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Redesigning Occupational Therapy Education in France: A Delphi Consensus on Essential Professional Activities

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Abstract

Introduction
France is advancing toward the full university integration of health professions education, requiring a contemporary, consensus-based description of essential occupational therapy (OT) activities to guide curriculum redesign.
Objective
To identify and organize essential OT activities in France to include in the future entry-level curriculum.
Methods
A national, three-round Delphi study (2016–2018) involved French occupational therapists (Rounds 1–3) and, in the final round, OT students and recent graduates. Round 1 collected open responses; Round 2 assessed importance ratings; Round 3 recorded binary inclusion decisions. Textual analyses were conducted by combining the Interface for Multidimensional Text and Questionnaire Analysis, R-based interface (IRaMuTeQ) and Bardin's content analysis. Consensus was defined as ≥85%. Ethical procedures complied with French law and EU GDPR.
Results
Round 1 generated 64 distinct activities, 49 of which were in Round 2. In Round 3, the professionals selected 35 activities and students/graduates selected 30, with 27 shared by both groups. These were organized into five domains: (1) Evaluation & Clinical Reasoning; (2) Occupation-centred Intervention & Environmental Adaptation; (3) Interprofessional Collaboration & Care Coordination; (4) Education, Advice & Therapeutic Guidance; and (5) Professional Development, Research & Student Supervision (primarily endorsed by professionals).
Discussion
The findings highlight the centrality of structured clinical reasoning, real-context interventions, environmental adaptation, and interprofessional practice in French OT. Organizing consensus activities into domains provides a scaffold for curriculum mapping within the Bachelor's–Master's–Doctorate framework.

Conclusion
Overall, the results provide an empirical foundation to support the ongoing transformation of occupational therapy education in France and highlight the need for curricula that integrate evolving professional practices, explicit learning outcomes, and aligned assessment strategies. Continued stakeholder engagement and periodic review will be important to maintain the framework's relevance.

Keywords

Universities, Occupational Therapy, Program Development, Educational Innovation, Qualitative Research.

1. Introduction

Health systems reforms in France have altered care delivery and professional expectations, reinforcing the need for curriculum renewal to prepare graduates for contemporary practice. In Europe, the Bologna Process harmonised higher education structures into a three-tier system, comprising the Bachelor's degree (three years), the Master's degree (two years) and the doctorate (three years). Internationally, occupational therapy (OT) programs commonly span three to five years depending on jurisdiction (Brunelle & Queneau, 2015). Since 2010, French OT programs have been structured around professional activities and competencies. Building on this foundation, researchers developed theoretical frameworks for OT education by adapting teaching and learning concepts to reflect the profession's core values and meaningful activities (Coulet, 2011). In 2015, the French Union of Occupational Therapy Training Institutes (SIFEF) submitted a proposal to the Ministry of Health advocating for full integration of OT education into the university system. This proposal paved the way for a reform to align healthcare programs with the Bachelor's–Master's–Doctorate structure, ensuring equal access to academic rights and services for health students. This transformation reflects a participatory and collective process to raise professional standards. Academic leaders and professional bodies require a current, consensus-based description of essential OT activities to guide the next curricular redesign (Berland, 2007).

Adapting educational programs to reflect the evolving scope and responsibilities of a profession is a common process worldwide. Since 1985, the expansion of Master of science (MSc) programs in occupational therapy in Canada has diversified professional roles and expectations (Coulthard, 2002). A Canadian study published in 2003 highlighted the need to develop decision-making based on professional values and evidence, interdisciplinary collaboration, evidence-based practice, and leadership and organisational skills in rehabilitation. Since 2010, all new graduate OTs in Canada must obtain a professional Master's degree in occupational therapy (Durand & Falardeau, 2003). In China, occupational therapy is part of rehabilitation education, offering associate, bachelor's, and master's degrees (Mu & al., 2020). In the United States, clinical practice requires either a master's degree (MSOT or MOT) or a clinical doctorate in occupational therapy (OTD), which may be entry-level or post-professional. Since 2014, PhD programs in rehabilitation science with an OT focus have also been available to address the growing need for advanced competencies (Case-Smith et al., 2014).

In this context, the present Delphi study sought to identify which professional activities are considered essential for inclusion in the future French OT training program. Specifically, the study aimed to generate an expert consensus list of essential occupational therapy activities, organise these activities into pedagogically meaningful domains to guide curriculum design, and compare perspectives from practitioners and students to identify convergences and divergences relevant to education.

The primary research question was: Which professional activities are considered essential for inclusion in the future French OT training program? The research objectives included: (1) Generate an expert consensus list of essential OT activities; (2) Organise these activities into pedagogically meaningful domains to guide curriculum design; (3) Compare perspectives from practitioners and

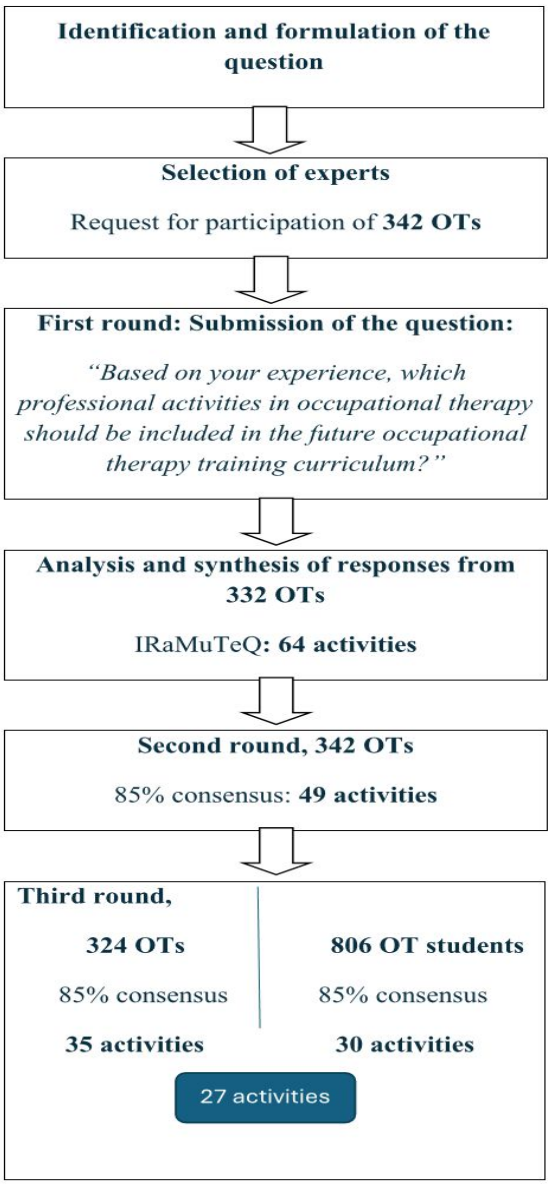
students to identify convergences and divergences relevant to education.
In this context, the present study was designed to inform the ongoing reform of occupational therapy education in France by identifying essential professional activities and considering contemporary international developments in occupational therapy.

