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Tribute to Dr. Sandra Patton
We are delighted to write the editorial for this Irish Journal of Occupational Therapy, Primary Care edition. As winners of the 2015 Ann Beckett Award, we were invited to contribute. The award was for our project entitled ‘Sharing Skills’, a project based in Primary Care Paediatric Services in County Louth. The service development which this fostered, and our involvement in the ‘Ann Beckett award’ process, has been rewarding and challenging. It has ultimately resulted in an improved, more accessible, responsive and sustainable service for children and their families. It was an honour to have our work recognised by our peer group.

The core intervention of the sharing skills model is a programme of one day educational seminars for parents/guardians and carers, teachers, health and social care professionals and community leaders, all of whom have, or work with children who have sensory motor difficulties. The seminar aims to provide an understanding of how sensory processing and co-ordination difficulties impact on children’s functioning in everyday activities and how the child can gain increased independence in everyday tasks. This is provided through the provision of both information and practical demonstrations. Parents are invited to this programme as soon as their child has been referred to Primary Care Occupational Therapy. Other elements of the model include parent coaching through a telephone clinic, ongoing access to the service throughout a child’s school years and targeted group work.

Our motivation for change was the increasing demands on our service, a situation familiar to many occupational therapists around the country. We were very conscious of how long children and their families had to wait to access the service, and of our inability to meet their expectations when they finally received an initial appointment.

Our development was largely guided by the research of Wendy Rudd, OT entitled ‘What Really Matters’ (2013), in which she identified areas of importance for parents of children with Dyspraxia/Developmental Co-ordination Disorder (DCD) including life-long needs, parental education, parent to parent support, awareness in the community, and service to schools. It was also guided by the European Academy of Childhood Disability, DCD Guidelines (2011). This document provides recommendations, based on international consensus, for the definition, diagnosis, assessment and intervention of DCD. More recent research and model developments in the areas of parent training and parent and teacher coaching were further influences in our service development. Examples of this are the work of Winnie Dunn, Cox et al. (2012) describing ‘Contextual Intervention’, and the work of Rodger and Ziviani (2013) in “Occupational Performance Coaching”.

Our experience of this process has been overwhelmingly positive. Early and direct access to parents, teachers and the wider community who support the children we work with has allowed us to learn from them, shape the further development of our service and influence how they support the children in their care. It has fostered inter-parent support and the development of community supports through the Dyspraxia Association locally. It has enabled us to promote Occupational Therapy while also developing team work within primary care and in the wider community, and we also welcomed the guest contributions from Psychology, Speech and Language Therapy and the Dyspraxia Association. In the past two years a total of 850 people have attended our seminar. Families who were typically waiting up to two years before their first contact from time of referral are now accessing the service within three months. This process embodies the start of a new and transformed model of service provision to children who both require and rely on our interventions, recognising that the same attention and reflection is required across other elements of our work and areas of service provision.

It is a challenging time for those of us working in Primary Care. A time of resource constraints in an ever increasing demand led service. A time of change in organisational structures and implementation of health service reform. It is also a time of opportunity for us. Primary Care priorities for 2016 include improving access to primary care services and reducing waiting lists and waiting times, and implementing models of care for chronic illness management. These priorities give us the scope to look carefully at what we do and how we do it, and make the changes that will lead to a better service for those we work with now and into the future.
ABSTRACT

This paper describes a practice based research study which explored the use of an occupation focused initial assessment tool in primary care Occupational Therapy with children. The study used a mixed methodological approach to explore the effectiveness of the SCOPE (The Short Child Occupational Profile, version 2.0, Bowyer et al., 2005) assessment tool. Findings from this study were positive with results indicating that the SCOPE was useful in a) identifying and communicating a child’s occupational strengths and challenges b) developing collaborative occupation focused treatment goals c) renewing therapists' confidence in applying occupation focused practice and d) empowering parents and children by adopting a more strengths focused approach to assessment. This study reflects recent literature advocating for occupation focused assessment tools to support occupation focused practice and contribute to positive outcomes for children.

KEYWORDS
Occupation centered practice, occupation focused assessment tools, primary care Occupational Therapy, practice based research.

INTRODUCTION

There has been a recent refocusing within our profession towards the provision of theory driven occupation focused practice (Boniface & Seymour, 2012). Recent studies have emerged providing evidence of the benefits of adopting such models in terms of service delivery, therapist confidence and client outcomes (Forsyth et al., 2011, p.5). In emerging areas of practice, such as the context for this exploratory study, it is necessary for therapists to collaborate in developing our practice knowledge and contributing to the ‘scholarship of practice’ that is crucial to evidence informed practice (Taylor, Fisher, & Kielhofner, 2005, p. 107). Initial assessment tools have been identified (Bowyer, Kramer, Kielhofner, Maziero-Barbosa, & Girolami, 2007, p.67) as a fundamental component in the implementation of occupation centered practice. This study aimed to explore if an occupation focused assessment would provide a useful tool in the delivery of Occupational Therapy in an Irish primary care context with children.

LITERATURE REVIEW

Occupation focused practice has experienced what Rodger (2010) describes as a renaissance within our profession. What constitutes occupation focused practice, how to measure this construct in the absence of a consensus definition and the evidence regarding the application of theoretical constructs in practice continues to occupy the literature (Polatajko & Davis, 2012, p.259). Bendixen and Kreider’s (2011, p.351) comprehensive review of Occupational Therapy research summarizes that most practice research tends to investigate variables representing constructs falling within the ICF...
(International Classification of Functioning, Disability and Health) domains of Body Functioning and Activity rather than participation. While Forsyth et al. (2011, p.5) contend that improvements are apparent in more recent studies, the limited findings reflecting participation outcomes for children is not reflective of the profession’s adoption of occupation centered practice.

The literature espouses the need for a ‘scholarship of practice’ to move forward the evidence on the implementation of occupation focused practice. The ‘scholarship of practice’ originally described by Kiellhofner (Taylor et al., 2005, p.107) describes a process whereby theoretical constructs developed in academic settings are validated through research and applied in practice providing further contributions to theoretical developments. Copley, Bennett, and Turpin’s (2010, p.320) review of decision making processes for occupation centered practice cautioned against therapists’ tendency to adopt their own theory of practice based on an eclectic mix of approaches that may lead to a gap between theory translation and treatment techniques. This review supported the need for therapists to adopt a specific model of practice. Lee (2010, p.206) reviewed the evidence of current occupation focused models to support practice and identified the Model of Human Occupation (MOHO) as the most widely used. The factors hypothesised for this popularity included a large body of research examining the model’s theoretical concepts and the systematic development of outcome measures. MOHO proposes that participation is influenced by a person’s motivation for occupation, internalised patterns of activity and demonstration of necessary actions for occupational performance influenced by the environment (Kiellhofner, 2008). Recent studies (Forsyth et al., 2011, p.5; Lee et al., 2012, p.450) describing the implementation of MOHO in practice outline benefits including clearly defined processes for assessment, case formulation and goal setting, enhanced person-centered practice, more effective treatment planning and strengthening professional identity for therapists.

In defining occupation based practice as enabling a person’s engagement in an occupation that a client needs, wants or is expected to do, it is clear than an understanding of a person’s participation is necessary to plan effective intervention (Twinley & Morris, 2014, p.275). Initial assessments provide a structure for and affect the direction and quality of service provision (Kramer et al., 2009, p.56). The use of assessments as outcome measures is also acknowledged as essential in establishing the effectiveness of Occupational Therapy. Coster (2008, p.743) questioned the legitimacy of traditional standardised assessments in measuring outcomes relevant to Occupational Therapy. The author criticized their focus on impairments limiting outcome measurement to improvements in body functioning with little evidence of improved participation. Bendixen and Kreider (2011, p. 357) called for a re-examination of how we measure effectiveness if we are to contribute to the knowledge regarding the benefits of Occupational Therapy in promoting participation. Within the Irish context, Stableton and McBrearty (2009, p.55) examined the tools used by Irish therapists. Their findings identified that while Irish therapists use goal achievement as their primary outcome measure, few therapists reported documenting their findings. Irish therapists also identified a challenge with communicating their clinical reasoning processes to colleagues and clients in the absence of a clear definition of their practice.

Brown and Chien’s (2010) review of assessment approaches with children concluded that theory based ‘top down’ assessment approaches provide more family centered, meaningful information across a variety of contexts. Several recent studies have highlighted the support an occupation focused assessment provides to therapists in restructuring their clinical reasoning towards occupation focused practice, enabling therapists to communicate their role more clearly within teams and facilitating more effective goal setting (Forsyth et al., 2011, p.5; Parkinson, Shenfield, Reece, & Fisher, 2011, p.148; Puttoff, 2007, p.19). The acknowledged importance of occupation focused assessments in implementing occupation focused practice has led to a growth in the development of assessments measuring occupational participation (Twinley & Morris, 2014, p.275).

A review of current occupation focused assessment tools identified several assessments developed within the MOHO that measure a child’s participation including the COSA (Child Occupational Self Assessment, Keller et al., 2005, p. 47) and the SCOPE (Short Child Occupational Profile, Bowyer et al., 2005). The SCOPE aims to provide a broad overview of children’s occupational participation and generate a profile of strengths and difficulties. This assessment tool seemed appropriate to a Primary Care context that aims to provide a first point of contact for children of various ages experiencing a wide variety of challenges as described by the Department of Health and Children (2001). The SCOPE was developed in collaboration with international practitioners as a valid and reliable initial assessment tool. SCOPE ratings are not norm or criterion referenced rather based on each child’s “individual developmental trajectory” (Bowyer et al., 2005). Bowyer et al. (2007, p.67) provided further evidence for the construct validity and reliability of the SCOPE.

METHODS

Research Aim

This study aimed to explore the use of the SCOPE initial assessment tool in primary care Occupational Therapy practice with children.

Research Objectives

(A) To explore the efficiency of administering the SCOPE.

(B) To explore if the SCOPE results provided a profile of the occupational participation strengths and needs of children.

(C) To explore if the SCOPE encouraged occupation based interventions.

(D) To explore therapists’ perspectives of using the SCOPE.
The exploratory nature of this study required the use of both qualitative and quantitative methods to examine different aspects of the overall question. A mixed methods sequential exploratory design provided the most appropriate methodological approach (Robson, 2011). Quantitative and qualitative data were collected and analysed separately producing two sets of findings. As advocated by Creswell and Plano Clarke (2007) these findings were combined in the interpretation stage of the study to answer the research question in more depth. Four data collection methods and tools were employed for the purposes of this study:

1) Demographic Questionnaire. Nominal data was gathered to place occupational participation data in context and included questions on the efficiency of using the SCOPE tool.

2) The Short Child Occupational Profile (version 2.0, Bowyer et al., 2005). The SCOPE assessment was completed following collection of information during the initial assessment process (Therapists can use interview, observation, standardised assessment and other means to gather information) providing ordinal data. The SCOPE (Bowyer et al., 2005) consists of 25 items. A four-point rating scale is used to rate each item under the domains: volition, habitation, motor skills, process skills, communication and interaction skills and environment, producing both domain and overall scores.

3) SCOPE Intervention Planning Form This template allowed for the documentation of initial intervention goals with a child following assessment and provided qualitative data.

4) Focus Group The focus group was guided by open ended questions designed to gather information regarding the perceptions of therapists using the SCOPE assessment tool. Questions were generated through a review of related literature and piloted with two therapists. The focus group was recruited and facilitated by an outside facilitator. Transcripts of the focus group provided qualitative data.

Therapists involved in data gathering for this study all participated in initial online SCOPE training. This study involved gathering data from children and colleagues which required implementing measures to address ethical concerns. The study was submitted to the Galway University Hospital Ethics committee and received approval.

Participants
Convenience sampling was employed for the purposes of this study. Two sample groups were included in this study:

1. 30 children referred for primary care Occupational Therapy were invited to participate as opened in date order from the waiting list (100% acceptance rate). The inclusion criteria was broad, reflecting the diversity of children referred to the service. The study did not attempt to control for possible confounding variables as it was exploratory in nature. This initial study was not intended to be representative; however, the sample did represent 13 % of children awaiting primary care (229).

2. Four primary care occupational therapists using the SCOPE occupational tool with children.

<table>
<thead>
<tr>
<th>Variable</th>
<th>Category</th>
<th>No</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>Average Age: 6 yrs Age Range: 7 years</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gender</td>
<td>Male</td>
<td>22</td>
<td>77.3</td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>8</td>
<td>26.7</td>
</tr>
<tr>
<td>Living Arrangement</td>
<td>Urban</td>
<td>6</td>
<td>20</td>
</tr>
<tr>
<td></td>
<td>Rural</td>
<td>24</td>
<td>80</td>
</tr>
<tr>
<td>Parents</td>
<td>Both Parents</td>
<td>26</td>
<td>86.7</td>
</tr>
<tr>
<td></td>
<td>One Parent</td>
<td>4</td>
<td>13.3</td>
</tr>
<tr>
<td>Diagnosis</td>
<td>Language</td>
<td>6</td>
<td>20</td>
</tr>
<tr>
<td></td>
<td>Difficulties</td>
<td>5</td>
<td>16.6</td>
</tr>
<tr>
<td></td>
<td>Dyspraxia</td>
<td>1</td>
<td>3.3</td>
</tr>
<tr>
<td></td>
<td>Intellectual Disability</td>
<td>2</td>
<td>6.7</td>
</tr>
<tr>
<td></td>
<td>Developmental Disability</td>
<td>None</td>
<td>16</td>
</tr>
<tr>
<td>Referrer</td>
<td>Assessment of Need</td>
<td>5</td>
<td>16.6</td>
</tr>
<tr>
<td></td>
<td>Speech &amp; Language</td>
<td>10</td>
<td>33.3</td>
</tr>
<tr>
<td></td>
<td>Psychology</td>
<td>4</td>
<td>13.3</td>
</tr>
<tr>
<td></td>
<td>Parent</td>
<td>4</td>
<td>13.3</td>
</tr>
<tr>
<td></td>
<td>G.P</td>
<td>1</td>
<td>3.3</td>
</tr>
<tr>
<td></td>
<td>Teacher</td>
<td>1</td>
<td>3.3</td>
</tr>
<tr>
<td></td>
<td>Public Health Nurse</td>
<td>1</td>
<td>3.3</td>
</tr>
<tr>
<td></td>
<td>Paediatrician</td>
<td>2</td>
<td>6.7</td>
</tr>
<tr>
<td></td>
<td>Specialist Service</td>
<td>2</td>
<td>6.7</td>
</tr>
<tr>
<td>Other Disciplines Involved</td>
<td>Speech &amp; Language</td>
<td>10</td>
<td>33.3</td>
</tr>
<tr>
<td></td>
<td>MDT</td>
<td>5</td>
<td>16.7</td>
</tr>
<tr>
<td></td>
<td>Psychology</td>
<td>2</td>
<td>6.7</td>
</tr>
<tr>
<td></td>
<td>Physiotherapy</td>
<td>3</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td>None</td>
<td>10</td>
<td>33.3</td>
</tr>
</tbody>
</table>

**Data Analysis**

Exploratory data analysis is advocated by Robson (2011) as a central approach to mixed methods design research analyses. Data gathered from the demographic questionnaire, SCOPE assessment and intervention planning form were anonymised and transferred to a data gathering sheet. This data was then transferred to an excel data analyses coding sheet. As the data is nominal/ordinal in nature, distribution free in the population and the research questions do not assume any directionality, frequency and descriptive statistical analyses were employed to answer the main research questions including measures of central tendency, dispersion of distributions and cross tabulation results. While relationships between certain constructs were explored descriptively, an experimental methodology was not appropriate given the sample group size and the exploratory nature of the research questions. Descriptive and thematic analysis was employed with data of a more qualitative nature, the SCOPE intervention
planning records and focus group transcripts. Inductive category development was used as advocated for initial exploratory studies (Tashakkori & Teddlie, 2010). Emergent themes from focus group analysis were forwarded to respondents for comment and validation. As themes emerged from the qualitative data, findings were also combined with quantitative findings in a process of triangulation (O’Cathain, Murphy, & Nicholl, 2010).

