ABLE 1.0 manual.

### **Data collection**

Both client and OT interviews were conducted during January and February 2018. The client interviews were planned to be conducted in a group, whereas individual interviews were scheduled for the OTs. Group interviews were chosen to facilitate that the clients could inspire each other during the conversations. This, to stimulate discussions potentially uncovering insights that might not merge based on individual interviews. The interviews were to take place at the facilities of the Department of Training and Health in the municipality [17]. Data was collected through qualitative in-depth semi-structured interviews to allow flexibility and to produce rich data [23]. Thus, semi-structured interview guides and open-ended questions were used. To capture relevant information about content and delivery, the interview guides were developed based on the framework by O'Cathain et al. [15] and the structure and content of ABLE 1.0. For example, sections in the interview guides were related to the overall experience with delivering/receiving ABLE 1.0. Examples of questions for the OTs within this section were: How did you experience delivering ABLE 1.0? What went well? What was challenging? What were your experiences with clients benefitting or not benefitting from ABLE 1.0? Examples of questions for the clients within the same section were: How did you experience receiving ABLE 1.0? What was it like to receive ABLE 1.0? What in the intervention programme were beneficial/less beneficial? What have you learned from receiving ABLE 1.0? During the interviews the participants were asked to provide examples.

The interviews were conducted in Danish by two members of the author group, not known to the OTs and clients. All interviews were audio recorded and transcribed verbatim.

### **Data analysis**

Data was analysed using qualitative content analysis inspired by Lindgren, Graneheim and Lundman [24, 25]. The analysis sought to identify emerging categories with regards to content and delivery of ABLE 1.0 i.e. the acceptability of intervention in principle and perceived value, benefits, harms, or unintended consequences of the intervention [15].

During the first step of the process, trained persons (not involved in the study) transcribed the recorded interviews by following a predefined transcription procedure. Next, to get a sense of the whole, two members of the author group (VH & MBB) listened to the recorded interviews and read each interview transcript repeatedly. Following this, to identify meaning units, each interview transcript was carefully read line-by-line focusing on manifest content in the participant statements [24]. Then the meaning units were condensed, labelled with codes, and brought together in categories based on manifest content. The same two members of the author group (MBB & KTN) conducted these first steps of the data analyses. To ensure trustworthiness, emerging categories were discussed based on a process involving all authors during an online meeting. During this process, a reflexivity strategy of collaboration was applied [26]. That is, the diverse methodological training and competencies of the authors and the different levels of involvement in e.g. intervention development, design of the feasibility study and data collection, allowed asking various questions related to assumptions and decisions [26]. Thus, the aim was to uncover blind spots, and reach consensus and confirmability of the findings [24, 26].

### **Ethical considerations**

Participants received oral and written information about the study and were informed that participation was voluntary and that they could withdraw from the study at any time. Informed consent was obtained from all participants. During the interviews the participants were given time for reflections and offered breaks as needed. The local research ethics committee in the region of Northern Jutland determined that the study did not need approval. The study complies with the General Data Protection Regulation (GDPR) and has been registered and approved by the University College of Northern Denmark (UCN) (journal no. FOU-PHD-2017-001 & FOU-PHD-2018-138).

## Findings

Of the 17 clients who agreed to be contacted, four were considered unable to participate. This, due to e.g. age-related impaired hearing or cognitive impairments making it difficult to engage in the group interview. Thus, a total of 13 clients were contacted in January 2018 of which 12 were successfully reached by telephone and invited to participate in the group interview. Three clients accepted the invitation to participate. Several others declined to participate with  $n=3$  providing no reasons,  $n=1$  expressing transportation as barrier and  $n=1$  stating having nothing to contribute with. A total of  $n=4$  expressed willingness to participate but were unavailable on the scheduled date for the group interview. Since one of the clients who accepted to participate did not show up (for unknown reasons) for the group interview, one of the clients who were unavailable on the date of the group interview (client A) was recruited post the group interview and interviewed individually to supplement client perspectives. The two OTs, who had been involved in delivering ABLE 1.0, participated in individual interviews. Demographic data for both clients and OTs are presented in Table 1.