2. Methods

2.1 Study design and setting (Tab. 1)

We conducted a national, multi-round Delphi study between September 2016 and January 2018 to elicit and refine consensus on essential OT activities in France. Iterative rounds were delivered online to support broad geographic participation and to preserve anonymity. The Delphi method is a structured method to achieve expert consensus through iterative rounds with controlled feedback (Powell & Case-Smith, 2010; Jorm, 2025). It combines qualitative and quantitative approaches and relies on two principles: expert anonymity and independence of judgment (Goodyear-Smith, 2021). The process typically involves four stages: forming a panel, designing the questionnaire, consulting experts, and analysing results. According to CREDES—Conducting and REporting DElphi Studies—standards, consensus thresholds and validation criteria should be defined before analysis (Jünger et al., 2017). Agreement is generally considered sufficient at 60–80% (Dionne & Tremblay-Boudreault, 2020). In Iran, this method is widely used in health and education research (Taymoori & Moshki, 2014) and in Germany, it helped define criteria to design practical learning experiences for nursing students (Bardin, 1993).

Table 1: *Summary of the Delphi technique combined with IRaMuTeQ*



2.2 Participants and recruitment

Two groups were targeted: licensed French-speaking occupational therapists practicing in France and occupational therapy students from the 2017 cohort enrolled across the 19 French OT programs. Professionals were invited via databases and mailing lists maintained by ANFE (French National Association of Occupational Therapists) and SIFEF (Union of French Occupational Therapy Training Institutes). Students were recruited through the participating training institutes.

Participation was voluntary and conducted online across the three Delphi rounds.

2.3 Study instrument and rounds

Initially, an invitation was emailed to 3,000 occupational therapists across France to participate in a Delphi study aimed at identifying essential occupational therapy activities for future curriculum design.

Round 1 (open-ended): Professionals answered a single prompt *'Based on your experience, which occupational therapy activities should be included in the future training curriculum?'* providing concise statements (≤10 words).

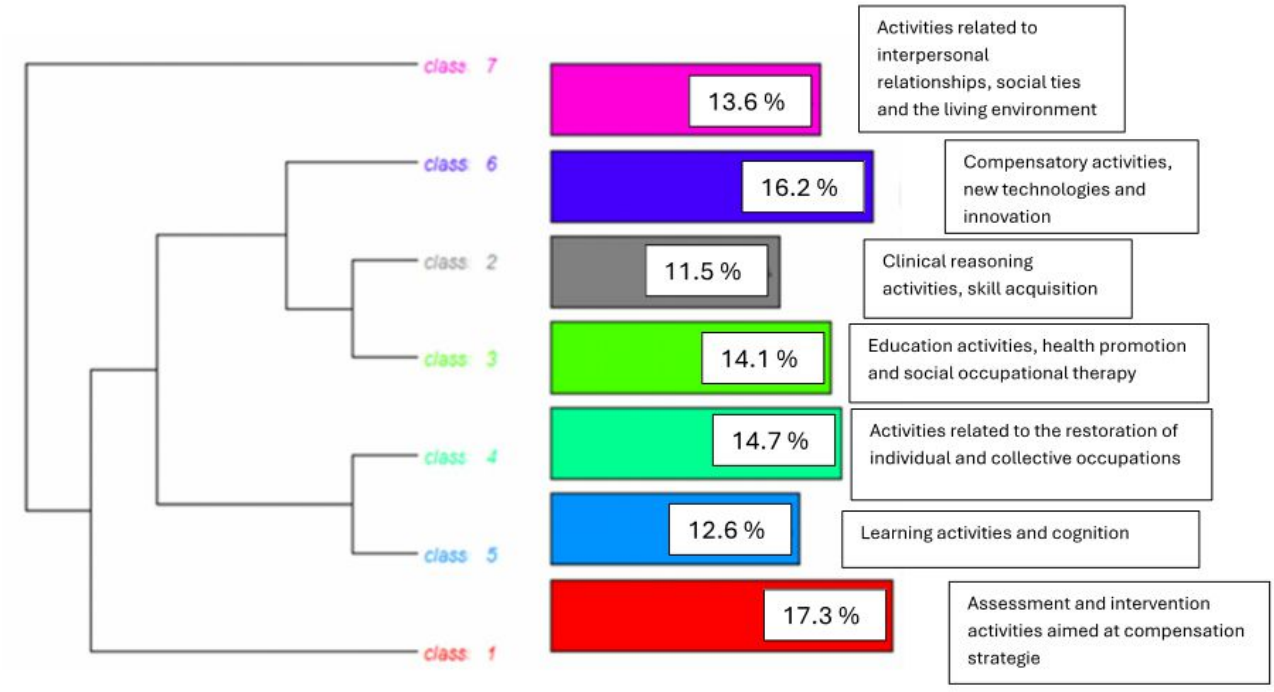
Round 2 (importance rating): Unique statements were randomized; professionals rated each on a 4-point Likert scale (1=strongly disagree to 4=strongly agree).

Round 3 (inclusion decision): Professionals and students indicated Yes/No for whether each activity should be included in the curriculum. Students were additionally offered 'I don't know'. Consensus calculations used definitive 'Yes' responses only.

2.4 Data management and analysis

Round 1, responses were processed using the Interface for Multidimensional Text and Questionnaire Analysis, R-based interface (IRaMuTeQ, lexical clustering) and Bardin's content analysis to merge duplicates, resolve synonyms, and retain units of meaning (short phrases rather than isolated words), producing 64 distinct activities. A categorisation process was then carried out to establish initial activity groupings. The words cited by occupational therapists were classified into seven representative categories, presented as a hierarchical clustering diagram illustrating the connections between terms (IRaMuTeQ dendrogram). These categories were further grouped into four main domains (Tab. 2).

Table 2: *Activity dendrogram – first Delphi round (IRaMuTeQ)*



A priori consensus thresholds were set at ≥85% agreement in Round 2 (agree/strongly agree) and ≥85% 'Yes' in Round 3.

The standard deviation (SD) was calculated to measure the dispersion of responses around the mean, indicating the variability and consistency of participants' ratings. A lower SD reflects greater agreement among respondents, whereas a higher SD indicates more divergent opinions.

