# Occupational therapists as contributors to health promotion

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## Abstract

This study was undertaken to explore the views of occupational therapists concerning their competencies in health promotion, and their perceptions of how they apply these competencies in their daily work. The study also elicited their views on the contributions that occupational therapists could make to health promotion if given the opportunity. Data were collected in five focus group discussions with 24 occupational therapists. These discussions were tape recorded and transcribed verbatim; data were analysed using qualitative content analysis.

The main findings are that the informants took an individualized salutogenic approach in their work and rarely engaged in health promotion on a systemic or societal level. They believed that their patients and collaborating partners, as well as public officials, remained unaware of their competencies in health promotion. The findings of this study could enrich the discussion among occupational therapists on how they could make a more significant contribution to health promotion on a broader level.


**Key words**: occupational therapy, professional competence, salutogenesis, focus groups, qualitative content analysis


## Introduction

Norwegians are living longer and their health has never been better (1). Paradoxically, according to the Norwegian Government, there are increasing pressures on the health and welfare systems, as well as on the cost of treatment (2). Issues involving lifestyle and the physical and social environment present the greatest challenges. In addition the Norwegian Government recognizes that an effective response must go beyond individual care and illness prevention efforts by health agencies (2). The Norwegian Public Health Act emphasizes the importance of policies that promote social equity in health and reduce the costs of treating diseases related to lifestyle (3). This official recognition underscores the urgency of public health efforts to improve health and living conditions.

Although no definition of public health is universally accepted, Acheson's is widely used: "The science and art of preventing disease, prolonging life and promoting health through organized efforts of society" (4). A 1985 Ottawa conference organized by the World Health

Organization recognized the importance of health promotion, which its so-called Ottawa Charter defined as "the process of enabling people to increase control over, and to improve, their health." (5) Rootman et al (6) have identified the guiding principles of health promotion as: Empowering; enabling individuals and communities to assume more power over the personal, socioeconomic and environmental factors that affect their health, Participatory; involving all concerned at all stages of the process, Holistic; fostering physical, mental, social and spiritual health, Intersectoral; involving the collaboration of agencies from relevant sectors, Equitable; guided by a concern for equity and social justice, Sustainable; bringing about changes that individuals and communities can maintain once initial funding has ended, Multistrategy; using a variety of approaches, including policy development, organizational change, community development, legislation, advocacy, education and communication, in combination (6). Working from a health promotion perspective requires focus on both individuals and community.

The primary task of occupational therapists (OTs) is to promote participation, health and well-being by enabling and facilitating participation in occupations at school, work, in the home and at leisure (7,8). Relying on their client-centred focus, they should be able to engage in empowering occupational therapy practice with individuals, groups and larger populations. The client-centred focus is about valuing and respecting the client, by facilitating a mutual dialogue between client and therapist (9,10), being intimately connected with and depending on participation (11,12). Collaboration is an essential component in client-centred focus (7). Fulfilling occupational therapy's goal of facilitating participation in everyday occupations (8) requires an understanding of how the environment affects health and how health can be promoted. This in turn requires an understanding of the everyday life of all people and the demands it makes on them (13). Occupation is a core concept of occupational therapy. OTs define occupation broadly, as "all that people need, want and are obliged to do" (14) . In this

paper “occupation” is used in terms of participation in various aspects of daily life, both paid employment and everyday activities (15), and henceforth this definition of occupation is used. Many definitions of occupation cited in the occupational therapy literature highlight occupation to be experienced by the individual and to be subjective (16). However, Polatajko et al (17) claimed that “the who of occupation may not only be a single person, but pairs, groups, communities, populations and even societies”. OTs also believe that being involved in meaningful occupations contributes to health (18).

Despite similarities between the guiding principles of health promotion and occupational therapy competencies, little research has been initiated on how OTs contribute or might contribute to health promotion at system- and community level. Seymour (19) looked at OTs view on health promotion, working with older people in Wales, and found that only 5 % of the OTs considered health promotion an important role element of their work (19). Flannery and Barry (20) found a broad positive view of health promotion among Irish OTs, but also more barriers than opportunities for involvement in health promotion. Scriven and Atwal (21) discussed the need for a paradigm shift when it comes to OTs’ perceptions of roles and functions in the United Kingdom, to become a part of the multidisciplinary health promotion workforce. Jones-Phipps and Craik (22) found that second-year OT students had very positive views of the future relationship between health promotion and occupational therapy. Johansson et al (23,24) identified heavy workloads, lack of guidelines and unclear objectives as significant obstacles for OTs and other health professionals to broaden the role of health promotion in the health service. The authors also found that the understanding of holism in health seems to be there. Quick et al (25) found that OTs in primary health care considered health promotion to be important, but they were not involved due to limited knowledge and clinical work taking priority.

