

FRAMING OCCUPATIONAL THERAPISTS'
KNOWLEDGE AND BELIEFS OF ALCOHOL
MISUSE IN PHYSICAL HEALTH CARE
SETTINGS

FIONA MACLEAN

Critical appraisal in partial fulfilment of a PhD
by Published Work



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Abstract

Background: Research exploring occupational therapists' knowledge, beliefs and practice associated with alcohol misuse in physical health care settings is scarce, despite the recognition that professionals are likely to work with people who misuse alcohol irrespective of practice context. Furthermore, the relationship between pre-registration occupational therapy education and practice in the area of alcohol misuse is currently poorly understood.

Aims: This critical appraisal aims to (a) frame the knowledge gaps and existing knowledge of occupational therapists related to alcohol misuse in physical health care settings, through the findings of five *prima facie* case papers and; (b) align this framed knowledge to wider professional literature in order to extend professional understanding of the relationship between education and practice, associated with alcohol misuse in physical health care settings.

Methodology: A gap analysis approach was selected and modified to provide a way of critically introspecting and occupationally classifying the gaps in, and existing knowledge of, student occupational therapists, practitioners and educators linked to physical health care settings and alcohol misuse, as reported in the five papers.

The introspective data linked to gaps and existing knowledge was unified and general inductive qualitative analysis undertaken. One practitioner working in physical assessment for older people in an acute hospital, and one occupational therapy educator provided stakeholder feedback of the tentative themes generated, further refining the analysis of data.

Findings: Two themes emerged from the analysis of data; delimiters of professional education and conceptual contradictions. These indicate there is a need to educate 'educators' concerning the value of teaching alcohol-related policy as part of educational programmes, and in raising the visibility of alcohol as a topic.

Therapists valued the Person Environment Occupation Model (PEO Model), however the essence of 'transaction' fundamental to this model, lacks fidelity in practice. Practitioners appear to separate out the entities of person and environment, placing greater emphasis on the observable aspects of the environment rather than the person, to support timely discharge. Thus, current practice in physical health care supports a process of occupational evaporation connected to alcohol misuse.

Conclusion: These findings help to inform the future direction of educational and practice developments connected to patients' alcohol misuse in physical health care settings, and in so doing, advance and re-emphasise the importance of the centrality of occupation to service delivery.

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Introduction

Research in occupational therapy associated with alcohol misuse has had a tendency to concentrate on mental health settings (Lancaster & Chacksfield, 2008) with an emerging focus in understanding addiction-as-occupation (Wasmuth et al, 2014). Far less professional attention has been paid to the role of education in understanding alcohol misuse, an increasingly prevalent discussion in other disciplines (Brems et al, 2011, Clark, 2005, Samet et al 2006). Additionally, whilst the profession has noted the importance of occupational therapists understanding the nature of alcohol misuse irrespective of practice context (Booth & Mulligan, 1994, Riley et al, 1998, Pierce 2003), limited research exists exploring alcohol misuse in physical health care settings beyond the use of brief motivational counselling to medical wards (McQueen et al, 2006).

Consequently, the collected prima facie papers (appendix 1) have considered occupational therapists' professional knowledge and beliefs associated with alcohol misuse in physical health care settings, informed by pre-registration education. Alcohol misuse as a term here is defined as encapsulating both hazardous and harmful alcohol use, including alcohol dependence (Scottish Government, 2007).

In undertaking the critical appraisal in partial fulfilment of the requirements for the degree of PhD by Published Works, the findings of each of the five prima facie papers have been explored more closely. A modified gap analysis has been created, explained and implemented in order to extend depth of understanding associated with occupational therapists' knowledge and beliefs of alcohol misuse in physical health care settings. This modified gap analysis has been used to generate introspective data that provides further uniqueness of insight exploring the relationship between education and occupational therapy practice, connected to alcohol use. Adopting a general inductive approach of qualitative analysis as part of this process, the

introspective data were analysed and generated two refined themes, each supported by two sub-themes. The refined themes, entitled 'delimiters of professional education' and 'conceptual contradictions', highlight important educational and occupation-focused findings revealing new and novel insights to professional practice and alcohol misuse, signalling a future direction of travel for research and development.

This critical appraisal therefore consists of two sections. Section one introduces the underpinning precepts of gap analysis, including a critical discussion of literature associated with this process. Section 2 introduces the purpose, development and implementation of the modified gap analysis, describing four discrete underpinning elements of this process, these being;

Quadrant 1: Purpose of analysis

Quadrant 2: Occupation-focused critical introspection of existing knowledge and beliefs

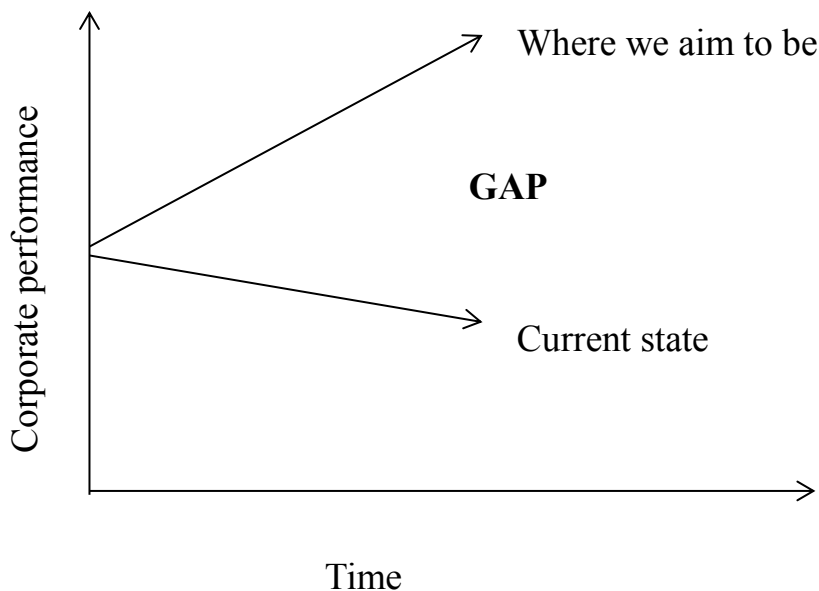
Quadrant 3: Occupation-focused critical introspection of gaps

Quadrant 4: Unification of introspective data, analysis and findings.

Section 1: Introducing Gap Analysis

Gap analysis has been defined by Blank (2015) as a technique used in business to determine what steps need to be taken in order to move from the current state to a businesses desired future state. The origins of gap analysis emerge from business use, typically to establish and list the organisation's current state, the desired state and a comprehensive plan to fill out the gap between these two states (Blank, 2015) (see diagram 1).

Diagram 1: Gap analysis connected to corporate performance.
(Adapted from: Blank, 2015)



Examples of the use of gap analysis in business include Davoren (2015) who has suggested its value in supporting business growth by differentiating between existing business practices that continue to support organisational growth, as opposed to those practices that have become out-dated and require modernisation. Similarly, Friesner (2014) outlines the benefits of gap analysis in helping to define existing marketing strategies and tools, in order to enhance organisational decision-making in defining and choosing future strategies. Both these examples have, at their heart, a focus on two key

questions that broadly underpin gap analysis; ‘where are we now?’ and ‘where do we want to be?’

The essence of these questions translates and connects to a range of practice areas, with the use of gap analysis expanding beyond the boundaries of business. This can be evidenced in bio-science where gap analysis has been used to capture global data associated with conservation planning, supporting the development of conservation priorities and protected areas (Rodrigues, 2004). Similarly, education has embraced gap analysis in order to determine college student satisfaction measured against professional service quality (Hampton 1993). These examples (Rodrigues et al, 2004, Hampton, 1993) illustrate both the growing use of gap analysis, but also the potential complexity associated with answering what appear, on the surface, to be straightforward questions. For example, the recognition in biodiversity research that gap analysis can embrace and frame complexity of data mapping ecological gaps (Convention on Biological Diversity, 2011).

Complexity in understanding the ‘current state’ is not solely confined to business, bio-diversity or education. Parallels can be drawn with health where gap analysis has been used by Continuing Education and Professional Development (CEPD) (2009) to clarify the discrepancy between current reality in health care and optimal health care, identifying an opportunity to be addressed. As such, the central tenets underpinning gap analysis in health are analogous to the use of gap analysis within other disciplines, but this health-related definition importantly also emphasises the identification of an opportunity to address change.

Predominately health and nursing literature has embraced the adoption of gap analysis using it as a tool to identify, understand, address and bridge gaps in service delivery and nursing practice (Davis-Ajami, 2014). Despite this, little discussion of the contradictions and potential challenges associated with using gap analysis exist in health-related literature, and indeed across

other disciplines. Table 1 therefore provides a critical interpretation of the literature associated with gap analysis.

Table 1: Critical interpretation of literature informing the use of gap analysis.

| Concept expressed in literature | Contradiction expressed in literature | Reasoned conclusion |
|---|--|---|
| Gap analysis as a dynamic feedback loop which can monitor progress and data (Davis-Ajami et al, 2014) | Static nature of gap analysis – provides a snapshot, where data can be dynamic and moveable (Washington Gap Analysis Program, 2015) | The goals/reasons why gap analysis is to be used must be clearly defined and stated, identifying if the purpose of analysis is to monitor gaps (dynamic analysis of data), or to address existing gaps (static analysis of data). |
| Gap analysis useful when the desired outcomes or objectives are known, as in benchmarking (Fater, 2013) | Undertaking gap analysis supports the ‘navigation’ towards the desired state by identifying previously unknown or poorly recognised ‘guide posts’ (Schwerzler, 2015) | The goals/reason for undertaking the gap analysis must be clearly stated. Process of implementation must be transparent in order to identify relevant ‘guide posts’ in order to navigate, and plan, pathway towards a desired state. |
| Gap analysis as a tool predominantly linked to business or organisational literature (Blank, 2015) | Increasing range and scope of disciplines utilising gap analysis evident: bio-diversity (Rodrigues et al, 2004), agriculture (van Ittersum et al, 2013), energy efficiency (Bunse et al, 2011), education (Hampton, 1993), geology (Bleiweiss, 1998) | Variations exist in the range of disciplines adopting gap analysis and the purpose for which the tool is used, Indicating flexibility and adaptability of tool. |

| Concept expressed in literature | Contradiction expressed in literature | Reasoned conclusion |
|--|---|--|
| <p>Only one study available in the occupational therapy literature that utilizes GAP analysis (CAOT, 2003).</p> <p>(Refer to appendix 2: search strategy and critical summary of gap analysis literature related to occupational therapy).</p> | <p>Precedents for the use of gap analysis within health have been set; Battye & McTaggart (2003) gap analysis to develop a model for sustainable delivery of outreach AHP services in rural Australia; Wild et al (2014) gap analysis to identify evidence informed priorities of addiction and mental health services from prevention to aftercare in Canada; College of Respiratory Therapists of Ontario (2010) undertook a gap analysis project to support the development of an enhanced model of education for health professionals wishing to become respiratory therapists.</p> | <p>These studies identify the precedent and utility of gap analysis for use in occupational therapy.</p> |
| <p>Tendency of health related literature associated with gap analysis to focus on service delivery (CAOT, 2003, Battye & McTaggart, 2003, Wild et al 2014)</p> | <p>Outwith health related literature, Bunse et al (2011) used gap analysis to compare and contrast the identified industrial needs of energy efficient manufacturing with concepts proposed in industry relevant literature, in order to explore potential implementation gaps.</p> | <p>Bunse et al (2011) effectively undertook an exploration of gaps between practice and theory in energy efficiency, thereby establishing the principle that gap analysis can be used to reconcile current understanding of practice, with theory proposed in professional literature.</p> |

Table 1 highlights that gap analysis has the potential to provide occupational therapy, in common with other professions, a structured tool and method with which to capture, understand and bridge gaps in practice.

Despite the value of gap analysis in providing a clear direction for action and identifying areas to allocate resources where improvement is required (Suh & Erdem, 2009), Tsai et al (2011) recognise that application of a traditional gap analysis can be unsuitable and require modification. Tsai et al (2011) outline in their research a novel, modified gap analysis to further reflect on the contribution of service quality gaps related to customer satisfaction. Consequently, discussion of gap analysis illustrates its use as an organic and flexible tool (Mikoluk, 2013) that can be modified (Tsai et al, 2011) in order to suit profession-specific needs, to reconcile what is known to a potential future state.

Irrespective of how a gap analysis may be modified for implementation, a common framework sustains its use. In conducting a gap analysis, typically a four-quadrant pattern can be followed (Mikoluk, 2013). Table 2 highlights this generalised quadrant structure.

Table 2: Quadrant stages in conducting a gap analysis (adapted from Mikoluk, 2013, CEPD, 2009 Schwerzler, 2015).

| Four Quadrants of Gap Analysis | Definition of stage |
|---------------------------------------|---|
| Quadrant 1 | Identify/describe purpose & current state of knowledge/business, for example |
| Quadrant 2 | Identify the future state or where unknown, identify the 'guide posts' that navigate towards a future state |
| Quadrant 3 | Clarify the gap/discrepancy between stage 1 & 2 |
| Quadrant 4 | Gap resolution; discussion how the gaps can be resolved |

This generic pattern of gap analysis (table 2) forms the foundation of a modified version, created and implemented as part of this critical appraisal.

As section 2 highlights in more detail, the modified gap analysis conducted here focuses specifically on framing the knowledge gaps and existing knowledge of occupational therapists related to alcohol misuse in physical health settings, through the findings of the five prima facie case papers. Additionally, it attempts to align this framed knowledge to wider professional literature in order to extend professional understanding of the relationship between education and practice, linked to alcohol misuse.

To understand the relationship between education and practice, the modified gap analysis embraced an introspective approach (refer to page 15), which acknowledges the cognitive processes and interpretations of our own actions (Overgaard, 2006). With a focus on knowledge and beliefs, this modified gap analysis supports introspective reflection on each of the findings sections of the prima facie papers. It crafts an organised way of extending understanding about, and critically reflecting on, occupational therapists' knowledge linked to alcohol misuse.