Retained activities were subsequently grouped into pedagogical domains (Evaluation; Intervention; Collaboration; Education & Guidance; Professional Development) to support curriculum mapping. This categorisation followed an inductive–deductive qualitative procedure. First, two members of the research team with expertise in occupational therapy education independently reviewed the list of retained activities and performed open coding to identify conceptual similarities. Codes were then compared and discussed in iterative meetings to develop preliminary domain groupings. Discrepancies were resolved through discussion until consensus was reached; when needed, a third senior researcher was consulted to arbitrate disagreements.

In a second phase, the emerging domains were examined deductively considering existing occupational therapy competency frameworks and curriculum structures to ensure conceptual coherence and pedagogical relevance. The final domain structure was validated by the full research team, and an audit trail documenting coding decisions and domain definitions was maintained to enhance transparency and methodological rigour.

2.5 Ethical considerations

The study complied with French legislation and the EU General Data Protection Regulation (GDPR). Participation was voluntary; electronic informed consent was obtained prior to each round; anonymity and independence of judgments were preserved throughout. No personally identifying data (e.g., names, IP addresses) were collected. Data were stored on secure servers with access restricted to the research team. Under French law, the study was classed as non-interventional research; institutional oversight and data protection procedures followed French Data Protection Authority (CNIL) guidance applicable at the time.

2.6 Rationale for including students in Round 3

Students were included in the final round to provide a convergent validity check across generations of practitioners and learners and to align curricular decisions with the learner perspective. Their single-round participation preserved the iterative nature of the Delphi among professionals while incorporating the educational viewpoint at the decision stage.

3. Results

3.1 Participant characteristics

In total, 342 professionals participated in Round 1, 332 in Round 2, and 324 in Round 3. The sample was predominantly female (≈85%). Professional experience varied, with most respondents reporting 3 to 9 years of practice. Respondents' year of qualification ranged widely, with the largest group graduating between 2000 and 2009 (n = 131), followed by 2010 and after (n = 92), 1990–1999 (n = 58), 1980–1989 (n = 53), and before 1980 (n = 8). Overall, 73% (n = 250) had obtained their National Diploma prior to the 2010 program reform. Practice settings were diverse, with 56.6% (n = 193) working in home- and community-based environments, 46.2% (n = 160) in rehabilitation and re-education institutions, 8.9% (n = 30) in mental health settings, and 5.8% (n = 20) in occupational therapy education.

In Round 3, the student sample comprised 806 participants drawn from second- and third-year cohorts. Third-year students represented the majority (62%, n = 498), followed by second-year students (38%, n = 308). Students were predominantly female (86%, n = 693), with men accounting for 14% (n = 113). Most students were under 23 years of age (n = 566), 194 were aged between 23 and 30 and 46 were over 30 years.

3.2 Round 1 — Generation of candidate activities (Tab. 3)

The first round of feedback from 342 occupational therapists resulted in an initial set of activities, drawn from 7,191 terms analysed using IRaMuTeQ. Open responses yielded a broad corpus of short activity statements. After lexical clustering

(IRaMuTeQ) and content analysis (Bardin), 64 distinct activities were identified, spanning clinical reasoning/assessment, occupation-centred interventions, environmental adaptation, therapeutic education, interprofessional collaboration, and professional development.

Table 3: *Items retained following the first expert consultation*

ACTIVITIES	ACTIVITIES
1. Gather data on the person and those around them: expectations, perception of occupational therapy intervention, social and family environment, resources, the person's life goals, etc. 2. Observation of a person, a group, the interaction between person/environment/occupation. 3. Conduct tests and assessments using generic or specific tools to describe and measure activity limitations, independence and autonomy, identifying participation restrictions and disability situations. 4. Evaluate the significance, experience and context of the occupation for the person and those around them. 5. Evaluate the impact of the cultural context on the person's lifestyle. 6. Formulate an occupational therapy diagnosis and structure an intervention plan. 7. Implement care and activities aimed at rehabilitation, readaptation, reintegration, and social reinsertion. 8. Conduct therapeutic activities, individually or in groups, to develop motor, sensory, cognitive, behavioural, interaction and communication skills. 9. Experiment with and use manual work, expressive activities, projective activities, recreational activities and socio-therapies with psychotherapeutic purposes. 10. Use activities related to self-care, mobility, communication and training through targeted exercises to develop adaptation skills. 11. Use activities related to self-care, mobility, communication and training through targeted exercises aimed at developing the ability to learn or relearn cognitive procedures and adapted gestures. 12. Use activities related to self-care, mobility, communication and training through targeted exercises to develop abilities and correct detrimental attitudes. 13. real-life situations and training in care, production and leisure activities. 14. Use of occupation in the person's living environment to improve quality of life and bring about a change in occupational habits 15. Apply and implement orthotic treatments and prescribe or adapt assistive devices, animal-assisted interventions, and technological assistance. 16. Recommend, apply and monitor standard or specific orthotic devices. 17. Inform the patient and their family about orthotic and prosthetic treatments, establishing a technical specification sheet in collaboration with the physician, prosthetists and orthotists. 18. Provide information, guidance, and recommendations regarding the use, benefits, and maintenance of assistive devices, animal-assisted interventions, and technological assistance.19. Manufacture compensation, substitution, prevention and recovery equipment using thermoformable materials and 3D printing. 20. Conduct technological monitoring and research information on existing assistive devices and technological assistance, including knowledge of legislation. 21. Provide information and guidance to individuals or groups and those around them, considering life stages, life transitions and context (family, friends, environmental support persons, school, work, leisure, etc.). 22. Make recommendations for adapting the environment to support maintenance or return to activity and occupation (work, leisure, sports, self-care). 23. Explore and assess the physical home environment to formulate development and modification recommendations. 24. Explore public physical environments to provide development and modification recommendations. 25. Inform and advise individuals or groups on the role of prevention and health promotion activities. 26. Expert assessment for organisations and businesses.	27. Advise on strategies for developing mobility or activity areas and improving environments to facilitate daily activities and reduce the risk of falls. 28. Explore and evaluate the relationship between occupation and community health, social justice at group and population levels. 29. Assessment of the needs or requests in consultation with the person, family and relevant professionals. 30. Facilitate the person's placement, alone or with their close circle, in their usual, new, or temporary environment. 31. Engage with partners supply, design and manufacture of equipment, home automation specialists, etc. 32. Develop and monitor a project for adapting, modifying and transforming living spaces. 33. Produce professional documents and research, focusing on evidence-based practices 34. Produce professional documents and research on how people perceive, experience and organise their occupations. 35. Develop occupation-based assessment tools 36. Engage in continuing education on the development of occupational therapy in relation to societal changes and student training. 37. Implement a training project. 38. Implement a therapeutic education project. 39. Implement a prevention project. 40. Welcome and support students. 41. Welcome and support new professionals. 42. Provide advice and training within the work team. 43. Supervise occupational therapy students. 44. Conduct interviews to understand the individual, those around them, physical environment and occupations. 45. Assess procedural and operational skills within the individual's living environment. 46. Observe and analyze meaningful and useful activities performed by individuals with disabilities within their physical and social environments. 47. Observe and analyze the specific occupations and roles of individuals with disabilities in relation to their family and daily life contexts. 48. Write and communicate the occupational therapy diagnosis. 49. Stay updated on scientific research in health, with a focus on occupational therapy. 50. Assess deficits and disabilities in individuals with impairments. 51. Evaluate activity limitations and participation restrictions. 52. Participate in Patient Therapeutic Education programs. 53. Participate in risk prevention programs related to physical activity. 54. Provide medical and psychological support for social inclusion. 55. Plan, prepare and organise interventions, activities and individual care. 56. Record and transmit clinical and administrative data, as well as verbal and written information, to the individual, those around them and the multidisciplinary team. 57. Coordinate activities and monitor care pathways and intervention plans. 58. Interact within an interdisciplinary team to facilitate collaboration. 59. Manage, maintain and adapt materials, equipment and assistive devices, ensuring hygiene standards are met. 60. Order equipment, materials, pharmaceutical products, medical devices and assistive technologies. 61. Manage and oversee hygiene and safety in occupational therapy facilities. 62. Reflect on professional practices and organise discussions on ethical issues. 63. Provide information and/or raise awareness about risk prevention and health issues related to activity or inactivity. 64. Offer information and advice on functional disorders (musculoskeletal issues, balance, breathing, stress, etc.) and health risk factors associated with activity.