The individual interviews with the two OTs lasted 75 and 82 min, respectively. The group interview with the two clients lasted 66 min, whereas the individual client interview lasted 30 min. In contrast to the group interview, the individual client interview was conducted in the client's own home.

The qualitative content analysis resulted in identification of a total of six categories; two categories related to acceptability of intervention in principle; 'Overall perception of the programme' and 'Potential for implementation' and four categories related to perceived, value, benefits, harms and unintended consequences of the intervention: 'Evaluation, goal setting, and clarification of reasons for ADL task performance problems'; 'Intervention: compensatory solutions'; 'Format and duration' and 'Preconditions for delivery'. Each category is described in detail below.

## Acceptability of intervention in principle

### Overall perception of the programme

Both OTs and clients provided insights into the overall value and benefits of ABLE 1.0. This with regards to new insights and understandings and with regards to interaction, communication, and therapeutic rapport throughout the intervention programme.

Two clients (clients A and B), described their experience with ABLE 1.0 as an 'eye-opener'. These clients had lived with disabilities for several years and had grown accustomed to their limitations. Receiving ABLE 1.0 provided new insights into their ADL task performance and potentially increased their quality of performance. They both were positively surprised by the potential of compensatory solutions and helping aids. Client A stated: 'It has made me see some of the things, that I was not aware that I was able to do'. Client B mostly valued the ideas proposed by the OT, especially concerning purchase of helping aids, encouragement and support related to acceptance and knowledge about how chronic disease may impact the ability to do: 'Yes, one thing that I became aware of is that I, for many years, have cursed myself and told myself that I was lazy and other not very nice things, because I get tired so fast'. In addition, Client B said: 'I was kind of uplifted...that is how it is. It is a part of your disease, right? Okay, so now one can forgive oneself for going to sit for an extra hour to finish what one was doing' (client B).

For clients A and B, the intervention programme had also been beneficial in terms of greater courage and motivation for engaging in ADL task performances, e.g. cooking and cleaning: 'But, with will power, I can change the sheets, it is hard, but I can do it. I participate more in the kitchen. Not as much as my husband would like, but I do participate after all' (client A). All three clients highlighted the flexibility of the programme and how their individual needs were addressed: 'Yes, I think so because I decide which things to work on. So, I think that is okay. The things you work on are designed for you' (client A).

Table 1. Demographic data on the participants.

Participant	Gender	Age	Diagnosis	Years working as OT	Years working with clients with chronic conditions	ABLE Intervention courses delivered (n)	ABLE sessions received (n)
OT A	Female	43	N/A	20	20	8	N/A
OT B	Female	61	N/A	16	16	12	N/A
Client A*	Female	67	Neurologic disease	N/A	N/A	N/A	4
Client B	Female	67	Rheumatologic disease	N/A	N/A	N/A	6
Client C	Male	62	Neurologic disease	N/A	N/A	N/A	4

\*Individual interview.

Overall, both OTs perceived that conversations and interactions with the clients during the intervention programme directly influenced the clients' outcomes of ABLE 1.0. The clients particularly valued the therapeutic rapport, feeling comfortable, safe, and open-minded during the programme. All the clients had met their OT before e.g. during previous individual or group-based occupational therapy services. The clients perceived that knowing the OT had resulted in a good and confident relationship and made it possible for the OT to increase the demands in the intervention sessions. Still, all the clients reported to also being open to an unknown OT as long as the 'chemistry' fits. Although delivery of ABLE 1.0 was new to the OTs, the clients did not perceive that this affected the occupational therapy process.