Although a majority of OTs in Norway currently work in the community (26), most of them mainly focus on rehabilitation and prevention for individuals, and very few of them work with health promotion at system- and community level. Why is it so? Are the OTs aware of what health promotion work is about? And do they feel that they have the knowledge and expertise to work in this field?

As the literature revealed, very few studies explore the scope of practice of community-based OTs or the use of health promotion in occupational therapy practice. This study aimed at exploring perceptions of the competencies in health promotion of OTs who were not specialized in the field, and elicit their perceptions of how they apply them in their daily work. The study also aimed at revealing their views on the prospects of expanding the contribution OTs make to health promotion.

**Method**

A qualitative research approach was applied in order to reveal unforeseen aspects. Data were collected by five focus group discussions (FGDs). FGDs are well suited for exploring people's views and experiences of concrete phenomena as well as more abstract concepts (27) The data were analysed with qualitative content analysis (28).The participants were encouraged to reflect, develop their own views and discuss statements with the rest of the group. In this way the FGDs elicited nuances and depth that would have been difficult to capture using other methodologies (29). The data were collected between December 2008 and March 2009.

*Participants and data collection*

We went to great efforts to obtain a strategic sample of the field when recruiting informants. Most participants were recruited from municipal public service agencies and hospitals, where

a majority of Norwegian OTs are employed. They were strategically selected with regard to working in different fields, i.e. somatic and mental health and in different municipalities (four). To obtain information on what OTs were taught at school, i.e. their pre-knowledge about health promotion, four teachers from one of Norway's five academic programmes in occupational therapy were recruited. OTs working in private workplaces were not included in the study. They represented only a few of the OTs in Norway, scattered across the country, and it was therefore not practical or economically feasible to include them. The participants were of both sexes and had a range of work experience (Table 1).

A total of 30 OTs were invited using their supervisors, and 29 of them accepted. Five of these individuals did not participate; two became sick, one was on vacation, one had a conflicting appointment with a patient and one gave no reason. Three groups consisted of informants from the same workplace. One group consisted of informants working in different locations but for the same hospital. The fifth group consisted of informants from three small municipalities.

Table 1 Characteristics of the group

| *Group* | *Male/Female* | *Average professional experience years (range)* | *Average experience at current workplace years (range)* |
|---|---|---|---|
| **1** | 0/4 | 31 (37.0-23) | **17 (18.5-13.5)** |
| **2** | 1/3 | 6 (17.5-0.5) | **6 (17.5-0.5)** |
| **3** | 1/5 | 9 (17.5-0.5) | **7 (16.5-0.1)** |
| **4** | 1/4 | 8 (13.5-2.5) | **7 (13.5-0.5)** |
| **5** | 0/5 | 12 (19.5-4.5) | **11 (16.5-4.5)** |
| **Total** | **3/21** | **13 (37.0-0.5)** | **10 (18.5-0.1)** |

In Norway approximately 8.5 % of all OTs are men (26). In this study 12.5% of the participants were male.

Each group had one session; the sessions lasted between 46 and 57 minutes. The first author (VH) was the moderator in every group. An interview guide that focused on the informants'

perceptions of personal competency in health promotion, how they utilize it in their work and their thoughts on the future of health promotion in occupational therapy was used. Examples of questions from the thematic guide included: As an occupational therapist, what kind of knowledge on health promotion would you say that you have? How do you use this knowledge in your daily work? All of the FGDs were tape recorded and transcribed verbatim.

*Ethics*

The Helsinki Declaration (30) was followed in designing and implementing the study, with particular attention to preserving anonymity, confidentiality and professional secrecy. As no patients were involved in the study, approval from the Regional Committee of Medical and Health Research Ethics was not required. The study was registered with the Data Protection Authority to verify proper collection and storage of the study materials. All of the informants were provided with written and oral information on the study in advance and signed these forms before the FGDs were held.