RESULTS

The findings from this study are presented in relation to the initial research objectives. Findings include both qualitative and quantitative results reflective of this mixed methodology study.

(A) To explore the efficiency of administering the SCOPE in primary care practice.

Table 2 presents the results of the amount of time therapists recorded for administering and scoring the SCOPE assessment, and the methods used to gather data. The assessment tool advises 10-20 minutes scoring time.

Table 2: Results of scoring times and methods used in SCOPE administration

<table>
<thead>
<tr>
<th>Time</th>
<th>Average</th>
<th>Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Administration Time</td>
<td>60.67mins</td>
<td>30mins</td>
</tr>
<tr>
<td>Scoring Time</td>
<td>13.5mins</td>
<td>20mins</td>
</tr>
</tbody>
</table>

Methods Used to Gather Information for SCOPE Assessment

Parental Interview 96.66 %
Clinical Observation 93.3%
Standardised Assessment 63.60%

Breakdown of Standardised Assessments Used

Movement ABC-2 70.6%
Sensory Profile 35.3%
Sensory Processing Measure 11.8%
Beery VMI 5.9%

Therapists identified two primary barriers to using the SCOPE tool efficiently in practice: (1) the MOHO language and (2) the scoring aspect.

Therapists described having to familiarise themselves again with the MOHO language to apply the SCOPE tool effectively. Therapists discussed the parent interview form and clinical observation as the core component of assessment with reduced use of performance component assessments. However, the quantitative findings suggest that therapists also used standardised assessment methods to gather data.

Therapists reported little confidence in the scoring system of the SCOPE tool as a reliable outcome measurement. Therapists queried the subjective methods of scoring the results and reported a clear preference for measuring outcomes based on goals set using the SCOPE intervention planning form.

(B) To explore if the SCOPE results provide a profile of the occupational participation strengths and needs of children accessing PCCC Occupational Therapy.

Results of SCOPE assessment domain scores and overall scores gathered for this study provide a profile of the occupational participation of the sample group. The average overall score obtained from this sample was 80.4, median score 81 with a range of 40 and standard deviation of 9.84. The lowest potential score on the SCOPE is 21 and the highest is 100. Findings of overall SCOPE scores related to demographic variables are presented in Table 3.

Table 3: Demographic Variables and Overall Average SCOPE tools. Lowest scores highlighted. (n=30)

<table>
<thead>
<tr>
<th>Variable</th>
<th>Results</th>
<th>Average Overall Score (80.4)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>3</td>
<td>71.53</td>
</tr>
<tr>
<td></td>
<td>4</td>
<td>82.60</td>
</tr>
<tr>
<td></td>
<td>5</td>
<td>77.50</td>
</tr>
<tr>
<td></td>
<td>6</td>
<td>85</td>
</tr>
<tr>
<td></td>
<td>7</td>
<td>81.60</td>
</tr>
<tr>
<td></td>
<td>8</td>
<td>77.60</td>
</tr>
<tr>
<td></td>
<td>9</td>
<td>84.40</td>
</tr>
<tr>
<td></td>
<td>10</td>
<td>80</td>
</tr>
<tr>
<td>Diagnoses</td>
<td>Developmental Delay</td>
<td>68.5</td>
</tr>
<tr>
<td></td>
<td>Mild Intellectual Disability</td>
<td>75.67</td>
</tr>
<tr>
<td></td>
<td>Dyspraxia</td>
<td>77</td>
</tr>
<tr>
<td></td>
<td>Language Difficulty</td>
<td>82.84</td>
</tr>
<tr>
<td></td>
<td>No diagnoses</td>
<td>83.29</td>
</tr>
<tr>
<td>MDT Involvement</td>
<td>MDT</td>
<td>72</td>
</tr>
<tr>
<td></td>
<td>Physiotherapy</td>
<td>76</td>
</tr>
<tr>
<td></td>
<td>Speech &amp; Language</td>
<td>78.30</td>
</tr>
<tr>
<td></td>
<td>Psychology</td>
<td>82</td>
</tr>
<tr>
<td></td>
<td>No discipline</td>
<td>87.10</td>
</tr>
<tr>
<td>Gender</td>
<td>Male</td>
<td>79.68</td>
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<tr>
<td></td>
<td>Female</td>
<td>82.38</td>
</tr>
<tr>
<td>Parents</td>
<td>Two parents</td>
<td>81.85</td>
</tr>
<tr>
<td></td>
<td>Single Parent</td>
<td>71</td>
</tr>
</tbody>
</table>
(C) To explore if the SCOPE encourages occupation based interventions.

Results from analysis of the intervention planning forms for therapy goals set are presented in Chart 1. Two or three initial goals were set with each child. Self-Care participation and development was the most frequently documented goal (18) (n=30) and accounted for the largest percentage of overall goals set 22.5% (n=80). Handwriting development was reported more frequently for children with dyspraxia and language disorders.

Chart 1: Results of the frequency of goals set (n=80)

D) To explore therapists perspectives of using the SCOPE.

Four core themes emerged from analysis of focus group data. Results of the challenges to implementing the SCOPE tool were presented in relation to Research Question 1. The remaining three themes relate to therapists’ clinical reasoning and are presented below. An interrelated theme of change is common to all themes.

(1) Occupation Focused Practice. Using the SCOPE tool in practice was described as renewing therapists’ confidence in applying occupation centred practice. Therapists spoke about occupation focused practice as ‘necessary’, ‘important’ and ‘what we do and should be doing’. Therapists discussed how the SCOPE tool provided a consistent framework within the overall department. Therapists outlined a movement away from previous practices towards a more occupation focused approach:

‘it’s emphasising our role is about function and occupation(al) performance as opposed to the components’

Therapist 2

Therapists consistently described both a change in their practice and also a change in how they communicated with others including referrers, parents and children:

‘It moves away from the medical model, even our referrals are more occupation focused after we’ve used this tool’

Therapist 4

(2) Strengths Focused

A key theme within the focus group discussion was therapists’ enthusiastic and rich descriptions of how the SCOPE enabled them as therapists to identify each individual child’s strengths and contributed to goal setting based on these strengths in a collaborative way:

The SCOPE is ‘positive for the parents to identify that their child has strengths and areas they are excelling in as opposed to areas they just need to address you know’

Therapist 1

The topic of change also emerged within this theme as therapists discussed a previous focus on identifying a child’s difficulties in the initial assessment process:

‘I would have been using more standardised assessments and you know addressing the area of difficulty the child was coming in with, rather than focusing on the bigger picture’

Therapist 2

(3) Empowerment

Therapists described how the SCOPE tool enabled them to verbalise and communicate their clinical reasoning around occupation focused practice thus increasing their confidence. Therapists discussed their reduced use of performance component assessments as a clear indication of their increased confidence. Therapists made initial suggestions of how they might introduce the SCOPE as a wider team based assessment again reflecting their confidence in the tool:

“It’s the only tool I’ve come across as an occupational therapist that delivers all the areas that we look at in a client centered way that’s relevant for the client”

Therapist 4

Overall, therapists attributed the SCOPE with enhancing their identity as occupational therapists and reaffirming their practice in occupation focused therapy. Using the SCOPE tool in practice was also described by therapists...
as empowering for parents and children. The theme of change was evident as therapists described how using the SCOPE offered a different, more positive experience for parents:

'I noticed a change in parents: by just being there and going through SCOPE...they actually came away feeling like they had achieved'

Therapist 3

DISCUSSION/RECOMMENDATIONS

This study aimed to explore the use of the SCOPE assessment in primary care Occupational Therapy practice with children.

Limitations of this study/Implications for research

The sample used in this study is small due to practice based time constraints. Inclusion of a focus group discussion with therapists prior to using the SCOPE assessment tool alongside analysis of previous assessment processes used would have been beneficial for comparative purposes. Further exploration of therapists’ clinical reasoning processes including perspectives of using standardised assessment tools, outcome measurements and the impact of assessment processes on therapists’ overall confidence in practicing occupation based therapy is highlighted in this study.

Initial findings from this study suggest that the SCOPE tool supports occupation focused therapy. Further research is required to evaluate this and will require a clearer definition of occupation focused practice to ascertain if treatment goals reflect this. Related studies have used the ICF framework as a means of evaluating occupation focused practice (Polatjko & Davis, 2012, p.259). This finding would also benefit from further analysis of actual interventions provided.

Therapists identified the SCOPE tool as an empowering tool for parents and children. Evaluation of this finding would be beneficial from both a parent and child perspective.

As an exploratory study, this study did not examine the relationships between variables and therefore the results from this study reflect this. However, initial findings suggest that the SCOPE may identify a different profile of occupational participation strengths and challenges for children with more significant difficulties. The SCOPE tool suggests that it is neither norm nor criterion referenced and therefore is not useful in comparing children but rather evaluating changes in an individual child’s occupational participation. It may be useful to consider further exploration of this finding in terms of the SCOPE’s benefits as a screening tool within a primary care setting.

Implications for Practice

The findings from this study are positive in relation to the use of the SCOPE as an initial assessment tool that promotes occupation focused practice with children and their families.

It is clear from the findings that further to the study therapists have embedded the SCOPE tool into their practice. Therapists described the tool as efficient, helpful, occupation focused and strengths focused. Results suggest that the tool provided a profile of children’s occupational strengths and challenges. The SCOPE was effective for all children within the study sample, reflecting the benefits of this tool as empowering for both parents and children. This finding is important in terms of the recent publication of the Department of Children and Youth Affairs (2013) policy framework for delivery of services to children. Supporting parents and listening to children are identified as two of the six main transformative goals.

Therapists identified the benefit of having a clearer means of communicating their ‘occupation focus’ to children, families and colleagues. Therapists described the challenges of adopting the MOHO language: however acknowledged the benefits of immersing themselves in a theory or framework. These findings suggest that the use of the SCOPE tool contributed to therapists’ ability to apply theory within their practice as described in Kramer, Bowyer, O’Brien, Kielhofner, and Maziero-Barbosa (2009, p.56).

The SCOPE tool states that it can be used as an outcome measure; therapists however described limited confidence in the tool for this purpose. Therapists reported a preference for using and reviewing the goal setting form to measure effectiveness. This is similar to the findings reported in Stableton and McBrearty’s (2009, p.60) study. Quantitative findings suggest that therapists in the study used more traditional standardised assessment tools to also gather data during the initial assessment process. It is unclear if therapists used these measures to follow up treatment progress. Therapists suggested that the subjective element of the scoring framework was the primary challenge. The SCOPE manual reiterates that it is neither criterion nor norm referenced and therefore is not useful in comparing children’s occupational participation. It may be useful to consider further exploration of this finding in terms of the SCOPE’s benefits as a screening tool within a primary care setting.

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in contributing to the profession’s knowledge regarding the effectiveness of therapy from a participation perspective.

CONCLUSION

The findings from this exploratory study concur with recent literature regarding the benefits of adopting occupation focused practices for service delivery. The SCOPE tool provided an alternative initial assessment tool that reflects the principles of occupation focused practice and proved suitable within a primary care context.

REFERENCES


EXPLORING THE CURRENT AND POTENTIAL ROLE FOR OCCUPATIONAL THERAPISTS IN MANAGING DEPRESSION IN PRIMARY CARE SETTINGS: PERSPECTIVES OF OCCUPATIONAL THERAPISTS IN IRELAND

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ABSTRACT

Background

Depression is a major public health concern. While a variety of evidence-based interventions exist there is a general reluctance for people to seek treatment. To overcome this, the integration of mental health services into primary care has been promoted for its strengths in intervening early in a less stigmatised setting. Occupational therapists, with key skills in managing depression, have an opportunity to address this public health concern within primary care.

Objective

This study sought to examine the perceptions of occupational therapists in Ireland with regards the role of Occupational Therapy in managing depression in a primary care setting.

Methods

Mixed methods were used to explore the perceptions of occupational therapists in Ireland towards assessment and intervention for depression in primary care. Primary care occupational therapists responded to a survey, and a second cohort of therapists working in community mental health engaged in qualitative interviews.

Results

A predominant focus on physical health within primary care settings was reported. Barriers to addressing depression included time and resource limitations, and strong perceived skill and knowledge gaps. Although primary care participants felt confident discussing depression with clients, just 18% felt they had the skills to intervene. The community mental health cohort provided suggestions regarding appropriate methods of assessment and intervention. Clear national guidelines were deemed critical.

Conclusion

An expanded focus within primary care beyond physical health in the context of a coordinated, national approach is essential. Resources required to facilitate this include comprehensive practice guidelines and provision of therapist education.

KEYWORDS

Depression, Assessment, Intervention, Primary Care

INTRODUCTION AND LITERATURE REVIEW

Approximately 350 million people worldwide are estimated to currently experience depression (WHO, 2012). By 2020, the World Health Organisation (WHO) predicts that depression will be the second leading cause of disability in the world, following cardiovascular
waiting list control group in the treatment of depression. Newby et al. (2013) concluded that internet based interventions are also becoming more prominent in the treatment of depressive symptoms. Internet based interventions are also becoming more effective in treating depression are behavioural activation (Barbui, Cipriani, Patel, Ayuso-Mateos, & van Ommeren, 2011), anti-depressant medications have proven efficacy in reducing depressive symptoms (Barbui, Cipriani, Patel, Ayuso-Mateos, & van Ommeren, 2011). A growing body of evidence suggests the most effective approach involves a combination of medication, lifestyle and psychological intervention (Jorm, Allen, Morgan, Ryan, & Purcell, 2013).

The annual cost of depression in terms of direct medical care is growing and estimated to cost the European economy €118 billion annually (Sobocki et al., 2007). O’Shea and Kennelly (2008) assessed the total economic and social cost of mental health problems in Ireland, of which depression is the most prevalent, at over €3 billion in that year. Luppia, Heinrich, Angermeyer, Konig, and Riedel-Heller (2007) argue that intangible costs represent the greatest loss from depression. These include pain, suffering, familial stress, disruptions in daily activities and marital breakdown.

Despite high prevalence of depression in society and growing evidence proving the effectiveness of interventions for depression, there can be reluctance amongst members of the public to seek help from mental health services. It is estimated that anywhere between 17.6 to 60.6% of individuals with minor depression seek help (Bristow & Patten, 2002). The consequences of failing to address minor depression are substantial. Systematic review of the evidence has indicated that untreated mild depression can shift into major depression (Cuijpers & Smit, 2004). Intervention to prevent escalation of depressive episodes can lead to long-term improved mental health, educational and economic participation outcomes in young adults. This was found independent of the presence or absence of physical or sensory disability (Fergusson & Boden, 2007).

Evidence-based intervention for depression

Evidence supports a number of interventions for depression, including drug therapy, psychosocial interventions, and psychological treatments. Amongst the psychological and psychosocial interventions shown to be effective in treating depression are: behaviour activation treatment (Ekers, Richards, & Gilbody, 2008), cognitive behavioural therapy (Lynch, 2010), interpersonal therapy (Cuijpers et al., 2011), and mindfulness (Piet & Hougaard, 2011). Anti-depressant medications have proven efficacy in reducing depressive symptoms (Barbui, Cipriani, Patel, Ayuso-Mateos, & van Ommeren, 2011). A growing body of evidence suggests the most effective approach involves a combination of medication, lifestyle and psychological intervention (Jorm, Allen, Morgan, Ryan, & Purcell, 2013).

Internet based interventions are also becoming more prominent in the treatment of depressive symptoms. Newby et al. (2013) concluded that internet based cognitive behaviour therapy was more effective than the waiting list control group in the treatment of depression. Baron et al. (2011) concluded that a telephone and web-based case management approach improves quality of primary care depression intervention at low cost.

