PJAHS
Philippine Journal of Allied Health Sciences

Special Collection: Short Report

Time-limited Occupational Therapy Model: A Guide to Optimizing the Occupational Therapy Process within a Specific Time Frame

Nadine Frances Reyes[1], Alexandra Nicole Diño[1], Patrizia Anne Miranda[1], Krista Abbygaile Nulud[1], Kimberly Punla[1], Rod Charlie Delos Reyes[1]

[1]The Graduate School, University of Santo Tomas, Manila Philippines

Correspondence should be addressed to: Nadine Frances Reyes[1]; nadinefrances.reyes.gs@ust.edu.ph

Article Received: December 9, 2024

Article Accepted: January 28, 2025

Article Published: February 15, 2025

Abstract

This paper presents the development of a Time-limited Occupational Therapy (OT) Model designed to address the significant challenge of organizing the OT process within the constraints of a time-limited protocol while maintaining a client-centered approach and promoting systematic interdisciplinary care. Rooted in the authors' clinical experiences and supported by existing literature, this challenge is compounded by multifactorial and contextual barriers within the Philippine healthcare system, including financial and resource limitations, institutional policies, and the uneven distribution of occupational therapists. Integrating the Dose-Effect (DE) and Good-Enough Level (GEL) models, this framework balances efficient treatment delivery with flexibility to meet client-specific goals. The DE Model emphasizes early improvement, while the GEL Model allows therapy to adapt dynamically to client progress. Key safeguards, such as Goal Attainment Scaling (GAS) and Post-Intervention Review and Feedback based on the 5 A's Model (Assess, Advise, Agree, Assist, Arrange), enable precise tracking of incremental progress and foster self-management through actionable feedback and goal-setting. The model comprises three main phases: evaluation, intervention, and re-evaluation, each structured by standardized measures, collaborative goal setting, and personalized intervention strategies. Interdisciplinary collaboration, informed by frameworks like the Occupational Therapy Practice Framework (OTPF-4), further enhances its adaptability across diverse clinical contexts. Demonstrating its practical application, a sample case of an 80-year-old inpatient highlights effective outcome measures and transition planning. While preliminary, this model provides a structured yet adaptable framework for delivering high-quality, outcome-driven care despite systemic constraints. Future research should prioritize empirical validation to refine the model and evaluate its long-term effectiveness in addressing the complexities of therapy delivery under resource-constrained conditions.

***Key Words**: time limit, occupational therapy, dosage, optimization*

INTRODUCTION

Time-limited therapy is a structured approach where assessment, intervention, and goal attainment occur within a set time frame or session limit.[1] Central to this approach are the Dose-Effect (DE) and Good-Enough Level (GEL) models. The DE Model suggests that most therapeutic progress happens early in treatment, with diminishing returns over time, emphasizing the optimization of therapy within a finite duration.[2] In contrast, the GEL Model posits that effectiveness depends on the client's response to treatment rather than duration, advocating for individualized therapy dosage based on achieving a "good-enough" level of progress.[3,4] Together, these models underscore balancing structured timelines with personalized care.

In practice, time-limited therapy addresses the demand for cost-effective, scalable interventions across healthcare settings. It encourages pragmatic, efficient clinical decision-making and aligns with controlled trial methodologies requiring time constraints.[1,5] However, evidence also indicates potential drawbacks, as externally imposed limits (e.g., by insurance or managed care) can negatively impact outcomes.[6] This highlights the need for an approach that balances

external constraints with client and therapist autonomy.

In occupational therapy (OT), the process typically includes evaluation, intervention, and outcome assessment.[7] These steps are intended to be executed dynamically, without a prescribed time limit, and with the client's best interests in mind to facilitate their occupational engagement, health, and well-being. However, real-world contexts, such as that of the Philippines, pose significant challenges to achieving ideal OT practices. Financial constraints are a significant barrier to healthcare access, with the Philippine Statistics Authority reporting that a significant proportion of Filipinos belong to the low-income class, leaving them unable to afford adequate healthcare, including therapy services.[8,9] Resource limitations further restrict the availability and reach of OT services, particularly in rural areas where healthcare infrastructure and personnel are severely lacking.[10] Additionally, the uneven distribution of occupational therapists exacerbates inequities, as urban areas disproportionately benefit from the available professionals, leaving rural and underserved communities with acute shortages .[11] Institutional constraints, such as insufficient funding for public health programs and strict caps on therapy durations due to budgetary limitations, further hinder consistent and comprehensive therapy provision.[12] These systemic issues create a challenging environment for OT practice, where professionals must devise innovative ways to deliver client-centered care despite significant constraints. A time-limited OT approach, blending the structured methodology of the DE Model with the client-focused adaptability of the GEL Model, offers a promising solution. By tailoring protocols to maximize therapy outcomes within the resource-constrained context of the Philippine healthcare system, this approach may improve access to and the quality of OT services for underserved populations, particularly in marginalized and rural areas, while aligning with broader efforts to promote equity in healthcare delivery.