In general, the OTs perceived, that conversations with the clients on compensatory solutions facilitated thoughts and ideas among the clients and that some clients acted on these between sessions. Although all changes were not apparent within the time frame of ABLE 1.0, OT B perceived that she sometimes initiated a process together with the client that would yield results over time: 'Seeds are sown ...we just don't see them harvested'.

### **Potential for implementation**

Both OTs and clients had viewpoints about the potential for future implementation of ABLE 1.0.

The OTs reported that delivering ABLE 1.0 overall, was positive. Still, new ways of doing e.g. in relation to evaluation and goalsetting were both demanding and challenging. Despite the challenges, they experienced that some parts became easier and more time efficient over time e.g. conducting AMPS evaluations. However, building up a therapeutic relation with a new client is one of the parts that takes time: 'Some of it gets faster...but the intensity and capturing it all, this does not change ...They [the clients] have a long history to tell, and you also have to look beyond that...'

Considering the potential for future implementation of ABLE 1.0 as part of community-based occupational therapy, the OTs expressed the envision to continue practicing based on ABLE 1.0. Especially the structure provided by the OTIPM was highlighted by the OTs: 'I use some of the elements...yes and I can really see that the OTIPM – way of doing it...the structure...we really have been through things' (OT A). Furthermore, goalsetting based on GAS was found meaningful and especially OT A perceived that the use of PEO in relation to clarification of reasons for ADL task performance problems was beneficial and

expressed a wish to use PEO as part of her clinical practice in the future.

The clients expressed that it had been positive to receive ABLE 1.0 and that the intervention programme in general was beneficial for persons living with chronic conditions. Client A found that ABLE 1.0 was to be an established service offered in the municipality and reflected on how to make ABLE 1.0 mandatory to persons living with chronic conditions: 'I think it must be something that one has to do. It sounds a bit harsh, but I actually think that one would get something out of it – and I really do' (client A).

Client A and B have been living with a chronic condition for long time and both expressed that municipality services and the possibility of receiving home visits were limited. Client B suggested for the municipality to use more resources on preventing decline in functional ability, including offering home visits for persons living with chronic conditions: '... what if this [ABLE 1.0] was made a part of the prevention services and one went out visiting persons with chronic conditions every third or fourth year?' (client B).

### **Perceived, value, benefits, harms and unintended consequences of the intervention**

#### **Evaluation, goal setting and clarification of reasons for ADL task performance problems**

The OTs and the clients both reported on the initial evaluation and the goal setting, including the use of GAS. The OTs also expressed their perception of the process related to clarification of reasons for ADL task performance problems.

Both OTs were positive towards the evaluation tools used in the intervention programme; ADL-I and AMPS. They perceived the first session to be the most important session affecting the clients the most: 'For a lot of them [the clients] I think it is the first conversation, I mean this long session, where we go through everything and we talk and talk about their everyday life, down to details, yes, this is the part that has moved them forward...' (OT A). As for ADL-I, the OTs experienced that the interview resulted in good conversations, where the clients along the way became more aware of their own challenges. The ADL-I, however, also sometimes resulted in clients feeling confronted with their decreased ADL ability. Even though the OTs were overall positive towards the ADL-I, they also occasionally found it difficult to use. For example, they found that some questions

were not meaningful to all clients, and sometimes clients, in a later session, changed their priorities made based on the ADL-I from session 1.

With regards to AMPS, it was sometimes challenging to complete a relevant observation of ADL task performance. For example, the clients (or relatives) might have been cleaning and doing all domestic tasks prior to the first session with the OT, resulting in less AMPS task options for use during the observation. The OTs also described that some clients were being 'unrealistic' about their own ADL ability (based on the ADL-I), and in such cases the OTs perceived that the AMPS observation was helpful, as it revealed the ADL ability from the perspectives of the OTs.