Occupational therapists working in mental health settings can offer a range of evidence-based interventions for depression. Lipskaya-Velikovsky, Avrech Bar, and Bart (2014) completed a review of Occupational Therapy psychosocial interventions of over 3000 people experiencing depression. They found evidence for the effectiveness of trauma-focused therapy, sensory modulation, work-simulation activities, exposure therapy, and lifestyle interventions such as writing and performing music, physical exercise, and stress management. Bullock and Bannigan’s (2011) systematic review indicates that Occupational Therapy intervention combined with appropriate medications was associated with improvements in clients’ perceptions of occupational performance and interpersonal relationships. Occupational therapists provide psychosocial interventions such as education in problem solving, daily living skills, routine and role development, and stress management. These are amongst the interventions strongly advocated in the treatment of mild depression according to the National Institute for Clinical Excellence (NICE) guidelines (2004).

Depression and Primary Care

In a bid to combat this global mental health crisis, the WHO has recommended the integration of mental health services into primary care ensuring people with milder disorders receive the treatment they require (WHO, 2008). WHO (2008) defines primary care for mental health as mental health services that are integrated with generalized health services in the community. All mental health disorders can be addressed at primary care level, including those that co-exist with physical health issues (WHO, 2008). Provision of opportunities for the treatment of depression in primary care not only reduces the stigma associated with mental health services but circumvents the possibility of long-term disability as people received more timely diagnosis and intervention (WHO, 2003). Optimal use of both primary and secondary care mental health service occurs when an individual can access the support they need at the ‘lowest possible’ level of care suitable to their needs (McDaid, 2013). Early detection and intervention in mild or sub-threshold depression at primary care level can help prevent the development of a depressive disorder and related social, functional and economic consequences (Cuijpers & Smit, 2004).

In Ireland, the Primary Care Strategy 2001 highlighted the potential for primary care teams to deliver generalist mental health services (DoHC, 2001). It is estimated that the primary care system addresses 90% of all mental health issues in the Irish context (McDaid, 2013). The ‘Vision for Change’ policy of 2006, set a direction for Irish mental health and described the ‘pivotal’ role for providing mental health care at primary care level. It also advocated for all staff to be trained in the provision of both preventative and health promoting intervention (DoHC, 2006). It also suggested that all individuals have...
access to a comprehensive range of intervention at primary care level, for disorders that do not require specialist mental health care (DoHC, 2006, p. 68).

Occupational therapists hold an established position in the provision of multi-disciplinary primary care internationally. Occupational Therapy intervention has an identified role in the treatment of mental health issues at primary care level, yet research suggests that occupational therapists in primary care are focusing primarily on physical illness. An unpublished qualitative study by Fitzgibbon and Chockalingham (2010) found that Irish primary care was primarily physically focused with limited provision of mental health interventions. Primary care settings offer an opportunity for the Occupational Therapy profession to work within the broader definition of health framework, yet Irish practice appears to continue to focus on specific aspects of predominantly physical health. A 2011 nationwide consumer consultation in Ireland (McDaid, 2013, p.2) has highlighted significant issues regarding provision of mental health care via the primary care system. A major concern included the dominance of the medical model of treatment whereby medication was the sole option offered. The findings of this consultation report support the need for lifestyle and occupation-focused interventions with people who experience depression and present to primary care settings.

There is a high prevalence of depression in primary care settings. Interventions in these settings are effective in the treatment of depression and Occupational Therapy has a prominent role in providing evidence-based interventions. This study sought to examine the current and potential role of Irish occupational therapists in primary care settings assessing and providing intervention with client groups experiencing depression.

**RESEARCH AIM**

The study aimed to identify the current barriers and enablers to occupational therapists in Irish primary care settings addressing depression within their practice. It sought to explore the potential role for occupational therapists addressing depression in primary care settings by exploring the opinions of two specific Occupational Therapy groups: primary care occupational therapists (PCOT) and community mental health occupational therapists (CMHOT).

**Figure 1: Research structure**

<table>
<thead>
<tr>
<th>Research Question</th>
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<tbody>
<tr>
<td>Quantitative Study</td>
</tr>
<tr>
<td>Cross Sectional Study - survey</td>
</tr>
<tr>
<td>Primary Care OTs N=39</td>
</tr>
<tr>
<td>Qualitative Study</td>
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<tr>
<td>Semi-structured interview</td>
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<tr>
<td>Community Mental Health OTs N=10</td>
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</tbody>
</table>

**RESEARCH QUESTIONS**

**Primary Care Occupational Therapists (PCOTs)**

* How confident are PCOTs in assessment and intervention for depression in primary care settings?
* What are the barriers to addressing depression in primary care settings?
* What do participants believe would enable them to treat depression within primary care settings and contribute to improved competence in this area?

**Community Mental Health Occupational Therapists (CMHOTs)**

* What do CMHOTs perceive the role of PCOTs to be when assessing and intervening for depression?
* Which specific methods of assessment and intervention for depression do CMHOTs feel are appropriate for use in the primary care setting?
* What do CMHOTs suggest that the potential Occupational Therapy role involve, working with depression in primary care settings?

**METHODS**

Following ethical approval by the Department of Occupational Therapy Ethics Committee at the National University of Ireland Galway, data was collected between January and March 2011.

**Primary Care Occupational Therapists (PCOT)**

Capturing the views of PCOTs was considered essential to meet the aims outlined for this study. A quantitative research design using a cross sectional study design using a survey was employed to collect data from this cohort. An unpublished non-standardised survey was developed in line with recommendations from Meadows (2003) and Stone (1993) utilising findings from qualitative research (Fitzgibbon & Chockalingham, 2010) as well as a literature review on the topic. A pilot study was conducted with eight occupational therapists in terms of administrative ease and revisions were made as a result. This included removing questions not specific to the study aims and reformatting the questionnaire to promote ease of use.

Participants were recruited via the Primary Care Support Network (PCSN) as well as by contacting Occupational Therapy managers in primary care in the Health Service Executive (HSE) across Ireland. The PCSN is a support network for allied health professionals in Ireland. Inclusion criteria required participants to be currently employed as a PCOT for a minimum of one year.

Completion of the survey, which included a participant information sheet detailing ethical considerations, was an indication of consent to participate. The survey was distributed by email and a reminder email was sent two weeks after the initial email to recruit additional participants. Descriptive statistics were used to
summarise response frequencies. Statistical Package for the Social Sciences (Version 18) was used to test for relationships in data variables.

Community Mental Health Occupational Therapists (CMHOT)

Qualitative methodology, namely semi-structured interviews were used to explore the research topic for CMHOTs. A topic guide was formulated based on literature in the area and following completion of three pilot interviews. The concept of reflexivity (Denscombe, 2003; DePoy & Gitlin, 1998) was used to control for research bias throughout the data collection process. This involved the researcher keeping a diary of personal beliefs and attitudes to reduce personal bias. Interviews were open-ended and lasted between 12 and 35 minutes. With the aim of data saturation, ten participants took part in the study. Interviews were audio recorded and field notes were kept to minimise further bias during data collection. Interviews were transcribed verbatim by the primary researcher (third author). Content analysis (Hsieh & Shannon, 2005) was used to organise the interview data. The framework approach (Ritchie & Spencer, 1993) was used consisting of five stages of analysis including familiarisation, identifying a thematic framework, indexing, charting and interpretation. Community mental health services are considered specialist community-based mental health settings and as such, form part of the secondary care system in Ireland. CMHOTs work within this secondary care system and were recruited by contacting Occupational Therapy managers. Inclusion criteria required that occupational therapists were currently working in community mental health and had a minimum of one year’s postgraduate experience in mental health services.

RESULTS

Table 1 highlights the demographic characteristics of participants in these studies.

Quantitative results

Fifty PCOTs participated in the study. Eleven were excluded due to incorrectly completed surveys, therefore 39 participant data sets were analysed. The response rate was 78%.

All participants were female with 41% in the age range of 20-30 years. The majority of respondents surveyed were qualified less than five years. Over 90% of participants had completed an undergraduate mental health fieldwork placement while less than 50% had experience in secondary-care level mental health settings as a qualified occupational therapist. 25% of participants had postgraduate training with a mental health component.

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>PCOT* N=39 (%)</th>
<th>CMHOT* N=10 (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td></td>
<td></td>
</tr>
<tr>
<td>-Female</td>
<td>39(100)</td>
<td>8(80)</td>
</tr>
<tr>
<td>-Male</td>
<td>2(20)</td>
<td></td>
</tr>
<tr>
<td>Age</td>
<td>9.7</td>
<td></td>
</tr>
<tr>
<td>-Mean</td>
<td>34.7</td>
<td></td>
</tr>
<tr>
<td>-Range</td>
<td>23-56</td>
<td></td>
</tr>
<tr>
<td>Standard Deviation</td>
<td>9.7</td>
<td></td>
</tr>
<tr>
<td>Years qualified</td>
<td></td>
<td></td>
</tr>
<tr>
<td>-0-5</td>
<td>19(48.7)</td>
<td>5(50)</td>
</tr>
<tr>
<td>-6-10</td>
<td>3(7.6)</td>
<td>3(30)</td>
</tr>
<tr>
<td>-11-20</td>
<td>8(20.6)</td>
<td>1(10)</td>
</tr>
<tr>
<td>-21-30</td>
<td>1(2.5)</td>
<td>1(10)</td>
</tr>
<tr>
<td>-Mean</td>
<td>11.7</td>
<td>7.5</td>
</tr>
<tr>
<td>-Range</td>
<td>1.5-34</td>
<td>1.5-25</td>
</tr>
<tr>
<td>Working Region</td>
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<td></td>
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<tr>
<td>-HSE South</td>
<td>5(12.8)</td>
<td></td>
</tr>
<tr>
<td>-HSE West</td>
<td>14(35.8)</td>
<td>1(10)</td>
</tr>
<tr>
<td>-HSE Dublin North East</td>
<td>7(17.9)</td>
<td></td>
</tr>
<tr>
<td>-HSE Dublin Mid-Leinster</td>
<td>13(33.3)</td>
<td></td>
</tr>
<tr>
<td>Mental Health Experience</td>
<td></td>
<td></td>
</tr>
<tr>
<td>-Undergraduate</td>
<td>37(94.9)</td>
<td></td>
</tr>
<tr>
<td>-Postgraduate work experience</td>
<td>17(42.6)</td>
<td></td>
</tr>
<tr>
<td>-Postgraduate Ed in mental health</td>
<td>10(25.6)</td>
<td></td>
</tr>
<tr>
<td>-Primary care experience</td>
<td>39(100)</td>
<td>2(20)</td>
</tr>
</tbody>
</table>

*PCOT = Primary Care Occupational Therapist
*CMHOT = Community Mental Health Occupational Therapist

Confidence in the assessment and intervention of Depression in Primary Care

PCOTs believed that depression should be addressed at primary care level. However there was uncertainty with regards to what extent depression was being addressed by Primary Care teams. There was a perceived reluctance at a service level to address depression in practice with a predominant focus on physical health.

Although PCOTs were somewhat comfortable with recognising depression, confidence in assessing and providing intervention for depression was low. The majority of respondents (56.4%) rated their ability to recognise a client with depression as ‘good’ and felt comfortable (74.3%) talking about depression with them. Only 33.4% felt they had assessment skills while just 17.9% of participants believed they had the required intervention skills. However, 76.9% of the cohort felt they could provide this intervention for depression if given adequate support and training.

Barriers to addressing depression

The biggest perceived barrier to addressing depression was the prioritisation of physical health needs (84.6% of respondents). Further barriers were: lack of time (79.5%), lack of training (79.5%) and a dearth of national guidelines (71.8%). Lack of knowledge (51.3%) and insufficient availability of screening tools (56.4%) was also highlighted by over half the cohort.

Ninety per cent of participants in this cohort were interested in addressing depression in primary care. The majority (87.2%) of respondents felt a presentation to
primary care for depression merited an Occupational Therapy assessment if functional performance was affected. A large percentage (86.4%) of participants felt that other healthcare professionals have a limited view of the scope of Occupational Therapy with one third of respondents believing that this could also be said of other occupational therapists. Most (94%) of respondents reported that Occupational Therapy should not solely focus on physical problems but 79.5% of participants felt that role of Occupational Therapy in managing the condition is unclear.

The majority (84%) of participants have previously referred a client to another service because of depression. The General Practitioner (GP) was the most common referral (76.9%) with Community Mental Health Nurse (41%), Social Worker (38.5%) and Community Mental Health Occupational Therapist (35.9%) the next most frequent professionals to refer to. A large percentage (74.4%) of participants felt there were factors impeding onward referrals. Barriers cited included: strict referral pathways, stringent referral criteria, lack of services, lack of communication between services, lack of knowledge on behalf of the therapist of mental health teams, and clients not wishing to be referred to secondary services.

No statistical difference was found between groups in terms of age, years qualified, working region or mental health experience.

Factors to improve competence

Participants believed that training and professional development were required to enable them to treat depression. Most (69%) of the participants thought this was needed to aid with assessment and 64% felt this was needed for intervention. Other factors included support at managerial and peer level and an increase in allocated intervention time to address depression with specific clients. Standardised pathways with guidelines on interventions for assessment and intervention were suggested and a deviation away from physically focused care to a broader view of client health.

Qualitative Results

Ten CMHOTs took part in the study, eight females and two males. Experience of participants ranged from 1.5 to 25 years with 50% qualified less than five years. All participants worked in adult community mental health, with the exception of one therapist working with child and adolescent groups. Two CMHOTs had previous experience in a primary care setting.

CMHOT perspectives on Occupational Therapy intervention in depression in primary care settings.

In tune with the philosophical underpinnings of the Occupational Therapy profession, participants agreed that addressing both mental and physical health needs within primary care settings is an opportunity for the profession. Qualitative findings indicate that intervention at primary care level can offer a number of benefits, including: the opportunity for early, timely intervention; care broader than pharmacological therapy; intervention in a less stigmatised setting; and the possibility to accept referrals from secondary and acute services, within certain criteria.

“... often we’re seeing clients when they become too ill and I think if they had had a little bit of preventive work maybe....they might have had a better chance at recovery” (p.6).

Various criteria for determining appropriate referral from secondary or acute care to primary care Occupational Therapy were suggested, encompassing severity of illness including level of fluctuation, functional impact, and level of risk and duration of illness. Participants felt that primary care intervention has a preventative function as well as having the potential to prevent the need for escalation to secondary or acute care.

“...maybe from the client’s point of view then they’d be better off because they weren’t in a mental health setting, and there is still stigma no matter how much we pretend there isn’t” (p.9).

The line between primary and secondary care was conceptualised by participants in terms of a specialist/generalist divide. Primary care clinicians could address general mental health concerns and the community mental health therapists would be in a position to address more complex presentations in the community. Acute care was considered psychiatric hospital-level care.

“I’d imagine my (CMHOT) role being a more specialist role” (p1.).

Methods of assessment and intervention for depression

CMHOTs gave suggestions with regards the assessment and intervention process in a primary health care setting. There was consensus that assessment should be occupational in focus and involve a functional viewpoint. Assessments proposed included the suite of Model of Human Occupation (MOHO) (Kielhofner, 2008) assessments, the Canadian Measure of Occupational Performance (Law et al., 2005), Mayers Lifestyle Questionnaire (Mayers, 2003), as well as generic symptom-focused assessments such as the Beck Depression Inventory-II (BDI-II) (Beck, Steer, Ball, & Ramien, 1996).

Participants felt interventions at primary care level should be brief and occupational in nature. Specific interventions could include teaching of skills and strategies for daily living, time planning and management, education surrounding depression, problem solving skills, vocational interventions and mindfulness. Group work was also suggested by participants focusing on interventions such as the Wellness and Recovery Action Plan (WRAP) (Copeland, 1997).
Developing Occupational Therapy role for depression in primary care settings

“OTs on the primary care teams so far seem to be primarily working with the physical clients” (p9)

There was a perception amongst CMHOTs that the main focus within primary care was towards physical health and that there was a reluctance to address depression in the sector. Barriers relating to the structure of the PCOT role were identified, including limited time, large caseloads and a perception that mental health interventions were more time consuming that physical health needs. Knowledge gaps and limited confidence in mental health skills were identified by CMHOTs as potential barriers to PCOTs in addressing mental health concerns. Training was suggested as a possible solution to this.