A categorisation process was then undertaken to establish initial activity groupings. Lexical analysis and hierarchical clustering were first performed using IRaMuTeQ to generate the dendrogram and identify seven preliminary categories based on word co-occurrence patterns. The research team subsequently reviewed, interpreted, and refined these software-generated classes through an iterative qualitative analysis, ensuring conceptual coherence and relevance to occupational therapy practice. The analysis was conducted by researchers trained in occupational therapy and qualitative methods, whose disciplinary backgrounds informed the interpretive phase.

These categories were further grouped into seven main domains:

- Assessment and intervention activities aimed at compensation strategies
- Compensatory activities, new technologies and innovation
- Activities related to restoring individual and collective occupations
- Education activities, health promotion and social occupational therapy
- Activities related to interpersonal relationships, social ties and the living environment
- Learning activities and cognition
- Clinical reasoning activities, skill acquisition.

3.3 Round 2 — Professional importance ratings (Tab. 4)

Professionals (n=332) reached ≥85% agreement on 49 activities. Highlights included: (a) Evaluation & clinical reasoning (comprehensive interviewing; observation/analysis of meaningful occupations; assessment of activity limitations and participation restrictions; development and communication of an OT diagnosis and plan; use of validated tools); (b) Intervention (rehabilitation and social participation; targeted activities—self-care, mobility, communication, cognitive training; ecological simulations in real-life contexts; environmental adaptations; orthotic treatments and assistive technologies); (c) Education & guidance (information/advice for individuals/families on assistive devices and environmental modifications; participation in Patient Therapeutic Education [PTE] programs; (d) Collaboration (interprofessional teamwork; engagement with equipment suppliers/designers; coordination of care pathways); (e) Professional development (scientific/technological monitoring; continuing education; supervision of OT students).

Table 4: *Results of the second consultation*

Activities	Average score	Standard Deviation
1. Implementing care and activities aimed at rehabilitation, readaptation, reintegration and social inclusion.	3.94	0.25
2. Exploring and assessing the home's physical environment to provide recommendations for development and modifications.	3.94	0.27
3. Occupational therapy diagnosis and formalisation of the intervention plan.	3.92	0.27
4. Individual or group therapeutic activities aimed at developing motor, sensory, cognitive, behavioural, interaction and communication skills.	3.92	0.32
5. Suggesting adaptations to the environment to maintain or resume activities and occupations (work, leisure, sports, personal care).	3.92	0.29
6. Placing individuals, with or without those around them, in their usual, new or temporary environment.	3.92	0.28
7. Using activities related to personal care, mobility, communication and learning with targeted exercises to develop the ability to learn or relearn cognitive processes and appropriate movements.	3.87	0.37
8. Providing information, advice and recommendations on technical, animal-assisted and technological aids.	3.87	0.41
9. Assessing activity limitations and participation restrictions.	3.86	0.41
10. Writing and transmitting occupational therapy diagnoses.	3.85	0.39
11. Using activities related to personal care, mobility, communication and training with targeted exercises to develop adaptive abilities.	3.84	0.41
12. Conducting interviews to understand the person, those around them, their physical environment and their occupations.	3.84	0.42
13. Engaging with partners, such as suppliers, equipment designers and manufacturers and home automation specialists.	3.83	0.45
14. Observing and analysing significant and useful activities of people with disabilities and those around them.	3.83	0.42
15. Ecological simulation and training in self-care, productivity and leisure.	3.81	0.46
16. Collecting data on the individual and those around them (e.g., expectations, perception of occupational therapy intervention, social and family environment, resources, life goals).	3.81	0.40