As mentioned earlier, the OTs expressed that this first session (the ADL evaluations) was time-consuming, but well spent as the OTs gained a solid understanding of the client and the client's ADL task performance problems. Similarly, client A explained that discussing the results of the ADL evaluations made her aware of the benefits of slowing down during task performance and taking small breaks to avoid increased physical effort and fatigue. Still, the OTs perceived that session 1 sometimes was overwhelming for the clients. In such situations, OT A found it beneficial to offer the client a pause between the ADL-I and the AMPS. OT B expressed that there could be advantages of doing the ADL-I at the first session and then do the AMPS at the next session. She found that this also could provide better opportunities for planning the AMPS.

In some instances, the OTs reported having intervened (e.g. guided and instructed the clients in relation to their ADL task performance problems) at the first session, even though reasons for ADL task performance problems and goal setting had not yet been discussed.

Both OTs agreed that setting relevant and measurable goals was difficult: 'I always think goal setting is difficult. I mean it must fit with what is in the client's head and the thing that the client wants to work with, and they can have a wish in a direction where it does not fit with a measurable goal' (OT A). OT B expressed that she had difficulties separating her wishes for the client from what the client wanted. That is, based on the ADL-I and the AMPS, the OT had ideas on what to change. However, the ideas were not necessarily related to what the client wanted to work with and set goals for: 'That part about folding laundry, whose goal was that? If he thinks he can do it well enough in his view it is good enough. He could do it in his own way' (OT B).

Working with goal setting was not new to the OTs, but using GAS was. OT A reported that it was a good exercise to work with GAS to formulate more specific and realistic goals for the clients. The OTs experienced that specific and measurable goals based on GAS made it easier to monitor the progress towards goal attainment.

OT B reported having ideas for goals during the first session after employing ADL-I and AMPS. She therefore suggested to discuss and formulate preliminary goals at the first session as she speculated if it would be more natural to the client to initiate in conversations about goals immediately after the initial ADL evaluations. Final goals could then be formulated after clarifying the reasons for ADL task performance problems.

The clients also found goal setting challenging. They did not completely understand the GAS instrument used for goal setting and felt that it focused primarily on problems: 'It was hard. It was really difficult because, I mean how do you measure? Goals are of course good to have, but I suddenly felt like a patient/client' (client B). Another challenge related to evaluation and goal setting, perceived by the clients, was their fluctuating health conditions, resulting in both 'good' and 'bad' days or periods. The clients perceived that evaluation and goal setting conducted during a good period and re-evaluation conducted during a bad period, potentially could affect the results.

The OTs agreed on the value of discussing the reasons for ADL task performance problems with the clients: 'They [the clients] got an explanation, and they could see what they could work with' (OT B). The OTs perceived that this part worked especially well among clients with less cognitive problems. OT A expressed that the PEO was kind of new to her and that she sometimes was in doubt about how to analyse reasons using the PEO (i.e. if the reasons were related to the person, the environment and/or the occupation).

### ***Intervention: Compensatory solutions***

Several aspects related to the intervention sessions were revealed, e.g. regarding the methods used, the involvement of relatives, the use of helping aides and homework between sessions.

The OTs emphasised that the methods used during the intervention sessions were mostly related to compensatory solutions such as energy conservation, use of adaptive equipment/assistive technology, and modifications of the physical environments. The OTs felt familiar with such methods, however, OT A felt



unfamiliar applying such methods before having implemented interventions aiming at enhancing performance skills or body functions. Further, OT A found it beneficial to sharpen her focus on how to make ADL task performance less demanding for the clients. OT B agreed and emphasised the importance of focusing on how environmental factors influence performance: 'Well, there were suitcases, wires and all kind of stuff and she had to propel her wheelchair over this every time she had to arrange the bed spread...well would it be possible to move the things into another room? Yes, we could actually do that.'

Some compensatory solutions involved the clients' relatives, and in several cases, this represented a challenge. In one case the client was more focused on the relative's problems which affected the collaboration with the client on the client's own challenges. Some solutions were related to changing the home environment and in such cases, it was sometimes necessary to involve relatives. This sometimes meant waiting for busy relatives to take care of matters.