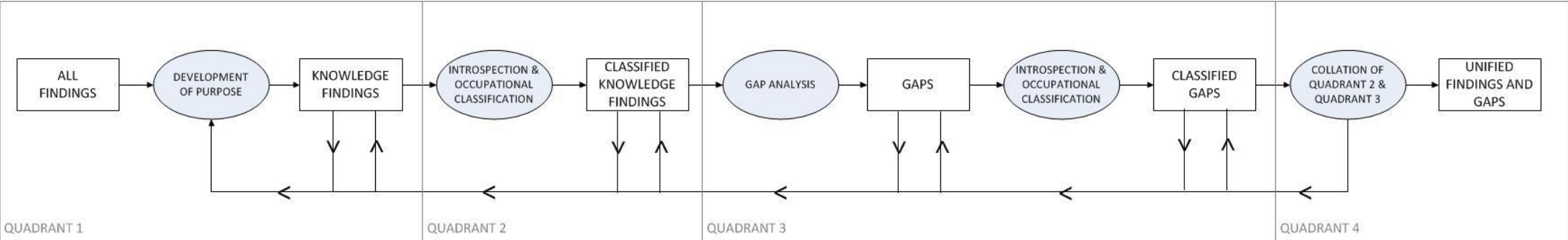
Diagram 2 illustrates this modified gap analysis capturing initially each of the findings sections of the prima facie papers, distilled in order to identify the purpose of analysis; the identification of professional knowledge and beliefs (quadrant 1, purpose). Findings linked to existing professional knowledge and beliefs were identified from each paper and compared to support understanding of the 'current state', viewed through an occupation lens (PEO Model) (quadrant 2). Quadrant 3 similarly sought to identify gaps in professional knowledge and beliefs from each paper, again framing these within the context of occupation using the PEO Model. Finally, in quadrant 4, gaps in knowledge and existing findings were collated to form an introspective transcript. General inductive qualitative data analysis was then used to identify consistent themes emerging from the introspective transcript, leading to conclusions signalling toward a desired 'future state'.

Whilst diagram 2 and subsequent discussion of this modified gap analysis essentially describes a linear process, in reality the implementation involved frequent iteration. Checkland & Poulter (2006) describe how linear systems theories, similar to this, are never followed “flat-footed” (p. xvii). Rather, they are described linearly in order to aid explanation. In practice, undertaking quadrants (1) to (4) involved fluidity and iteration of each element within the process.

Noteworthy also is that this is a system that can be similarly described by Checkland & Poulter (2006) as an “action to improve” (p. xvi). It presents a process through which thinking is structured and organised in order to bring about improvement of professional practice. In this case, how education can influence alcohol misuse practice in physical health settings. The analysis conducted here however, represents only one world-view or perspective of the existing knowledge and gaps in the findings of the prima facie papers. Indeed, another individual researcher undertaking this same process may influence an alternative direction and outcome of the analysis presented here. It is also recognised that incorporating a group process in order to embrace different people with potentially conflicting worldviews of the prima facie findings, could further influence this analysis. This has been balanced, to some extent, through the inclusion of stakeholder feedback in to the process, outlined on page 31.

Section 2 of the critical appraisal now outlines in detail each quadrant of the modified gap analysis conducted here.

Diagram 2: Diagrammatic representation of a modified gap analysis.



Section 2: Modified Gap Analysis and Findings

Quadrant 1: Purpose of analysis

Clark & Estes (2008) suggest that when undertaking a gap analysis three critical factors may be examined during the process. Those three factors are:

1. People's knowledge and skills;
2. Their motivation to achieve a work goal (particularly when compared with other work goals they must also achieve); and
3. Organizational barriers such as a lack of necessary equipment and missing or inadequate work processes.

Essentially, the purpose therefore of a gap analysis is to identify whether all employees have adequate knowledge, motivation and organizational support to achieve important work related goals (Clark & Estes, 2008). To understand why these three elements are important in 'analysing' gaps, Clark & Estes (2008) use the metaphor of 'people as cars'. Knowledge is seen as the engine and transmission system, motivation is what energises the system as fuel and charge in the batteries, and organisational factors are the current road conditions that can make it easier or more difficult to get to your intended destination.

Translating this metaphor to the five prima facie papers included in this critical appraisal, illustrates the combined papers' focus has been on the 'engine' or understanding the transmission of occupational therapist knowledge and skills. This is of importance as people are often unaware of their own lack of knowledge and skill deficits, or reluctant to disclose difficulty (Clark & Estes, 2008), thus limiting the potential to achieve goals.

Whilst professional knowledge and beliefs is the focus of this modified gap analysis, there is recognition that this will capture only one aspect of the three-part purpose identified by Clark and Estes (2008). Knowledge is however the key 'connector' between the prima facie papers and, whilst analysis of motivation and organisational barriers is indicated in aspects of the collective findings, these elements are far less aligned to the original stated aim and objectives of the research papers. In developing the purpose of analysis, and guided by Clark & Estes (2008), there is a focus on understanding occupational therapists' knowledge and beliefs. Consequently, the aims of this modified gap analysis are to:

1. Frame the gaps and existing knowledge of occupational therapy students, practitioners and educators related to alcohol misuse in physical health care settings, through the findings of the five prima facie case papers.
2. Align this framed knowledge to wider professional literature, in order to extend professional understanding of the relationship connecting education to practice, associated with alcohol misuse in physical health care settings.

The objectives of this modified gap analysis are to:

1. Critically introspect and occupationally classify existing knowledge and beliefs identified in the findings of the five prima facie case papers;
2. Critically introspect and occupationally classify existing gaps in knowledge and beliefs identified in the findings of the five prima facie case papers
3. Unify the occupation-focused introspective data from objectives 1 and 2, aligning this to wider professional literature in order to propose new knowledge supporting the direction of travel towards a future state.

With the purpose of analysis clearly delineated, quadrant 1 culminated with iterative reading of each of the findings sections of the prima facie papers to identify occupational therapists' knowledge and beliefs connected to alcohol misuse. The existing knowledge and belief findings identified from each paper are documented in appendix 3, leading to the occupation-focused critical introspection, considered in quadrant 2.

Quadrant 2: Occupation-focused critical introspection of existing knowledge and beliefs

Mikoluk (2013) states that every gap analysis should start with introspection, however introspection as a concept remains undefined within literature associated with gap analysis. Historically, introspection as a technique emerged from the discipline of psychology, considered by Wilhelm Wundt (1832-1920) (Cherry, 2015). Wundt developed a process through which trained observers were presented with controlled sensory events, and then asked to describe their mental experiences of these events, repeated on numerous occasions (Cherry, 2015). The purpose of these observations was not simply to identify the structure or elements of the mind, but of essential importance, also the processes and activities that occur as people experience the world around them (Cherry, 2015). Introspection therefore, was seen as a process of tracking, experiencing, and reflecting on one's own thoughts, mental images, feelings, sensations and behaviours (Gould, 1995). Despite its origins in psychology, introspection as a psychological technique has, as Hatfield (2005) points out, been in decline and rarely used in the 20th century, due to concerns surrounding the unscientific nature of introspection and the belief that it was conceptually impossible. This controversy can be typified by Frith & Lau (2006), who summarise critical views of introspection, thus;

“The implication, when people introspect [concerning] such processes, they are effectively making up a story” (p761).

Alternative interpretations of introspection do exist however; acknowledging people do not have introspective access to their own cognitive processes, but still have experience and interpretation of their own actions (Overgaard, 2006). Consequently, it does not automatically follow that the introspective report is invalid (Overgaard, 2006). Whilst not explicitly stated as such, introspection was used by Neville-Jan (2003) in her auto ethnography of her experience of chronic pain, creating her own narrative to reflect on how occupational therapists can more effectively work with persons experiencing chronic pain.

Wallendorf & Brucks (1993) note this form of introspection as that of researcher-introspection. In this form of introspection, the researcher is the sole introspector of the study and studies him/herself, whilst the context of study is some aspect of the researcher's life experiences (Wallendorf & Brucks, 1993). In applying researcher introspection, Wallendorf & Brucks (1993) argue that the time period covered by introspection can be through retrospection reports; reports in the present on an event from the past, commonly associated with survey research. Time is also applied as a projection into a hypothetical future, asking the introspector to conjecture about responses that might occur under certain circumstances (Wallendorf & Brucks, 1993). Crucially, these elements of introspection connect with the overarching purpose of a gap analysis; that retrospective analysis of research can support the description of a pre-existing 'current state', and a projection in to a hypothetical future, supporting the navigation towards a desired 'future state'. Further, the synergy between introspection and survey research as suggested by Wallendorf & Brucks (1993), articulates with the recommended process of data collection underpinning gap analysis suggested by Clark & Estes (2008). In other words, multiple data collection techniques should be used to form the foundation of gap analysis (Clark & Estes, 2008) in order to understand and close identified gaps. Data collection techniques suggested by Clark & Estes (2008) include focus

groups, surveys and active listening; all of which underpin the data collection processes connected to the prima facie papers.

Whilst parallels between introspection and gap analysis can be drawn, increasingly the terms introspection and reflection can be seen to be used interchangeably in the health science literature. For example Rod (2011) uses the basis of introspection to revisit a piece of action-orientated research he undertook, providing a 'first-hand' critical account of the research process, inter-changeably framing this using both reflection and introspection. Additionally Vachon et al (2009) consider both introspection and critical reflection as key to the continuing education of occupational therapists to challenge previous assumptions and taken for granted knowledge, in order to facilitate self-evaluation and the development of self-directed emotional skills to identify when and how to try new knowledge in practice. In other words, an introspective orientation, as suggested by Hunt et al (2014), supports clinicians to be alert to the ways that their assumptions shape perceptions of a given situation.

Finlay (2003) however perhaps most closely describes introspection as it is understood and used within occupational therapy literature. Finlay argues that introspection is merely a variant of reflexivity and therefore the researcher is a central figure that actively constructs the collection, selection and interpretation of data. The challenge for the introspective researcher is to use personal reflection not as an end in itself, but as a springboard for interpretations and more general insight.

This view offered by Finlay (2003), informed by a researcher-introspective stance (Wallendorf & Brucks, 1993), has been used to 'shape' the introspective perspective adopted here as part of quadrant 2 of this modified gap analysis. An introspective, critical self-evaluation of the assumptions and thoughts connected to the knowledge and beliefs identified from quadrant 1, has been undertaken and presented in appendix 3. This perspective also incorporates the identification of potential, existing 'guide

posts', in order to reconcile introspective thinking with theoretically sensitive theory proposed in the professional literature. Key elements of introspection informing the researcher-introspective stance adopted are outlined in table 3.

Table 3: Key elements of the researcher-introspective stance (& related techniques) adopted for use.

| Identified elements of introspection (or related techniques) relevant to the modified gap analysis | Translation of introspective elements to modified gap analysis |
|--|---|
| Researcher introspection: the researcher/introspector are the same person (Wallendorf & Brucks, 1993); the context of study is some aspect of the researcher's life (Wallendorf & Brucks, 1993). | Introspection was undertaken by the author of the critical appraisal (Maclean) related to the research she has undertaken, associated with her experiences, thoughts and assumptions of the findings sections of five prima facie papers. |
| Retrospective reports (Wallendorf & Brucks, 1993) | Introspection of the findings sections occurred retrospectively, supporting the identification of potential 'guide posts' (see table 1) |
| Projection in to a hypothetical future (Wallendorf & Brucks, 1993) | Introspection supported identification of 'guide posts' supporting and/or connecting navigation of the existing state, to a 'future state'. |
| Additional sources of data used to support researcher-introspection, associated with survey data (Wallendorf & Brucks, 1993) | Researcher-introspection did not occur in isolation, instead focused on the findings of the five prima facie papers, utilising (in three papers) survey methodology. Wider literature was also explored. |
| Introspection allied to critical reflection (Vachon et al, 2009) | Past assumptions were challenged; facilitating critical self-evaluation of findings, to identify when and how findings could inform and/or connect to the future state. |
| An orientation towards introspection and critical reflection, supporting an alertness to potential assumptions (Hunt et al, 2014) | Past assumptions were challenged; facilitating critical self-evaluation of findings, to identify when and how findings could inform and/or connect to the future state. |
| Use of personal reflection not as an end in itself, but as a springboard for interpretation and more general insight (Finlay, 2003) | Supported the navigation towards a 'future state', by providing additional and refreshed insight and thinking. |

To critically reflect on existing knowledge and beliefs, introspection must also be supported by the occupational classification of key findings framed by a theoretical structure. The Person Environment Occupation Model (PEO Model) (Law et al, 1996) was used to classify and organise introspective knowledge and belief findings connected to this modified gap analysis, as it is clearly an occupation-focused model. This is of relevance as the use of an occupation-focused model to organise and structure key findings enables the data to be organised in a manner that retains a focus on occupation, which is philosophically crucial to occupational therapists (Hitch et al, 2014). Many of the major conceptual models of practice in occupational therapy have been developed in the context of Western views of health (Turpin & Iwama, 2011), historically concentrating on the participation of individuals (Turpin & Iwama, 2011). Examples include the Model of Human Occupation (MOHO) (Kielhofner, 1985, 1995, 2002, 2008), and the Canadian Model of Occupational Performance and Engagement (CMOP-E) (Townsend & Polatajko, 2007).

Whilst the PEO Model can be placed within this context, in addition it offers an approach providing a systematic way to analyse complex occupational performance issues within the context of occupational therapy (Law et al, 1996). This is supported by a 'transactive' element of the model, where the person and environment are seen as interdependent and that a person's behaviour cannot be separated from the context in which it occurs (Turpin & Iwama, 2011). It has been used therefore to provide a framework for data analysis and interpretation of findings (Strong & Gruhl, 2011). For example, Gibbs et al (2010) used the PEO Model as a framework for illuminating the acquisition of parenting occupations in neonatal intensive care. Further, Metzler & Metz (2010) used the PEO Model to examine current research related to barriers and facilitators of knowledge translation relevant to occupational therapy from the perspective of the PEO Model. The advantage, according to Metzler & Metz (2010) of employing the PEO Model to frame knowledge around the concepts of occupation, person and

environment, are two fold. Firstly, it utilises a systems approach (compatible with gap analysis) which they define as the use of a structured, holistic model that encompasses both micro-influences, (e.g. within this context therapist knowledge), and macro-influences (e.g. within this context Government driven policy). Secondly the PEO Model supports a focus on occupation, already identified by Hitch et al (2014) as of central importance.

Using this model the fit between patients' occupation-focused activities underpinning alcohol misuse in physical health care practice (the occupation), the occupational therapist (the person), and the context in which therapists provide service (the environment) may be closely examined. Law et al (1996) defines the relationship between these three concepts as 'transactive' in the sense that a transactive approach presents the person and environment as interdependent, and that a person's behaviour cannot be separated from the context in which it occurs. As Turpin & Iwama (2011) point out, occupational performance is thus a context-, person-, and occupation specific process, interacting dynamically across the lifespan.

Consequently, the introspective data generated from the five prima facie papers were then categorised as person, environment or occupation, recognising that aspects of some findings are likely to overlap, highlighting key transactions among person-environment-occupation factors.

Finally, quadrant 2 also reconciled the generation of occupation-focused introspective data with potential 'guide posts' identified from existing professional literature. Journal articles and books were explored and selected via the QMU library catalogue and databases CINAHL, PsycINFO and Proquest from 1990 to 2015. Relevant articles and books were also obtained via snowballing by going through the reference lists of selected articles. Literature was also obtained via personal communication with colleagues.

Appendix 3 outlines the tables generated of critical introspection and occupational classification connected to professional knowledge and beliefs from the findings of the prima facie papers.