17.	Producing and following up on projects for adapting, modifying and transforming living spaces.	3.81	0.44
18.	Interacting within an interdisciplinary team to facilitate collaboration.	3.81	0.43
19.	Supervising occupational therapy students during fieldwork	3.79	0.43
20.	Welcoming and supporting students.	3.78	0.45
21.	Conducting tests and evaluations using generic or specific tools to describe and measure activity limitations, independence and autonomy, and identify participation restrictions and disability situations.	3.77	0.51
22.	Applying and providing orthotic treatments, recommending technical, animal-assisted and technological aids.	3.77	0.51
23.	Assessing procedural and operational skills in the individual's living environment.	3.77	0.50
24.	Evaluating deficits and disabilities in individuals with impairments.	3.77	0.53
25.	Observing and analysing specific occupations of people with disabilities and their families.	3.73	0.51
26.	Advising on strategies for mobility and activity areas and improving the environment to facilitate daily activities and reduce the risk of falls.	3.73	0.51
27.	Continuing education on the evolution of occupational therapy in relation to societal changes and student training.	3.71	0.50
28.	Observing individuals, groups and the person-environment-occupation interaction.	3.68	0.57
29.	Assessing needs or requests in consultation with the individual, family and relevant professionals.	3.68	0.56
30.	Participating in the patient's therapeutic education programs.	3.68	0.56
31.	Monitoring technological advancements and researching information on existing assistive devices and technologies, including legal knowledge.	3.65	0.57
32.	Implementing therapeutic education projects.	3.63	0.60
33.	Providing advice and training within the work team.	3.63	0.57
34.	Planning, preparing and organising interventions, activities and care.	3.62	0.63
35.	Keeping up with scientific advancements in healthcare, with a focus on occupational therapy.	3.61	0.62
36.	Implementing prevention projects.	3.60	0.56
37.	Welcoming and supporting new professionals.	3.58	0.56
38.	Exploring public physical environments to provide recommendations for developments and modifications.	3.56	0.60
39.	Recommending, applying and monitoring standard or specific orthotic devices.	3.52	0.66
40.	Recording and transmitting clinical and administrative data, as well as verbal and written information, to the individual, those around them and the multidisciplinary team.	3.52	0.73
41.	Informing individuals and families about orthotic and prosthetic treatments, establishing specifications in collaboration with physicians, prosthetists and orthotists.	3.52	0.68
42.	Reflecting on professional practices, organising discussions on ethical issues.	3.51	0.63
43.	Providing information and advice to individuals or groups about the role of activities in health prevention and promotion.	3.45	0.64
44.	Manufacturing compensatory, substitute, preventive and recovery equipment using thermoformable materials and 3D printing.	3.45	0.71
45.	Producing professional documents and research, with a focus on evidence-based practices.	3.44	0.71
46.	Providing information on functional disorders (musculoskeletal, balance, respiratory, stress-related) and health risk factors linked to activity, along with advice.	3.43	0.71
47.	Developing occupation-based assessment tools.	3.42	0.74
48.	Using activities related to personal care, mobility, communication and learning with targeted exercises to develop abilities and correct harmful habits.	3.42	0.74
49.	Coordinating activities and monitoring care pathways and intervention plans.	3.42	0.71
50.	Providing information and advice to individuals, groups and those around them, depending on life stages.	3.39	0.76
51.	Managing, maintaining and adapting materials, equipment and assistive devices, while applying hygiene regulations.	3.39	0.72
52.	Implementing training projects.	3.37	0.70
53.	Raising awareness and providing information on risk prevention and health issues related to activity or inactivity.	3.37	0.73
54.	Professionally integrating individuals into their living environment to improve quality of life and promote changes in professional habits.	3.31	0.79
55.	Assessing the significance, experience and context of an occupation for an individual and those around them.	3.30	0.78
56.	Experimenting with and using manual work, expressive activities, projective activities, playful activities and socio-therapeutic approaches with psychotherapeutic goals.	3.29	0.79
57.	Producing professional documents and research on how people perceive, experience and organise their occupations.	3.24	0.81
58.	Intervening in prevention programs related to risks associated with physical activity.	3.24	0.82
59.	Assessing the impact of cultural context on individuals' lifestyles.	3.23	0.71
60.	Ordering equipment, materials, pharmaceutical products, medical devices and assistive technologies.	3.21	0.79
61.	Providing medical and psychological support for social inclusion.	3.04	0.84
62.	Managing and controlling hygiene and safety in occupational therapy facilities.	2.97	0.88
63.	Providing expertise for organisations and businesses.	2.92	0.86
64.	Exploring and evaluating the relationship between professional activities, community health and social justice at the group and population levels.	2.69	0.89

3.4 Round 3 — Inclusion decisions (Professionals + Students)

In the final round, students (n=806) selected 30 activities (Tab. 5a) and professionals (n=324) selected 35 for inclusion (Tab. 5b). The intersection yielded 27 essential activities shared by both groups and organised into four core domains, with a fifth domain primarily endorsed by professionals (Tab. 5c). The domains and their associated activities are presented below.

Domain A: Evaluation and Clinical Reasoning included activities related to comprehensive information gathering, analysis, and diagnostic formulation. Participants emphasised the need to conduct comprehensive interviews and gather data on the person, environment, and occupations. This domain also encompassed collecting information on expectations and perceptions of occupational therapy, the social and family environment, available resources, and life goals. Observing and analysing meaningful activities and procedural or operative skills in the living environment, assessing activity limitations and participation restrictions using validated tools, and developing and communicating an occupational therapy diagnosis and intervention plan were also identified as core components.

Domain B: Occupation-centred Intervention and Environmental Adaptation encompasses activities that promote participation through targeted therapeutic actions and contextual modifications. Participants highlighted the importance of implementing rehabilitation and readaptation interventions focused on participation, reintegration, and social inclusion. They also emphasised the use of targeted activities—such as self-care, mobility, communication, and cognitive training—to support the development of adaptive strategies and the learning or re-learning of cognitive procedures and appropriate movements. In addition, this domain includes conducting ecological simulations in home and community contexts related to self-care, productivity, and leisure. Recommending and implementing environmental adaptations in home and public settings, as well as designing and monitoring projects to adapt, modify, and transform living spaces, were considered essential. Finally, the application of orthotic treatments and the provision of advice on assistive technologies and assistive devices (including, where appropriate, animal-assisted approaches) were identified as key elements.

Domain C: Interprofessional Collaboration and Care Coordination focused on teamwork and the organisation of care processes. Participants underscored the importance of collaborating within interdisciplinary teams to facilitate communication and collective decision-making. This domain also included coordinating activities and monitoring care pathways and intervention plans, as well as engaging with relevant stakeholders such as suppliers, designers, manufacturers, and home-automation specialists.

Domain D: Education, Advice and Therapeutic Guidance related to the informational and preventive role of occupational therapists. Key activities included providing information and advice to individuals and families regarding assistive devices, assistive technologies, and environmental strategies. Participants also highlighted involvement in Patient Therapeutic Education (PTE) and prevention programmes, including fall-risk mitigation and activity-based health promotion.

Domain E (professionals only): Professional Development, Research and Student Supervision reflected activities primarily endorsed by professionals. This domain included maintaining scientific and technological monitoring, keeping abreast of advances in health and occupational therapy, engaging in continuing education, supervising and tutoring occupational therapy students, as well as supporting early-career practitioners.