Client C described the importance of involving relatives in the therapy process. Thus, client C's wife was present at every session with the OT to support the client in remembering what was discussed: 'My wife was there every time they [the OTs] were there. She was there with a third pair of ears. Then she could remember what was said. I am so forgetful'. The other two clients expressed no wish to involve relatives. One of the clients expressed that involvement of her husband would be transgressive and that this would interfere with her private sphere: 'But this has to do with how I am. I don't want to show when I am not well, and I avoid asking for help.... This is too private, this is my [problems] and he doesn't have to know a lot about this' (client B).

The OTs pointed into challenges related to limited access to helping aids while trying out different solutions together with the client. Limited access to helping aids resulted in inefficient time use and affected progression of the occupational therapy process. OT A said: 'It would have been really nice if we had our own box [of helping aids]...I think it costs a lot of working hours to deal with this'. Having access to a box with various helping aids were perceived to solve some of the problems related to this matter. Still, several of the clients were to order and pay for helping aids themselves online. According to the clients this was a challenge and it sometimes resulted in clients not achieving goals related to enhanced ADL task performance.

From time to time the clients were engaged in homework between sessions i.e. trying out new ways

of doing. However, the OTs found that the clients' motivation varied. Further, homework was not considered suitable for all types of goals. For example, one client worked on changing the bed sheets which was typically done every two weeks. Hence, practising this specific task performance was not considered relevant between sessions. The clients reported doing homework and described that practicing ADL task performance based on instructions from the OT resulted in progress. For example, client B expressed how practising bathing enhanced her endurance: 'Yes, I practiced bathing and I really progressed. After having finished bathing, I was able to do other things. I did not have to go and sit down' (client B).

### *Format and duration*

The clients only received face-to-face delivery of ABLE 1.0 sessions and agreed that the sessions could not be replaced by telephone sessions. In terms of the total number of sessions, client C reported that he would have liked one or two more sessions. The time between the sessions was experienced to be sufficient. The clients agreed that the duration of each session was appropriate. Client B found that the first session lasted a long time (approximately 2h) and perceived the session as demanding: 'It was hard, I got very tired, I was exhausted, I can promise you that'. On the other hand, she also stated that the session could not have been delivered differently: '...I think if you have to go through the ADL-I then you have to do it without pausing, if you get interrupted and kind of have to talk yourself back into 'what was I just saying' and 'where was I?' ....No, I think that would be a mess' (client B).

While the OTs generally experienced the delivery of the ABLE 1.0 to be time-consuming, they agreed that the duration of ABLE 1.0 was sufficient. They also agreed with the clients on session 1 being particularly time-consuming but experienced that this first session was of great importance to reduce overall time use: 'Allowing yourself to use plenty of time in the beginning, does not necessarily mean that everything takes longer time' (OT A). Hence, OT A described that after session 1, several of the clients independently initiated problem-solving, reducing the total number of sessions needed. Thus, the OTs experienced that less than the maximum number of sessions in the ABLE 1.0 ( $n=8$  sessions) were sometimes needed. Moreover, OT B stated that introducing and teaching new solutions during the intervention sessions were less time-consuming compared to e.g. skills training or physical exercises. Despite agreeing on

fewer number of sessions within the programme, the OTs suggested a long-term follow up session to support the clients in sustaining the problem-solving. Also, OT A experienced a need to have some weeks with only a few sessions to create room for documentation and intervention planning.

### *Preconditions for delivery*

Several issues were described as preconditions for delivering ABLE 1.0. Some issues were related to the clients and their expectations, motivation, and level of ability. Other issues were related to the home setting and the training of the OTs prior to delivering ABLE 1.0.