A standardised referral process with clear referral criteria was identified as a need. Currently, a lack of clear referral process leads to inappropriate referrals to, and between, both primary and secondary care levels. CMHOTs felt there may be a potential for a referral pathway to request the assistance of PCOTs for brief interventions for maintenance and relapse prevention role.

“They should still be on the psychiatrist’s book, so that there is that back up and so they’re known to the service” (p1).

Participants highlighted a number of developments that would be needed from an organizational and governance perspective to support PCOTs in addressing client mental health concerns. These included practice guidelines and clear communication pathways and boundaries in terms of the remit of primary care. At service-delivery level, strategies are needed to address confidence, provide supervision and shadowing opportunities, and address training needs such as suicide prevention training, risk assessment, and brief interventions.

“we need guidelines so we are clear on what their work would be and then what our work would be..” (p3.).

DISCUSSION

This study sought to examine the perceptions of occupational therapists on the current and potential role of Occupational Therapy in managing depression in primary care. A number of interesting themes emerged including the predominant focus on physical health in primary care and the added barriers of time and resources to provide this level of care. In the event depression was to be addressed at this level, participants felt that practice guidelines would need to be developed, offering clear understandings of the scope of the Occupational Therapy role at primary and secondary care levels. Practice guidelines also need to articulate the Occupational Therapy specific focus of care.

Early intervention for depression in primary care settings

As advocated by the WHO (2008) both PCOTs and CMHOTs in this study agreed that addressing depression in primary care offered the opportunity to intervene early, the provision of a less stigmatised service and one that focuses on prevention. There was consensus amongst participants that brief, occupation-focused intervention could yield optimal outcomes. This is consistent with evidence derived from the literature. For example Duhoux, Fournier, Gauvin and Roberge (2013) concluded that even one focused brief intervention, as defined in clinical guidelines for a major depressive episode in the previous 12 months, was associated with greater improvements in depression symptoms at 6 and 12 months. This was when a psychosocial intervention was combined with pharmacotherapy, and psychotherapy was combined. It points to the fact that brief evidence-based intervention delivered with adequate competence could result in positive health outcomes for consumers. Significant workforce capacity building is required prior to implementing screening and early intervention for depression in primary care (McDaid, 2013). Adequate training, capacity building and clear intervention strategies need to be developed to ensure quality services when addressing depression in the primary health care sector.

The influence of health professionals’ attitudes and priorities in primary care

As concluded in the qualitative study by Fitzgibbon and Chockalingam (2010), both PCOTs and CMHOTs in this study identified the current overwhelming focus on physical care in primary care practice. This is resonant with results found by Aas and Grotle (2007) who concluded that the majority of clients of occupational therapists in primary care had chronic diagnoses, most notably cardiovascular disease and neurological and musculoskeletal disorders, with only 13% of the most frequent principal diagnoses being mental disorders. Although there was willingness amongst occupational therapists who participated in this study to address depression in primary care, qualitative findings indicate that it is unclear if willingness applies uniformly to all therapists working in primary care, with confidence, skill level, role uncertainty and time constraints identified as factors influencing attitudes to managing depression. Nutting, Rost, Dickinson, Werner, and Dickinson (2002) found that depression was often sidelined as physical health conditions were seen as higher priority. They revealed a perception amongst participants that mental health conditions would be more time consuming to treat and participants did not have the time to invest in this. Baik, Crabtree, and Gonzales (2013) identified a perception amongst clinicians that addressing depression was a complex task and sometimes beyond the scope of the role; this perception becomes a barrier to intervention. This study found that clinicians identified lengthy negotiations requiring significant time and emotions on behalf of the clinician to engage a client in the process of mental health seeking help. They identified how addressing physical health conditions was more
manageable in this regard (Baik et al., 2013). These examples from the literature combined with findings from this study highlight the potential for low-level or emerging depression to be overlooked by occupational therapists in primary care settings, particularly when mental health was not the primary reason for referral.

**Perceived Skill deficit as a barrier**

The lack of perceived skills to address depression was evident amongst occupational therapists who participated in the study. Only 25% of participants identified having completed postgraduate study with a mental health component. Similarly, Naji et al. (2004) found that 25% of their practice nurse sample working in primary care in Scotland had postgraduate training with a mental health focus. In this study, GPs and Public Health Nurses (PHN) who had received training reported a higher proportion of their patients had a mental illness and had a better awareness of mental health problems. They were less likely to refer to specialist services. Although a recommendation from the Irish policy document ‘A Vision for Change’ was to provide training to primary care staff, McDaid (2013) reports this training has only been provided to 100 primary care professionals to date.

Although 74.3% of the primary care cohort felt comfortable talking about depression with their clients, only 34% felt they would have the necessary skills to assess for it and 17.9% to intervene for it. However, there are a number of authors who question whether the assessment and intervention for depression is as complex as perceived by clinicians (Bland & Streiner, 2013; Thomas & Ziegelstein, 2013). Ayalon, Goldfracht, and Bech (2010) compared a single item question “do you think you suffer from depression?” with existing depression screening tools and found that the single item question has as good or better sensitivity (83%) than all other screens. This would suggest that merely asking this question can be a good start in the assessment and subsequent provision of intervention for depression in primary care. Custom-designed professional development opportunities are required to build occupational therapist skill and confidence in providing brief, effective, occupation-focused interventions.

**The line between primary and secondary care**

Baik et al. (2013) completed a qualitative study exploring how primary care clinicians address mental health issues in practice. Similar to this study, these included clinicians’ clinically judged severity and cause of the condition, patients’ preference of treatment option, clinicians’ comfort level in dealing with depression, access to professional support network and time. They also identified presentations that could be dealt with in a primary care setting including mild depression, with a low functional impact and of potentially short duration. The issues of time constraints in addressing mental health concerns is highlighted across the literature, and participants in this study agreed that mental health interventions can require time investment and this is challenging in practice. Strong clinical leadership, including support and supervision of PCOTs, is needed to enable staff effectively intervene and refer to secondary care where necessary.

**Broader systemic barriers and enablers**

Participants in this study called for clear practice guidelines on addressing depression in primary care in Ireland, from an Occupational Therapy and primary care team perspective. From a systemic perspective, the Mental Health Commission (MHC) in Ireland identified that currently there are inadequate guidelines to develop a clear approach and philosophy to mental health care in Ireland (MHC, 2008). McDaid (2013) identifies the need for a national approach to the coordination between mental health services and primary care. She reports options that are being considered including a ‘shared care’ model enabling primary care managed mental health clients with the support of the secondary care system. Glied, Herzog, and Richard (2010) suggest that depression can be managed through the adaptation of principles of chronic disease management already established in primary care settings, including longitudinal tracking and care management services coupled with specialist consultation.

Current models of primary care in Ireland may be a limiting factor to occupational therapists providing effective mental health support and intervention, and the findings of this study indicate it may be worth exploring alternative models alongside developing the existing structures. Models that provide pathways directly to psychological and lifestyle interventions, including Occupational Therapy, in primary care settings by self-referral or referral by GP, are gaining support. For example, in the Australian setting, the ‘Better access to mental health’ initiative enables clients to access occupational therapists by GP referral (Department of Health Australia, 2014). In the United Kingdom (UK), the ‘Improving Access to Psychological Therapies’ initiative, which includes occupational therapists as providers of evidence-based mental health interventions in a primary care setting, has reported a recovery rate averaging 40% with individuals experiencing depression and anxiety (Clark, 2011). Both the Australian and UK example highlight the need for occupational therapists to advocate for such approaches in an Irish context. Further, internet-based mental health interventions are a potential avenue for providing Occupational Therapy mental health intervention at primary care level that is as yet unexplored in the Irish context.

**Limitations**

In the quantitative study, the use of non-purposive sampling is a significant limitation to which the high level of interest expressed by participants in the management of depression could be attributed. Findings should be interpreted with caution as it is likely that self-selected participants had a pre-existing knowledge or interest in mental health matters.

The low rate of male participants is an additional limitation. The use of a non-standardised questionnaire
with no proved reliability or validity is an additional limitation.

The questionnaire did not address whether participants actively provide intervention for depression at present. Future research should determine to what extent therapists do provide intervention.

CONCLUSION

This study sought to examine the role of Occupational Therapy in addressing depression at a primary care level. With a strong physical health focus within the sector, participants agreed there was an opportunity for Occupational Therapy to address depression at primary care level particularly with early intervention with reduced stigma. While therapists felt confident in assessing for depression, the perceived confidence in intervening was low. Participants agreed there is a need for occupational therapists to develop this role through clearer practice guidelines, supervision and support, and professional development opportunities directly addressing depression. Broader systemic issues influence Occupational Therapy practice in primary care, including team-level scope of practice, and the need for a defined role for therapists within primary and secondary level care. This study contributes to a growing body of evidence highlighting the potential positive contribution of Occupational Therapy in managing depression in primary care settings.

REFERENCES


CONSTRUCTING PERSONAL PHILOSOPHIES OF PRACTICE USING HABERMASIAN KNOWLEDGE DOMAINS

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ABSTRACT

As practitioners enter the profession and move through their careers, they require a tool to assist them in critical reflection on how and why they practice Occupational Therapy. In this article, the authors explain the origin and use of a framework for constructing personal philosophies of practice as derived from the technical, practical, and emancipatory knowledge domains of philosopher Jürgen Habermas. This article provides specific guiding questions and a template for creating personal philosophies of practice. Also included is discussion of the challenges inherent in writing personal philosophies of practice, as well as the benefits of use for both practitioners and clients. Occupational Therapy providers need a way to frame critical reflection on the match between their fundamental values and beliefs and the actual state of their practice. Personal philosophies of practice are powerful tools to enable practitioners to improve practice and client outcomes through critical and reflective thinking.

KEYWORDS

beliefs, education, philosophy, professional practice, values

INTRODUCTION

Occupational therapists are socialized to practice by a wide variety of core concepts and skills; chief among these include evidence-based practice, client-centered practice and critical thinking (World Federation of Occupational Therapists, 2011). Given the growth of Occupational Therapy programs and new therapists over the past decade, the quality of practice across time is an important element that requires constant evaluation (McKinstry & Fortune, 2014). This evaluation of practice is valuable for self-improvement as well as supporting ongoing assessment of professional competence. Occupational Therapy has long embraced and adopted the need for practitioners to be ‘critical’ in domains of knowledge, self and the world, in addition to varying levels of criticality (Barnett, 1997). Robertson, Warrender, and Barnard (2015) elaborate on the need for reflective thinking and critical reasoning in order to become an expert practitioner, but do not offer a specific mechanism on how therapists can build these vital skills. Barnett (1997) cites specific activities like peer reviewing, publishing, mentoring, professional development and evidence evaluation as building critical reasoning and critical reflection. However, these important activities may be variably accessible to practitioners depending upon level of experience and existing technology, resources, and professional networks. We propose that practitioners need a self-driven mechanism to deliberately and critically examine their beliefs and values surrounding their practice of...
Occupational Therapy, a vital but missing activity. We describe how personal philosophies of practice can serve as tools to enable occupational therapists to thoughtfully engage in critical reflection. We outline a theoretical foundation based upon Jürgen Habermas’ three domains of knowledge to frame and organize the content of a personal philosophy of practice. Finally, we propose a template to guide the development and writing of the statement for use in career-long reflective practice.

The Need for Personal Philosophies of Practice

While writing a personal philosophy of practice may not be commonplace in Occupational Therapy, writing philosophies of teaching in schools and higher education is an established practice for professional development and in making hiring decisions (Brookfield, 2006; Goodyear & Allchin, 1998). Teaching philosophies require educators to consider the “big” questions surrounding the teaching and learning experience, such as “why do I teach?” and “how do I know when I’ve taught successfully?” (Goodyear & Allchin, 1998; O’Neal, Meizlish, & Kaplan, 2007). Thoughtful consideration of these sorts of questions develops educators’ skills as reflective and critical practitioners in the classroom. Philosophies of practice are equally valuable for healthcare practitioners, offering critical scaffolds for development. Quality philosophies of practice facilitate development in three comprehensive ways (O’Neal, Meizlish, & Kaplan, 2007; Osterman & Kottkamp, 1993). First, they offer evidence of critical thinking by illustrating how professionals reflect on their practice. Second, they express reflectiveness and demonstrate a desire to enhance the quality of their work. Third, they convey enthusiasm and commitment to practice as a valued priority. Ann Wilcock (2000) adds a fourth developmental aspect specific to Occupational Therapy - using a personal philosophy of practice to illustrate how occupation is embedded within one’s belief system and mental schemas.

Professional programs in pharmacy and medicine are requiring new graduates and residents to prepare personal philosophies of practice as they embark on their careers (Leinum & Trapskin, 2011; Svenaeus, 2001). More importantly, this statement is not a recapitulation of information found in a resume or curriculum vitae. A philosophy of practice is intended to serve two fundamental purposes. It serves as a guidepost for the practitioner as they work and gain knowledge and expertise in the field. It also functions as a reflective tool to examine whether the current position fits with an ideal or desired practice, whether career goals are fulfilled or if there is satisfaction with the current path. A philosophy of practice can be a powerful tool to assist practitioners in performing their roles more effectively, thoughtfully, and in alignment with their personal beliefs (Kinsella, 2001). While personal philosophies of practice are being utilized more and more across different professions, the philosophical foundation and template to create a philosophy of practice is lacking in the Occupational Therapy literature.

Habermasian Knowledge Domains

Jürgen Habermas is a philosopher and sociologist associated with the later Frankfurt School, where he enhanced the existing critical theory approach by incorporating more focus on communication, pragmatism and democracy (Geuss, 1981; Terry, 1997). Habermas (1971) provided a model of human interests that corresponds to three areas of knowledge: technical, practical, and emancipatory (see Table 1). Technical knowledge (knowing “that”) is exemplified in the natural sciences, where prediction and control over the environment are key factors. This type of knowledge is empirical, analytical, produces information, and has explanation as its goal (Scott, 1978). In Occupational Therapy, technical knowledge includes environmental, developmental and occupational theory, applied anatomy and neuroscience, research, statistics, and psychology. Practical knowledge (knowing “how”) is interactive, interpretive, and integrative. It is typically represented within the social sciences and focuses on understanding practical relevance and the meaning of everyday life events. Practical knowledge is illustrated in Occupational Therapy within the therapeutic encounter itself through transfer skills, communication, assessment, activity analysis, clinical reasoning, and intervention strategies. Emancipatory knowledge (knowing “why”) involves expanding possibilities and effecting beneficial change, processes initiated with critical reflection. It is informed by a social justice schema which values awareness, critique of the status quo and transformational action or change. The emancipatory aspects of Occupational Therapy include empowerment, ethical self-monitoring, client-centered care, policy development/revision, and advocacy on multiple levels. A particular strength of the Habermasian framework is its attention to the emancipatory domain, which is frequently minimized in professional education and continuing education activities.

<table>
<thead>
<tr>
<th>Domain</th>
<th>Knowledge Type</th>
<th>Goal</th>
<th>Context</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Technical</td>
<td>Instrumental</td>
<td>Explanation</td>
<td>Science/Technology</td>
<td>Theory</td>
</tr>
<tr>
<td>Practical</td>
<td>Interpretive</td>
<td>Understanding</td>
<td>Everyday Life</td>
<td>Therapeutic Skills</td>
</tr>
<tr>
<td>Emancipatory</td>
<td>Critical</td>
<td>Reflection/Change</td>
<td>Social Justice</td>
<td>Advocacy</td>
</tr>
</tbody>
</table>

Creating a Personal Philosophy of Practice

Personal philosophies of practice can be broken down into three major categories: core professional values, therapeutic style and beliefs, and assessing outcomes and quality. Practitioners should limit their philosophy of practice to approximately two or three pages, avoid excessive use of professional jargon or technical terms, and write in a narrative, first person format. The philosophy statement should be reflective and personal, and should clearly explain why and how one practices. In Table 2 below we offer a suggested template for developing a personal philosophy of practice; including...
specific guiding questions and their respective categorization in the technical (T), practical (P), or emancipatory (E) domains of knowledge. Students and practitioners can use the responses to the template questions as the basis for constructing their personal philosophies of practice.