Given the current literature gap, this study aims to propose an overarching framework to:

1. Guide the organization and prioritization of the OT process within a time-limited protocol tailored to the Philippine context.
2. Develop an integrative clinical pathway for multidisciplinary teams using frameworks from various disciplines.
3. Promote holistic, client-centered care throughout the OT process.

DEVELOPMENT PROCESS

The authors identified a significant challenge faced by therapists: effectively organizing the OT process within the constraints of a time-limited protocol while maintaining a client-centered approach and promoting systematic interdisciplinary care. This roadblock, rooted in multifactorial and contextual constraints such as financial and resource limitations, institutional policies, and the uneven distribution of occupational therapists, particularly in resource-constrained settings, was observed in the authors' clinical experiences and corroborated by existing literature. These factors underscore the need for a structured yet adaptable framework to address the complexities of delivering effective therapy under such conditions.

To address this roadblock, the authors first initiated a preliminary search of the existing literature on time-limited protocols and frameworks. Subsequently, a group discussion synthesized key findings and gaps from the search and established the model objectives.

Following this, the primary authors created the initial draft of the Time-limited OT Model. Specifically, the authors ensured that the model was founded on a robust theoretical framework and a comprehensive review of relevant literature. The primary authors then held a group discussion to provide an initial critique of the model. Thereafter, consultation was conducted with the last author, who provided additional insights and recommended further revisions.

Utilizing the group discussion and consultation feedback, the primary authors revised the model to promote clarity, conciseness, and coherence. Subsequently, a manuscript was drafted

explaining the model's theoretical foundations, components, and integration into OT practice. Two external experts reviewed the manuscript to promote rigor and trustworthiness. Based on expert feedback, the authors applied the necessary revisions to the manuscript.

THEORETICAL BASES

The Time-limited OT Model integrates multiple frameworks to provide a structured, client-centered approach. Rooted in the Integrative Clinical Pathways Model, commissioned by AOTA and the Alliance for Comprehensive Integrated Pain Management, it emphasizes interdisciplinary collaboration and biopsychosocial assessment to guide intervention and outcomes.[13] This approach aligns with the steps outlined in the Occupational Therapy Practice Framework (OTPF-4) and is organized using the Occupational Therapy Intervention Process Model.[7,14] It also incorporates the holistic, contextual factors in the Canadian Practice Process Framework.[15] The 5 A's Behavior Change Model (i.e., Assess, Advise, Agree, Assist, Arrange), adapted for self-management, is a key component of the Post-Intervention Review and Feedback process, ensuring clients receive clear, actionable feedback each session.[16–18] During this review, the therapist and client assess progress, discuss strategies, and agree on the next steps, empowering the client to take an active role in their self-management. This model provides structured guidance on addressing barriers and reinforces independent practice outside therapy. For documentation, the SOAP (Subjective, Objective, Assessment, Plan) note method is used, integrating subjective and objective data to guide data-driven interventions. The model combines DE and GEL principles to balance therapy duration with flexible, client-centered goals, optimizing benefits within a limited time.[2,3] Goal Attainment Scaling (GAS) further enhances goal-setting and progress tracking, using specific, measurable, attainable, relevant, and time-bound criteria and a 5-point scale.[19] Together, these elements create a comprehensive approach that supports effective, individualized OT care.

CONCEPTUAL FRAMEWORK

Phases

The framework involves three phases: evaluation, intervention, and re-evaluation, grounded in a client-centered and occupation-based approach. In the evaluation phase, the therapist assesses the client's needs and collaborates on goals for therapy. During the intervention phase, the therapist integrates evaluation findings in devising interventions and tracks corresponding client progress. The re-evaluation phase determines if the intervention has adequately improved the client's occupational performance and entails appropriate recommendations. This process dynamically proceeds such that phases may be repeated as needed to target ongoing goals.