The clients reported different expectations for participating in ABLE 1.0. While client A initially questioned the personal benefits of participating, she felt motivated for supporting the OTs and researchers involved in the study. Still, during the process she did experience to benefit from the intervention programme: 'I haven't thought a lot about the gains. I must admit that. But I have had benefits ...' (client A). Though client B had previously declined participating in especially group-based health care services, due to the focus on disease and problems, she accepted the invitation to participate in ABLE 1.0 out of curiosity. In contrast, client C expressed high expectations initially due to having received highly specialised services at a neurorehabilitation centre resulting in a lot of progress. Therefore, client C was expecting the same kind of progress but was somewhat disappointed about ABLE 1.0. The OTs reported that positive expectations among several of the clients could be explained by previous involvement in other services in the municipality. However, some clients might have misunderstood what ABLE 1.0 was about and expected physical exercise in line with the services they previously had received. OT A expressed that: 'in general I found that they (the clients) had to adjust to not talk about their physics, I mean, that we did not focus on physical exercise'.

Several of the clients had been living with their chronic condition for several years. The OTs experienced that this affected the motivation of the clients. For example, some clients had over the years accepted spending more time during ADL task performance and therefore did not perceive performance problems: '...we find it [the task performance] slow, but to them it is not a problem' (OT B). In addition, the OTs reported, that clients were more motivated if they had experienced and acknowledged challenges related to ADL task performance.

The OTs also perceived variation in the benefits of participating in ABLE 1.0 among the clients. OT A stated: 'So it has been kind of different and some has gained a lot, and some has gained less'. The OTs also provided examples of clients having either too low (e.g. persons in a lot of pain or with cognitive deficits) or too high (e.g. persons who could problem solve on their own and thus had no need of the compensatory solutions suggested by the OTs) levels of abilities to participate in ABLE 1.0. The OTs perceived that clients who could easily participate had less cognitive deficits, had completed services related to physical exercise some time ago, and had the energy to work on changes.

The fact that ABLE 1.0 was delivered in the clients' own home (and local area) was perceived positive by all three clients. The home setting was, by the clients, described to be ideal for working with compensatory solutions including helping aids. The home provided a naturalistic setting with few disturbances: 'There was kind of calm surroundings...so that was fine' (client C). Client B expressed it like this: 'I think that it [the home setting] provides the most realistic picture, right? This is where we experience the problems'. The participants explained how they worked with compensatory solutions at home e.g. rearranging the kitchen to make it possible to sit during task performance, trying out new ways of changing sheets or cleaning the bathroom. Further, the clients discussed having tried out different helping aids to see what worked in the actual situation or context: 'At the second session, she [the OT] brought a box with it [helping aids], and I could just pick and borrow and there were useful things' (client B). The clients also explained how this inspired and provided insights into which helping aids to purchase.

The OTs expressed that participating in the two-and-a-half-day workshop prior to delivering ABLE 1.0 provided a solid basis for delivery. Still, one of the OTs experienced that the workshop was too compressed and that introduction to goal setting using GAS could have been more thorough.

During delivery of ABLE 1.0 the support from colleagues was limited. Colleagues were aware that the OTs were delivering ABLE 1.0 but did not otherwise express interest or ask questions about the programme. OT A called it a pity that her colleagues did not participate in the workshop as she felt that this could have been an inspiration to them. The management supported the delivery of ABLE 1.0, however mostly in relation to practical matters (e.g. permission to decline participation in unit meetings). In addition, the OTs expressed that the management did not ask

about ABLE 1.0 and did not ask the OTs about their experiences with the programme. Instead, OT A and OT B reported to be continuously supportive of each other. They also expressed that the ABLE 1.0 manual was very helpful during delivery. However, the OTs used the manual differently. While OT A read selected parts of the manual to prepare herself for the next session, OT B brought the manual with her during the sessions and used it to look up things.