*Data analysis*

The data were analysed by qualitative, manifest content analysis as recommended by Graneheim and Lundman (28) and carried out in the following steps: (i) The text was read through several times to provide an overall impression; (ii) Words and sentences expressing a central meaning (meaning units) were identified; (iii) Data were systematically condensed without changing the original meaning; (iv) The meaning units were labelled with a code, stating their content; (v) Categories, including a number of subcategories, were created. These consisted of groups of codes according to the main themes of the interviews. Special attention was paid to establishing clear differences between (external homogeneity) and similarities within (internal homogeneity) codes and categories (28). The categories were presented to

both authors for agreement, together with selected data extracts. The categories and data extracts were discussed and refined until both authors reached consensus. Validity was increased through the use of two analysts (31), with different discipline backgrounds (one was a physiotherapist, social scientist and professor of public health, well familiar with qualitative methods, the other was an OT and master of public health). These analysts increased validity through their on-going discussions regarding the findings (32).

Table 2 Example of the analytic process

| *Meaning unit* | *Condensed meaning unit* | *Code* | *Sub-category* | *Cate-gory* | *Theme* |
|---|---|---|---|---|---|
| Because we (OTs) know a lot about how to encourage others and facilitate their competency and improved functioning | We know a lot about encouraging other individuals and making them feel competent | Knowledge about encouraging others and helping them feel competent | Client focus | User perspect ive | The OTs' competen-cies in health promotion |
| How do we express our skills, what are we talking about, what do other people understand about what we do, what words are we using to express what we do (in health promotion) | What are we talking about, what do other people understand about what we do, what words do we use to express what we do | How to commu-nicate health promotion in OT | Professions and com-petency | Visi-bility and develop ment | The OTs' thoughts on the potential occupational therapy contribution to health promotion |

## Results

Two themes emerged from our analysis. The first is labelled "The OTs' competencies in health promotion" and includes three categories and sub-categories. The second is labelled "The OTs' thoughts on the potential occupational therapy contribution to health promotion" and

includes one category and two sub-categories. The themes, categories and sub-categories are presented in Table 3.

Table 3 Units of analysis: themes, categories and sub-categories

| ***Themes*** | ***Categories*** | ***Subcategories*** |
|---|---|---|
| *The OTs' competencies in health promotion* | User perspective | Client focus |
| | | Student focus |
| | Occupational perspective | Meaningful occupation |
| | | The occupational therapy process |
| | Health promotion perspective | Health promotion perspective |
| *The OTs' thoughts on the potential occupational therapy contribution to health promotion* | Visibility and development | Profession and competencies |
| | | Roles and jobs |

*Occupational therapist competencies in health promotion*

User perspective

According to the informants, the user perspective is primarily considered to be a client focus, and some suggested a student focus as well. The client focus, according to the informants, refers to a client-centred approach, in which participation of the client is fundamental to ensuring cooperation between the client and the therapist on a basis of equality. The informants emphasized the importance of respecting the client's opinions, needs, wishes and goals, as well as using methods for assuring cooperation between equals. They further viewed assessment of motives and goals as essential to offering and arranging the best possible interventions for clients. As one informant put it, "then we work together [with the client], and we also rely on the expert opinion of the client ... the client expresses great appreciation for ... having a high degree of participation in the process." Regarding the student focus, both the teachers and the OTs stated that when they were students they learned to focus on the

wishes and goals of the users, and had the opportunity to experience this process themselves. The lessons they learned from working in groups included the value of cooperation and being attentive to their peers, as well as how to lead student groups and be aware of each member of a group. Their education included "training in listening and giving.. leading and ensuring that all the participants are included in the group." The teachers confirmed this way of working as an intention of the current teaching in occupational therapy programmes.

Occupational perspective

The occupational perspective, according to the informants, concerns meaningful occupation and the OT process. The informants emphasized that meaningful occupation should be understood as being connected to the holistic view of health that underlies the meaning of occupation in the term occupational therapy. This includes an understanding of the interaction between the individual and the environment. One informant said, "'Based on the environment' means that we adjust our response to individuals based on their environment." Meaningful occupation was primarily understood as referring to the clients' focus. The informants elaborated on this by discussing the importance of respecting each client's understanding of daily living and how he or she experiences it. They stressed that OTs focus on resources and possibilities as well as problem areas. They also emphasized the importance of providing sufficient information and facilitating client efforts to maintain motivation, cope with occupations and continue to manage the routines of daily life on their own. "We definitely experience it… all of us," one informant stated. "What clients are motivated to do and want to do ... we can work to achieve that." The occupational therapy practice process, according to the informants, is fundamental. This process refers to systematic and close collaboration with clients in mapping, assessing, arranging, organizing and initiating actions. The informants particularly emphasized the importance of applying thorough and systematic

mapping and assessing to establish sustainable actions for clients. They emphasized that a focus on solutions rather than problems, and skill in analysing occupations are both essential to effective interprofessional cooperation. To illustrate why this twofold focus is important, one informant cited a situation in which the Norwegian Labour and Welfare Service had enrolled a client with back pain in a training programme to become a bus driver. "If you can't sit for more than five minutes, you do not become a bus driver," observed the informant, who was brought into the case only after the retraining effort had failed.