Table 5a: *Results of the third consultation with Student Occupational Therapists (OTs)*

Activities	Average score	Standard Deviation
1. Suggestions for adapting the environment to maintain and return to activity and occupation (work, leisure, sport, personal care).	99	0.17
2. Interview to get to know the person, those around them, their physical environment and their occupations.	97	0.23
3. Use of activities related to personal care, mobility, communication and training through targeted exercises to develop the ability to learn or relearn cognitive procedures and adapted gestures.	96	0.35
4. Ecological simulation and training in care, production and leisure activities.	96	0.34
5. Exploration and assessment of the physical home environment to formulate recommendations for development and modification.	96	0.31
6. Implementation of care and activities aimed at rehabilitation, readaptation, reintegration and social rehabilitation.	96	0.33
7. Occupational therapy diagnosis and formalisation of the intervention project.	96	0.32
8. Information, advice and recommendations on technical or animal-assisted aids and technological assistance.	96	0.35
9. Assessing the deficits and incapacities of a person with a disability.	96	0.30
10. Writing and transmitting occupational therapy diagnoses.	95	0.38
11. Therapeutic activities, individually or group-based, aimed at developing motor, sensory, cognitive, behavioural, interaction and communication skills.	95	0.40
12. Assisting the person, with or without those around them, in their usual, new or temporary environment.	95	0.36
13. Advice on strategies for developing mobility or activity areas and improving environments to facilitate daily activities and reduce the risk of falls.	95	0.40
14. Use of activities related to personal care, mobility, communication and training through targeted exercises to develop adaptation skills.	94	0.44
15. Observation and analysis of meaningful activities of people with disabilities and those around them.	94	0.38
16. Collecting data on the person and those around them: expectations, perceptions of occupational therapy intervention, social and family environment, resources, personal life goals, etc.	94	0.39
17. Assessment of activity limitations and participation restrictions.	94	0.39
18. Conducting tests and evaluations using generic or specific tools, describing and measuring activity limitations, independence and autonomy, identifying participation restrictions and situations of disability.	94	0.42
19. Collaborate within an interdisciplinary team to facilitate communication.	93	0.44
20. Applying and implementing orthotic treatments and recommending technical or animal-assisted aids and technological assistance.	91	0.48
21. Observation of a person, a group or the interaction between person/environment/occupation.	91	0.50
22. Implementing a therapeutic education project	89	0.48
23. Observation and analysis of the specific occupations of people with disabilities and their families.	89	0.55
24. Use of activities related to personal care, mobility, communication and training through targeted exercises aimed at developing capacities and correcting harmful attitudes.	88	0.60
25. Designing and monitoring a project to adapt, modify and transform the living environment.	86	0.59
26. Assessing the need or request in consultation with the person, their family and relevant professionals.	86	0.62
27. Exploration of the public physical environment to formulate recommendations for development and modification.	85	0.61
28. Contact with partners, supply, equipment design and manufacture and home automation specialists.	85	0.63
29. Intervention in Patient Therapeutic Education programs	85	0.63
30. Coordination of activities and monitoring of care pathways and intervention plans.	85	0.66

Table 5b: *Results of the third consultation with Occupational Therapists (OTs)*

Activities	Average score	Standard Deviation
1. Exploration and assessment of the physical home environment to formulate recommendations for development and modification.	99	0.10
2. Suggestions for adapting the environment to maintain and return to activity and occupation (work, leisure, sport, personal care).	99	0.11
3. Interview to get to know the person, those around them, their physical environment and their occupations.	99	0.10
4. Use of activities related to personal care, mobility, communication and training through targeted exercises to develop the ability to learn or relearn cognitive procedures and adapted gestures.	98	0.15
5. Ecological simulation and training in care, production and leisure activities.	98	0.12
6. Therapeutic activities, individual or group-based, aimed at developing motor, sensory, cognitive, behavioural, interaction and communication skills.	98	0.13
7. Occupational therapy diagnosis and formalisation of the intervention project.	98	0.12
8. Information, advice and recommendations on technical, animal-assisted and technological aids.	98	0.13
9. Assisting the person with or without those around them, in their usual, new or temporary environment.	98	0.13
10. Writing and transmitting occupational therapy diagnoses.	97	0.16
11. Use of activities related to personal care, mobility, communication and training through targeted exercises to develop coping skills.	97	0.17
12. Implementing care and activities aimed at rehabilitation, readaptation, reintegration and social rehabilitation.	97	0.16
13. Advice on strategies for developing mobility or activity areas and improving environments to facilitate daily activities and reduce the risk of falls.	97	0.18
14. Observation and analysis of meaningful activities of people with disabilities and those around them.	96	0.20
15. Assessment of the need or request in consultation with the person, family and relevant professionals.	96	0.19
16. Conducting tests and assessments using generic or specific tools, describing and measuring activity limitations, independence and autonomy, identifying participation restrictions and situations of disability.	96	0.20
17. Collaborate within an interdisciplinary team to facilitate communication.	95	0.22
18. Contact with partners, supply, equipment design and manufacture and home automation specialists.	95	0.22
19. Collect data on the person and those around them: expectations, perception of occupational therapy intervention, social and family environment, resources, personal life goals, etc.	95	0.22
20. Assessment of activity limitations and participation restrictions.	95	0.22
21. Assessing the deficits and incapacities of a person with a disability.	95	0.22
22. Assessment of procedural and operative skills in the person's living environment.	93	0.26
23. Planning, preparation and organisation of every intervention, activity and care.	93	0.26
24. Applying and implementing orthotic treatments and recommending technical or animal-assisted and technological aids.	93	0.26
25. Observation and analysis of the specific occupations of people with disabilities and their families.	92	0.28
26. Designing and monitoring a project for adapting, modifying and transforming the living environment.	91	0.28
27. Supervising occupational therapy students during fieldwork	91	0.28
28. Welcome and support students.	91	0.29
29. Continuing education on the development of occupational therapy in relation to societal changes and student training.	89	0.31
30. Technological monitoring and research on existing assistive devices, technological assistance and knowledge of legislation.	89	0.31
31. Use of activities related to personal care, mobility, communication and training through targeted exercises aimed at developing capacities and correcting harmful attitudes.	88	0.33
32. Observation of a person, a group and the interaction between person/environment/occupation.	88	0.33
33. Maintaining scientific monitoring on healthcare, particularly on occupational therapy.	87	0.34
34. Recording and transmission of clinical and administrative data, oral and written information to the person, those around them and the multidisciplinary team.	85	0.35
35. Intervention in Patient Therapeutic Education programs.	85	0.35

Table 5c: *Results of the third consultation with Occupational Therapists (OTs) and Student Occupational Therapists (OTs)*