Quadrant 3: Occupation-focused critical introspection of gaps

Quadrant 2 of the modified gap analysis presented an opportunity to critically introspect and occupationally classify the 'current state' or 'what is known', connected to knowledge and beliefs. Now in quadrant 3, the focus is to consider what Clark & Estes (2008) describe as the 'known to be unknown' in gap analysis. In this case the identification, critical introspection, and occupational classification of the knowledge gaps evident in the findings of the prima facie papers. In understanding the 'known to be unknown' it may be possible, through the focus here on professional knowledge, to enhance practice performance. Clark & Estes (2008) acknowledge the opportunity to enhance performance, but further, through the recognition and acceptance of potential gaps, this can also mark the frontier of knowledge development. There are risks due to the unknown, where knowledge may be incomplete or inadequately tested, however opportunity exists to learn more and contribute to knowledge enhancement (Clark & Estes, 2008).

The analysis of gaps seeks to identify both the known gaps in knowledge from the findings of the prima facie papers, as well as gaps not previously considered. In tandem with quadrant 2, quadrant 3 also critically and boldly seeks to introspect the identified gaps and classify these within an occupational framework. Whereas quadrant 2 considered the identification of 'guide posts' to reconcile knowledge findings with theory proposed in the professional literature, quadrant 3 instead replaces this aspect of the analysis by defining an alertness of opportunity, promoting and encouraging creative boldness of theory enhancement.

Alternative methods of contributing to knowledge enhancement are available in the occupational therapy literature, of which parallels can be drawn with the identification of gaps. For example, Ikiugu (2010) outlines the use of the extrapolation method, originally proposed by Mosey (1996), defined as the process of extrapolating “an unknown from something known” (p. 197). This process, as discussed by Ikiugu (2010), involves sequential steps, as does gap analysis. It was developed in order to address clinical problems for which no guidelines were available, or existing available guidelines were perceived to be inadequate (referred to as an ‘enigmatic’ problem). Unlike gap analysis however, Ikiugu (2010) proposes that the use of the extrapolation method requires that the problem under consideration must be “clearly and completely defined and described, including determining whether it is a single or a multicomponent entity” (p.198), linking this directly to clinical problems and/or to theoretical conceptual models of practice. An advantage in the selection and use of gap analysis is its attention to broader areas of concern, which can include professional knowledge, as is the case here. Additionally, gap analysis can also provide greater flexibility in organically ‘growing’ and understanding the current state of knowledge, including disparities within, which can support interpretation of the implied and/or unspoken recognition of problems or challenges, scaffolding the potential of an enhanced future state.

Similarly, Wimpenny et al (2006) attempted to ‘bridge’ the theory/practice gap by using a scholarship of practice framework, embedding therapist group reflective supervision throughout three occupational therapy mental health teams in order to focus on MOHO. Whilst the scholarship of practice framework supports the use of reflection to inform the development of theory from practice, this research specifically encouraged therapists to consider how their reflective contributions had the potential to add specifically to the growing MOHO evidence base (Wimpenny et al, 2006). Transferability of this process to explore broader gaps in professional knowledge, beyond MOHO, appears limited. The method described by Wimpenny et al (2006)

supports the refinement and knowledge diffusion of a pre-determined existing conceptual model of practice (MOHO), as opposed to a broader understanding of knowledge gaps. The approach undertaken by Wimpenny et al (2006) does however value a reflective approach in advancing understanding of therapist knowledge related from theory to practice.

Whilst similarities can be identified between the extrapolation method (Ikiugu, 2010), in terms of identifying an unknown, and Wimpenny et al (2006), through the use of reflection, each has limitations in their transferability to exploring professional knowledge gaps connected to alcohol misuse in physical health settings. By embracing gap analysis, Clark & Estes (2008) suggest that identifying and understanding gaps in knowledge provides an opportunity to learn more about the potential of existing knowledge, contributing to theory development and enhancement. Consequently, a gap analysis adopting a critical researcher-introspective stance, allied to occupational classification, exploring knowledge gaps of therapists linked to alcohol misuse in physical health care settings has been adopted. This aspect of the modified gap analysis is also founded on an alertness to opportunities, which has not gone unrecognized in wider occupational therapy literature.

To some extent McClure (2011) alludes to the alertness of opportunities in her discussion of entrepreneurship. She defines entrepreneurship in occupational therapy as developing and enhancing existing organisations and developing and renewing communities. She argues that entrepreneurship essentially focuses on acting, thinking and behaving in an enterprising and innovative manner, which makes a difference and adds value to society. McClure (2011) links this explanation to Timmons & Spinelli (2009) description of entrepreneurs as individuals on the lookout for new opportunities that add value to people's lives. Essentially therefore the discussion of entrepreneurship in occupational therapy has generally tended

to centre on the development of innovative ways in which to deliver services to enhance people's lives.

Beyond occupational therapy, from the nursing literature, Herron & Herron (1991) concur with McClure (2011) the essence of entrepreneurship to be that of innovation, leading to the recognition of two central tenets; the importance of embracing alertness to opportunity and therefore the potential to implement change. Unlike McClure (2011) however, Herron & Herron (1991) also consider entrepreneurial vision, alertness and action, to focus on an alertness of opportunity to build a firmer conceptual basis for practice in hospital environments. That is, the profession of nursing, in order to support the building of professional practice models, could use entrepreneurship theory to accommodate theoretical developments. To achieve this, Cutcliffe (2003) introduces a case for intellectual entrepreneurship. Intellectual entrepreneurship implies a conscious and deliberate attempt on the part of academics to explore the world of ideas boldly (Cutcliffe, 2003). Cutcliffe (2003) argues that the process and emphasis on writing reflexive accounts and engaging in reflexive activities connected to qualitative research, may create a situation where researchers become more concerned about accounting for themselves, than bringing all their creative, analytical and interpretative abilities to bear with their data. Cutcliffe (2003) does not suggest this means there is the possibility to ignore rigour and credibility within qualitative research, but,

“there may be merit in encouraging researchers to pay less attention to matters of reflexivity and more attention to allowing all their creative, analytical, and interpretative abilities to flourish – to being bold” (p. 145).

Relating this to theory development and construction, Cutcliffe (2003) argues that intellectual entrepreneurship points to the need for researchers to be bolder in their theory construction and to trust their own tacit and intuitive knowledge. These ideas presented by Cutcliffe (2003) are of relevance both

in establishing the need to be alert to opportunities, but also in influencing and framing the colour and hue of introspective thinking undertaken by the researcher here, linked to the exploration of knowledge gaps in the findings of the prima facie papers.

Appendix 4 outlines the tables of gaps, occupationally classified, and introspective data generated as part of quadrant 3

Quadrant 4: Unification of introspective data, analysis and findings

Analysis

Objective three of the purpose of this modified gap analysis is to unify the occupation-focused introspective data from quadrant two and three, aligning this to wider professional literature in order to propose new knowledge supporting the direction of travel towards a future state. To achieve this the introspective data from quadrants 2 and 3 were combined to form an introspective transcript. Steps taken to unify the introspective data are outlined in Table 4.

Table 4: Six-step process undertaken to unify introspective data from quadrants two and three.

| |
|--|
| <p>Step 1: The introspective data from quadrant 2 were electronically selected from each table of occupation focused critical introspection found in appendix 3, and copied to produce and assemble a combined catalogue of introspective thinking connected to existing knowledge and beliefs.</p> |
| <p>Step 2: Introspective data from quadrant 3 were electronically selected from each table of occupation focused critical introspection of gaps found in appendix 4, and copied to produce and assemble a combined 'catalogue' of introspective thinking connected to gaps in knowledge.</p> |
| <p>Step 3: Separately, each catalogue of introspective data was checked and matched against the original introspective thinking in each of the tables in appendix 3 and 4, to ensure accuracy. A second, independent researcher undertook this process of matching and checking.</p> |
| <p>Step 4: The introspective catalogues were then electronically combined to form one complete introspective transcript, consisting of two parts: (i) introspective data connected to existing knowledge and beliefs (ii) introspective data connected to gaps in knowledge.</p> |
| <p>Step 5: Introspective transcript formatted into a table (appendix 5), to support initial analysis in context of raw data.</p> |
| <p>Step 6: Iterative reading of the introspective transcript in order to compare gaps in knowledge against existing findings to begin to pinpoint consistency of patterns emerging from the introspective critical reflections.</p> |

The combined introspective transcript became the key data source for further analysis for two reasons;

1. It provided an informative, critical discussion of the five prima facie paper findings, originating from a systematic framework, supporting transparency in the evolution and creation of data used for analysis.
2. Amalgamation of the introspective data provided a conduit between the 'current state' and a possible 'future desired state', helping to 'unpick' anomalies, regarded by Schutt (2011) as the "windows to insight" (p. 323).

A general inductive approach for qualitative data analysis, as recommended by Thomas (2006) was adopted. The process of inductive analysis primarily refers to detailed readings of raw data (the introspective transcript), in order to derive concepts, themes, or a model through interpretations made (Thomas, 2006). As part of this modified gap analysis, the generation of themes, defined as general propositions that emerge from data (Bradley et al, 2007), provides the platform through which the desired future state can be identified.

Whilst alternative data analysis strategies exist (see table 5), a general inductive approach has no set expectations concerning the data, thus it provides a framework that captures key themes and processes judged to be important by the researcher (Thomas, 2006). This essence of a general inductive qualitative analysis has synergy therefore with the introspective approach adopted throughout.

Table 5: Comparison of qualitative analysis approaches (adapted from Thomas, 2006).

| | General Inductive Approach | Grounded Theory | Discourse Analysis | Phenomenology |
|--|---|---|--|---|
| Analytic strategies & questions | What are the core meanings evident in the text, relevant to evaluation? | To generate or discover theory using open and axial coding and theoretical sampling | Concerned with talk and texts as social practices and their rhetorical or argumentative organization | Seeks to uncover the meaning that lives within experience and to convey felt understanding in words |
| Outcome of analysis | Themes or categories most relevant to research objectives identified | A theory that includes themes or categories | Multiple meanings of language and text identified and described | A description of lived experiences |
| Presentation of findings | Description of most important themes | Description of theory that includes core themes | Descriptive account of multiple meanings in text | A coherent story or narrative about the experience |

The initial analysis involved reading and re-reading the introspective transcript in order to generate impressions of the data. Iterative reading of the transcript led to the creation of initial summary themes, developed in the context of the raw data (see appendix 5). The summary themes from the raw data were then explored for emerging patterns, and initial tentative themes were generated, outlined in appendix 6. These tentative themes were then matched back to the raw data and used to 'frame' the reading of the transcript 'horizontally', which involved grouping segments of text by theme. The segments of texts were then matched to theoretically sensitive literature from both within and beyond the discipline of occupational therapy,

constructing the emerging precepts, scaffolding the process of theme generation. This iterative process of structuring, sifting and shaping the tentative themes, collapsing one in to another, distilled two refined central themes (appendix 6), supported by subthemes. These themes are identified in table 6, and considered in detail in the Findings section (page 36).

Table 6: Refined themes and supporting sub-themes.

| Refined Theme | Supporting Sub-Themes |
|---|---|
| Theme 1: Delimiters of Professional Education | Sharing policy perspectives Educational locus of control |
| Theme 2: Conceptual Contradictions | Partitioning of the person Occupational evaporation |

Trustworthiness

The introspective data essentially represents a first person account, or self-examination using an occupational filter, of opposing thoughts and feelings associated with the findings of the prima facie papers. Whilst criticism of this form of introspection exists, lacking validity (refer to step 2), Gould (2006) nevertheless values first person, introspective experience as an indispensable source of evidence. However attention to trustworthiness is of importance in establishing rigour within this work.

Lincoln and Guba (1985) describe four general types of trustworthiness in qualitative research: credibility, transferability, dependability, and confirmability. Of these, Thomas (2006) argues undertaking peer debriefings and stakeholder checks in order to establish credibility, and conducting a research audit linked to dependability are amongst the most important. A further step in attempting to assure trustworthiness has also been included here, that of creative abundance (Schutt, 2011). Schutt (2011) argues that it is imperative to seek creative abundance in order to look for alternative interpretations of data. Each of the aforementioned elements noted associated with trustworthiness have been integrated into this stage of the analysis and each are now described.

Peer debriefing: peer review meetings were undertaken within the doctoral supervisory team probing the methodology, interpretation and direction of the critical appraisal. This supported refreshed thinking associated with the appraisal generally and specifically supported the generation of themes. Caution however has also been noted in literature associated with using only peers who may be connected to the research in some way, as they may fall in to the same habitual thinking as the researcher themselves (Bradley, 2007). Therefore diversity of backgrounds should also be sought to improve the breadth and depth of the analysis process and subsequent findings (Bradley, 2007). Consequently, the summary themes, refined themes and findings were also reviewed, checked and agreed by an experienced, independent researcher.

Stakeholder checks: Thomas (2006) argues the value of stakeholder checks allows people with a specific interest in the field under consideration to comment and/or assess the findings, interpretations and conclusions. As part of this process the themes, findings and conclusions were distributed to two experienced occupational therapy practitioners, currently working in physical health care settings. One responded with feedback, see table 7. Additionally, the same material was provided to a member of the occupational therapy academic teaching team at Queen Margaret University, external to the doctoral supervisory team for comment (table 7). In both cases the extent to which their personal comments matched and/or contrasted with the themes, findings and conclusions were explored, and feedback integrated in to the final analysis.

Table 7: Stakeholder check feedback

***Stakeholder feedback 1**

Description of stakeholder: Stakeholder 1 is an occupational therapy practitioner working in a physical assessment ward for older people in an acute hospital. Stakeholder 1 has 20 years experience as an occupational therapist and has worked for the last 10 years in this setting.

Stakeholder 1 feedback:

I've had a read through the draft findings and agree with your findings, in particular that there is a lack of use of occupation-focused theories within the area of alcohol misuse (and in general!). I feel in-patient therapists in a physical setting are unsure of how to address this area of a patient's lifestyle due to a lack of time / education / belief that the person's behavior can be influenced / acceptance that it may be part of their role, as well as pressure from the service to expedite discharges. As a result they are simply dealing with what's in front of them (e.g. effects of alcohol misuse - falls / liver disease / cognitive impairment / housing issues) and getting people to a level where they are physically ready for discharge and their home environment is safe(r) for them to be discharged to.

***Stakeholder feedback 2**

Description of stakeholder: Stakeholder 2 is an occupational therapy academic and member of the learning and teaching team at Queen Margaret University. Stakeholder 2 is external to the doctoral supervisory team and has five years experience of working and engaging with both quantitative and qualitative research methods.

Stakeholder 2 feedback:

How far is it the responsibility of/reasonable for educators (as opposed to continually developing professionals) to ensure that practicing OTs are able/willing to stay up to date with policy and make sure this informs their practice? It would seem to be a Sisyphean task as policy changes (arguably faster than evidence at times!). Should the focus of professional education courses be less about a specific subject area (i.e. alcohol policy) and more about equipping students with the ability and confidence to engage with and act upon policy throughout their careers? I don't know if that makes sense but presumably it aligned with thoughts about theory and practice gaps – if memory serves some of the conceptual models suggest political context as part of the environment in which human act as occupational beings – is it another example of the a lack of engagement with some models?