<u>The health promotion perspective</u>

The informants stated that health promotion is part of their occupational therapy curriculum. In the teacher FGD, it was discussed how this perspective is described and explained to students and the terminology that is used. They also discussed the concept of health. Most of them expressed the view that people can feel healthy in spite of having a disease, and conversely might not feel healthy although they don't have a disease. According to the informants work from a health promotion approach is dependent on the context, and must be based on the interaction between the individual and his or her situation, culture and environment.

*Occupational therapist thoughts on the potential contribution of OT to health promotion*

<u>Visibility and development</u>

The informants were eager to discuss how the profession and competencies of OTs could be utilized more effectively in health promotion efforts. They noted that Norway has relatively few OTs, and many people are not aware of their competencies and skills. Based on this observation, they concluded that greater public information efforts would be valuable. However, many of the informants also admitted that OTs themselves have not been vocal

enough in declaring their skills and competencies. Some said they were unclear about the terminology OTs should use. "What are we talking about is how we ensure that other people understand what we are doing", explained one informant. "What words do we use to explain what we do? Do we have terms for our health promotion work?" According to the informants, meaningful occupation and participation are key concepts in both OT and health promotion. Both concepts should be clearly defined among OTs, as well as in situations involving intersectoral cooperation, officials and society as a whole. "The most important aspect of this in our jobs is to explain what we do and what we can do, both to the public and in the business world," one informant said. "The problem is that the authorities ... everything they want solved, they say that nurses can do it," complained another. "When does it ever occur to them that an OT can do it? They don't understand what our competencies are." Many informants highlighted health policy and knowledge of the authorities to be essential to ensuring that health promotion work will be given the priority it merits and who the contributors will be. In discussing roles and jobs, the informants noted that OTs must innovate if they are to extend their role into new areas, such as health promotion. Some informants suggested that OTs have to win recognition of their competencies and skills through their practice; this could include applying for jobs in new areas. There is a need for more jobs, according to the informants. They believed that more jobs could contribute to innovation in the municipalities, enabling students to obtain new fieldwork placements and good role models in health promotion. They argued that good role models are currently lacking in this field.

## Discussion

This paper elucidates perceptions on the competencies in health promotion of OTs not being specialized in the field, eliciting their perceptions of how they apply them in their daily work

and their views on the prospects for health promotion in OT. The informants of the study described that they worked from a health promotion and salutogenic approach and mostly from an individual perspective.

They considered client participation a fundamental aspect of their work. This view was clearly articulated in the FGDs. They also emphasized that participation and user perspective are closely linked and interdependent. This is consistent with the common health promotion approach, in which participation means being involved (5,6). The informants claimed that promoting clients' health requires ensuring their participation in meaningful occupations. This is consistent with Antonovsky's theory of Salutogenesis (33), in which meaningfulness is a central concept. The client's participation and influence on his or her own life is a basic premise of the Ottawa Charter's discussion of the importance of developing the client's personal skills by providing information, education for health, and enhancing life skills (5). It is also a prerequisite for empowerment, as argued in individual empowerment perspectives (34,35). In the FGDs the informants talked about the influence the individual and the environment have on each other, which could indicate a focus on both personal, socioeconomic and environmental factors (6,36). Studies show that OTs have acquired competencies in health promotion at the systemic and societal level, and therefore could participate in ensuring that municipal health promotion policies encourage citizens to participate and achieve good health on their own terms (20,24). Other studies show that OTs could also contribute to ensuring that clients benefit from sustainable changes and development at the systemic and societal level by pursuing a systematic approach to ensure that clients participate in developing their own long-term goals, as well as by understanding the importance of participation and applying their holistic view of health (7,14). Informants of the present study also expressed that they were convinced that health policy and official knowledge are decisive in determining the priority given to health promotion, as well as who