Table 2: Personal Philosophy of Practice Template

<table>
<thead>
<tr>
<th>Core Professional Values</th>
<th>Emancipatory</th>
<th>Practical</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Why did you enter the profession of Occupational Therapy?</td>
<td>Emancipatory</td>
<td>Practical</td>
</tr>
<tr>
<td>b. How do you define health and well-being?</td>
<td>Emancipatory</td>
<td>Practical</td>
</tr>
<tr>
<td>c. What about being an occupational therapist is rewarding to you?</td>
<td>Emancipatory</td>
<td>Practical</td>
</tr>
<tr>
<td>d. What basic principles or theories underpin your therapeutic approach?</td>
<td>Emancipatory</td>
<td>Practical</td>
</tr>
<tr>
<td>e. What is your definition of “effective therapy”?</td>
<td>Emancipatory</td>
<td>Practical</td>
</tr>
<tr>
<td>f. How do people learn?</td>
<td>Emancipatory</td>
<td>Practical</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Therapeutic Style and Beliefs</th>
<th>Technical</th>
<th>Practical</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. How are you unique as a therapist?</td>
<td>Technical</td>
<td>Practical</td>
</tr>
<tr>
<td>b. How do you establish rapport with clients?</td>
<td>Technical</td>
<td>Practical</td>
</tr>
<tr>
<td>c. How do you facilitate learning?</td>
<td>Technical</td>
<td>Practical</td>
</tr>
<tr>
<td>d. What expectations do you have of clients?</td>
<td>Technical</td>
<td>Practical</td>
</tr>
<tr>
<td>e. Describe preferred therapeutic strategies you frequently use.</td>
<td>Technical</td>
<td>Practical</td>
</tr>
<tr>
<td>f. What are your career goals?</td>
<td>Technical</td>
<td>Practical</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Assessing Outcomes and Quality</th>
<th>Technical</th>
<th>Practical</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. What are your goals for clients?</td>
<td>Technical</td>
<td>Practical</td>
</tr>
<tr>
<td>b. Describe how you address change in professional endeavors.</td>
<td>Technical</td>
<td>Practical</td>
</tr>
<tr>
<td>c. How do you assess/improve your performance?</td>
<td>Technical</td>
<td>Practical</td>
</tr>
<tr>
<td>d. What strategies benefit your learning and development as an occupational therapist?</td>
<td>Technical</td>
<td>Practical</td>
</tr>
<tr>
<td>e. What are your career goals?</td>
<td>Technical</td>
<td>Practical</td>
</tr>
<tr>
<td>f. How do you define your role in the context of interprofessional teams?</td>
<td>Technical</td>
<td>Practical</td>
</tr>
</tbody>
</table>

**Overcoming Challenges in Drafting a Personal Philosophy of Practice**

Leinum and Trapskin (2011) discuss two major challenges in drafting a philosophy of practice: finding a balance between idealism and practice and overcoming initiation issues. The first challenge highlights situations where the fledgling practitioner may have high aspirations and unrealistic goals, while the experienced practitioner may be burned-out or jaded thus suppressing their values, vision or professional goals. The second challenge lies in starting or completing a statement. Many professionals have not purposefully reflected on how they ply their trade and what specific influences drive their everyday decisions, much less with the added complication to condense all those big thoughts into a roughly two-page statement (Kinsella, 2001). Therefore, initiating the personal philosophy statement can be a daunting task that requires time to collect one’s thoughts and relevant theoretical and philosophical support from the literature. In either case, the need to find a balance and clarity in drafting an honest philosophy of practice could be met through discussions with colleagues, teachers, mentors or practitioners working in the field. While introspection may aid in exploration of values, beliefs and roles, conversations with others may support distilling and synthesizing the personal and professional information needed to draft a statement. The statement will require revisions and numerous iterations for a strong presentation. One can create a philosophy statement at any time during the career path; however, we suggest that Occupational Therapy students should begin drafting a philosophy of practice during their first semester of coursework. The statement should be revisited every semester as new knowledge and experience will undoubtedly shape how the student thinks about and approaches practice. In addition to teachers and practitioners, the student can also consult with their peers. Students should explore themes including the role of Occupational Therapy in health care, the role of the therapist, the role of the client, the role of the employing institution, interventions used, evidence guiding use of specific interventions and effectiveness, and personal assessment of work performance. It is intended that the combination of classroom and fieldwork experiences will create rich alternative resources to support drafting a philosophy of practice to answer many of the questions outlined before the student graduates.

**Using a Personal Philosophy of Practice to be a Reflective and Ethical Practitioner**

A personal philosophy of practice is a positive and self-motivating statement from a practitioner that describes how they envision practice and what practice means to them. The statement describes their personal and professional values, theories supporting their practice perspective and their unique approach to practice. The philosophy of practice is a foundation for practice which creates internal awareness to one’s personal methods and approach to treating clients. The philosophy of practice is critical in shaping how one creates career goals which are aligned to beliefs and desires, and develops reflective practitioners skilled in identifying discrepancies between current and ideal practice (Argyris & Schon, 1992). Leinum and Trapskin (2011) elaborate that a philosophy of practice can “help avoid career pitfalls, such as developing a sense of entitlement, settling for the status quo, succumbing to peer pressure, and having difficulty finding a purpose in organizational involvement” (p. 117). Furthermore, the statement is not something that is drafted solely for the purposes of securing employment and then shortly abandoned. It is an extension of the practitioner, one that is revised as the practitioner’s knowledge domains, career goals, and learning context changes. Revisiting a philosophy of practice may help a practitioner identify if there are obstacles such as toxic stress in an environment, burnout, incongruities between practice philosophies or a need for personal growth that is unmet in the current position. More importantly, the aforementioned obstacles may reduce the quality of service delivered by a practitioner or diminish the efficacy and effectiveness of treatments, all of which negatively impact client care. A philosophy of practice becomes a checklist tool and roadmap for the practitioner to be reflective and hold him or herself ethically accountable for how practice is delivered. Kinsella (2001) refers to this critical reflection as a matter of comparing what you say to what you do. A reflective practitioner also keeps a critical eye towards the emancipatory potential of the therapeutic encounter. Delivered services are not limited to the realm of rehabilitation or remediation. Occupational Therapy can be transformational for clients, who become empowered through participation in a therapeutic process guided by reflective practice. The emancipatory facet of the therapist-client relationship is one frequently overlooked in professional development literature, but holds great importance as a sociocultural view of health and well-being gains support at the person, community, and population levels.
CONCLUSION

Philosophies of practice are becoming a standard convention in healthcare; new practitioners can integrate theories learned into a practice identity, encourage critical and reflective thinking about practice, and organize their values, goals and perspectives as a practitioner. However, a philosophy of practice statement should be firmly rooted in a theoretical foundation to frame and organize the content to strengthen its impact (Leinum & Trapskin, 2011). The Habermasian knowledge domains and framework discussed in this paper provide examples to guide development of a personal philosophy of practice. The process of reflecting upon, writing, and revisiting the philosophy statement encourages the practitioner to be accountable to their profession, institution, clients and most importantly, themselves. We believe that Occupational Therapy education programs should require and centralize philosophies of practice into curricula, and support development of this statement as a student transitions from didactic coursework, through fieldwork, and into the practitioner role. Once established, a philosophy of practice can be a continuous presence and powerful tool for practitioners as they move through their careers successfully meeting clients’ occupational needs.

REFERENCES


ARTICLE

PRIMARY CARE OCCUPATIONAL THERAPY: EXPLORING THE PERCEPTIONS OF THERAPISTS’ ROLE AND THEIR CURRENT PRACTICE IN IRELAND

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ABSTRACT

Introduction: Co-ordinated multidisciplinary primary care as a model of healthcare delivery has been utilised for over a decade in Ireland. Occupational therapists work according to this model in primary care teams throughout the country. This study aimed to examine their current practices and perceptions of practice, including perceived facilitators and barriers to practice.

Method: A cross-sectional descriptive web-based survey was used to generate both quantitative and qualitative information. All occupational therapists who were members of functioning primary care teams were targeted for inclusion, and a response rate of 52.7% was achieved.

Results: Primary care occupational therapists working primarily with an elderly population are experiencing high referral rates and service users are experiencing long wait times for services. The majority of their time is spent on tertiary health promotion activities such as providing enabling equipment, completing functional assessments and providing instruction in daily living tasks. These activities aim to reduce the negative impact of symptomatic disease through rehabilitation and treatment.

Conclusion: Common barriers facing primary care occupational therapists include unrealistic caseloads and inadequate resources; however, support from occupational therapy colleagues and primary care team members is viewed positively. There is a need for guidelines and protocols to assist therapists with planning and delivering services in an environment with reduced resources.

KEYWORDS
Primary care, Occupational Therapy, community-based practice, health promotion

INTRODUCTION

Internationally healthcare system reforms have a strong primary care focus. This approach to healthcare provision commenced with the World Health Organisation (WHO) Declaration of Alma Ata, which pursued values of social justice, better health for all and a population-focused approach to healthcare delivery (WHO, 2008). National healthcare systems which adopt this approach and infrastructure ultimately have healthier populations, less health-related discrepancies, reduced healthcare costs (Mackinko, Starfield, & Shi, 2003) and provide scope for health professionals to champion new and effective service models which focus on health, well-being and participation in society (WHO, 2008).

The publication of the Department of Health and Children (DoHC)’s strategy, Primary Care: a New Direction outlined the central role of primary care in the future development of modern health services in Ireland. This new model aimed to address the many inadequacies of the system including service fragmentation, emphasis on diagnosis and treatment, professional isolation and reduced team working (DoHC, 2001). The inception of
primary care in Ireland commenced with ten national implementation sites in 2001. Primary care teams consist of general practitioners, nurses, physiotherapists, occupational therapists, social workers, home help workers and administrators and aspire to meet 90-95% of a population’s health and social needs in local communities (DoHC, 2001).

Negative health trends are prevalent in Ireland, including growing levels of chronic disease and increasing health inequalities (Darker et al., 2011). The prevalence of chronic disease has rising costs for the health service and society. Primary care aims to provide early intervention and improve the health and wellbeing of the population through co-ordinated and comprehensive local services (DoHC, 2001; DoH, 2013).

Unfortunately, the ambition and development of primary care teams have been below target (Darker et al., 2011; Houses of the Oireachtas, 2010; Tussing & Wren, 2006), resulting in challenges for both professionals and service users.

LITERATURE REVIEW

Occupational therapists have a sustained history of practicing in the community (McColl, 1998). Terms for healthcare provision located in the community are varied throughout the literature including community health service, primary care practice and local authority practice (Aas & Grotle, 2007; Mitchell & Unsworth, 2004). Community-based practice is categorised as services provided to clients both at community health centres and in their homes that concentrate on maintaining the client in the community (Aas & Grotle, 2007; Mitchell & Unsworth, 2004). Traditional interventions undertaken by community-based occupational therapists include functional assessment, providing advice on activities of daily living, provision of equipment, and environmental adaptations (Forsyth & Hamilton, 2008; Mitchell & Unsworth, 2004; Stalker et al., 1996; Tyrell & Burn, 1996). Home-based intervention with individual clients was cited as the most frequent type of practice (Forsyth & Hamilton, 2008; Quick et al., 2010).

Primary care practice provided in a community setting has evolved to include an additional and alternative focus for healthcare delivery including prevention and health promotion (Mitchell & Unsworth, 2007). Occupational therapists practicing in primary care are thought to have considerable impact in supporting strategies for health promotion. This includes taking on the role of agents of health, establishing supportive environments and enabling communities to take ownership for their own development (Wilcock, 2006). Respondents in an Irish study had a positive view of health promotion, where 81% recognised a role for occupational therapists in this area. This study targeted occupational therapists from various practice settings; however, 62% represented those who were community-based. Fifty-four per cent described health promotion activities they were involved in e.g. stress/anxiety management, falls prevention, access issues and service development (Flannery & Barry, 2003). More recently, Quick et al.’s (2010) study in Australia outlined high levels of Occupational Therapy involvement in health promotion (61.6%, n=44). Primary health promotion interventions including environmental education for an elderly population, health information for adolescents, and promotion of physical activity were the most commonly engaged in areas (55.65%, n=50).

Occupational therapists working in primary care have the scope to provide needs-based approaches to enhance health via lifestyle and behavioural modalities (DoHC, 2001; Mitchell & Unsworth, 2007). The ageing population in Ireland is predicted to place extra demands on health services by up to 60% in the next 10 years (DoHC, 2009). Also, rising levels of chronic disease have placed additional demands of the health service. This change in society’s structure also requires a change in the provision of health care.

Numerous challenges for community-based occupational therapists have been acknowledged in the literature such as diverse caseloads (Mitchell & Unsworth, 2004; Quick et al., 2010), waiting list pressure (Boshoff & Hartshorne, 2008) and resource constraints (Forsyth & Hamilton, 2008). Significant waiting periods for Occupational Therapy services are a pervasive challenge for community-based services (Boshoff & Hartshorne, 2008; Forsyth & Hamilton, 2008; Mitchell & Unsworth, 2004; Quick et al., 2010). The impact on service provision due to resource constraints including time restrictions, reduced staffing, and time spent on administrative tasks are also noted (Cheng et al., 2001; Flannery & Barry, 2003; Quick et al., 2010). Although the role of community-based Occupational Therapy is not without its challenges, the literature demonstrates a high level of job satisfaction among therapists (Lysack, 1995; Mitchell & Unsworth, 2004; Quick et al., 2010).

Occupational therapists have been working on primary care teams since the publication of the national primary care strategy in 2001. Each primary care team should have one occupational therapist assigned (DoHC, 2001). However, there is a distinct absence of published literature on the role or practice of occupational therapists working in accordance with this model in Ireland.

The aims of this study were to:
- Determine the profile of primary care occupational therapists in Ireland.
- Identify the type of work practices which primary care occupational therapists are currently engaged in.
- Explore the perceived facilitators and barriers for primary care occupational therapists.

METHODS

Study Design
A cross-sectional descriptive web-based survey was used in this study. A survey research design was adopted as a methodological approach. The survey was designed to be completed online, allowing for easy access and completion. The survey was developed using Qualtrics, a web-based survey software. The survey consisted of both closed-ended and open-ended questions. The survey was pilot tested with a small group of occupational therapists to ensure clarity and feasibility. After pilot testing, the survey was refined and made available to participants.

The survey was advertised to occupational therapists working in primary care teams in Ireland. The survey was distributed through various channels, including email, social media, and professional networking sites. Participants were incentivised with the opportunity to win a prize draw. The survey was open for a period of four weeks.

The survey included questions on demographic information, job satisfaction, workplace challenges, and perceived facilitators and barriers. The survey also included questions on practice settings and the types of interventions provided. The survey also included an open-ended question allowing participants to provide detailed narrative responses. The survey was designed to be completed in under 15 minutes.

The data was analysed using descriptive statistics. The data was cleaned and checked for completeness. The data was then imported into SPSS for analysis. The data was analysed using both descriptive and inferential statistics. The data was presented in tables and figures.

The results of this study will provide valuable insights into the profile of primary care occupational therapists in Ireland. The results will also provide insights into the types of work practices that occupational therapists are currently engaged in. The results will also provide insights into the perceived facilitators and barriers for primary care occupational therapists.

The results of this study will be of interest to occupational therapists working in primary care teams in Ireland. The results will also be of interest to managers and policy-makers in the healthcare sector. The results will also be of interest to researchers in the field of occupational therapy.
One week and four-week reminders were sent following the initial email. The survey was available online for six weeks. Data was collected between January and February 2011.