Activities
1. Exploration and assessment of the physical home environment to formulate recommendations for development and modification.
2. Suggestions for adapting the environment to maintain and return to activity and occupation (work, leisure, sport, personal care).
3. Interview to get to know the person, those around them, their physical environment and their occupations.
4. Use of activities related to personal care, mobility, communication and training through targeted exercises to develop the ability to learn or relearn cognitive procedures and compensatory approaches.
5. Real-life situations and training in care, productivity and leisure activities.
6. Therapeutic activities, individual or group-based, aimed at developing motor, sensory, cognitive, behavioural, interaction and communication skills.
7. Occupational therapy diagnosis and formalisation of the intervention plan.
8. Information, advice and recommendations on technical or animal-assisted aids and technological assistance.
9. Assisting the person, with or without those around them, in their usual, new or temporary environment.
10. Writing and transmitting occupational therapy diagnoses.
11. Use of activities related to personal care, mobility, communication and training through targeted exercises to develop coping skills.
12. Implementation of care and activities aimed at rehabilitation, readaptation, reintegration and social rehabilitation.
13. Advice on strategies for arranging mobility or activity areas and improving environments to facilitate daily activities and reduce the risk of falls.
14. Observation and analysis of the meaningful activities of people with disabilities and their entourage.
15. Assessment of the need or request in consultation with the person, family and professionals concerned.
16. Conducting tests and evaluation using generic or specific tools, describing and measuring activity limitations, independence and autonomy, identifying participation restrictions and disability situations.
17. Collaborate within an interdisciplinary team to facilitate communication.
18. Contact with partners suppliers, equipment designers and manufacturers, home automation specialists.
19. Collecting data on the person and those around them: expectations, perception of occupational therapy intervention, social and family environment, resources, personal life goals, etc.
20. Assessment of activity limitations and participation restrictions.
21. Assessing the deficits and incapacities of a person with a disability.
22. Applying and implementing orthotic treatments and recommending technical or animal-assisted and technological aids.
23. Observation and analysis of the specific occupations of people with disabilities and their families.
24. Designing and monitoring a project to develop, adapt and transform the living environment.
25. Use of activities related to personal care, mobility, communication and training through targeted exercises aimed at developing capacities and correcting harmful attitudes.
26. Observation of a person, a group and the interaction between person/environment/occupation.
27. Intervention in Patient Therapeutic Education programs.

4. Discussion

Consensus among practitioners and students highlighted four pillars of French OT education: structured clinical reasoning, occupation-centred interventions in real contexts, environmental adaptation, and interprofessional collaboration. These 27 shared activities formed a strong curricular core, whereas professional development, research development and supervision were emphasised by practitioners. Organising these activities into domains provides a clear framework for curriculum mapping within the Bachelor's–Master's–Doctorate system, supporting longitudinal learning in evaluation, integrated lab and field

experiences for intervention, interprofessional modules, and competencies in therapeutic education and health promotion. Although rooted in the French context, these findings align with global OT trends and are published here in English to foster international comparability and mobility.

4.1 A contemporary training program oriented towards an occupation-based paradigm

The results from the third round, which included occupational therapy students (n = 806) and occupational therapists (n = 324), indicate that a shift is occurring in France towards an occupation-based paradigm. The availability of translated literature on occupational science (Pierce, 2016), conceptual models in occupational therapy (Morel, 2024), occupational therapy assessment (Criquillon-Ruiz, Soum-Pouyalet & Tétreault, 2023) and person-centred, occupation-focused therapy (Caire and Poriel, 2023) are all examples of the development of a top-down approach (Wong and Fisher, 2015) in France.

Reasoning based on person, environment and occupation interaction was reflected in the third round in five occupational therapy activities amongst students and four amongst professionals. This finding underscores the importance of a strong conceptual foundation in undergraduate training. A survey conducted across 193 occupational therapy programs in Australia, Canada, the United Kingdom and the United States revealed that each program included between three and ten occupation-focused models. The Canadian Model of Occupational Performance and Engagement and the Model of Human Occupation were included in 98.5% of the programs studied (Egan and Restall., 2022). Previous studies have emphasised the importance of understanding how professional training influences students' values and attitudes toward occupation-centred practice (Ashby & Chandler, 2010) and their perspectives on occupational justice (Bailliard et al., 2016), a need that our findings also support. Further research is warranted to identify which theoretical models should be prioritised and further developed within initial occupational therapy education to ensure alignment with evolving professional and societal needs.

4.2 A training program that develops structured clinical reasoning in occupational therapy

Clinical reasoning and the assessment process in occupational therapy involve a thorough exploration through comprehensive interviews, observation, and analysis of meaningful occupations for the individual, as well as analytical assessments of activity limitations. Survey responses highlight the importance of using validated, occupation-oriented assessments, reinforcing a person-centred approach. Supported by health policies, this approach benefits service users, professionals and the healthcare system as a whole (Nolte, Merkur, and Anell, 2020). Ongoing scientific monitoring by professionals emphasises the need to develop students' clinical reasoning. Research suggests that pedagogical methods focused on problem-solving and reflective learning can strengthen their future practice (Mørk, Gramstad, Åsli and al., 2022).

Finally, the occupational therapy diagnosis, regarded as a written synthesis, structures clinical reasoning and facilitates professional communication (Dubois, Thibault Samson, Trouvé, et al., 2017).

4.3 A training program that encourages a top-down intervention process without excluding the bottom-up approach

Expert feedback highlights that occupational therapy interventions focus on developing new occupational strategies. These include targeted activities to promote cognitive development and adaptive movements, as well as real-life simulations in diverse ecological contexts. This approach is strongly supported by the Occupational Therapy Intervention Process Model (OTIPM) (Fisher and Jones, 2017), recognised for its effectiveness in student learning during placements (Kaelin and Dancza, 2019).

Therapeutic activities related to activity compensation and environmental adaptation are also emphasized, particularly in home-based interventions that support individuals with disabilities or older adults in maintaining or regaining independence (Lockwood, Harding, Boyd, & Taylor, 2020). The value of home visits in occupational therapy intervention is well documented (Liimatta, Lampela, Laitinen-Parkkonen, & Pitkala, 2020). The recent authorisation for occupational

therapists in France to prescribe certain medical devices further underscores the growing importance of these activities.