The quote from nursing would perhaps appear to be in relation to the practice education element of professional courses (as opposed to the classroom

elements). I'm not sure if the distinction is made elsewhere but I would argue that classroom based education would not be the best way to equip students with the skills to 'cope' with patients in real life – I would expect this to be the sort of skill learnt on placement so perhaps the focus from a curricular point of view should be on identifying addressing this from a PP point of view.

This is simply because, whilst it's a contributory factor, very few OTs will see people for alcohol problems unless in specialists services (knowledge about alcohol might be very useful for people being seen for falls, cardiac problems etc.) but in this way alcohol is analogous to many different contributory/risk factors that don't necessarily get looked at in huge detail during a professional education course (how much time do we actively spend teaching other elements of risk for commonly seen occupational dysfunctions

- previously experience of sexual/psychological abuse, topically- PTSD
- associated with military service, other common chronic conditions (obesity, diabetes, physical inactivity)

*Permission was sought and granted from both stakeholders 1 and 2 to include their feedback in this critical appraisal. In order to anonymise the data some unessential descriptive details may have been removed from the text.

Creative abundance: As previously discussed, Schutt (2011) argues that it is imperative to seek creative abundance in order to look for alternative interpretations linked to the data. This has been considered in two ways. Firstly, through the creation and implementation of an innovative modified gap analysis, it is hoped this novel process to the profession of occupational therapy will support the generation of fresh insight to the unified findings of the prima facie papers. Secondly, creativity has also been embraced to support fresh insights through poetry. Willis (1999) suggests that poetry can provide a medium through which the practitioner can represent and express reactions to, and interpretations of, experience. Further, research-voiced poems are often written based on the reflections of auto ethnographical writing as a data source (Prendergast, 2009), drawing parallels to the work undertaken here.

As part of the dynamic craft of interpreting the shaping and sifting of qualitative data, poetry was initially used to tentatively reflect and identify the focus of potential themes. Using poetry as a tool early in the interpretation of data helped to familiarise and begin to draw links between the summary

findings. Importantly, poetic representations can provide the researcher with a different lens through which to view the same scenery, and thereby understand data and themselves in different and more complex ways (Prendergast, 2009). Consequently, the initial use of poetry also acted as a tool of critical self-reflection; I wrote, took a break, re-wrote, repeating this and, in so doing, began to move closer to the data and the ways it could be moved, changed and represented. This process initially suggested policy, education, environment and occupation as potentially important themes (table 8). This tentative focus continued to evolve as the introspective text was read interpretively, leading to the generation of the refined themes.

Table 8: Use of poetry to support the initial shaping and focus of potential summary themes in the early stages of analysis.

Temperate Disquiet.

Policy drivers, shaping me
Pushing me, towards
Ever changing schemes
Unsure of where my role will start
Of where this all will end.
The confusion that lies
Within and beyond
These certain walls of learning
Will surely only really add
To education's over-bearing burden.

But that's not all
I scream and cry
As the person slowly shrivels
Practice trending discharge dates
Environmental bias

But stop right there, what do you mean?
Beware my friend, beware!
There is no hole within my sole
No inkling troubling me
But if I were to stop and stare
Take stock to disagree
There may emerge a single voice
Whispering, t'ward me.
So I will say this once,
Then speak no more
Of what may lie inside
A restless, fearful feeling,
My practice no longer centred
On an occupational being

Audit trail: throughout this work transparency and clarity of description has been attempted by providing a thorough description of the modified gap analysis itself, including the generation of raw data (appendices 3 & 4), the data reduction process within the context of the raw data, leading to the generation of summary themes, refined themes, and data reconstruction

through the use of wider theoretically sensitive literature (appendices 5 & 6). Finally, steps taken to ensure trustworthiness have been outlined.

Methodological reflections

In interpreting the findings of this modified gap analysis, limitations also need to be considered. This modified gap analysis used a qualitative, critical researcher-introspective stance in generating data unifying the findings of the *prima facie* papers, reconciling these to theoretically sensitive literature, creating fresh insight, and pointing towards a desired future state.

Consequently, the analysis and findings are influenced by the researcher's values and experiences in creating the data and in analysis, effectively becoming an instrument of data collection (Schutt, 2011). This first-hand account and experience made aspects of understanding perhaps easier, but could also potentially lead to bias of interpretations and assumptions as part of the introspective collection of data, when it is likely that multiple realities do exist. Consequently, an important part of this methodological reflection is to acknowledge potential influences on the findings and interpretations therein, and make transparent the position of the researcher. Creswell (2013) suggests that discussing the researcher's role, reflecting on the researcher's background, culture and experience offers more than simply an autobiography, it positions the individual themselves in the qualitative work. With this in mind, appendix 7 considers the position of the researcher, relating to the introspective data.

As part of the process of introspection it was important to reflect on the researchers' own experience (Finlay, 2003). To achieve this, Koch & Harrington (1998) ask researchers involved in research to consider the whole research process reflexively, underpinned by a position of philosophical hermeneutics that essentially asks the question 'what is going on' while researching. Therefore a reflective journal was kept throughout in order to support self-critique and self-appraisal, challenging personal assumptions. Examples of some of these challenges are highlighted in appendix 7.

Nevertheless, care must be taken in generalising these findings and further research based upon the themes generated would be of value.

Findings

Analysis of the introspective data resulted in two refined themes;

1. Delimiters of Professional Education
2. Conceptual Contradictions

Each underpinned by two sub-themes. These themes and findings were also subject to a stakeholder check process, as outlined on page 31. The findings from the analysis of the introspective data are outlined below including examples of stakeholder feedback, relevant to each theme. This has been included to support the progressive refinement and interpretation of results (Thomas, 2006).

Theme 1: Delimiters of Professional Education

Professional pre-registration education is a consistent theme throughout the introspective data, highlighting two sub-themes, 'sharing policy perspectives' and 'educational locus of control'.

Sharing Policy Perspectives

The modified gap analysis indicates that there exists an opaqueness of explanation in education associated with current Government policy and alcohol misuse. The analysis suggests that alcohol policy has been largely ignored by education in occupational therapy curricula, influencing practice. For example;

“Why are we not addressing important policy proposals/changes associated with [alcohol and] health in our undergraduate pre-registration curricula in Scotland?” (p. 158)

The introspective analysis illustrated frustration surrounding this point is further emphasised due to the sparseness of alcohol-related policy discussed in teaching programme content, highlighted thus:

“Limited scope and consideration of alcohol-related policy identified. Interesting disconnect here in that Barbara & Whiteford (2005) suggest that consistent efforts have been made to make the profession of occupational therapy more aware of legislative and policy contexts....”. (p. 166)

However, reasons why alcohol policy and, more generally alcohol misuse as a topic, were not considered in depth emerged. These tended to be associated with largely pragmatic explanations such as “lack of time, competing priorities” or a “lack of interest”. The introspective data indicated a perceived sense of “disquiet” was palpable in response to an educators’ view that alcohol policy should be no different to other areas of occupational therapy education linked to policy:

“Concern, disquiet...reasons for this lack of consensus, appear to be flippant in places; [e.g.] ‘is alcohol use/misuse different from any other area of practice?’” (p. 159)

Interestingly, this concern is also touched on in feedback offered by stakeholder 2 who implicitly recognises limitations surrounding the teaching of alcohol policy in programme content, but questions the value of changing this, suggesting:

“Should the focus of professional education courses be less about a specific subject area (i.e. alcohol policy) and more about equipping students with the ability and confidence to engage with and act upon policy throughout their careers?” (p. 31)

In summary, the perspectives offered here indicate contrasting views of the value of further emphasising alcohol policy as part of occupational therapy teaching programme content. A shared introspector-stance/stakeholder feedback perspective of the importance of teaching policy is evident, however the inter-dependence of pragmatic teaching and learning restrictions, allied with an educational view of the value of teaching broader critical engagement with policy, is evident.

Findings: Educational locus of control

This tension between educational practice realities and subject specific teaching also affected the extent to which occupational therapy education broadly believed and took responsibility for alcohol misuse teaching. It was challenging to discern the extent to which alcohol misuse was embedded in to teaching practice, rather than a topic that was reliant on practice placement experience:

“across Scotland as a profession we are unable to state with a degree of precision the number of teaching hours each student is exposed to alcohol [content].” (p. 159)

Moreover, the outcome of this lack of clarity surrounding alcohol misuse teaching potentially pinpoints an uncomfortable practice reality where:

“...the lack of clarity around this [alcohol teaching content], unsurprised at some of the findings noted throughout our research journey concerning limitations of occupational therapist knowledge associated with alcohol misuse.” (p. 159).

This point is further emphasised by stakeholder feedback (stakeholder 1) which notes a lack of alcohol education as an issue linked to occupational therapists’ ability to respond with confidence in physical health care settings, where alcohol misuse is identified:

“I feel in-patient therapists in a physical setting are unsure of how to address this area of a patient's lifestyle due to [including other factors] education.” (p.31).

A further aspect of the introspective data sought to evaluate and consider reasons why education may not support the profession of occupational therapy to respond in practice to alcohol misuse in physical health care settings. This identified discomfort, linked to teaching strategies used:

“I feel uneasy concerning an integrated approach” [to teaching alcohol misuse]. (p. 158)

An implied consequence of using an integrated approach would appear to be the lack of visibility given to alcohol misuse as a topic in educational programmes:

“the broader scope and role alcohol plays across our society and thus, filtering through to physical health care settings in the NHS and beyond, lacks definition” (p. 166).

Similarly, reduced visibility of alcohol-related discussion in educational programmes meant that it was difficult to determine how the relevance and knowledge of alcohol misuse was defined in relation to the practice of occupational therapy, irrespective of practice context:

“This is key. Where is the evidence and theoretical basis in the profession of occupational therapy to support working with people who misuse alcohol, irrespective of practice setting?” (p. 159)

There was evidence that a divide existed between mind and body in the way education considered alcohol misuse, as the:

“relationship of alcohol clearly defined with all three HEIs [Higher Educational Institutes] teaching alcohol associated with mental health” (p. 166)

Similarly feedback from education through stakeholder 2 described the relevance of understanding alcohol misuse to the profession of occupational therapy as potentially limited, as:

“very few occupational therapists will see people for alcohol problems unless in specialists services” (p. 32).

Theme 2: Conceptual contradictions

The relative position of theory in relation to practice in physical health care settings and alcohol misuse was a striking feature of the introspective data.

Partitioning of the person.

The use of the PEO Model in physical health care could be viewed as ambiguous, despite its apparent popularity. On the one hand, the use of this model is valued, for example:

“PEO model used as a subconscious ‘filter’ and ‘organizer’ in order to support understanding of occupational complexity and the variables surrounding occupational performance in context” (p. 156).

As such, the use of the PEO Model throughout the introspective data indicates:

“the potential value of using the PEO Model as an underpinning theory in physical health care settings” (p. 160)

The use of theory is however heavily dependent on the specific practice context, and the nature of care delivery in physical health care settings appeared to impact the extent to which the PEO Model could represent the ‘person’:

“emphasis seems to be placed on the person’s environment, in terms of getting them home, as a pressure noted to get people “in and out” as quickly as possible” (p.163)

As such, boundaries appeared to emerge in relation to which aspects of the PEO Model theory could be used, for example:

“no mention of the ‘transactive’ nature of the PEO Model, representing the person and environment as interdependent and that a person’s behaviour cannot be separated from the context in which it occurs” (p.163).

This implied a tendency of practice in physical health care settings to assess:

“only the observable features of the environment, constricting consideration of the meaning of the ‘event’ [leading to hospitalisation] to people” (p. 163).

This represents a challenge to consideration of the ‘person’ and potentially explains the reticence of therapists to “ask about and consider alcohol as routine questions in practice” (p. 163), when the practitioner focus is to assess:

“what is in front of us, rather than considering the wider perspectives of health and well-being” (p. 163).

A potential consequence of this process is for the ‘person’ to become suppressed:

“Deeper understanding of the person in the context of their environment seems missing” (p. 164).

The theoretical base of occupational therapy practice in relation to alcohol misuse in physical health care settings can thus be restrictive, a point emphasised by stakeholder 1:

“They [occupational therapists] are simply dealing with what's in front of them (e.g. effects of alcohol misuse - falls / liver disease / cognitive impairment / housing issues) and getting people to a level where they are physically ready for discharge and their home environment is safe(r) for them to be discharged to.” (p. 31).

Occupational evaporation.

A noticeable aspect of the introspective data captured was consideration of the scarcity of the centrality of occupation in education and practice when considering alcohol misuse. For example:

“alcohol-related [educational] content noted in the findings does not include discussion of the occupational nature of alcohol misuse” (p. 165-166).

As a consequence, there is recognition that educational enhancement around alcohol misuse could relate to:

“professional knowledge associated with occupation-focussed theory and alcohol misuse [with older people]” (p. 168).

The impact of the relationship between education and practice is again highlighted. As practice is heavily dependent on learning and teaching, educational investment in the value of occupation appears important. This appears to be challenging as:

“occupation has been largely ignored within Scottish occupational therapy curricula, perhaps explaining the difficulties in articulating this role [occupational therapy] in practice” (p. 166)

In practice “there seems very limited discussion of occupation” (p. 164) linked to alcohol misuse:

“representing a clear gap in service delivery associated with an occupation-focus to alcohol, but more broadly, it represents an area of concern connected to wider [delivery] of occupation-focused services” (p. 167).

Whilst there was concern that education may not support understanding of an occupation-focus to alcohol misuse, stakeholder 1 noted:

“there is a lack of use of occupation focused theories within the area of alcohol misuse (and in general).” (p. 31)

A view was also expressed that:

“current conceptual models of occupational therapy....tend to largely ignore the health promoting agenda. Instead [there is] a focus on occupational issues arising from disease, ill health and disability” (p. 167)

It was also acknowledged that future educational and practice developments perhaps required the profession of occupational therapy to:

“look inwards and consider how we discuss, think about and teach occupation and specifically occupation and its relationship with alcohol misuse.” (p. 165).

Discussion

Theme 1: Delimiters of Professional Education

Professional pre-registration education is a consistent theme throughout the introspective data, characterised by two sub-themes, 'sharing policy perspectives' and 'educational locus of control'. Each of these are explored below.

Sharing Policy Perspectives

Existing Scottish Government policy seeks to engage society in a conversation about alcohol use, in order to manage change in attitudes to alcohol misuse (Scottish Government, 2008). The analysis here highlights however that whilst educators believe they are teaching current alcohol policy supporting proposed changes in attitudes, in fact, limited consideration of alcohol policy actually exists in education. The legitimacy of including alcohol specific policy is further questioned through educational stakeholder feedback suggesting teaching emphasis could favour a broader-based approach to understanding policy, suggesting this would support a wider spectrum of policy developments and implementation, impacting health and social care.