Processes

Screening. Screening is done before meeting the client to determine whether OT is needed. It involves evaluating the client's biopsychosocial needs, collaborating with other providers, and deciding on an OT referral. When OT services are deemed unnecessary, the process ends, represented by a dotted arrow. Conversely, if OT services are needed, the process continues.

Evaluation. The evaluation process involves creating an occupational profile, analyzing occupational performance, and synthesizing the evaluation process. The occupational profile is created through formal or informal interviews to gather information about the client's background and contexts, aiding in establishing client-centered outcomes. The analysis of occupational performance involves reviewing and analyzing data collected to form hypotheses about the causes of identified concerns. Specifically, this considers the various OT domains and identifies client-supporting and hindering factors that shape the intervention plan and impact outcomes.

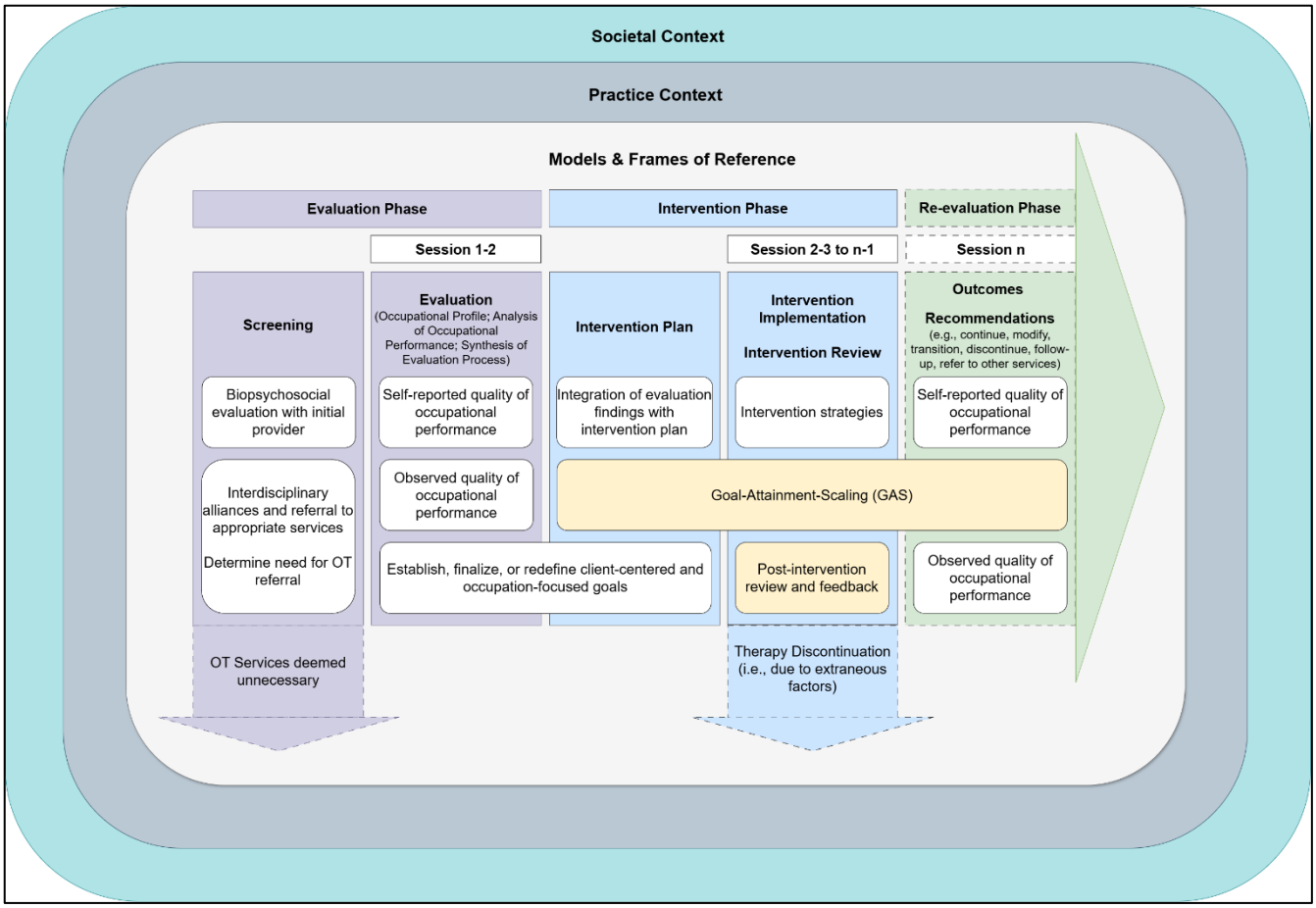

Figure 1. Time-limited OT Model

Analyzing the client's performance in valued occupations involves using standardized and non-standardized measures, specifically in two areas: self-reported quality of occupational performance and observed quality of occupational performance. Informed by the SOAP notes model, the aforementioned sections enable the triangulation of subjective and objective data, respectively, thus facilitating comprehensive and client-centered assessment. Serving as an example of a subjective measure, the Canadian Occupational Performance Measure (COPM) assesses clients' perceived occupational performance and satisfaction levels using a 10-point scale.[20] Objective measures are used to gather information on the client's cognitive, sensory, and motor functions, and how these interact with the client's contexts and influence occupational performance. Common assessments include the Sensory Processing Measure, Manual Muscle Testing, and the Beery-Buktenica Developmental Test of Visual-Motor Integration .[21–23]

Synthesis of the evaluation process facilitates an integrated analysis of how each component influences occupational performance. This, in turn, enables the process of establishing, finalizing, and refining goals, which continues into intervention planning.

Intervention Plan. Intervention planning takes place between the evaluation (i.e., *Session 1-2*) and the intervention implementation session (i.e., *Session 2-3*).

According to the OTPF-4,[7] intervention planning includes three steps:

1. Selecting
    a. Objective and measurable occupation-based goals and related time frames
    b. OT intervention approach/es

   c. Service delivery methods
2. Considering potential discharge needs and plans
3. Making recommendations or referrals to other professionals as needed.

As mentioned, the evaluation process is dynamic, with ongoing goal refinement. Due to the time-limited protocol, GAS is used for efficient outcome setting and measurement throughout the intervention and re-evaluation phases.