In psychiatry, occupational therapy contributes to psychosocial rehabilitation through interventions targeting social participation, cognitive functioning, and patient education (Kirsh et al., 2019). Beyond symptom management, occupational therapy interventions have also been associated with broader public health outcomes, including improved autonomy and reduced hospital readmissions, particularly through transitional care and community-based interventions (Lockwood & Porter, 2022). In older populations, occupational therapy interventions such as environmental adaptation, discharge planning, and support for daily functioning may also facilitate ageing in place and continuity of care (Molitor et al., 2020). In this context, integrating preventive approaches, patient education, and environmental adaptation into occupational therapy curricula may help prepare future practitioners to address current health system challenges, including cost containment and equitable access to rehabilitation services.

Historically, occupational therapy in France has predominantly followed a bottom-up approach focused on restoring impaired functions (Delaisse et al., 2022). Although efforts to incorporate occupation-based perspectives are increasing, current research indicates that a more comprehensive understanding of both top-down and bottom-up approaches is needed to strengthen occupational therapy training (Burley et al., 2018). Expanding occupational therapy practice beyond functional remediation also requires greater attention to health promotion and person-centred interventions. In this regard, activities related to counselling, information-sharing, support, and therapeutic patient education have been identified as important components of contemporary occupational therapy practice (Vas et al., 2021), reflecting the profession's broader role in promoting health and well-being (Reitz et al., 2020).

4.4 A training program that promotes interprofessional collaboration and soft skills

Interprofessional intervention and collective decision-making—including individuals with disabilities and their families—were strongly emphasised in the third-round consensus. This interdisciplinary approach was supported by both students and professionals. Collaboration within interprofessional teams fosters communication, exchange, and cooperation in rehabilitation settings.

A study emphasises that integrating soft skills—such as communication, adaptability, and teamwork—into occupational therapy curricula is essential to better prepare students for clinical practice and collaborative healthcare environments (Engels, Oubaya, & Thomas, 2025).

A 2019 study involving 1,466 occupational therapy lecturers highlighted the importance of interprofessional education throughout training and stressed the need to prioritise ethical competency as the most fundamental aspect of this education (Hughes, Allen, McLane, et al., 2019). Another study of physiotherapy and occupational therapy students emphasised the significance of implementing joint collaborative programs that develop teamwork, cultural competence and humility in health and social care settings (Ozcan Edeer, and Rust., 2022)

The Canadian Model of Occupational Participation (CMOP), published in 2022, underscores the role of collaborative relationships with individuals, families, groups, communities, and populations in the occupational therapy intervention process. It is grounded in interprofessional collaboration, highlighting the importance of working alongside other health professionals to address both individual and community needs and promote occupational and social justice (Egan & Restall, 2022). It provides a framework for teaching collaboration and ethical decision-making, fostering a more equitable and inclusive society that embraces cultural diversity.

4.5 Strengthening research in rehabilitation from the early stages of training

The professionals emphasised evidence-based practice (EBP), scientific monitoring, research, innovation, and new technologies—areas that students tend to prioritise less. Previous studies have highlighted the crucial role of EBP in clinical occupational therapy (Powell & Case-Smith, 2010) and the need to develop competencies in personal and professional growth and service delivery (Bennett et al., 2003). Our findings reinforce these

concerns by showing that students place less emphasis on these domains, suggesting a gap between current training and the evolving demands of the profession in France. Addressing this gap is essential to align education with contemporary practice expectations (Milat, Bauman, & Redman, 2015).

5. Limitations

Invitations to professionals to participate in this study covered ~3,000 of ~10,000 OTs at the time; although substantial, the sample is not fully representative. Students participated only in Round 3; their selections should be interpreted as confirmatory rather than iterative consensus-building. In light of this methodological choice, we interpreted the students' responses with caution, presenting them alongside the different consensus outcomes from the survey. Additionally, the inclusion of the "I don't know" option in the student questionnaire led some participants to refrain from making a definite choice. The consensus calculation was based solely on definitive "yes" responses.

Although the data were collected from 2016 to 2018, the activity domains identified are foundational and remain central to contemporary OT. Recent French literature and translated resources on occupational science, conceptual OT models, and occupation-centred assessment support continued relevance and curricular alignment.

Translation and terminology harmonisation may have introduced minor differences between the items published here and the original items validated by participants in French.

Conclusion

In the third round of this Delphi study, professionals identified 35 activities and students selected 30, with 27 activities shared by both groups. These were organised into five domains: four core areas—Evaluation & clinical reasoning, Occupation-centred intervention & environmental adaptation, Interprofessional collaboration, and Education & therapeutic guidance—plus a fifth domain focused on professional development, which practitioners emphasised. This structure provides a pragmatic framework for redesigning French OT curricula within the Bachelor's–Master's–Doctorate, reinforcing occupation-centred education, readiness for interprofessional practice, and community-based learning. Future work should update the consensus through new rounds, integrate learning outcomes and assessment strategies for each activity, and examine implementation impacts across programs. These updated findings represent an essential first step in documenting core occupational therapy activities in France, as no previous studies have systematically addressed this area. The data provide a foundational baseline for understanding current practices, particularly regarding the prescription of assistive technologies by occupational therapists—a competency recently authorised. By highlighting emerging trends and integrating recent regulatory and clinical developments, these results shed light on the evolving scope of occupational therapy and its alignment with international standards. This contribution is important for informing future research, curriculum design, and policy decisions aimed at strengthening evidence-based practice in occupational therapy. The findings of this study informed the national process of updating the occupational therapy training framework in France and contributed to the preparatory work supporting the experimental university-based program rollout initiated in 2021. Beyond its international contribution, this work has supported the ongoing transformation of occupational therapy education in France. Continued dissemination in French and engagement with national stakeholders are intended to promote the integration and sustainable use of these findings within training programs.

Ethics Statement

This study complied with French law and the EU GDPR. Participation was voluntary, with electronic informed consent. Anonymity and independence of judgments were ensured; no identifying data were collected. Institutional oversight and data protection procedures followed CNIL guidance applicable at the time.

Data Availability

Data supporting the findings are available from the corresponding author upon reasonable request.

Competing Interests

The authors declare no competing interests.

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Supplementary material

SD1 - Summary of the Delphi technique combined with IRaMuTeQ
SD2 - Activity dendrogram - first Delphi round (IRaMuTeQ)
SD3 - Demographic elements of the expert population French Occupational Therapists (OTs)
SD4 - Demographic elements of the expert population French Student Occupational Therapists (OTs)
SD5 - Items retained following the first expert consultation
SD6 - Results of the second consultation
SD7 - Results of the third consultation with Student Occupational Therapists (OTs)
SD8 - Results of the third consultation with Occupational Therapists (OTs)
SD9 - Results of the third consultation with Occupational Therapists (OTs) and Student Occupational Therapists (OTs)

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