If this latter view is adopted by education, it may explain why practitioners were reticent to engage people specifically in conversations around alcohol intake (Maclean et al, 2015), in order to support and manage the change in attitudes to alcohol misuse desirable to the Scottish Government and adopted by recent policy developments. This is of significance, as the symbiotic relationship between education and practice has been highlighted in research elsewhere. For example, Ashby & Chandler (2010) found that occupation-focused theories taught in education, were a powerful predictor of graduates' use of theory in practice. Thus the potentially narrow base of topic-specific policy covered in pre-registration programmes may help to

explain elements of therapists' 'non-action' in translating policy to practice in managing changes in attitudes to alcohol misuse.

This finding is of importance as it resonates with Barbara & Whiteford's (2005) view that occupational therapy may theoretically acknowledge the broad social, economic and political environment influencing consumers of services however the profession is often reluctant to engage with the political context and consequences which can influence their practice. This poses an important dilemma for the profession as, allied to educational opaqueness of alcohol policy context, this can restrict and limit the extent to which therapists 'act' in practice on key messages associated with alcohol misuse.

The importance of sharing, understanding and becoming conversant with government policy has been emphasised by Crouch (2014), due to the relevancy and impact of policy to practice. In order to address this, however, education must first ensure the relevancy of its educational content, as defined by the health needs of the population. The World Health Organisation (WHO) (1993), in a report entitled, 'Increasing the Relevance of Education for Health Professionals', emphasised that educational programmes must;

1. Be relevant to social and community concerns, as well as the prevailing health needs and priorities, and
2. Increasingly advocate for healthy behaviour in the population.

Consequently Hocking & Ness (2005) summarize a four-step process suggested by WHO (1993) for adoption of these values by educational curricula. Firstly, defining the population that will be the recipients of health services, secondly, determining their health-related problems, and in so doing ensuring new educational programs respond to the identified problems and finally, monitoring how effective graduates of educational programs are in addressing these health priorities.

Prevalent health conditions linked to alcohol globally results in 2.5 million deaths each year (WHO, 2013), and nationally there is recognition of Scotland's unbalanced relationship with alcohol (Scottish Government, 2013). In terms of defining the recipients of health services therefore, there is a strong case to recommend that alcohol, and its related policy perspectives, should be one of the public health priorities included and focused on in occupational therapy programmes. This is further emphasised by Hocking and Ness (2005) conclusion that for graduates to be effective in practice, there needs to be a good match between their skills and the prevalent health conditions. By extension therefore, educational curricula needs to reflect both the national and globally defined health needs of the populations that occupational therapy programmes will serve, therein recognising that occupational therapy programmes are likely to contain diversity of content, defined by population need.

Sharing policy perspectives linked to alcohol is not, in and of itself, the only conduit in which to shape and advance practice. As Hocking & Ness (2005) point out, diversity of education also concerns itself with the ways in which students are taught. Integral to this theme therefore is discussion of educational 'locus of control'.

Educational 'locus of control'

There are several examples of findings indicating gaps in knowledge such as alternative safe limits for older people (Maclean et al, in press) and the belief captured by both graduates and therapists in practice that education did not prepare them for working with people who misuse alcohol (Gill et al, 2011, Maclean et al, in press). Consequently, the clarity and visibility of alcohol content in occupational therapy education appears to be either confused, or submerged.

Whilst the teaching of programme content as integrated course work receives little attention in the occupational therapy literature, Clark (2005) in nursing research indicates that where the focus of alcohol use is not made explicit in pre-registration education, the opportunity to learn how to cope with patients who have alcohol related issues might be lost. She argues that as part of an existing nursing curriculum, where only one module explicitly mentioned alcohol and substance misuse, students could interpret this as the only opportunity in which to learn about alcohol. Additionally Rassool (2007) notes education concerning drugs and alcohol and their impact on health finds insufficient space within nursing programmes, with limited resources to teach core competencies. Allied to concerns surrounding insufficient space and clarity of alcohol discussion, the findings here suggest educators themselves seem less convinced that there is a need to re-appraise alcohol related content.

Tangentially, Brems et al (2011) illustrates this point when considering fetal alcohol spectrum disorders (FASD) and the educational needs of health and allied health programs offered in higher education in Alaska. Academic directors of 52 health and allied health programmes (including occupational therapy, although response rates filtered for each discipline were not included in the results) were asked to complete an online survey capturing educational content of FASD (87% response rate). Findings demonstrated that the behavioural health programmes (which included occupational therapy) considered some FASD-related content, however, as they face realities of overburdened academic programmes and paperwork, they were reluctant to include further taught content of FASD. Additionally Brems et al (2011) suggest the results indicate health and allied programmes experience misunderstandings concerning their own discipline's roles related to primary and secondary prevention, limiting their commitment to incorporating FASD education.

Indeed this can be further supported through the findings of Thompson (2007) who argues that non-mental health occupational therapy practitioners may need further education to increase their knowledge and confidence linked to substance misuse (including alcohol), in order to support their role in routinely incorporating questions related to substance use in practice. She voices concern that a deficiency in the education of therapists working in physical health settings linked to substance misuse, precludes practitioners from undertaking the essential role and opportunity to detect unrecognized substance use disorders, supporting early intervention and prevention. As alcohol misuse has traditionally been viewed within the context of mental health in occupational therapy (Lancaster & Chacksfield, 2008), it may not be entirely surprising that mental health practitioners are more likely to consider addiction and alcohol misuse than their non-mental health counterparts. Yet as a profession in the UK, the College of Occupational Therapists (2010) contend that education offers “dual training” in both mental and physical health, leading to the provision of holistic services that are bio-psychosocial in nature. Consequently, Jacob-Lloyd et al (2006) suggests this provides an opportunity to explore and implement more fully a person-centred approach, although they recognise in practice this is challenging to deliver because of the need to use physical and mental health knowledge and skills. As a result, Rigney (2000) confirms the existence of a physical and mental health divide in occupational therapy practice, and suggests one possible solution could be to approach this issue through further training and education.

Thus the foundation for considering alcohol misuse from beyond the boundaries of labels such as physical and mental health potentially seems appropriate, and could offer a way forward in how alcohol education might be shaped by occupational therapy programmes. In contrast, however, the emerging findings here suggest education is a reticent partner in supporting practitioners to actively shape and influence occupational therapy practice in alcohol misuse. Insufficient time, overburdened curricula and integrated teaching can submerge alcohol programme content. However wider

consideration of the introspective data within the context of the existing research offered here, also infers a degree of guardedness from within education connecting and supporting practice to alcohol misuse. These findings offer the novel view that those interested in the advancement of alcohol education in occupational therapy need to be prepared to educate educators concerning the role of their discipline in the practice of alcohol misuse across all health settings, including non-mental health.

Theme 2: Conceptual Contradictions

This second theme, emerging from the analysis of the introspective data, consists of two sub-themes, 'partitioning of the person' and 'occupational evaporation'. Each is discussed below.

Partitioning of the person

Theory, and how this is translated to practice has been given extensive attention in occupational therapy literature (Turpin & Iwama, 2011). Indeed in physical health settings the need to understand the organisation and process of occupational therapy through the use of conceptual models has been highlighted (Trombly Latham, 2008). Rigby & Letts (2003) suggest occupational therapists are placing emphasis on client-centred practice, seeing individuals in the context of where they live, work and play. As such, they argue this has resulted in a greater awareness of the influences of the environment on the performance of occupations. In turn this has meant the environment has become an integral part of occupational therapy practice models, many of which are grounded in theories of person-environment relationships. Set within this context, the PEO Model has received specific attention as a theory through which analysis of the PEO relationship can support the identification of factors influencing occupational performance (Strong et al, 1999). Further, the originators of the PEO Model also considered it important to have an occupational therapy model that could be easily understood by those both inside and outside the profession (Rigby & Letts, 2003).

Set within this context the findings here suggest a strong synergy between the PEO Model and practice in the physical health care settings included as part of the prima facie papers. Analysis would seem to suggest that the academic debate indicating the value of the PEO Model, closely mirrors its appeal to practitioners as a substantive theoretical foundation in physical health care settings.

Nevertheless, an anomaly appears to exist within the introspective analysis, highlighting a disconnect between the theoretical beliefs of occupational therapists, as they are applied to practice. There is an absence of discussion surrounding the 'transactive' element of the PEO Model, which emphasises that the person and environment are seen as interdependent and that a person's behaviour cannot be separated from the context in which it occurs (Turpin & Iwama, 2011). This absence of discussion appears to impact practice, as therapists were reluctant to use occupation-focused theory to guide wider understanding of the challenges the person may face in the context of their environment (such as alcohol use), and a reticence to engage with person specific health promotion related to alcohol misuse (Maclean et al, 2015). Consequently, allied to therapist acknowledgement that the practice setting can restrict client-centeredness (Maclean et al, 2012), the importance of the person considered within the context of his or her own environment, can be curtailed.

A dichotomy exists therefore shaping how therapists' theoretical sensitivity to the PEO Model deviates when translated into practice in physical health care settings. The introspective data points towards this, highlighting occupational therapists tendency to assess the "observable features of the environment"; a point supported by stakeholder feedback. As such, rather than the application of the PEO Model to practice encompassing a transactive understanding of occupational performance, such that the person and environment are interdependent (Law et al, 1996), instead it is proposed here that an implicit partitioning of the person from the environment takes place.

The essence of 'transaction' lacks fidelity in practice, as therapists separate the entities of person and environment into discrete elements, placing greater emphasis on the observable aspects of the environment rather than the person, in order to support timely discharge.

Stewart & Law (2003) argue that recent theoretical developments in occupational therapy have built on theories of person-environment relationships to incorporate environment more explicitly into theories of occupational performance. They challenge therapists to enable occupational performance through the use of the PEO Model offering the view that the environment in relation to health, disability and occupation has promoted new understandings and beliefs about person-environment relations, resulting in changing assessment and treatment practices (Stewart & Law, 2003). The proposed dichotomy presented here however suggests that this prevailing direction of discussion, influenced by practice setting and the tendency of therapists to eschew the transactive nature of the PEO Model, has promoted an unbalanced professional understanding of person-environment relationships, the consequence of which leads to the theoretical partitioning of the person in occupational therapy physical health care settings. This conspires to constrain therapists' reasoning connected to wider, often 'hidden' reasons leading to admission, such as alcohol misuse in older people. This dichotomy helps to explain why, in part, therapists were reluctant to engage in conversations with patients around alcohol intake, as guided by the PEO Model. The following sub-theme, 'occupational evaporation', extends this discussion further.

Occupational evaporation

Professional debate in occupational therapy has reflected the need to 'anchor' practice in occupation (Kielhofner, 2004). Indeed, Whiteford & Wilcock (2001) argue that research understanding humans as occupational beings has contributed to a revitalized knowledge base that informs professional practice globally. Ikiugu (2010) however cites Kielhofner's view

in 2002 that very often a gap exists between every day practice and the theory and research generated by occupational therapy academics. Clearly delineated within the introspective analysis is evidence of this gap, related to professional knowledge and understanding connecting occupation and alcohol in physical health care settings. Essentially the findings capture the occurrence of occupational evaporation in professional education associated with alcohol, influencing practices in physical health care settings.

The absence of discussion from within education embracing current and emerging occupational perspectives of addiction may support why practitioners did not value using an occupation-focused model of practice when considering older people and alcohol misuse (Maclean et al, 2015). Further, it may also explain why respondents generally felt pre-registration education had not prepared them for working with people who misuse alcohol (Maclean et al, 2015), or to articulate an occupation-focus to their practice (Maclean & Breckenridge, in press). This finding is in keeping with Kinn & Aas (2009) who argue that a clearer link between philosophy, theory, and practice is recommended, and that educational programs must focus on helping occupational therapists to articulate their knowledge of occupational therapy concepts.

Whilst Helbig & McKay (2003) acknowledge the limited existence of literature examining addiction from an occupational perspective, increasingly this field of research is advancing. Wilcock & Hocking (2015) suggests a link exists between an occupational understanding of health and excessive use of alcohol. They argue that alcohol misuse is a form of occupation; it is what people do to feel a certain way, to belong, and to become temporarily happy. Wilcock and Hocking (2015) believe this is a response to the pressures;

“created by contemporary forces, such as the media, fashion, conformity, and corporate bodies whose occupation is aimed at making money by selling addictive products” (p. 279).

They offer an occupation-focused perspective that seeks to prevent illness by asking questions such as what basic needs are fulfilled by alcohol use? What occupational needs are not being met to make it necessary to drink and, alternatively, are there occupations that appear to reduce the incidence of drinking?

Andersson et al (2012) cross-sectional study (n=851) exploring women's patterns of alcohol consumption lends support to this occupational perspective. Using a broad concept of occupation, including employment status, distribution of household work, leisure activities, time for free disposal, and satisfaction with each of these, they demonstrated a strong association between problematic alcohol consumption and patterns of everyday occupations, characterized by low engagement in leisure activities and a large amount of spare time.

These recent findings illuminating our professional understanding of an occupational perspective of alcohol misuse are important and opportune. Pierce (2003) clearly states that given the extent of alcohol misuse in Western society, any occupational therapist will deal with clients who abuse alcohol regardless of practice area or the degree to which clients disclose such interventions. Occupational therapists in physical health care settings will therefore work with people who misuse alcohol, disclosed or not, and are therefore ideally placed to recognize and understand the occupational risk factors that can contribute to, and trigger, alcohol misuse. Our unique occupation-focused contribution is to understand the occupational aspects of ill-health, such as the impact of low engagement in leisure activities and large amounts of spare time, which are identified as occupational risk factors associated with problematic drinking (Andersson et al, 2012). We therefore have a role to play in physical health care settings, where admissions to hospital due to alcohol misuse in Scotland exceed 100 people a day (ISD, 2012), demonstrating our own occupation-focus in prevention, supporting

Scottish Government policy aimed at managing changing attitudes to alcohol (Scottish Government, 2008).

Yet the findings here capture practice in physical health care connected to alcohol misuse, operating in an occupational void. This occupational void may originate from education, where an occupational perspective of alcohol misuse appears to be submerged. This void translates to practice, essentially supporting a process of occupational evaporation of the unique contribution the profession can make to understanding, recognising and supporting interventions, such as occupation-focused health promotion with alcohol misuse. The recognition of the complexity of factors explaining why individuals choose some occupations over others, less healthy that may provide experiences of power and the opportunity to exert control over their lives (Wilcock, 2006), is important. This is due, according to Heuchemer & Josephsson (2006), to occupational imbalance, where the risk factors that occur when individuals are unable to meet their physical, social, mental, or rest needs, is related to the narrowing repertoire of daily occupations that typifies addiction-related behaviour. Factors affecting occupational imbalance are very often beyond the control of the individual and, as such can be seen to be a form of occupational injustice. Occupational justice challenges professionals to adopt an occupational perspective, exploring what people do every day on their own and collectively; how people live to seek identity, satisfaction and autonomy; how people organise their habits, routines, and choices to promote health and how people collectively have organised systems such as education and health to support, or not, what all populations need and want to do in their occupations to live well and be healthy (Whiteford & Townsend, 2011).