Intervention Implementation and Review. The OTPF-4 describes intervention implementation and intervention review as follows[7]:

"Intervention implementation is the process of putting the intervention plan into action and occurs after the initial evaluation process and development of the intervention plan" (p. 25).

"Intervention review is the continuous process of reevaluating and reviewing the intervention plan, the effectiveness of its delivery, and progress toward outcomes" (p. 26).

Due to the time-limited nature of the model, the intervention implementation and review ensues from *Sessions 2-3* to *n-1* through the performance of the following:

Intervention Strategies. Interventions may focus on single or multiple aspects of the OT domain, such as specific occupations, contexts, performance patterns, and performance skills. Strategies to be used may include the following[7]:

- Therapeutic use of occupations and activities
- Interventions to support occupations
- Education
- Training
- Advocacy
- Self-advocacy
- Group intervention
- Virtual Interventions

GAS. GAS will be used to objectively assess the client's performance after each session by scoring their progress on defined levels (-2 to 2). This approach allows the therapist to document incremental gains and set realistic, measurable goals.

Post-Intervention Review and Feedback. Using the 5 A's Model, the therapist will engage the client in ***assessing*** their occupational performance, ***advise*** on intervention options and benefits, and ***agree*** on prioritized goals for sessions and home practice. The therapist will then ***assist*** the client by providing feedback and recommendations, such as home activities or specific strategies (i.e., short-term and/or long-term applicability) during or after activities to address barriers and support occupational performance. A follow-up plan will then be ***arranged*** to monitor progress and ensure effectiveness.

Post-Intervention Review and Feedback after each session act as safeguards, ensuring continuity if therapy is limited or ends early. In such cases, the therapist provides clear feedback and home strategies to help clients maintain progress, even without re-evaluation. Addressing premature therapy discontinuation, an issue targeted by the model, these safeguards use GAS and structured feedback:

- **GAS**. Documents goals and progress, offering clients a clear plan for independent continuation or supported follow-up.
- **Post-Intervention Review and Feedback**. Delivers actionable feedback and strategies for real-life application, fulfilling the therapist's duty to ensure a safe and effective discharge.

Premature discontinuation, often seen between *Sessions 2-3 to n-1*, is represented by a dotted arrow element to illustrate potential early terminations due to external factors.

Outcomes and Recommendations. Outcomes and recommendations are addressed in the re-evaluation phase, typically in the final session (i.e., *Session n*). As clients may not reach this phase, these steps are optional in the model; the dotted line indicates that this phase is ideal but not required.