## Discussion

In the present part of the feasibility evaluation aspects related to content and delivery of ABLE 1.0 were explored from the perspectives of both OTs delivering and clients receiving the intervention programme. More specifically, the acceptability of the intervention in principle and the perceived value, benefits, harms, or unintended consequences of the intervention were explored. The findings indicated that ABLE 1.0 overall was perceived to be feasible and acceptable in terms of content and delivery. The ABLE 1.0 was perceived to provide value and benefits in relation to ADL ability, however some degree of unintended consequences was identified. That is, both clients and OTs reported that the first session was demanding. Still, the first session was also perceived to be valuable and neither clients nor OTs expressed wishes related to changing the first session. No harm was identified. However, minor adjustments are needed in relation to e.g. client information about the purpose of ABLE 1.0 and training of OTs in relation to goal setting using GAS.

Information from the present and previous paper [17] reporting on the feasibility of ABLE 1.0 have been used to revise the ABLE intervention programme (ABLE 2.0) and prepare for the evaluation phase [27], involving a pilot [28] and a full-scale randomised controlled trial including evaluation of effectiveness [29], realist evaluation [30] and evaluation of process and economy. The present part of the evaluation revealed that it was important to pay attention to previous experiences with health services among the participating clients, since previous experiences seemed to affect the clients' expectations and willingness to participate in the programme. Also, providing specific information about the purpose and content of the programme may reduce expectations related to receiving interventions aiming at enhancing e.g. body functions. Thus, before inviting/referring clients it is necessary to ask questions about their previous experiences and to clearly communicate the purpose and

content of the ABLE programme. Further, it is important to ask clients about motivation for participation, including readiness to participate and to make changes related to ADL task performance. Consequently, inclusion criteria related to motivation and readiness to make changes related to ADL task performance were implemented in evaluation studies related to the ABLE programme [28, 29].

The programme structure based on the OTIPM [11] was beneficial according to the OTs. The OTs found that the OTIPM supported them in being systematic throughout the therapy process. Several other studies have revealed information about the impact and benefits of using the OTIPM to guide clinical practice [31, 32]. Hence, in studies by Sirkka et al. the use of OTIPM was found to provide a 'map' or a 'compass' for the work of the OTs leading to strengthened professional identity [32] and a shift from a disease and impairment-oriented focus towards a more client-centred focus based on the clients' occupational needs and wishes [31].

Both the clients and the OTs expressed that the first session was demanding and time consuming. The actual time use at each session, reported in the first feasibility paper [17], revealed that the initial evaluation, based on standardised assessments, were conducted within a reasonable time frame. That is, both interview- and observation-based assessments were conducted within less than 90 min.

Further, the findings in the present part of the feasibility evaluation revealed that the first session was found to be the most important session leading to clients gaining increased awareness and insight into own challenges, sometimes resulting in the clients initiating problem-solving on their own. In line with these findings, a high degree of meaningfulness in relation to the first session was also revealed based on client and OT registrations following each session of the ABLE 1.0 programme [17].

The OTs described how evaluation based on observations (i.e. the AMPS), as part of the initial occupational therapy evaluation, were perceived to provide valuable information on ADL ability from the perspective of the OT, supplementing the information on ADL ability gained based on self-report (i.e. the ADL-I). This is in line with previous research, concluding that evaluations based on self-report and observation (as prescribed by OTIPM) elucidate distinct, yet complementary aspects related to ADL ability [33, 34]. Thus, indicating that the use of both methods provides a solid foundation for planning and implementing ADL interventions.

Goal setting was perceived to be challenging by both OTs and clients. In the literature it is well established that goal setting represents a challenge for both health professionals, including OTs, and clients [35–39]. This is also supported by data collected during the intervention process, reported in the first feasibility paper [17] revealing omission of goalsetting in a few cases. Based on these findings a more detailed introduction to GAS, especially related to identifying the clients' goals and formulating relevant, realistic, and measurable goals, has been provided in the ABLE 2.0 manual and used in the evaluation studies related to the ABLE programme [28, 29].