will contribute to the multi-strategy approach recommended by the Ottawa Charter (5). Their salutogenic focus and their integration of health promotion into their work, in combination with their experience and knowledge on the health and lives of their clients, would indicate they could make an important contribution to health promotion on the systemic and societal level. However, the informants in this study described their current work as being primarily focused on individuals, rather than a systemic or societal approach. One explanation for this narrow focus could be that taking a client-centred approach with an individual emphasis, in line with many occupational therapy definitions on client-centred approach (9-12), prevents them from thinking about or carrying out health promotion at a broader level. Maybe client-centred approach as the definitions are today, is not suitable for health promotion at system- and societal level, and needs to be redefined to match? Leclair (16) argues that a definition and classification of occupation that focuses primarily on the individual creates an inherent bias against encouraging participation in the community's shared occupations. The author also questions whether occupational therapy models of practice focusing on the individual can be adapted for use in a focus on the community (16). Johansson et al (24) emphasizes the need to develop a multidisciplinary model for health promotion practice. Another study found that even though OTs believed that health promotion was one of their responsibilities, many did not get involved in it, claiming their knowledge of the subject was insufficient (25). On the other hand, other studies have concluded that OTs do know a lot about health promotion (21,23). Johansson et al (24) have suggested an explanation for this apparent contradiction; Having a theoretical understanding of health promotion does not automatically mean that OTs will integrate it into their practical work.

The occupational therapists in this study noted that they are a relatively small group in Norway, and lack good role models and placements for students working from a health promotion approach. This affects recruitment to the field of health promotion, according to

the informants. Other studies exploring OTs' views on health promotion have concluded that they experience more barriers than opportunities in their pursuit of involvement in work with a health promotion approach. The barriers cited included staff, time, resources, support and knowledge, heavy workload, lack of guidelines and unclear objectives (19,20,25). The informants in the present study also discussed some of these obstacles, and they advocated the creation of more jobs for occupational therapists in the community. They complained that the public, their collaborators from other fields and public officials are all unaware of their competencies in health promotion. Johansson et al (23) have observed that some professions, among them occupational therapists, are not usually associated with health promotion, even though they have the knowledge and desire to focus on it more intensively. The same authors state that officials have a responsibility to utilize the knowledge of these professionals and facilitate their participation in health promotion work (23). At present this is rarely done. In a study of the role of occupational therapy in primary care, Metzler, Hartmann and Lowenthal (37) found occupational therapy to be only a "supplemental service," even though OTs had core competencies that could enable them to make a much more substantial contribution.

The findings in the present study challenge OTs to discuss and reflect on their role in health promotion work. The informants in this study stated that they work primarily with individuals, and their competencies at a systemic and societal level seem to be little known to agency management, officials and others. They also claimed that their competencies in health promotion could be used to strengthen welfare services and create a community that is more inclusive and promotes health more effectively. The findings also indicate a need for role models that can provide examples of how OTs can work from a health promotion approach in practice. This could stimulate students, other occupational therapists and officials to better use OTs' knowledge and expertise in health promotion work. Therefore new occupational therapy models of practice may be needed for community health promotion work. More emphasis

should then be put on competencies in health promotion on the systemic and societal level in occupational health education.

Further studies on occupational therapists engaged in health promotion work would provide valuable information on how they work and their perceptions of how they apply health promotion in their work, as well as the contributions others in their field could make if given the opportunity. Also a quantitative study of all Norwegian occupational therapists would provide an overview of their current venues and jobs in health promotion.

*Strengths and limitations*

Data were obtained from five FGDs with a broad range of occupational therapists. A qualitative approach was chosen, and is often used to explore people's knowledge and experiences and examine not only what they think about a topic, but also how and why (29). Group interaction is an integral part of FGD studies. By encouraging the participants to talk to each other, ask each other questions and exchange and comment on each other's stories and experiences, they will be stimulated to explore and clarify their views in ways that would be difficult to replicate in one-on-one interviews. Three of the FGDs consisted of individuals from the same workplace; however this did not appear to prevent them from expressing candid opinions. On the contrary, we believe that the FGDs enriched the interviews. However, we are aware that group norms and culture could prevent FGD participants from revealing significant information (29). The informants in this study were recruited from a variety of working areas, as we wanted to obtain the perceptions of individuals who had not chosen to specialize in health promotion. We consider this to be a strength of the study. It might be that some of the informants might have felt that they were coerced into participating, as the invitation came through their supervisor. However, before participating, all of them were provided with written and oral information prepared by the authors containing

assurances that their participation would be voluntary and anything they said would be kept strictly confidential. A third person, not involved in this study, has read the themes and results to validate that the quotations from the group discussions match the content of the text. We also consider this to be a strength of the study.


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