Outcomes. Outcomes are evident throughout the process. During evaluation, the therapist determines targeted outcomes in collaboration with the client, caregiver, and/or stakeholders. Moreover, outcomes are one of the considerations for intervention planning,

implementation, and review, and these processes should ultimately result in outcomes.

According to the OTPF-4, the outcomes targeted in OT are summarized into the following[7]:

- Occupational performance
- Prevention
- Health and wellness
- Quality of life
- Participation
- Role competence
- Well-being
- Occupational justice

The outcome is measured using the same methods used in the evaluation process. It is determined by comparing the client's status at evaluation with the client's status at discharge or transition. This may be done through the following outcome measures:

- **Objective Outcome Measures.** According to OTPF-4, objective outcomes refer to measurable and concrete aspects of improved performance and are often derived from standardized assessments. Moreover, objective outcome measures are selected early in the process based on the following[7]:
    - Valid, reliable, and appropriately sensitive to change in the client's occupational performance,
    - Consistent with targeted outcomes, and;
    - Congruent with the client's goals and able to predict future outcomes.

  GAS is considered one of the objective outcome measures in addition to other tools used that are under the *Observed quality of occupational performance* of the evaluation process.
- **Patient-Reported Outcomes (PRO).** Defined as "any report of the status of a patient's health condition that comes directly from the patient, without interpretation of the patient's response by a clinician or anyone else."[7]

  In addition to the PROs gathered through an informal or formal interview, the assessment/s used for the *self-reported quality of occupational performance* under the evaluation process are also included under patient-reported outcomes.

  Following the example mentioned under the evaluation process, if the COPM, a self-report outcome measure, is used as a means for self-reported quality of occupational performance, this would be considered one of the PROs.

Recommendations. During the recommendations process, the therapist determines whether to continue, modify, transition, discontinue, follow up, and/or refer to other services.[7]

- **Transition.** When transitioning is needed, the therapist plans for the client's transition in terms of the client moving from one setting to another and/or need for other services. Thus, referral to another OT service provider and/or other professionals, as necessary, is included in transition planning.
- **Discontinuation.** Discontinuation is done when the client terminates services due to meeting set outcomes.

Dosage or Number of Sessions

The Time-limited OT Model combines the structured approach of the DE Model with the flexibility of the GEL Model to enhance therapeutic outcomes within limited time frames. The DE Model provides a foundation by linking therapy duration to outcomes, typically suggesting 8-12 sessions for significant progress, with most gains occurring early on.[2] This guides practitioners in setting a structured session plan for measurable improvements from the outset. Meanwhile, the GEL Model introduces flexibility, allowing therapy duration to adapt to each client's progress, recognizing that some clients may achieve results sooner while others may need