In moving forward it may be that education should embrace and promote this occupational understanding of addiction and alcohol misuse in order to support the centrality of occupation to practice in physical health care settings. Additionally, this could be informed by Hocking's (2014) broader

vision of educational reform to support the radical paradigm shift required to engage in occupation-based practice. She argues that the profession should produce occupational therapists imbued in occupation and its relationship to health (Hocking & Ness, 2002), supported by a revised World Federation of Occupational Therapists (WFOT) standard. Hocking (2014) proposes that all educational programmes state their commitment to societal change, in order to envisage graduate practitioners skilled in recognizing and responding to occupational injustices in every practice context.

This has resonance with professional understanding of alcohol misuse in two distinct ways. Firstly, the enormous health burden alcohol misuse presents, with its numerous social problems associated with disorders attributable to alcohol use, is distributed unevenly; poor and underprivileged groups are often at higher risk and are deprived of health and social interventions that can help to alleviate individual and family distress (Poznyak et al, 2005). Hocking (2014) argues that this revised WFOT standard in the United Kingdom (UK) could mean practicing 'social occupational therapy', which makes a point of attending to occupational injustices such as poverty and unemployment, in order to effect change in the incidence of preventable disease and high rates of addiction.

Secondly, this proposal for educational reform recognises the need for therapists to respond to occupational injustices irrespective of practice context. This recognition of the need to consider alcohol misuse across specialities further reinforces the view expressed by Pierce (2003) of consideration of alcohol misuse irrespective of practice area. In drawing parallels between the proposed revised WFOT standard (Hocking, 2014) and alcohol in physical health care settings, a conversation can be initiated in order to allow the profession to potentially breathe renewed energy into reframing how we think about the centrality of occupation related to service delivery, thus promoting the decline of occupational evaporation in practice.

Thus, in translating the idea of 'social occupational therapy' to practice, therapists need to emphasise their understanding of the social aspects of the communities and populations with whom they work. This clearly connects to the role and importance of education in supporting development of this understanding, as described by Hocking and Ness (2005) (p. 44), to ensure occupational therapy curricula content is relevant to social and community concerns connected to health and well being. For example, an illustration of Poznyak's et al (2005) global discussion highlighting the impact of alcohol misuse to areas of deprivation can be illustrated in the community surrounding Queen Margaret University. According to the East Lothian Health and Social Care Partnership (2015) where Queen Margaret University is situated, 5% (approximately 5,000 people) of the East Lothian population live in the most deprived Scottish quintile, from which the East Lothian Drugs and Alcohol Partnership (MELDAP, 2010-13) suggest there were 150 discharges from acute hospitals due to alcohol. Conversely, 18% (approximately 18,000 people) live in the least deprived quintile in East Lothian, from which 40 discharges from acute hospitals due to alcohol were accounted for through MELDAP (2010-13.) Exploration of these statistics reveals that this equates to 1 hospital discharge due to alcohol per 33 people in the most deprived areas of East Lothian, compared to 1 hospital discharge per 450 people in the least deprived areas of East Lothian. This 'local' example connects to and highlights Poznyak's et al (2005) global discussion of the disproportionate impact alcohol misuse has on those living in deprived communities. As such, in positioning occupational therapy connected to alcohol misuse, the profession could consider prioritising their contribution in practice to communities characterised by poverty and deprivation.

If occupational therapy should be positioned in, and prioritise, deprived communities, its form and shape in practice also requires definition. Given the proposed existence of occupational evaporation in physical health care settings connected to alcohol misuse, embracing the centrality of occupation to practice is of importance. One potential element of this in practice could

be to prescribe meaningful occupations that encourage social interaction, prioritising women and older people, in order to support the prevention of alcohol misuse, and instead promote health and well being. The work of Andersson et al (2012) who have demonstrated the association of problematic alcohol consumption in women, characterised by low engagement in leisure activities and large amounts of spare time, partly informs this view. However Smith & Foster (2014) also emphasise that in older people there is a group of late onset drinkers (reactors), who begin problematic drinking in later life, often in response to a disruption in lifestyle such as retirement, bereavement and pain, which can lead to decreased social activity. Other contributory factors in older people who develop problems with drinking may also be isolation and loneliness (Smith & Foster, 2014). Smith & Foster (2014) argue that emphasis should be placed on non-drinking social activities in the context of the person's life circumstances and social support network. This may mean redefining a social or family support mechanism for an older person. Occupational therapy can contribute to and 'scaffold' the design of redefined social and/or family supports through developing opportunities with people to engage in meaningful occupations. A further focus should be on sustaining meaningful occupations that emphasise social interaction with others, centred within the context of a person's life circumstances, directed by emerging evidence (Andersson et al., 2012, Smith & Foster, 2014).

Developing opportunities in partnership with people, who experience deprivation and poverty to sustain, enable and empower engagement with occupation, has the potential to promote health and well being connected to alcohol misuse. This suggested focus of therapy in a health promoting context is opportune, as it articulates with the recognition that the responsibility for public health cannot be achieved through the traditional public health workforce (Public Health England & the Council of Deans, 2015). Creating and sustaining health across all our communities also needs the essential involvement of allied health professionals (AHPs) (Public Health

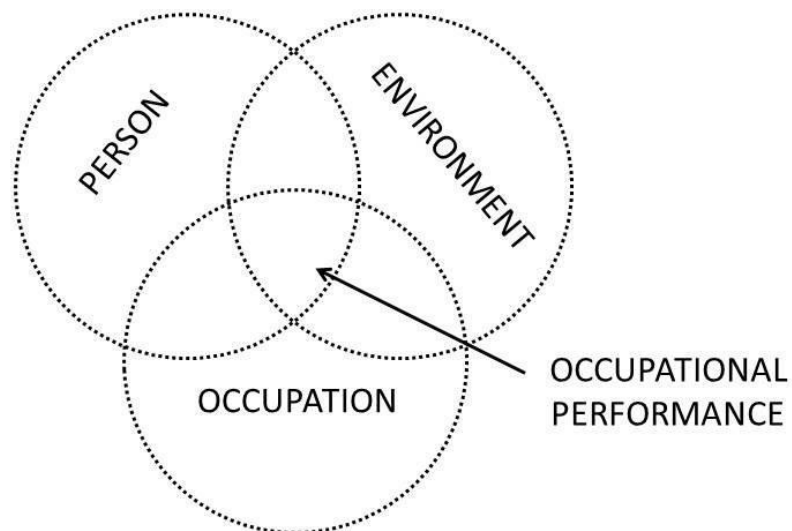
England & the Council of Deans, 2015). The potential for emphasising the social understanding, and therefore practice, of occupational therapy in deprived communities connected to alcohol misuse suggested here, can make an important contribution to health promotion.

In taking time to understand and explore socio-economic inequalities between communities, the emerging policy context influencing AHPs, as well as research evidence, a clearer picture comes to the foreground of the transactional relationship of environment, person and occupation, connected to alcohol misuse. With this awareness also brings insight in to how the PEO Model itself could be refreshed and redrawn to further enhance its meaningfulness to practice. The ecological nature of the PEO Model suggests that it could evolve from a conceptual model of practice, to the first translational model of practice in occupational therapy.

As Cornelissen (2000) recognises, the purpose of a translational model is not to passively receive knowledge for practical purposes, rather it is an active process of interpretation and reframing by practitioners within the context of professional understanding. A translational model shifts the emphasis towards practitioners as they selectively decide which scientific insights are to be used and in what way (Cornelissen, 2000). This movement is towards the recognition of the existence of reflective practitioners, actively shaping and framing knowledge derived from the academic world (Cornelissen 2000), influenced by their practice context. A translational model articulates an 'ebb and flow' between science and practice as two mutually influential entities. Arguably, this reciprocal relationship reflects and mirrors the process of transactionalism between person, environment and occupation in their sense of inter-dependency. Similarly, science cannot be understood without the context of practice, and practice cannot be understood without science as a source of knowledge. The organic importance in understanding this relationship should influence the re-design of the PEO Model into a translational model of practice.

As part of this re-design the diagrammatic representation of the PEO Model should be altered in order to further emphasise the importance of the essence of transaction between person-environment and occupation, discussed on page 50. The current diagrammatic representation of the model as three circles drawn with a solid line, each representing person, environment and occupation, overlapping to produce congruence (or 'fit') in occupational performance, should be replaced. Instead, as illustrated in diagram 3, below, the circles should be drawn with a dotted line, effectively representing a semi-permeable membrane as each element of person, environment and occupation 'breathes' in and out, between and within the elements. This could more accurately reflect, and emphasise, the essence of transaction.

Diagram 3: Refreshed diagrammatic representation of transactionalism embedded in the PEO Model.



In addition, the discussion of transaction as part of the PEO Model could be further reviewed and refreshed by incorporating and considering recent

developments in understanding transactional perspectives, considered by Cutchin & Dickie (2013). Largely based on the work of American philosopher, John Dewey who pursued an understanding of pragmatism, a “transactional perspective” of occupation has emerged of which the relations of person, context and occupation are considered as an inseparable part of one whole (Cutchin & Dickie, 2013). This contemporary scholarship on a transactional perspective of occupation could inform and refresh the theoretical underpinning of transaction that is fundamental to the PEO Model. Further research and reflection of potential parallels that could be drawn between the PEO Model and Cutchin & Dickie’s (2013) work, would seem to be an important direction of travel in further developing and embracing the idea of the first translational model of practice in occupational therapy.

Contribution to new knowledge

Through 'framing' the findings sections of the five prima facie papers using a modified gap analysis, insight and understanding has been extended in relation to alcohol misuse, occupational therapy education and physical health care settings. Specifically, the contribution of this critical appraisal has been to demonstrate new knowledge, situated within the profession of occupational therapy, highlighted below;

1. An important contribution to new knowledge offered in this critical appraisal is that of the innovation, design and implementation of the first modified gap analysis for use in the profession of occupational therapy. The integration of an 'occupational filter' through the use of the PEO Model, seeks to retain a focus on the centrality of occupation in forming a view of the future direction of travel. Further, the proposed definition and use of introspection as part of this modified gap analysis provides the first detailed account of how this concept can be used in practice. The development of this modified gap analysis, combining introspection, an occupational 'filter' and conceptual entrepreneurship, provides a blend and fusion of ideas to produce a quadrant linear design that supports creative thinking, set within a systematic framework.
2. The critical appraisal indicates an opportunity to re-design and refresh aspects of the PEO Model. Specifically, it is proposed that this model could evolve to become the first translational model of practice in occupational therapy. As part of this, the diagrammatic representation of the model should be redrawn, as discussed on p. 58, to further emphasise the essence of transaction, fundamental to this model. A future research aspiration would be to pursue this refreshed thinking around the PEO Model, incorporating also deeper consideration of the potential parallels that could be drawn between emerging transactional perspectives of occupation.

3. The importance of emphasising practitioner understanding of the nuances of social issues connected to alcohol misuse should be integrated in to occupational therapy education. Alcohol misuse could act as an exemplar to illustrate the priority the profession should place in positioning its contribution to, and prioritising communities, experiencing deprivation and poverty. A key element to this aspect of practice would be to develop opportunities to prescribe and sustain meaningful occupations, emphasising social interaction, to promote health and well being in the prevention of alcohol misuse in women and older people.
4. Practice in physical health care settings experiences a process of occupational evaporation connected to alcohol misuse, which may be linked to the submerged focus of alcohol as a topic in occupational therapy educational programmes.

Conclusion

The introspective findings presented here represent important key messages for the profession of occupational therapy connected to both education and practice. In terms of education, information gathered here would suggest that pre-registration occupational therapy programmes could increase the scope and potential of learning opportunities for students in order to appreciate and understand the public health ambitions of current policy contexts linked to alcohol. There is value in educational programmes defining, recognising and prioritising distinct health challenges, such as alcohol, given the extent to which occupational therapists will work with people who misuse alcohol, irrespective of practice context. If alcohol misuse is defined as an occupational challenge facing the population of Scotland, it may be valuable to prioritise alcohol public health policy in pre-registration programmes. Alcohol misuse is closely related to human occupational behaviour and is an area of concern for practitioners. This insight could offer a conduit to greater clarity of graduate and practitioner understanding of alcohol misuse in physical health care settings.

In practice, therapists appear positive in acknowledging their use of occupation-focused theory, however the way this is translated to practice, or not, requires further attention. Whilst value is placed on the use of the PEO Model in physical health settings, care needs to be taken to emphasise a fundamental precept of occupational therapy; holistic occupational understanding of the person in transaction with their environment through occupation. Care should be taken to ensure the pragmatic restraints of the practice setting must not result in professional understanding of the person becoming partitioned. In addition, our wider professional lens should seek to retain our occupational focus as central to practice in understanding alcohol misuse in physical health care settings.

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Appendix 1 Prima Facie Papers

Paper 1

The usefulness of the Person-Environment-Occupation Model in an acute physical health care setting

Fiona Maclean,¹ Gail Carin-Levy,² Heather Hunter,³ Lorna Malcolmson⁴ and Elizabeth Locke⁵



Key words:

Models (theoretical), Person-Environment-Occupation Model, occupational therapy, hospital.

Background: Limited evidence is available to illustrate the use of theory to underpin occupational therapy practice in acute physical health care settings in the United Kingdom.

Method: A generic qualitative method investigated the views, knowledge and perceptions of seven Scottish occupational therapists about the potential usefulness of the Person-Environment-Occupation Model (PEO Model) in acute care. This convenience sample participated in two focus groups: the first to examine and understand the PEO Model and the second to explore further reflections of the strengths and limitations of its use in practice.

Findings: The PEO Model has the potential to provide a meaningful framework in which to conceptualise patients in an acute physical health care setting.

Conclusion: The PEO Model offers flexibility regarding the extent to which occupational performance is addressed, in a setting characterised by short hospital admission stays. Also, a range of occupation-focused models was valued to practise effectively in this setting.

¹Lecturer in Occupational Therapy, School of Health Sciences, Queen Margaret University, Edinburgh, Scotland.

²Lecturer in Occupational Therapy, School of Health Sciences, Queen Margaret University, Edinburgh, Scotland.

³Lecturer in Occupational Therapy, School of Health Sciences, Queen Margaret University, Edinburgh, Scotland.

⁴Senior Occupational Therapist, Falkirk Community Hospital, Falkirk, Scotland.

⁵Allied Health Professions Strategic Lead, NHS Forth Valley, Stirling, Scotland.