Data Analysis
Closed questions were analysed descriptively using Statistical Package for Social Sciences (SPSS, Version 18). Reports on frequency distributions, measures of central tendency (mean and mode) and variability (standard deviation or SD) were completed. Also, written summaries, tables, and figures were used to describe and illustrate the data. Inferential statistics were considered beyond the scope of this study due to its descriptive nature, therefore group comparisons were not required.

Data obtained from open-ended questions were managed using QSR International’s NVivo (www.qsrinternational.com) qualitative data analysis software. Constant comparison method of analysis of open question data was completed, incorporating three distinct phases including open, axial and selective coding. In open coding, data was read line by line with the examination of the information and application of labels or codes to individual segments of text. During axial coding further questioning and grouping occurred. Lastly, themes are developed to describe the content of the grouped codes (Strauss & Corbin, 1998). In order to enhance accuracy and rigor in analysis, peer debriefing was utilised to affirm emerging interpretations for qualitative data (DePoy & Gitlin, 2005).

RESULTS
Response Rate
One hundred and fifty-five questionnaires were returned and 74% (n=115) met the inclusion criteria as the respondents were part of functioning primary care teams and partaking in regular clinical team meetings. At the time of the study, there were 224 primary care occupational therapists nationally (six were excluded as they were involved in the pilot study). Therefore, the response rate for the study was 52.7%.

Quantitative Findings
Profile
Table 1 shows that the majority of respondents were female (92%, n=103). Less than half (43.9%, n=50) were covering one primary care team. A small number (9.6%, n=11) indicated they were covering a population of 5,000-7,000. Approximately one-quarter of respondents (24.6%, n=28) did not know the size of the population they were covering.

Recruitment
All primary care occupational therapists in the Republic of Ireland were targeted for inclusion in the study. At the time of the study, the national primary care office’s monthly statistics indicated there were 224 occupational therapists working on primary care teams (National primary care services office, personal communication, 2011). A multi-faceted approach was used to access as many of these therapists as possible. This included contacting therapists through the national primary care peer support group (n=109), Occupational Therapy managers (n=45), primary care managers (n=34) and the national Health Service Executive (HSE) broadcast email. To meet the inclusion criteria for the study, participants had to be qualified occupational therapists employed by the HSE and working as part of a functioning primary care team. At the time of this study, a functioning primary care team was described by the HSE to be those teams who were participating in regular clinical team meetings, including participation of general practitioners (Houses of the Oireactas, 2010).

Questionnaire
No similar research had been conducted in Ireland; therefore, a suitable questionnaire was developed for an Irish context and in accordance with the study’s objectives. A questionnaire from a similar study by Quick et al. (2010) conducted in Australia was also reviewed. Permission to use some questions was granted by the first author. The questionnaire for this study included 27 closed and three open-ended questions, each question linked to a designated study objective. The questionnaire was divided up into five sections including therapist demographics, current practice, facilitation and barriers, the unique contribution of Occupational Therapy in primary care and models/frames of reference used in practice. Closed questions included multiple choice answers, likert scales and rating scales. An example of an open-ended question included “What factors would assist you in completing your job effectively as a Primary Care OT?”

Piloting and Distribution of Questionnaire
Six occupational therapists working in primary care were purposively selected to pre-test the questionnaire. Field pre-testing provides important information on the practicalities of administering the survey tool, thus allowing evaluation of the intended instrument and unforeseen issues to be addressed prior to the main study (Forsyth & Kviz, 2006; Fowler, 1995). Feedback from the six occupational therapists was used to refine the content of the questionnaire. Following feedback, minor changes were made to clinical practice terminology to improve clarity.

As primary care professionals are heavily researched a modified version of Dillman’s Total Design (TDM) was implemented to maximise response rates (Dillman, 2000).
Experience and Training

The majority of participants were senior occupational therapists (70.4%, n=81). A large proportion (69%, n=78) had worked in primary care for less than two years. Less than one-fifth had postgraduate training (19.1%, n=22); the most common education areas included healthcare management (3.5%, n=4) and mental health and psychology (4.3%, n=5). The most common areas of previous work practice included community care (52.2%, n=60), care of the elderly (56.5%, n=65) and acute care (52.2%, n=60). Many occupational therapists also had experience in the following areas: mental health (34.8%, n=40), paediatrics (24.3%, n=28), intellectual disability (15.7%, n=18) and private practice (11.3%, n=13). The majority of participants (69%, n=78) cited an average of two practice areas where they previously worked; the range was one to seven.

Caseload

Occupational therapists were requested to indicate the number of referrals received in a sample month. It was revealed that 56.2% (n=41) received 16+ referrals (see Table 2). It is evident that clients aged 65 years or older featured heavily on caseloads, as 37.9% (n=28) of therapists had more than 31 clients actively open in this age group.

Assessments

The vast majority 96.3% (n=78) used an initial assessment form developed by their local department. Sixty-five occupational therapists responded to the question which gathered information on the use of standardised assessments. Cognitive assessments were the most regularly used standardised assessments (83.1%, n=54). A number of cognitive assessments were indicated by respondents (Mini-Max5); the most commonly used were the Mini-Mental State Examination (MMSE) (Folstein et al., 1975), Middlesex Elderly Assessment Memory Score (MEAMS) (Golding, 1988), Clifton Assessment Procedures for the Elderly (CAPE) (Pattie, 1981), Rivermead Behavioural Memory Test (RBMT) (Wilson et al., 1985), and Rivermead Perceptual Assessment Battery (RPAB) (Whiting, Lincoln, Bhavnani, & Cockburn, 1985).

Interventions

Providing equipment, functional assessment, and instruction in daily living skills were identified as the most frequently engaged-in areas of practice (see Table 3); eighty-two respondents answered this question. Therapists were also asked to consider which clinical areas they perceived should be part of their role. Respondents unanimously (100%, n=82) agreed that providing equipment and completing functional assessment should be part of their role (eighty-two respondents also answered this question). Respondents were requested to indicate the amount of time spent on activities during a typical working week, the mean percentage of time spent on health promotion activities was two percent. Furthermore, 67.2% (n=53) stated they rarely or never facilitate health promotion groups. It was indicated 35% of therapists’ time was spent on indirect

Table 1. Profile of the Participants

| Age (n=115) | 21-30 | 37 (32.2%) |
| 31-40 | 48 (41.7%) |
| 41-50 | 16 (13.9%) |
| 51+ | 14 (12.2%) |

| Gender (n=112) | Male | 9 (8%) |
| Female | 103 (92%) |

| Client population Covered (n=114) | 5,000-7,000 | 11 (9.6%) |
| 7,000-10,000 | 21 (18.4%) |
| 10,000-12,000 | 17 (14.9%) |
| 12,000+ | 37 (32.5%) |
| Don’t know | 28 (24.6%) |

| Number of primary care teams covered (n=114) | 1 | 50 (43.9%) |
| 2 | 37 (32.5%) |
| 3 | 27 (23.7%) |

| Years worked as a primary care occupational therapist (n=113) | 0-2 | 78 (69%) |
| 3-4 | 16 (14.2%) |
| 5-6 | 9 (8%) |
| 7+ | 10 (8.8%) |

Table 2. Referrals and caseload (Sample month November 2010)

| Referrals received (n=73) | None | 3 (4.1%) |
| 1-5 | 0 |
| 6-10 | 12 (16.4%) |
| 11-15 | 17 (23.3%) |
| 16+ | 41 (56.2%) |

| Actively Open* clients 0-17 years (n=74) | None | 38 (51.4%) |
| 1-10 | 33 (44.6%) |
| 11-40 | 0 |
| 41-50 | 1 (1.4%) |
| 51+ | 2 (2.7%) |

| Actively Open* clients 18-64 years (n=74) | None | 7 (9.5%) |
| 1-10 | 35 (47.3%) |
| 11-20 | 18 (24.3%) |
| 21-30 | 10 (13.5%) |
| 31-50 | 1 (1.4%) |
| 51+ | 3 (4.1%) |

| Actively Open* clients 65 years + (n=84) | None | 2 (2.7%) |
| 1-10 | 2 (2.7%) |
| 11-20 | 35 (33.8%) |
| 21-30 | 17 (23%) |
| 31-40 | 13 (17.6%) |
| 41-50 | 6 (8.1%) |
| 51+ | 9 (12.2%) |

*Clients actively open on occupational therapists caseloads and receiving intervention.
Table 3. Most frequently engaged-in clinical areas (n=82)

<table>
<thead>
<tr>
<th>Clinical Area</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Providing equipment</td>
<td>78 (95.1%)</td>
</tr>
<tr>
<td>Functional assessment</td>
<td>62 (75.6%)</td>
</tr>
<tr>
<td>Instruction in daily living skills</td>
<td>48 (59.3%)</td>
</tr>
<tr>
<td>Pressure care</td>
<td>47 (57.3%)</td>
</tr>
<tr>
<td>Seating</td>
<td>44 (53.7%)</td>
</tr>
<tr>
<td>Environmental adaptations</td>
<td>38 (46.9%)</td>
</tr>
</tbody>
</table>

Facilitators and Barriers to Practice

The majority of respondents (79.7%, n=59) agreed that their role had expanded since moving to primary care. Half were satisfied with their role as a primary care occupational therapist (50.6%, n=41), approximately one quarter were not satisfied with their role (27.1%, n=22). The most common barriers highlighted were inadequate funding (87.7%, n=71), difficulty prioritising time for health promotion activities (76.5%, n=62), high demand for service (67.9%, n=55), lack of administration support (64.2%, n=52) and pressure to reduce waiting lists (59.3%, n=48). Each therapist (n=81) who responded to this question identified at least one barrier to practice; the range was one to nine.

Qualitative Findings

The questionnaire included three open-ended questions seeking to gather information on perceived supports available, assistive factors and the unique contribution of Occupational Therapy to primary care. Questions were analysed individually and themes emerged as outlined below and illustrated with direct quotations.

Perceived Supports for Occupational Therapists working in Primary Care

Three themes emerged under the question of perceived supports, sixty-six responded to this question. Themes included sources of support, lack of support and resources.

Sources of Support

The most commonly acknowledged supports highlighted by respondents were from their Occupational Therapy colleagues. Positive descriptions of Occupational Therapy colleague support were consistently put forward. This support came in the form of supervision, occupational therapy assistant support and regular in-service training:

“Excellent human resources, other OT's working in primary care, everyone is willing to share their experience and knowledge. There is an interest in developing and expanding our role at a service level” (OT17).

Multidisciplinary colleagues and relationships were also documented as supportive and promoted a positive working environment:

“Good MDT relations formed as a result of clinical meetings and PCT meetings” (OT75).

Support from management came from both Occupational Therapy management and primary care managers. Management who had a positive attitude towards primary care development acted as a strong support for therapists, and assisted in developing other areas of practice and the primary care role:

“Support from manager to try and start health promotion initiatives while also working on waiting list” (OT103).

Lack of Support

Higher management support was viewed as an intrinsic ingredient in developing primary care teams and strengthening the primary care model. The absence of management support was noted to stall the development of primary care teams:

“The manner in which the teams have been “set-up” looks good on paper (and the papers too”) but are not as successful in reality. What constitutes the launch of a team appears to be a tick-box list by higher management and does not include realistic support to facilitating the establishment of a team” (OT17).

Factors to Assist Occupational Therapists working in Primary Care

Sixty-seven respondents provided answers to this open-ended question. Themes which emerged included resources, management and guidance, realistic caseloads, and team involvement.

Resources

Comments consistently described a need for staffing increases including administrative staff, Occupational Therapy staff and support staff. This additional support would allow therapists time to complete assessments, intervention and develop the primary care Occupational Therapy role. Provision of appropriate facilities were highlighted as a need from both the Occupational Therapy perspective and primary care team:

“Develop the role... (currently) feel you are firefighting all the time to get people on waiting list seen and respond to urgent referrals” (OT24).

Management and guidance

Clear policies, standardised approaches, transparent service delivery and communication from a national level...
were recommended by therapists in to facilitate role development. Many occupational therapists perceived a non-uniform approach to practice around the country, whereby health promotion and service delivery initiatives develop and occur locally and in isolation. Increased support was advocated in order to further develop practice:

“increased support for “non-traditional” tasks of job, i.e. liaising with community groups and voluntary groups to identify needs in community” also “needs to be more support and frameworks put in place to allow Primary Care OTs time to evaluate and publicise the many excellent projects being run around the country” (OT79).

Realistic Caseloads
Large waiting lists, catchment areas, and caseloads were reported to impact on occupational therapists’ ability to function effectively and also on their ability to engage in primary health promotion activities. Respondents expressed concern about these pressures and the effects on the developing Occupational Therapy role within primary care:

“We go to the extreme and end up trying to do it all resulting in a dilution of skills, reduced specialism and reduced quality” (OT115).

Team Involvement
Provision of appropriate facilities was highlighted as a need both from an Occupational Therapy and team perspective. Access to clinical space in designated primary care centres was viewed as an avenue to support engagement in rehabilitation, clinic-based treatment and health promotion initiatives. Additionally, designated primary care centres facilitating co-location were viewed as providing a positive foundation for developing primary care team working and collaboration. Unfortunately, many respondents were not co-located and general practitioner involvement was identified as an area requiring improvement:

“I think the primary care teams are a good model but the GPs are unwilling to participate” (OT37). “Co-location with other team members would be brilliant, rather than sporadic contact as is the present case” (OT17).

Perceived Unique Contribution of Occupational Therapy in a Primary Care Setting
Respondents were requested to indicate the unique contribution that Occupational Therapy could offer clients in a primary care setting; sixty-six answered this question. Emergent themes included: promoting independence and understanding of the person, environment, and occupation interaction.

Promoting independence
Promoting independence and improving the quality of life for clients appeared frequently as a strong focus of practice for respondents. It was outlined that a unique understanding of disability supports these aims. Client-centeredness was seen as a cornerstone of practice. Respondents reported this approach which focused on client identified issues, client autonomy, collaboration and empowerment was authentic to Occupational Therapy practice and ultimately led to supporting clients to fulfill goals and realise their potential:

“A client-centred holistic approach to treatment, goals are set like a partnership, client is empowered to make decisions about their therapeutic intervention. Focus is on client-identified issues; our intervention is purposeful to them, enabling them to live safely and independently” (OT110).

Understanding of the person, environment, occupation interaction
Respondents outlined that they are consistently mindful of the environment when considering clients’ meaningful occupations. The natural contexts of home and community were considered in combination with the unique circumstances of each person, and how this may affect their occupational performance:

“OTs assess a person’s ability to function in their personal situation, the barriers and enablers they possess both intrinsically and extrinsically, and the environment that this occurs in. We work with the person to develop an intervention plan to sustain or improve that functional ability (OT103).

DISCUSSION
This study aimed to capture detailed information on the role, practice, and perceptions of occupational therapists in Ireland, who are working in accordance with a primary care model of healthcare delivery. This is the first published research article capturing this data from an Irish perspective.

Demographical information compiled from this study indicates a young population. The majority of therapists were aged 40 years or younger and practicing as senior therapists, indicating they have at least three years of experience. Research by Mitchell and Unsworth (2004) and Quick et al. (2010) indicated that therapists working in community health settings were experienced practitioners with varied clinical backgrounds. This study confirms these international findings as Irish-based therapists have worked in various clinical areas other than community health including acute care, mental health, care of the elderly, and paediatrics. Although therapists have vast experience in other areas, a high number have been practicing in primary care for two years or less. This demonstrates that there has been a recent surge in occupational therapists moving into primary care roles.

This research demonstrates that the primary care Occupational Therapy role remains in the development phase and is largely associated with traditional community-based practice including the provision of equipment, functional assessment and environmental
adapts. Occupational Therapy has a sustained identity of providing equipment, both within the profession and among professional colleagues (Barbara & Curtin, 2008). Respondents unanimously agreed that prescription of equipment should be part of their role, demonstrating their perceived importance of providing assistive devices to promote independence and engagement in meaningful activities for community-dwelling clients. While this is a determined and valued role for respondents, there is also a desire to expand the role towards preventative care and health promoting initiatives, and share initiatives which have been developed.