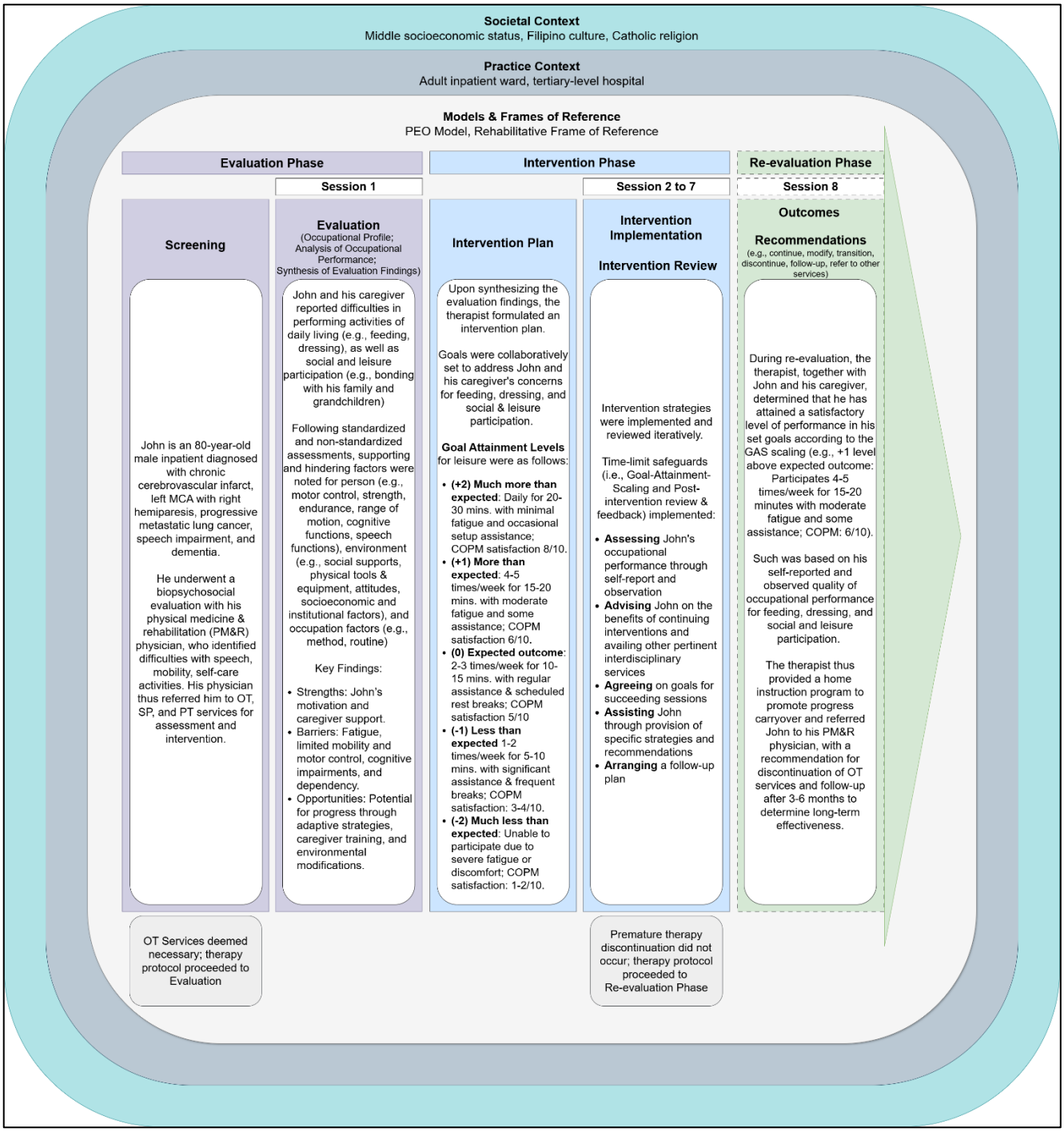

Figure 2. Utilizing the Time-limited OT Model

additional time.[4] Through tools like GAS, the model continuously evaluates client progress, allowing for tailored adjustments. This balanced approach, incorporating 'boundaries responsive regulation' from the GEL Model, creates an environment where clients actively shape their therapy. The Time-limited OT Model thus ensures a results-driven, client-centered approach that aligns with best clinical practices for optimized outcomes.

Contexts

The Time-limited OT Model includes three contexts: societal, practice, and models and frames of reference. Therapists, through

reflective practice, select suitable OT models and frames to guide client assessment and intervention, shaped by both the practice and societal contexts. The practice context includes personal and environmental factors; personal factors encompass the experiences, skills, and beliefs of both therapist and client, forming the therapist-client relationship, while environmental factors include cultural, social, and physical aspects of the therapy setting. The practice context is nested within the broader societal context, which includes cultural, institutional, social, and physical dimensions that influence clients' occupational participation and the OT process. Together, the societal and practice contexts dynamically shape the course of therapy.

Figure 2 outlines the Time-Limited OT Model for an 80-year-old inpatient, John, diagnosed with chronic cerebrovascular infarct and metastatic lung cancer, affecting his mobility, self-care, social, and leisure participation. The model is structured across three phases: Evaluation, Intervention, and Re-evaluation.

1. Evaluation Phase (Session 1): John's difficulties with daily activities (e.g., feeding, dressing) and social and leisure participation are assessed using standardized and non-standardized tools. Factors such as strength, endurance, cognitive function, and environmental barriers are considered. His PM&R physician refers him to OT due to challenges in self-care, social, and leisure activities.
2. Intervention Phase (Sessions 2-7): Goals are collaboratively set with John and his caregiver, targeting feeding, dressing, social, and leisure participation. Interventions are reviewed and adjusted iteratively, and safeguards (i.e., GAS and Post-Intervention Review and Feedback) are implemented to ensure continuity if therapy ends prematurely.
3. Re-evaluation Phase (Session 8): John demonstrates progress, achieving a GAS level of +1 by participating in leisure activities 4-5 times per week for 15-20 minutes with moderate assistance. COPM scores reflect improved performance and satisfaction. The therapist provides a home program, refers him back to his PM&R physician, and recommends discharge from OT services.