Corresponding author: Fiona Madean, Lecturer in Occupational Therapy, School of Health Sciences, Queen Margaret University, Queen Margaret University Drive, Edinburgh, East Lothian, Scotland EH21 6UU. Email: fmadean@qmu.ac.uk

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Introduction

Central and local government are facing difficult decisions in funding allocation and in maintaining traditional methods and standards of service provision (Scottish Government 2010). Greater fiscal prudence in the health and social care sector, combined with increasing need, presents challenges for occupational therapy in delivering cost-effectiveness whilst also demonstrating its impact and meeting patient needs. To achieve service delivery and/or to advocate change, occupational therapy services must substantiate the rationale for practice and underpin clinical interventions in a theoretical framework. The integration of the Canadian Model of Occupational Performance (CMOP) in a service redesign is an example of this (Boniface et al 2008).

Wilding and Whiteford (2008) indicated that insufficient representation and promotion of the profession can have serious implications and argued that the need to become more visible is self-evident, especially to recipients of occupational therapy services and funding bodies. Despite the documented need for theory to underpin practice (Mitcham 2003), growing financial concerns resulting in radical changes in practice environments, and demand for new skill sets (Baptiste 2005), there is limited evidence outlining the use of theory to support occupational therapy in acute physical settings in the United Kingdom (UK).

Literature review

Occupational therapy in acute care

In Scotland, acute hospital care is typically diverse, but can include consultation with specialist clinicians, emergency treatment following accidents and

short-term care of patients with worrying symptoms (Information Services Division 2011). The literature characterises acute practice as an area where occupational therapists work with patients experiencing impaired occupational performance (Eyres and Unsworth 2005), combined with an increasing pressure to discharge patients once they are medically stable (Crennan and MacRae 2010). Griffin and McConnell (2001) concluded from a survey of 349 occupational therapists (response rate 64.7%) in Australian acute hospitals that short stays in acute care result in a focus around self-care, with little time to address a client's leisure and work needs.

Several studies characterise the nature of occupational therapy in acute physical settings (Griffin and McConnell 2001, Wressle et al 2006), but they concentrate more on the practice and less on the premise underpinning it. Craig et al (2004) and Blaga and Robertson (2008) provided information on theory supporting practice, using questionnaires with both quantitative and qualitative elements exploring the models and frames of reference most used in acute physical health care settings in New Zealand. The results showed heterogeneity in the models and frame of reference used, with the most common being the compensatory frame of reference, the biomechanical frame of reference, the Model of Human Occupation (MOHO) and the CMOP. The only two occupation-focused models identified in both studies were MOHO and CMOP, although therapists did not use the standardised assessments specific to these models. Instead,

the models guided therapist reflections to keep the focus of input on the core values of the profession.

This choice of occupation-focused models to guide reflection is supported by Ashby and Chandler (2010), who found that the most commonly included occupation-focused models taught in accredited occupational therapy programmes in Australia, Canada, the UK and the United States were the Canadian Model of Occupational Performance and Engagement (CMOP-E) and MOHO. Despite this emphasis on teaching CMOP-E and MOHO and their use in practice, Blaga and Robertson (2008) concluded that in acute physical health care settings, finding satisfactory ways to articulate practice could be further explored. These findings in the literature therefore guided the decision to explore the potential use of an alternative occupation-focused model.

Person-Environment-Occupation Model

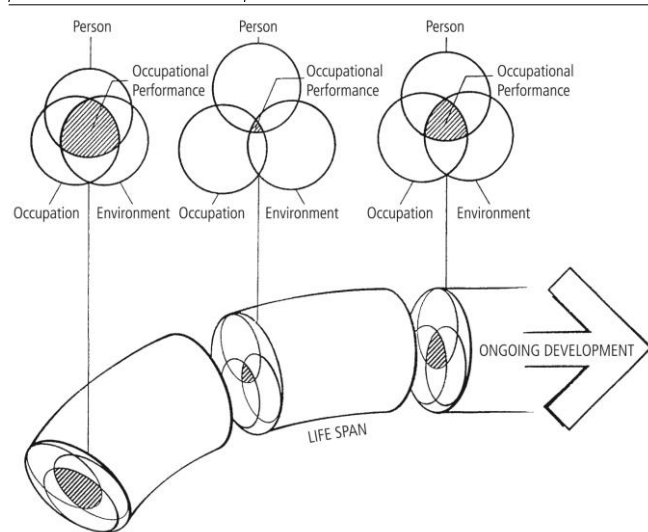
The Person-Environment-Occupation (PEO) Model (Law et al 1996) was developed to examine PEO processes and how these combine to shape occupational performance. The model is conceptualised as the person and his or her environments and occupations interacting dynamically over time (Fig. 1).

Law et al (1996) explained that the model is defined by its attempt to describe what people do in their daily lives, what motivates them, and how their personal characteristics combine with the situations in which occupations are undertaken to influence successful occupational performance.

Turpin and Iwama (2011) noted that the PEO Model had moved away from the assumptions inherent within the biomedical model, and developed a transactive (Law et al 1996) understanding of occupational performance. This approach presents the person and the environment as interdependent, such that an individual's behaviour cannot be separated from the context in which it occurs (Turpin and Iwama 2011).

This theoretical shift from predominantly biomedical roots to an understanding of the relationship between person and environment is useful when considering occupational therapy in acute health care settings. Cheah and Presnell (2011), in their qualitative study of older people's experiences of acute hospitalisation, found that the occupations of older people lacked meaning in the hospital environment and that hospitalisation was seen as a stressful experience. In the PEO Model, Law et al (1996) considered environmental contexts and the enabling or constraining effect on occupational performance. Thus, while Cheah and Presnell (2011) were unclear what this aspect of their findings meant to

Fig. 1. Depiction of the Person-Environment-Occupation Model of Occupational Performance across the lifespan illustrating hypothetical changes in occupational performance at three different points in time.*



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*Source: Law M, Cooper B, Strong S, Stewart D, Rigby P, Letts L (1996) The Person-Environment-Occupation Model: a transactive approach to occupational performance. *Canadian Journal of Occupational Therapy*, 63(1), 9-23. Printed with permission from CAOT Publications ACE.

occupational therapy in the context of treatment planning and safe discharge, a potential link between these findings and the PEO Model begins to emerge. Use of this model in acute physical settings could help guide therapists to recognise that a person's environment has a direct effect and impact on how a person performs an occupation.

As acute care is largely focused on hospitals (Wilding and Whiteford 2008), Strong et al (1999) postulated that the PEO Model is a useful tool to examine complex occupational performance issues in hospitals. They suggested that it provides a practical analytical tool that assists therapists to analyse problems in occupational performance, guides intervention planning and evaluation and communicates occupational therapy practices clearly. Strong et al (1999) argued that the PEO Model offers occupational therapists the opportunity to articulate to clients and funders the scope of their practice and how it influences outcomes. They also argued that the flexibility of the model to interface with other perspectives, theories and practices facilitates communication in and beyond the profession. This is relevant as recent policy changes in the National Health Service (NHS) advocate the development of flexible and collaborative working patterns for health professionals (Department of Health 2001, NHS Scotland 2003). Despite this, Wilding and Whiteford (2008) suggested that occupational therapists need to become more articulate about what they do to ensure a viable future for the profession in acute settings. Therefore, the PEO Model could provide a useful language in which to describe and explain practice in acute settings.

Although parallels between the theoretical foundations of the PEO Model and acute practice can be drawn, little research is available to substantiate its use in acute physical settings. Evidence of the general application of the model is available in a variety of contexts and countries (Broome et al 2009, Gibbs et al 2010, Gupta and Sabata 2010, Metzler and Metz 2010, Vrkljan 2010), but none explores the use of the PEO Model in acute physical health care settings in the UK or Scotland.

Aim and objectives

This study aimed to ascertain occupational therapists' perceptions regarding the application of the PEO Model in an acute physical health care setting. The objectives were as follows:

- To explore the potential usefulness and value of the PEO Model in an acute physical health care setting
- To ascertain the potential limitations of the PEO Model in an acute physical health care setting.

Method

A generic qualitative methodological design was used, defined by Caelli et al (2003) as:

one that exhibits some or all of the characteristics of qualitative endeavour but rather than focusing the study through the lens of a known methodology it seeks to do one of two things: combine several methodologies or claim no particular methodological viewpoint at all (p2).

As this study investigates therapists' views of the potential usefulness of the model in their own therapeutic (natural) setting, the study design uses the latter of the description by Caelli et al (2003) in that no defined qualitative method is identified. Instead, a generic qualitative approach has been used to obtain a general overview (Cooper and Endacott 2007) of this area of research. This does not exclude the need to ensure clarity and robustness, and quality in this study is examined.

Data generation

The data generation method was focus groups. According to Wressle et al (2002), a focus group comprises 6-10 individuals with shared characteristics, who are selected to discuss, from personal experience, the subject of the research. In this study, both focus groups had the same seven participants. A semi-structured list of questions was used as a guide. Each focus group was facilitated by the first author.

Sample and setting

To ensure the shared experience of participants, the inclusion criteria required that all were occupational therapists currently working in an acute physical service in one NHS hospital in Scotland. Participants were a self-selecting convenience sample of practitioners, who volunteered following attendance at an education session introducing the PEO Model underpinnings. They had between 2 and 15 years of experience when the focus groups were conducted.

Procedure

An education session was conducted, to which the 10 occupational therapists working in the acute service were invited. It introduced the PEO Model, discussed its theoretical underpinnings and asked attendees to consider its potential applications in their setting. After the education session, the fourth author contacted attendees by email to request volunteers to participate in the study. Seven people meeting the inclusion criteria responded.

Four weeks after the education session, the seven people participated in the first focus group, where they described their initial impressions of the PEO Model and identified areas for clarification. They outlined the aspects that could be useful, any limitations and what might influence their decision to use or not to use it. Finally, they were asked to reflect on the model and consider examples where it would be valuable in their setting, or if not, why, for the next focus group.

Twelve weeks later, to allow for practical considerations, the second focus group was conducted. It began with an opportunity to describe their further reflections on the model. They were informed that from the initial analysis, there was some confusion about its complexity, and they were asked for their views on this and if they could see any application of the model in their setting and what would influence this. Finally, they were invited to contribute any other views not covered in the discussions.

Both focus groups were recorded and transcribed, with the transcripts of both focus groups returned to the participants after each event for data verification.

Data analysis

The data were transcribed separately by the fourth and fifth authors for both focus groups and then compared for accuracy. The data were analysed using NVivo8 (QSR International 2009), adopting a thematic analysis framework, a useful tool when the purpose of the research is exploratory (Pope et al 2006) as in this case.

Ethics

Ethical approval was gained from Queen Margaret University Ethics Committee and the relevant Trust Health Board, and participants gave informed consent prior to data collection. Participants were assured of confidentiality and anonymity, and of their right to decline participation.

Quality issues

Cooper and Endacott (2007) noted that quality issues in generic qualitative research are important in establishing rigour. Reflexivity, trustworthiness and credibility were addressed in the following ways.

Reflexivity

Lincoln and Guba (2000) suggested that reflexivity is the process of reflecting critically on the self as researcher and it challenges the researcher to consider and come to terms with the choice of the research question. The research aim was influenced by three main factors: the lack of research on the PEO Model in acute practice; the view of Ashby and Chandler (2010) that perceptions surrounding the utility of occupation-focused models in part determine inclusion in occupational therapy curricula; and the lead researcher's background in education.

It was also fundamental to be transparent concerning the lead researcher's values as she felt that current conceptual models of practice might be impractical in a physical occupational therapy setting and that the PEO Model might potentially provide a useful framework. Practitioners may already inherently use this framework without formalising its use and so its value may not be fully appreciated. Others in the research group had no prior experience of the PEO Model and, therefore, were felt potentially to balance these views. A reflexive diary was maintained throughout the study to consider critically the influence and/or biases that the lead researcher may have had on this process.

Trustworthiness

A full and clear description of the research process has been presented to ensure transparency. To attempt to establish interrater reliability, the focus group transcripts were reviewed and analysed independently, to take account of any potential bias of the lead researcher. The initial coding of the data was completed separately and then compared, and the themes were discussed and consensus agreed by the authors conducting the analysis.

Credibility

Janesick (2000) described the value of member checking to

aid the credibility of qualitative work and this was embedded in the transcription process. It was particularly important given that two of the authors, one working within an acute physical setting, had provided support for gaining ethical approval and transcription of data. Kitzinger and Barbour (1999) recommended the use of a voice check at the start of each focus group to ensure accuracy of responses. This was achieved by ensuring that all participants introduced themselves and presented brief background details concerning their practice setting to aid voice recognition in the transcription.

Findings

Three major themes emerged from the data: Value – 'It certainly feels comfortable'; Continuum of complexity – 'It's how much depth you want to take it'; and Impinging factors – 'Pressures on you all the time to get people in and out'.

Value – 'It certainly feels comfortable'

The model was seen overall as a potentially helpful theory for use in an acute setting. Some participants felt that elements of the model were being used subconsciously, but perhaps were not valued as being PEO 'driven'; for example, 'we don't actually have to think beforehand because we just naturally do it'. Asked to describe what they did naturally, one participant suggested that the model was accessible, the language was simple, and that it fitted with her philosophy, providing a framework 'that we don't actually have to think about'. It was most valued as a framework for practice, in that 'it guides your thinking'. However, the lack of a formal assessment made documenting this framework harder: 'I wouldn't think of writing this down, I would just think of these areas.'

Other participants highlighted that this framework obviously included person, environment and occupation, and these were consistent with treatment planning in this setting. One participant liked the fact that these areas overlapped in the theory, as it provided a focus for outcome. The importance of environment within the theory was noted: 'That's our job to think about people and how they cope at home, so I think it is very adaptable to our job.'

The use of the model as a framework could help therapists move beyond considering the ability to manage activities of daily living, in order to address coping and meaning for the client in his or her environment.

The model would be useful in explaining clinical reasoning to medical staff, and it offered a short, concise language, which was advantageous over other occupation-focused models. Value was placed on the possibility of using the model to communicate effectively in and beyond the profession, illustrated by the following quotes: 'It gives you a user-friendly terminology to use'; it is 'a way for OTs to communicate with each other'; and could 'use as a metaphor to explain to other professionals or the public.'

Continuum of complexity – ‘It’s how much depth you want to take it’

A variety of perspectives was obtained regarding the detail and application of the model. One perspective highlighted its simplicity: ‘it’s very basic, easy to understand’ and ‘It’s quick and I don’t look in enough depth to warrant using a complex model’. Another participant suggested, ‘This could be your basic model ... but maybe need another model to take it on in depth’, whereas others felt that the PEO Model could help to focus on areas such as the ‘person’ in depth, which may not routinely be undertaken within an acute setting. Generally, it was implied that it was up to the individual therapist as to how in-depth he or she chose to use the model in practice: ‘You can pick your own assessments, you can use it as you want, you can be as in depth as you like with it.’