In terms of the content and delivery of intervention, the home (and local area) was considered the ideal context. The home setting was ideal for both evaluation and intervention planning as the setting facilitated explanations related to reasons for ADL task performance problems and ideas on which intervention components to apply and how. Home-based interventions have been a part of occupational therapy practice since the origin of the profession [40] and existing research have established the benefits of home-based occupational therapy interventions [41–43]. Also, the home setting has been described as the ideal context for implementing both occupational therapy evaluations and interventions within the occupational therapy literature [20, 44]. For example, Fisher and Marterella [44] have proposed in their theoretical framework *Powerful Practice* that authentic and quality occupational therapy interventions are to be client-centered (based on collaboration between the OT and the client), occupation-based (with the client being engaged in occupational performance), occupation-focused (with a proximal focus on occupation) and ecologically relevant (obviously contextualised to the client). Thus, according to Fisher and Marterella [44], fully ecologically relevant interventions are when clients are being engaged in prioritised task performances, in their preferred way, in their own home, with their own tools and materials. Consequently, the findings of the present feasibility evaluation both support the existing research and the theoretic assumptions described in the occupational therapy literature.

As for the adaptational intervention components, the OTs stated to be familiar with these. Still, the OTs were not familiar with applying such compensatory solutions as their first and primary choice of intervention. Thus, there may be a need to support a paradigmatic change in reasoning among OTs delivering ABLE in the future, from a bio-medical focus on enhancing underlying capacities and body functions to an occupation-centred reasoning.

The process of developing and evaluating ABLE 1.0 was guided by the MRC guidance on development and evaluation of complex interventions from 2008 [14]. In 2021 an updated guidance was presented [45], still describing four phases. However, a set of core elements were added to be considered throughout the research process, especially when going from one phase to another. The core elements refer to considering context, developing and refining programme theory, engaging stakeholders, identifying key uncertainties, refining the intervention and economic considerations [45]. The feasibility study is in line with the updated guidance by revealing information on these core elements, except for economic considerations. Still, the feasibility study described in a protocol paper [16] and the results reported in the previously published paper [17] and the present paper, serves as an example of how to evaluate the feasibility of an occupational therapy intervention, prior to evaluating the intervention in a large-scale RCT.

### ***Methodological considerations/limitations***

The present feasibility evaluation revealed perspectives on aspects related to content and delivery of ABLE 1.0 from the perspectives of both OTs and the clients. Hence, elucidating important nuances and adding important knowledge about the content and delivery of ABLE 1.0 to what has previously been published [17]. Client perspectives were derived from a relatively small subsample. The group interview only involved two clients and was therefore supplemented with one individual client interview. Consequently, the findings may not fully portray the client group having received ABLE 1.0 nor the variations in experiences with the programme. The only two OTs (100%) with experiences in delivering ABLE 1.0 (during the feasibility study) participated in the interviews, thus, representing a strength. Interviews with OTs and clients were conducted relatively short time after the intervention programme was delivered, respectively received, minimising the risk of recall bias. More individual client interviews might have strengthened the present part of the feasibility evaluation. However, this was not possible within a reasonable time frame post intervention.

### **Conclusion**

In conclusion, the findings indicated that the ABLE 1.0 intervention programme overall was considered feasible and acceptable in terms of content and delivery by three clients having received and two OTs

having delivered the programme. Further, the findings indicated that the ABLE 1.0 intervention programme had potential for future implementation in usual practice. The ABLE 1.0 intervention programme was perceived to provide value and benefits in relation to ADL ability, however some degree of unintended consequences was found as the first session of ABLE 1.0 was perceived demanding by both clients and OTs. Still, neither clients nor OTs expressed wishes for change. No harm was identified. The findings have provided valuable information about content and delivery of ABLE 1.0 from the perspectives of providers and receivers and this knowledge has been used to further develop the intervention programme and prepare for the studies related to the evaluation phase.

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