The broader context includes societal (socioeconomic, cultural, and religious background) and practice settings (adult inpatient ward), guided by the PEO Model and Rehabilitative Frame of Reference.

The sample case demonstrates the application of the Time-Limited OT Model in an adult physical dysfunction setting. However, the model is adaptable across diverse settings and populations, including clients with physical, cognitive, or mental health conditions. It is suitable for both pediatric and adult populations and can be effectively applied in outpatient clinics, community programs, and beyond.

LIMITATIONS AND RECOMMENDATIONS

In the development of the Time-limited OT Model, several limitations should be acknowledged. First, the absence of a participant sample means that findings are based on theoretical frameworks and practitioner insights rather than empirical data, which may limit the model's validation and generalizability. Additionally, without longitudinal data, assessing the long-term effectiveness of the model remains challenging. To strengthen future iterations, pilot studies with diverse participant groups are recommended to gather empirical data. Incorporating structured feedback mechanisms and developing evaluation metrics would further enhance the model's reliability and applicability across various clinical settings.

CONCLUSION

The Time-limited OT Model addresses a critical roadblock identified by therapists: effectively organizing the OT process within the constraints of a time-limited protocol while maintaining a client-centered approach and fostering interdisciplinary care. This challenge, rooted in multifactorial constraints such as financial and resource limitations, institutional policies, and the uneven distribution of occupational therapists in resource-constrained settings like the Philippines, underscores the need for a structured yet adaptable framework to navigate

these complexities. Integrating the DE and GEL models offers a balance between efficient treatment delivery and flexibility to meet individual client needs. The inclusion of safeguards, such as GAS and Post-Intervention Review and Feedback based on the 5 A's Model, ensures structured and measurable feedback at each session. These tools support incremental progress, empower self-management, and help sustain therapeutic outcomes even if therapy is prematurely discontinued. GAS provides a clear and reliable way to track small, meaningful gains. At the same time, the 5 A's Model enhances post-session reviews, helping clients assess their progress, address barriers, and refine strategies for continued independent practice. By addressing the systemic and contextual barriers that complicate therapy provision, this model lays a strong foundation for delivering high-quality, outcome-driven OT care in settings with limited therapy duration. While further empirical research is needed to validate its effectiveness, the Time-limited OT Model represents a significant step toward improving access to and equity in therapy services within resource-constrained environments, particularly in the Philippines.

Individual Author's Contributions

NFR: Conceptualization, data gathering, manuscript writing, revisions; AND: Conceptualization, data gathering, manuscript writing, revisions; PAM: Conceptualization, data gathering, manuscript writing, revisions; KAN: Conceptualization, data gathering, manuscript writing, revisions; KP: Conceptualization, data gathering, manuscript writing, revisions; RCDR: Conceptualization, revisions.

Disclosure Statement

All authors declared no conflict of interest. However, this paper is a requirement for specific coursework under the MSOT program of the University of Santo Tomas.

Conflicts of interest

The authors of this paper declare no conflict of interest.

References

1. Wright T, Simpson-Young V, Lennings C. Therapeutic process in the context of third party determined time limits. Clinical Psychologist. 2012;16(2):82–92. DOI: 10.1111/j.1742-9552.2012.00043.x
2. Howard KI, Kopta SM, Krause MS, Orlinsky DE. The dose–effect relationship in psychotherapy. American Psychologist. 1986;41(2):159–64. DOI: 10.1037/0003-066X.41.2.159
3. Barkham M, Connell J, Stiles WB, Miles JNV, Margison F, Evans C, et al. Dose-effect relations and responsive regulation of treatment duration: The good enough level. Journal of Consulting and Clinical Psychology. 2006;74(1):160–7. DOI: 10.1037/0022-006X.74.1.160
4. Bone C, Delgadillo J, Barkham M. A systematic review and meta-analysis of the good-enough level (GEL) literature. Journal of Counseling Psychology. 2021;68(2):219–31. DOI: 10.1037/cou0000521
5. Phelps R, Eisman EJ, Kohout J. Psychological practice and managed care: Results of the CAPP practitioner survey. Professional Psychology: Research and Practice. 1998;29(1):31–6. DOI: 10.1037/0735-7028.29.1.31
6. Seligman MEP. The effectiveness of psychotherapy: The Consumer Reports study. The American Psychologist. 1995;50(12):965–74. DOI: 10.1037//0003-066x.50.12.965
7. American Occupational Therapy Association. Occupational therapy practice framework: Domain and process (4th ed.). American Journal of Occupational Therapy. 2020;74(Supplement_2):7412410010p1–87. DOI: 10.5014/ajot.2020.74S2001
8. Philippine Statistics Authority. Philippine National Health Account - Households Share 44.4 Percent of the Country's Total Health Spending in 2023 [Internet]. 2024. Available from: https://psa.gov.ph/statistics/pnha
9. Philippine Statistics Authority. Poverty Statistics - 11 out of 18 Regions Recorded Significant Decreases in Poverty Incidence in 2023 [Internet]. 2024. Available from: https://psa.gov.ph/statistics/poverty
10. Dayrit MM, Lagrada LP, Picazo OF, Pons MC, Villaverde MC. The Philippines health system review. Health Systems in Transition [Internet]. 2018;8(2). Available from: https://iris.who.int/handle/10665/274579
11. Abrigo MRM, Ortiz DAP. Who are the health workers and where are they? Revealed preferences in location decision among health care professionals in the Philippines. 2019. Available from:

https://pidswebs.pids.gov.ph/CDN/PUBLICATIONS/pidsdps1932.pdf

12. Martinez AB, Co M, Lau J, Brown JSL. Filipino help-seeking for mental health problems and associated barriers and facilitators: a systematic review. Social Psychiatry and Psychiatric Epidemiology. 2020;55(11):1397–413. DOI: 10.1007/s00127-020-01937-2
13. Reeves L, Sako M, Malloy J, Goldstein A, Bennett K. Role of OT in comprehensive integrative pain management | AOTA [Internet]. 2022. Available from: https://www.aota.org/practice/practice-essentials/quality/quality-resources/role-of-ot-pain-management
14. Fisher AG. Uniting practice and theory in an occupational framework. American Journal of Occupational Therapy [Internet]. 1998;52(7):509–21. DOI: 10.5014/ajot.52.7.509
15. Townsend E, Polatajko H. Enabling occupation II: Advancing an occupational therapy vision for health, well-being & justice through occupation. [Internet]. Ottawa: Canadian Association of Occupational Therapists; 2013. Available from: https://books.google.com.ph/books?id=JEQ6ngEACAAJ
16. Glasgow RE, Funnell MM, Bonomi AE, Davis C, Beckham V, Wagner EH. Self-management aspects of the improving chronic illness care breakthrough series: Implementation with diabetes and heart failure teams. Annals of Behavioral Medicine. 2002;24(2):80–7. DOI: 10.1207/S15324796ABM2402_04
17. Whitlock EP, Orleans CT, Pender N, Allan J. Evaluating primary care behavioral counseling interventions: An evidence-based approach 1. American Journal of Preventive Medicine [Internet]. 2002;22(4):267–84. DOI: 10.1016/S0749-3797(02)00415-4
18. Pan American Health Organization. Innovative care for chronic conditions: Organizing and delivering high quality care for chronic noncommunicable diseases in the Americas. 2013; Available from: https://iris.paho.org/handle/10665.2/18639
19. Kiresuk TJ, Sherman RE. Goal attainment scaling: A general method for evaluating comprehensive community mental health programs. Community Mental Health Journal. 1968;4(6):443–53. DOI: 10.1007/BF01530764
20. Law M, Baptiste S, McColl M, Opzoomer A, Polatajko H, Pollock N. The Canadian Occupational Performance Measure: An outcome measure for occupational therapy. Canadian Journal of Occupational Therapy [Internet]. 1990;57(2):82–7. DOI: 10.1177/000841749005700207
21. Parham L, Ecker C, Kuhaneck H, Henry D, Glennon T. Sensory Processing Measure (2nd ed.) [Internet]. 2021 Jan 1; Available from: https://www.wpspublish.com/spm-2
22. Medical Research Council. Aids to the examination of the peripheral nervous system. HMSO, London; 1976.
23. Beery KE, Buktenica NA, Beery NA. Beery-Buktenica Developmental Test of Visual-Motor Integration (6th ed.) [Internet]. Available from: https://www.wpspublish.com/beery-vmi-beery-buktenica-developmental-test-of-visual-motor-integration-sixth-edition

Note: This article is part of a special collection of articles by some graduate students of the Master of Science in Occupational Therapy degree of the University of Santo Tomas. The peer-review was facilitated by the respective course, from which these articles arose from. PJAHS was not involved in the peer-review process of this article. Nevertheless, this article underwent editorial review of PJAHS prior to online publication.