Health promotion is considered a central tenet of primary care (DoHC, 2001) and community-based practice (Fazio, 2008). However, a strong contribution to this practice area was not apparent from the study. Lack of knowledge, experience, and/or confidence may have impeded engagement in health promotion tasks. Over half of respondents were unsure or disagreed that they had adequate knowledge to implement health promotion interventions. Similarly, in Australia, the majority of respondents felt they did not have the satisfactory knowledge to engage in health promotion activities with clients (Quick et al., 2010). This lack of knowledge may have implications for the participation and exploration of this role in practice. Education, training, peer support and management support are essential in order to bridge this gap. Secondly, there is a need to research the effectiveness of established and future health promotion interventions in the community.

Many occupational therapists are covering more than one primary care team. This is not consistent with the recommendations of the primary care strategy which indicate each team should have one occupational therapist assigned (DoHC, 2001). This has direct implications for service users and professionals. Service users may experience lengthy waiting times for services and inequitable access to services dependent on how primary care teams are staffed in their local area. High demand for service and pressure to reduce waiting lists may have affected occupational therapists’ reported reduced levels of satisfaction related to the primary care role. These levels of satisfaction are lower than those reported in other international studies (Lysack, 1995; Mitchell & Unsworth, 2004; Quick et al., 2010).

Nationally, an irregular approach to assessment is revealed as the majority of respondents are using locally-developed initial assessment forms. Functional assessment is frequently undertaken by respondents; however, there is a low reported use of standardised functional assessments. Forsythe and Hamilton (2008) also acknowledge that a high proportion of therapists did not use any evidence-based assessments. Conversely, a study of Irish-based mental health occupational therapists indicated that most were using standardised assessments (O’Connell & McKay, 2010). Community-based practice is a diverse area to work in, due to a high occurrence of disability and a broad range of chronic disease (Aas & Grotle, 2007). This broad scope of practice may contribute to varying assessment practices. Laver-Fawcett (2007) acknowledges the challenges of measuring outcomes due to the variable nature of occupational performance. However, despite barriers, there is a need to communicate our effectiveness (Laver-Fawcett, 2007). This is difficult to achieve without the use of outcome measures. In addition improved outcomes and cost-effectiveness are intrinsic objectives of the primary care model (DoHC, 2001).

Participants of this study report the primary care strategy has expanded the role of Occupational Therapy; however, practice appears to have remained consistent with traditional community-based practice. Irish nurses similarly feel that their role has grown and expanded, particularly in order to meet the additional health promotion initiatives required from the primary care model (Burke & O Neill, 2010). Implications on workforce capacity and enhanced remits should be acknowledged if this preventative role is fully realised for occupational therapists working in primary care.

Supports pertinent and valued by respondents were primarily in the form of colleagues, which adds strength to the importance of teams and the support they provide on a daily basis. This is worthy to note as the vast majority of respondents have been working in teams for two years or less. Irish nursing studies also highlighted the importance of teams and co-location which leads to greater integration and team working (Burke & O Neill, 2010; O Neill & Cowman, 2008). Unfortunately, co-location in “modern, well-equipped, accessible premises” (DoHC, 2001, p.32) is not a reality for all primary teams.

RECOMMENDATIONS

Respondents cited a low frequency of use of standardised assessments and outcome measures. Research examining the reasons for limited use is required, and furthermore, barriers/challenges to incorporating them into practice need to be addressed. Similarly, health promotion initiatives are restricted due to prevailing barriers. However, there is the incidence of health promoting activities throughout the country. Further research examining the types and frequency of health promotion activities is required. Additionally, these existing health promotion initiatives should be disseminated among colleagues, as communication is essential for sharing expertise, resources and formalising standards of practice.

Development of policies and guidelines are recommended to determine equity of service provision and guide practice.

LIMITATIONS

A significant limitation of this study was obtaining access to occupational therapists directly, due to the constant development of teams nationwide and a lack of state registration. While a response rate of 52% is acceptable for a cross-sectional survey, it does mean the findings may not be generalisable to the wider population of interest. Missing data was evident in a significant proportion of questions which may have been due to the length of the
CONCLUSION

Since the introduction of the primary care model to Ireland’s health system, occupational therapists have consistently been viewed as a core member of the team (DoHC, 2001). Occupational therapists are aware of the unique contribution the profession can offer to primary care, particularly in collaborating with clients to promote independence within the natural contexts of home and community.

Supportive colleagues feature strongly in primary care teams which have strengthened team working and cohesion. The scope of practice is mainly centred on tertiary health promotion activities, and respondents collectively agree that providing equipment and completing functional assessment should be part of their role. However, there is an underlying view that respondents would like to be increasingly engaged in health promotion activities. Unfortunately, barriers to practice including reduced staffing, large waiting lists, and time pressures are impeding this process.

ACKNOWLEDGEMENTS

Sincere thanks to all the primary care occupational therapists nationwide who took the time to complete the survey.

REFERENCES


National Primary Care Services Office. (2011). Email to Helen Kelly, 6th April.


OPINION PIECE

OCCUPATIONAL THERAPY PRACTICE IN PRIMARY CARE:
RESPONDING TO CHANGING HEALTH PRIORITIES AND NEEDS IN IRELAND

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ABSTRACT

With a rapidly changing age demographic and an increasing incidence of chronic diseases, healthcare systems internationally are developing primary care services that are accessible and responsive to the health needs of their local population. National and international guidelines for chronic disease management recommend reducing lifestyle risk factors and empowering individuals with knowledge and skills to become effective self-managers. Occupational therapists in primary care play an important role in promoting positive health behaviours and addressing health inequalities at the level of the individual and the community. This article will discuss occupation-focused interventions for primary care practice in Ireland that align with recommendations in national health policies and strategies for the prevention and treatment of chronic disease.

INTRODUCTION

Primary care focuses on health promotion, disease prevention and management through providing a range of health services to individuals, families and communities (World Health Organisation, 1978). It is provided as close as possible to where people live and work and is usually the first point of contact for individuals with their health care system. In 2001, the Department of Health and Children published a Primary Care strategy for Ireland to develop and deliver a primary care service that would meet the future health and social service needs of the people of Ireland (Department of Health and Children, 2001).

As is regularly reported and clearly documented, people in Ireland are living longer. It is generally expected that on average men will live up to approximately 76 years and women up to 81 years (Department of Health, 2013a). As people age, they develop chronic health conditions. Almost three quarters (73%) of the Irish population over 65 years report the presence of a long term illness. In Ireland the most common types of chronic diseases include arthritis, coronary heart disease, cancer and mental health difficulties (Department of Health and Children, 2008). Chronic disease results in considerable levels of morbidity, mortality and lower quality of life (Duguay et al., 2014). The population forecasts show that we can expect an increasing incidence of chronic disease as our population ages. The number of adults living in Ireland with chronic disease is expected to increase by approximately 40% by 2020 (Department of Health and Children, 2008). This has a considerable impact on the economy and healthcare service delivery in Ireland.

Activity participation is considered an important lifestyle factor that contributes to improving the health of those with chronic conditions. Health professionals regularly recommended increased activity to improve morbidity in chronic conditions such as heart disease, diabetes, musculoskeletal injuries and mental health diseases. A number of Department of Health policy documents targeting all age groups with different chronic diseases, identify the importance of physical activity to reduce morbidity. These include Tackling Chronic Disease...
(Department of Health and Children, 2008), Changing Cardiovascular Health (Department of Health and Children, 2010), and Healthy Ireland (Department of Health, 2013b). A National Positive Ageing Strategy was launched in 2013 with an overall aim to enhance health, well-being and quality of life of people as they age (Department of Health, 2013a). This document also recommends active participation in productive, cultural and spiritual activities to promote successful ageing. More recently the Institute of Public Health identified that being physically active reduces the risk of developing dementia (Cleary & McEvoy, 2015). This demonstrates the mediating effect of physical activity on health and well-being.

The National Guidelines for Physical Activity recommend a minimum of 150 minutes of physical activity per week (Department of Health and Children, 2009). In order to achieve this, many health professionals recommend increasing physical activity through participation in exercise classes, attending a gym, joining swimming classes etc. However, as effective as these activities are in increasing physical endurance, there are other ways to increase people’s physical activity levels. As is evidenced in Occupational Therapy practice and research, the beneficial effects of physical activity are also attained through engaging in valued productive and leisure-based occupations (Law, 2002). This has also been confirmed in non-occupational therapy led research (Anaby et al., 2011; Paganini-Hill, 2011). It is believed that people are motivated to maintain physical activity levels when participating in valued occupations. The benefits of participating in meaningful occupations on mental health is also well documented (Stevens-Ratchford, 2011). Given the self-referral nature of primary care practice and the autonomy occupational therapists in primary care have regarding discharge decisions, they are well placed to facilitate identification of valued occupations and to provide occupation-based interventions for sustained occupational engagement.

However, as a profession, occupational therapists need to increase their colleagues’ awareness of the benefits of productive and leisure-based occupations for improving physical and mental health. For example, a recent Irish study of the impact of participating in a dance programme saw a significant increase in occupational participation of those attending the programme. Although not significant, improvements were also identified in participants’ mood (O’Toole et al., 2015). The qualitative findings showed that through engaging in the dance programme, participants reported increased self-efficacy and confidence to become involved in other social activities. Findings of a national survey carried out by Healthy Ireland have recently been published (Department of Health, 2015). Mental well-being, in addition to a number of other health-related variables, was examined. Women reported higher levels of mental health difficulties than men (13% and 6% respectively). Mental health is influenced by many factors with social isolation increasingly being recognized as a modifiable risk factor (O'Regan et al., 2011). There are many community and voluntary-based organisations that provide a variety of social and creative activity programmes. Knowledge of the range and location of these organisations is therefore important for primary care occupational therapists in order to facilitate occupational choices for their clients.

Self-management is also widely promoted as an important element of chronic disease prevention and treatment. Packer (2013) describes self-management as supporting individuals with chronic diseases to develop knowledge, skills and confidence to manage the medical, emotional and role aspects of their health. Occupational therapists can play a central role in facilitating effective self-management programmes. However, occupational therapy interventions must be firmly embedded in an occupation-focused framework which will then enable occupational therapists to differentiate their self-management practice from other health care professions also involved in this area. An example of an occupation-based self-management programme is OPTIMAL, which has been evaluated in Ireland with varying chronic diseases including multimorbidity (O’Toole et al., 2013). This 6-week group-based programme has demonstrated significant improvements in performance of, and satisfaction with, occupational participation, self-efficacy and quality of life (Garvey et al., 2015). As this programme was tested with community dwelling adults it is particularly suitable for delivery in primary care contexts.

Recently the Department of Health is placing particular emphasis on improving the health and well-being of the Irish population through health promotion. This is evidenced by the release of policy documents such as Healthy Ireland (Department of Health, 2013b) and the Healthy Ireland National Implementation Plan 2015-2017. Health promotion is defined as the process of enabling people to increase control over, and to improve, their health (WHO, 1986). The Health Service Executive (HSE) launched a Health Promotion Strategic Framework (Health Service Executive, 2011) to address determinants of health and health inequalities. Deliverable outcomes for achieving these two objectives include reducing health inequalities, improving health, and preventing and reducing disease. Creating environments which are supportive of health and that provide health improvement opportunities is identified as an important method for achieving these outcomes. Occupational Therapy theories which are explicit frameworks for guiding Occupational Therapy practice, have as a central tenet the importance of the impact of the social, physical, cultural and economic environments on occupational participation. Occupational therapists in primary care practice have considerable expertise in assessing the environment and providing suitable interventions to reduce or eliminate environmental barriers to health and well-being. Therefore, the profession has a responsibility to actively contribute towards achieving this objective of the Health Promotion Strategic Framework at both an individual and community level.

Occupational therapists regularly address activities of daily living (ADL) and instrumental activities of daily living (IADL) difficulties. Thompson et al. (2012) reported a direct relationship between ADL difficulties
and health-related quality of life. For the Healthy Ireland survey, 7,539 people over the age of 15 years were interviewed on a range of topics including general health, physical activity levels, social connectedness and wellbeing (Department of Health, 2015). Almost one fifth (19%) of the study participants reported difficulty in daily activities with this percentage increasing to 41% for people over the age of 65 years. More than one in four people over the age of fifteen (28%) reported having a chronic condition with 57% of this group reporting limitations in daily activities.

The WHO contends that when risk factors for functional decline in daily activities are addressed people will live longer and enjoy a better quality of life. Risk factors for functional decline in ADL and IADL activities have been identified for older adults in Ireland (Connolly et al., 2016). These risk factors include pain, poor self-rated memory, and depression. Early interventions are required for these risk factors to reduce their impact on daily activities. Occupational therapists frequently intervene with people with chronic and enduring pain, cognitive impairments and mood disorders. There is therefore a role for occupation-based self-management programmes for these risk factors delivered by primary care teams. Research is also required to evaluate the effectiveness of such programmes on improving and/or maintaining occupational participation.

It is an ethical and professional responsibility for all health care professions to examine the effectiveness and cost efficiency of their practice (Muir, 2012). The Healthy Ireland framework (Department of Health, 2013b) also stresses the importance of measuring and evaluating the effectiveness of health and well-being interventions. There are a number of outcome measures that are suitable for use within the context of primary care. However, as the focus of Occupational Therapy is on facilitating occupational participation and engagement, then the outcome measures used in practice should reflect this professional focus (Packer, 2013). There are now a wide range of occupation-based measures that have been developed over the past 10-15 years that are suitable for use in primary care. Such measures include, but are not limited to, the Canadian Measure of Occupational Performance (Law et al., 1998), the Occupational Self-Assessment (Barron et al., 2006), and the Model of Human Occupation Screening Tool (Parkinson et al., 2006). The use of occupation-focused measures will assist occupational therapists in primary care to measure and clearly articulate their contribution to facilitating successful occupational participation for all age groups. Having evidence to demonstrate the impact of Occupational Therapy in primary care will also provide objective data to support funding requests for additional resources required to achieve the goals of national health policies.

CONCLUSION

Occupational therapists in primary care make a distinct contribution to health promotion, chronic disease management and population health (Braveman, 2016). The profession’s knowledge and understanding of the impact of occupational participation on health and well-being clearly aligns with core recommendations of national and international health policies for health promotion and disease prevention. The challenge for the profession is for Occupational Therapy practitioners, researchers and the Association of Occupational Therapists of Ireland to evaluate, document and disseminate the contribution of Occupational Therapy to current and future priorities of Irish healthcare.

REFERENCES


BOOK REVIEW:

Creek’s Occupational Therapy and Mental Health, FIFTH EDITION.

Edited by: Wendy Bryant, Jon Fieldhouse & Katrina Bannigan.
Publisher: Churchill Livingstone, 2014.
ISBN: 978-0-7020-4589-9

Originally published in 1990, this book is the fifth edition of Occupational Therapy and Mental Health. Newly titled “Creek’s Occupational Therapy and Mental Health,” this is the first edition without the original author Jennifer Creek acting in an editorial capacity. While contributing to a number of chapters she has handed the editorial baton to three distinguished fellow occupational therapists in Wendy Bryant, Jon Fieldhouse, and Katrina Bannigan. Like previous volumes, this edition contains contributions from many experts working in Occupational Therapy Practice in Mental Health settings and people with self-experience of mental ill-health.

The textbook takes us from the roots of Occupational Therapy practice in psychiatry to contemporary practice in the community and specialist settings. Core topics, including approaches to practice, assessment, treatment planning, and use of outcome measures are covered. Furthermore, some very useful generic chapters are included, which will be of interest to all occupational therapists, such as Professional Accountability (Chapter 7), Management and Leadership (Chapter 8), Ethics (Chapter 10) and Developing the Student Practitioner (Chapter 12).

Reviewers identified limited deficiencies in the chapters they read. In many cases, their feedback indicated a hunger for more information on the topic. One good example was in Chapter 19 on Lifeskills where it was felt that a table outlining which standardised assessments are available in this area of practice would have been a worthwhile addition to an otherwise comprehensive chapter. The case studies and service user perspective on the topic were highlights.

Chapter 13 on student education outlines the context in which contemporary Occupational Therapy practice occurs (from political, professional, and educational perspectives). The concept of competence is explored and the old question of “how does a student become competent and ready to be a practising occupational therapist?” is discussed in some length. There is very useful guidance on how practice educators can facilitate learning and the importance of sharing their clinical reasoning and modelling good practice. Some challenges commonly encountered during clinical education, such as a student’s lack of life experience, poor confidence, or difficulty accepting their insecurities about a situation is not overlooked, and thankfully, strategies for managing these difficulties are provided. Given the increase in the use of role emerging placements, the chapter discusses the values and risks of such placements in preparing students to be therapists.

Chapter 14 deals with the emerging focus on the important link between body and mind. Written by Fiona Cole, this chapter introduces the health benefits of physical activity and describes types of physical activity. It details evidence on the impact of physical activity on a range of common mental health conditions and describes the links between physical inactivity, mental illness, and physical health conditions such as coronary heart disease and stroke. The author advocates viewing physical activity in the context of satisfying occupations and life roles rather than aerobic activity or alleviating symptoms. Types of interventions such as walking and strength training are described and exemplified through some case studies.

The highlight in Chapter 16 is the provision of an overview of the ‘new’ generation of cognitive-based therapies, including Dialectical Behavioural Therapy, Acceptance and Commitment Therapy, Mindfulness, and Schema Therapy. These are relatively new and extend what would have been covered in previous editions. Cognitive Behavioural Therapy is not forgotten and is covered in some detail. One notable exception to the comprehensiveness of this chapter is the absence of a discussion on approaches to address poor cognitive functioning, such as Cognitive Adaptation Training or cognitive remediation strategies.

The reviewer of Chapter 17 (Creative Activities) felt that the chapter provided real inspiration for including more creative activity in practice. Therapists will also have increased confidence in the evidence base for creative activities having read the positive, albeit limited, overview of the research that has examined the efficacy of creative activities. Three case studies are included with each providing a description of the creative medium being used, an introduction to the client, and an account of the OT goals, intervention, and outcomes.

Green Care and Occupational Therapy (Chapter 20) and Work and Vocational Pursuits (Chapter 21) are two welcome new additions to the table of contents. While the former details Green Care interventions, constructs and theories, the latter provides definitions of the various forms of work highlighting valuable alternatives to conventional paid employment. Traditional and contemporary models of vocational rehabilitation are discussed, and some interesting examples of UK initiatives are provided that could be applied to the Irish context.

Community Practice is covered in Chapter 23 and provides an overview of very topical issues in mental health service delivery such as the Recovery Approach, the Strengths Based Approach, the Trans Theoretical Model and the Stress Vulnerability Model. Having read
this chapter occupational therapists will be more familiar with these concepts and be better able to educate service planners and funders as to how Occupational Therapy can contribute in reorienting services in line with these approaches and models. One critique is the focus on UK community mental health practice which may have limited applicability to some healthcare systems in other parts of the world.

The final chapter, Working on the Margins: Occupational Therapy and Social Inclusion, brings us into the future. The authors discuss how Occupational Therapy is about being responsive to the social determinants of mental health and human wellbeing and enabling people to return to the centre of society rather than exist excluded and unable to enjoy life to the full. The authors introduce the reader to the occupational science concept of occupational injustice, providing evidence that for some, there is an inequity of opportunity in occupational engagement, and certain groups in society must make occupational choices based on what is allowed, rather than what is preferable to them. This may provide some opportunities for Occupational Therapy to broaden its scope of practice to include social/political/economic interventions. Our unique focus, occupation, provides a platform for people from all parts of society to connect and develop their capacities and potential through doing together.

In short, Creek’s Occupational Therapy and Mental Health (5th Edition) is a worthwhile addition to the bibliographic resources of any Occupational Therapy Department in a mental health setting.

Reviewed by: Cluain Mhuire Occupational Therapy Department (Niall Turner MSc BScOT, Niamh Groome BScOT, Criosa Houston BScOT, Tara O’Leary BScOT, Niall Kirrane BScOT, Stephen Smith MScOT)

Pain - A Textbook for Health Professionals

Edited by: Hubert Von Griensven, Jenny Strong, and Anita M. Unruh.

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Pain is the one most common and prevalent presentation that we all see in our daily clinical practices and lives, yet it still remains the one factor that can be overwhelmingly cathartic in terms of occupational dysfunction and loss. This alludes to the clinical relevance of this book.

The 2nd edition of Pain - A Textbook for Health Professionals is an anticipated update of the previously published textbook, which was written with a narrower framework and was for therapists only. In the 12 years that have passed, research has instigated a revolution in the way pain is considered and treated in healthcare settings globally. This revised book acknowledges this and attempts to translate persistent pain theory that is relevant to us all as health professionals.

This edition is a 400 page tome which uses a broader framework for the consideration of Pain and its treatment from a client-centred perspective. It pulls on a biopsychosocial paradigm to help us understand the multifaceted aspects of pain and appropriate treatment approaches. That notwithstanding, it also showcases new empirical findings on the more physiological aspects of pain and contributes greatly to the reader’s theoretical basis for their assessment and intervention plans for those with chronic pain as a result.

The book is edited by Hubert Van Griensven, Jenny Strong and Anita Unruh and has a host of esteemed multidisciplinary (including Occupational Therapy) contributors from across the globe. It carries 3 defined sections and spans 27 meaty but inviting chapters. Excellent use is made of reference lists, summary boxes, study questions and appendices to up the user-friendly aspect of what could be mistaken as a lengthy and intimidating book.

The book opens from an unusual but justified perspective, that being from the clients’ standpoint, setting the scene for the ethos of the book to follow. Here, defined chapters in Section 1 on the Patient’s Voice and Social Determinants of Pain allow us to frame our learning which follows on the issues that are most pertinent from a human perspective.

From here the book gets a little more technical. Section 2 spans a range of significant topics on the issue of Assessment and Management of Pain. This is done in such a structured way however, that it encourages learning in a non-intimidating fashion on matters that can sometimes be daunting, such as neuroanatomy and pain.
theory. Clinical Assessment, Psychological Models and Treatment, Pain Pharmacology, Manual Therapy, Transcutaneous Electrical Nerve Stimulation and Complementary Therapies are all covered in an informative and evidence-based manner. The text certainly touches all bases from a multi-disciplinary perspective.

Of note from an Occupational Therapy perspective, it is encouraging to see a chapter dedicated to Workplace Rehabilitation, and also the Model of Occupational Performance being cited as a guiding tool for assessment. Nonetheless it should be not be expected that this is a book with a distinct occupational perspective. We will have to use our own clinical judgement to bring occupation to the pain domain and indeed to our intervention plans.

There is also lots of learning to be gained in the chapters dealing with the psychology of pain to aid the practice of an occupational therapist in this arena. Conceptual perspectives and descriptors of sample psychological interventions are provided in a manner which is relevant to all treating those with persistent pain. Sources for more information are also flagged, which inspires further reading for the more enthused. The chapters on content heavy topics, such as that on Neuropathic Pain and Chronic Regional Pain Syndrome aid learning for a variety of learning styles. This is done through the use of well-illustrated tables, diagrams, and algorithms. Digesting these morsels of valuable clinical information can be helpful for those more novice in pain management or indeed for those of us needing a revision boost now and again!

The final section handles pain from a population specific viewpoint. It carries 11 chapters detailing case intervention approaches across the life-span and across co-morbidities. These topic areas traverse Childhood, Elderly, Cancer and Spinal Pain, Acute Pain and pain for those with Psychiatric Illnesses. These chapters are peppered with case-studies which demonstrate application of theory to practice in a very sound and culturally-sensitive manner. Of particular note are references to the ill-fated trend of stigmatising those with chronic pain as “difficult patients” as opposed to patients “with difficult problems”. This is a point which those of us working routinely with clients with chronic pain should particularly heed. The book also nods to international issues and frameworks, with chapters dedicated to Rehabilitation and the International Classification of Functioning, Disability and Health, and Persistent Pain and the Law.

In summary, this book would be a useful addition to the majority of Occupational Therapy bookshelves and should provide a very useful resource to students, novice practitioners and also those more knowledgeable in the field. It is a quick reference tool for updated evidence in the field of chronic pain, while managing to keep the client at the centre of our learning at all times. As stated by the eminent Ronald Melzack (author of the widely acknowledged Pain Gate Theory) “Chronic Pain is the most challenging type of pain” (p.vii Foreword) and we all need to learn to how to treat and respect it in the most effective and client centred away. This book is a good foundation for achieving just this.

Reviewer: Eimear Lyons, MSc. Clinical Therapies; BSc. Occ. Therapy. Senior Occupational Therapist, Dept. of Clinical Therapies, University of Limerick
OCCUPATIONAL THERAPY NEWS:

PhD Conferring

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Title:
The Impact of Preterm Birth on Adaptive Behaviour and Participation in Childhood Occupation

Aim:
Outcome studies to date have focused their attention on the motor, neurodevelopmental and behavioural impairments of preterm infants without relating these deficits to the impact they have on the child’s everyday life. The aim of this study was to compare the adaptive behaviour and everyday participation of children born preterm and Very Low Birth Weight (VLBW) to children born full term and of average birth weight. The World Health Organisation’s International Classification of Functioning, Disability and Health: Children and Youth Version (2007) demonstrates a strong congruence with occupational therapy models and was chosen as the framework to capture Irish preterm infants’ behaviours at the level of ‘activity and participation’.

Method
A case-control study design was used to compare 44 former preterm, VLBW (<1,500 g and/or <30 weeks) (Vermont Oxford Network, 2011) infants between 6 months – 5 years 6 months of age, born in Galway University Hospital, Ireland, with 51 term born peers. Infants were matched for both age and gender. The VLBW infants had an average gestation of 29 weeks, an average birth weight of 1145 grams and did not have a physical or intellectual disability. The Adaptive behaviour Assessment Scale-II (ABAS-II) (Harrison & Oakland, 2003), the Assessment of Preschool Children’s Participation (King et al, 2006) and socio-demographic and medical questionnaires were used to gather data. Data was analysed using both the preterm infants’ chronological ages and their ages adjusted for prematurity. The Irish control group’s scores on the ABAS-II were also compared to the data on the North American reference population in which the scale was developed. Statistical analysis included independent and one-sample t-tests, and linear and multiple regression analysis.

Results
Regardless of whether chronological age or corrected age for prematurity was used, the VLBW group demonstrated statistically significant lower mean scores in overall adaptive functioning in comparison to their full term peers. This difference remained significant when the preterm infants were adjusted for prematurity. The preterm infants also demonstrated significantly lower mean scores in conceptual, practical and social adaptive domains in comparison to the control group when the infants’ chronological ages were used, however this only remained significant for the practical and social domains when the infants’ ages were adjusted for prematurity.

There was no significant difference between the VLBW group and the control group in their intensity of participation in Skill development, Social activities, Active Physical Recreation and Play. There was also no significant difference found between the diversity of participation of both groups in 45 childhood activities.
ABAS-II General Adaptive composite scores of the Irish control group and the North American data. Differences were however found between the practical and social domains, with the Irish control group demonstrating significantly lower mean scores in the practical domain and significantly higher mean scores in the social domain in comparison to the North American normative data. No significant difference was found between the conceptual domain scores.

There was a significant difference between the the ABAS-II General Adaptive Composite score, and Conceptual, Practical and Social Composite mean scores of the Irish VLBW infants and the North American normative data, in favour of the North American data.

**Conclusion:**
Irish children born preterm demonstrated significantly lower scores in adaptive behaviour than their full term peers. This discrepancy was present despite the two groups reportedly participating in a similar intensity and diversity of childhood activities. A number of hypotheses for these discrepancies were explored and merit further investigation.

Cross-cultural testing of the ABAS-II for an Irish population of children is also recommended given the differences between the Irish control group scores and those of the North American normative sample.

**Publications**

Tribute to Dr Sandra Patton
15th March 1972 - 22nd May 2016

We lost a dear friend, colleague, clinician, teacher and talented researcher, Dr Sandra Patton, in May of this year. As a member of the OT community, she is remembered as a passionate therapist with great expertise in the field of paediatrics. In University College Cork and Trinity College Dublin she was a respected lecturer and colleague. In recognition of her great contribution to the lives and learning of students and the wider university community, the UCC College flag flew at half mast on the day of Sandra’s funeral.

Born in March 1972, Sandra was brought up on a farm near Ballybofey, Co. Donegal. She survived the challenges of a childhood illness to excel in education. Sandra qualified with distinction as an Occupational Therapist in 1994 from Trinity College, Dublin and worked in community paediatric services for over 12 years in the UK and Ireland. Sandra chaired the AOTI Paediatric Special Interest Group from 2003 to 2006 and during that time she returned to Trinity College, Dublin as a lecturer in Occupational Therapy. After a great deal of hard work and determination, Sandra completed her PhD entitled ‘Collaborative approach to handwriting with children with Down Syndrome’ in 2011. She was appointed as a lecturer in Occupational Science and Occupational Therapy at University College Cork in February 2012. Her clinical and academic work has centred on therapists, teachers and parents collaborating to support children with special educational needs with particular emphasis on the complexity of task achievement and the importance of environmental and social supports. She prepared papers for publication (several of them pending publication at the time of her death) and contributed to numerous conferences in the field of occupational therapy and in education. Sandra always showed great enthusiasm and attention to detail in planning lectures for students and workshops for parents, teachers and therapists. Parents in particular welcomed her practical approach and support.

Sandra became ill in October 2013 and underwent major surgery in St. James’s Hospital Dublin, followed by chemotherapy in Letterkenny Hospital. The resilience with which Sandra faced her illness over the past two and a half years was remarkable. Never one to sit idle, she used her time in hospital to continue to work on projects and research articles.

Sandra was a friend to many both in Ireland and overseas, and had a particular ability to maintain friendships with those she met throughout her life. To her family and those of us who had the privilege of having her as a friend, her care and kindness was constant and unstinting. She had great compassion and empathy for others in times of difficulty, and always wanted to help in practical ways. She was a modest person, kind and loving, with a wry sense of humour and a hearty laugh.

Sandra was very astute and witty. She was a keen observer of human nature which she often used to gently poke fun at her friends. She was a fantastic writer, a clear thinker and great to talk to. She was interested and supportive, empathetic and insightful.

Sandra was very astute and witty. She was a keen observer of human nature which she often used to gently poke fun at her friends. She was a fantastic writer, a clear thinker and great to talk to. She was interested and supportive, empathetic and insightful.

Sandra had the gift of being able to work extremely hard and had incredible focus. We watched with amazement as she overcame all of the obstacles to complete her PhD. We were astounded and humbled by her heroic journey through her challenges with cancer.

Sandra’s unremitting illnesses took up a large part of her life but they were not what defined her. Last December, she travelled from Donegal to join her colleagues and friends in UCC for the department’s Christmas celebration and spoke enthusiastically of her intended return to UCC in Spring 2016. She had an immense love of life. Sandra loved to travel, in particular to Greece. She loved theatre, music and was a gifted craft person. Sandra was accomplished at knitting, embroidery and crochet. She was able to interpret complicated patterns to create beautiful gifts for her family and friends. Sandra embraced life and new experiences, even when she was gravely ill.

We are so thankful for Sandra, her caring personality, her appreciation of beauty in art, in flowers and handmade things. We are thankful for her tenderness and honest loving concern for her family and friends, for her adventurous attitude and desire to see the world. We are thankful for her bravery, strength and fighting spirit.

Sandra is irreplaceable to so many of us and will be forever missed.

Rest in peace.

Karen Nolan