One participant felt that the model was both simple and in depth, depending on the practice setting. However, another participant disagreed, saying: ‘It’s good for fast track wards, medical, but not meaty enough for issues in stroke.’

In acute settings participants felt that the model would be of value, but when asked why it might not be useful with, for example, stroke patients, one participant said: ‘Occupational performance is a hugely complex thing – maybe the model doesn’t address this complexity?’

Regardless of its perceived degree of complexity, overall participants emphasised the model as a ‘good framework to structure thinking, rather than something that’s very detailed in terms of how you should actually apply it’.

Impinging factors – ‘Pressures on you all the time to get people in and out’

The general feeling was that there were clear influences about choosing the PEO Model. The first was time; the fast pace of acute care meant that the model could be used to consider quickly appropriate occupation-focused goals; for example, ‘... if you are practising as a discharge planner this [model] is ideal because you are looking at everything quite quickly within a short time spell’.

Linked with time pressures, concern was raised that although the PEO Model advocates client-centred care, this could be challenging to deliver, as the following quote illustrates:

You would like to think that you are patient-centred ... but in an actual biomedical place it is fairly difficult not to end up allowing a setting to dictate what’s happening ... even the type of interventions you might be able to undertake can be limited by the amount of time.

Another participant said, ‘... in somewhere like A&E it’s really not about the patient goals, it’s about ... prevent bed admissions, bed blocking’.

The speed at which patients were seen also impacted on the potential focus: ‘In a ward situation, the tendency is to focus on the environment’ and ‘Basically environment – what they need to do to get home’.

Another factor influencing choice of model was the education received by participants, with a perception that

some universities emphasised certain occupation-focused models: ‘I trained in [University A] and there was this big emphasis on models, so there was things like ... MOHO, COPM’ and ‘I trained at [University B] and a lot of the emphasis ... was based around MOHO and PEO Model ... but it had changed ...’

Participants also felt that education forced choices to be made between models:

essay questions are about which model do you think is best and why, it almost sets models up against each other and ... I don’t know if that is useful.

This shaped a consensus that the patient is central to the decision an occupational therapist makes regarding the choice of model in practice:

I don’t see models as being in competition with each other, I see them as a resource that we can tap into in that the patient ... will determine which we use and where.

The participants valued a choice regarding which occupation-focused model could be used in practice: ‘We would be doing an injustice if we sat with one model because then that could be reductionist also.’

Discussion

The responses capture an interesting insight into the potential value and use of the PEO Model in an acute physical setting, the first of its kind. This research was based on the premise that the model would be useful in this practice context and, generally, the findings support this view.

For these occupational therapists, the PEO Model offered a clear framework to structure and guide practice. Participants described a synergy between the theory and what they thought about and did in their practice. So, it has the capacity to contextualise practice for therapists in this setting; for example, the emphasis placed by therapists on the home environment and coping at home. Turpin and Iwama (2011) suggested that the authors of this model saw the need for occupational therapy to make explicit the contextualised understanding of human occupation. This is particularly significant in this setting, as previous research has highlighted how the hospitalisation of older adults in acute care can mean that occupational performance becomes decontextualised (Cheah and Presnell 2011). Thus, these findings suggest that the PEO Model appears to anchor occupational therapy in this setting.

In addition, the language of the PEO Model was accessible and valued for its ability to articulate practice both in and beyond the profession. These findings further support the view of Strong et al (1999), who suggested that the PEO Model facilitates communication within and outside the profession. The accessibility of the language used was, therefore, seen as an advantage, and could help to promote and explain occupational therapy in acute settings, a need identified by Wilding and Whiteford (2008). Secondly, Cheah and Presnell (2011) highlighted the necessity to ensure consistency of

communication in acute settings across all disciplines to maximise therapeutic potential. Recent health policy (NHS Scotland 2003), advocating further collaborative working across health professionals, also indicates the need for occupational therapy to articulate what it does and to do so in an accessible manner. Consequently, the PEO Model appears to assist occupational therapists to explain what they do and how they do it, to a range of health professionals and clients, in this setting.

Occupational therapy in acute care can lead to a focus around self-care (Griffin and McConnell 2001), yet these findings seem to indicate that the model can be used to consider the more complex interactions between person, environment, occupation and occupational performance, beyond just self-care. Varying perspectives were evident from the occupational therapists as to how complex the model was and in how much depth it could explore occupational performance issues with a client. Participants appeared to be in one of three groups, essentially representing a continuum of complexity: the model was simplistic; it offered complex analysis; and it could, at the same time, be both simplistic and complex. These alternatives can perhaps be explained by the flexibility of the model, because Strong et al (1999) argued that the use of the model as a framework has a broad scope of practice and there are many potential variations to the PEO elements that can be examined. These findings represent further evidence of the inherent flexibility of the model, where it was seen as useful throughout the varying acute contexts in this study. However, it is less clear why alternative perspectives concerning complexity exist. It may be that the interpretation of the concepts and language used by individual occupational therapists, to explain their practice, is influenced by experience and exposure to differing acute practice settings.

Alternatively, it may be that while therapists thought the theory was useful to frame thinking, it lacked detail on how this framework could be implemented in practice. This may explain why there was some reluctance to document practice using this model. Further research would be of use, exploring the views of participants who felt that the model could be both simplistic and complex, as the versatility and flexibility of this was clearly valued.

Irrespective of whether the PEO Model does or does not offer complex analysis of occupational performance, the reality of time constraints impacting on practice in this setting was evident. These findings support Crennan and MacRae (2010), who indicated that there was increasing pressure to discharge patients. The challenges of remaining client-centred versus the pressure to discharge patients and, consequently, the tendency to focus on the environment to achieve a successful discharge were clearly evident. The PEO Model was seen to focus on the environment in acute practice; however, the transactive relationship between person, environment and occupation, and how this influences occupational performance, was largely ignored in the discussion. This would be useful to explore further, as it is unclear whether the transactive relationship between these components was unclear

to the participants or whether the pressure to discharge forced participants to focus mainly on the environment.

Nevertheless, the PEO Model appeared to support therapists in their practice to consider environmental priorities, leading to discharge, and was, therefore, valued. There is, however, a disconnect emerging between occupation-focused models generally, which advocate client-centred practice, versus the reality of trying to deliver this within acute settings.

A further finding was that the models taught during pre-registration education strongly influenced model preference in practice. All participants could remember characteristics of education surrounding occupation-focused models. Ashby and Chandler (2010) suggested that pre-registration education is fundamental to therapist knowledge and understanding of occupation-focused models of practice. This finding further reinforces the responsibility of education providers when teaching occupation-focused models, raising questions concerning curriculum content. Within occupational therapy curricula, it may not be useful to concentrate on very few models when Baptiste (2005) indicated that students will graduate and work in a range of settings, requiring different skill sets. If the inclusion of occupation-focused models in curricula is in part determined by perceptions about its utility in practice (Ashby and Chandler 2010), then these findings indicate the need for curricula to explore the use of the PEO Model in acute physical settings.

Therapists also expressed a view that the needs of the patient should determine which model is used. This view is in direct contrast to research outlining one occupation-focused model throughout a service (Boniface et al 2008, Wimpenny et al 2010). Consequently, although the PEO Model is seen to be valuable in acute physical settings, it may not be appropriate to apply it across an entire service.

Study limitations

This was a small convenience sample and comprised participants who had attended the education course, therefore representing some degree of knowledge of the model. It is, therefore, difficult to transfer these findings to other settings. A larger sample, representing other acute physical sites, would be of use. In addition, the participants were all employed in one setting. Although the sample represents the broadness of their acute service, it may have been useful to narrow the focus further in the selection criteria.

Conclusion

Using a generic qualitative research design, this study has highlighted that the PEO Model can provide occupational therapists working in acute practice with a meaningful framework in which to conceptualise patients. The model offers flexibility regarding the extent to which occupational performance is addressed, in a setting characterised by short hospital admission stays. The PEO Model offers therapists a way to articulate their practice and, therefore, offers a connection with the underpinning values and beliefs of

occupational therapy. This is in spite of the challenges associated with delivering client-centred practice in acute settings. The importance of pre-registration education in the future choice of occupation-focused models was identified. Although the value of the PEO Model in this setting has been demonstrated, ultimately a combination of factors impact on the choice of model used by therapists, including university education, practice context and the needs of the individual patient.

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Conflict of interest: None declared.

Key findings

- The PEO Model mirrors occupational therapists' values and beliefs concerning their practice in an acute setting.
- Client-centred practice is challenging to deliver within acute hospital settings, representing an emerging disconnect between aspects of occupation-focused theory and practice.
- Models taught during pre-registration education strongly influence model preference in practice.

What the study has added

This is the first UK study to demonstrate that the PEO Model has potential value within an acute practice setting as the application of its theory is flexible, combining effectively with practice realities.

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Paper 2

Occupational therapy graduates of 2009: knowledge and attitudes relating to their role in the area of alcohol misuse

Jan Gill,¹ Fiona Maclean,² Linda Renton³ and Fiona O'May⁴



Key words:

Students, alcohol, professional role, knowledge, attitudes.

¹Senior Lecturer in Physiology and Pharmacology, Division of Nursing, Occupational Therapy and Arts Therapies, School of Health Sciences, Queen Margaret University, Edinburgh.

²Lecturer in Occupational Therapy, Division of Nursing, Occupational Therapy and Arts Therapies, School of Health Sciences, Queen Margaret University, Edinburgh.

³Senior Lecturer in Occupational Therapy, Division of Nursing, Occupational Therapy and Arts Therapies, School of Health Sciences, Queen Margaret University, Edinburgh.

⁴Research Fellow, School of Health Sciences, Queen Margaret University, Edinburgh.

Corresponding author: Dr Jan Gill, Senior Lecturer, School of Health Sciences, Queen Margaret University, QMU Drive, Musselburgh, East Lothian EH21 6UU. Email: jgill@qmu.ac.uk

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Purpose: Within Scotland, health policy changes are being considered to address the misuse of alcohol. Concurrently, a shifting of professional roles within the National Health Service is under way. The purpose of the study was to investigate personal knowledge and attitudes relating to alcohol use/misuse amongst all final year Scottish occupational therapy students.

Procedure: A self-completed questionnaire was developed for delivery in spring 2009 within scheduled lectures to students (n = 161) at all three Scottish universities providing occupational therapy education.

Findings: Of those in class, 93% (n = 109) provided completed questionnaires. There was evidence of gaps in knowledge around the understanding and application of United Kingdom responsible drinking guidelines; however, students reported confidence in their professional and personal ability to act effectively in this area of clinical practice. There was a distinct lack of congruence with key proposals put forward by the Scottish Government to address alcohol misuse.

Conclusion: Identified knowledge gaps have implications for the alcohol teaching content of the curriculum in Scotland. Additionally, while investigation of student attitudes revealed a self-belief in personal and professional skills, the findings nevertheless stress a need to ensure that the potential value of occupational therapists' contribution is more effectively communicated to their health professional colleagues.

Introduction

Societal costs associated with alcohol drinking in Scotland have been estimated at £3.56 billion per annum (Scottish Government 2010). According to Scottish Health Action on Alcohol Problems (2007), 90% of the adult population drink alcohol and it is unsurprising, therefore, that Scotland has witnessed significant increases in alcohol-related ill health and death in recent decades (ISD Scotland 2009).

The need to respond to the toll that alcohol exerts on both the individual and society has been prioritised by health professionals and politicians alike. Against a background of government-driven alcohol policy changes, and the concurrent overlapping of professional responsibilities within the National Health Service (NHS), this study contributes to the description of the occupational therapist's role in this important area of practice. It describes the knowledge, views and perceptions of soon-to-graduate Scottish occupational therapy students.

Literature review

A brief literature review was performed using the following search terms: students; alcohol; professional role; knowledge; attitudes; alcohol and occupational therapy. The inclusion criteria were English language, published

between 1985 and 2010. The databases searched were CINAHL, Medline, PsycINFO, EBSCO, British Nursing Index, Web of Science, SCOPUS and the NHS e-library.

Occupational therapy and alcohol

Current health statistics continue to highlight the associated costs of Scottish drinking habits and, with some justification, they feature regularly in both media and political agenda. Occupational therapists are among the health care professionals who work with people who misuse alcohol. Helbig and MacKay (2003) explored addictive behaviours from an occupational perspective and considered addiction in relation to occupational risk factors, flow and boredom. They suggested that addiction is occupational in nature and can lead to occupational disruption.

The role of occupational therapy in working with people who misuse alcohol has been discussed by several authors: Stone (1985), Cassidy (1988), Moyers (1988), Nixon (1988), Stensrud and Lushbough (1988), Clarey and Felstead (1990), Booth and Mulligan (1994), Cornvinelli (2005), McQueen and Allan (2006) and McQueen et al (2006). Most of these studies focus on how occupational therapists work within specialist addiction units and mental health units. While some work was conducted over 25 years ago, much information is still pertinent. The studies include a United Kingdom (UK) survey (Nixon 1988) and narrative accounts of intervention (Stone 1985, Cassidy 1988, Moyers 1988, Nixon 1988, Stensrud and Lushbough 1988, Clarey and Felstead 1990).

Counselling and the use of counselling skills are highlighted in four articles, along with occupational therapists working with clients to reduce their reliance on alcohol by incorporating occupational techniques into their daily life. The therapeutic relationship is also considered important (Stone 1985, Cassidy 1988, Clarey and Felstead 1990).

More recently, a review of interventions for people with substance use disorders was undertaken by Stoffel and Moyers (2004). Four effective interventions are identified: brief interventions, cognitive behavioural therapy, motivational strategies and 12-step programmes. Suggestions for occupational therapy are that interventions should be modified to include an occupational perspective, leading to occupationally focused outcomes. In a recent study, Cornvinelli (2005) offered specific guidelines for occupational therapists when working with young men who misuse substances (including alcohol). With regard to occupation, she suggested that offering choice, discussing expectations, relating to peers, matching the client's skills to opportunities, setting achievable goals and offering clear feedback are vital for this client group.

There is some reference to the potential for the role of occupational therapy being aligned to health promotion (Cassidy 1988, Booth and Mulligan 1994). McQueen et al (2006) highlighted the potential role of brief motivational counselling techniques as appropriate interventions for consideration by occupational therapists. McQueen and Allan (2006) contended that there was a clear role for

occupational therapists when working with individuals who were not classified as alcohol dependent but who were consuming in excess of health guidelines.

Implications for the profession

The argument for a clear, identified role for occupational therapy in this key area of public health brings two responsibilities. First, there must be a commitment to educate new and practising therapists appropriately, equipping them to meet the particular demands of this area of practice. Secondly, there must be a recognition of the need to promote the views and voice of occupational therapy in the area of policy development. Booth and Mulligan (1994) explored levels of educational input in relation to alcohol use. Interestingly, they concluded that 'the quantity of occupational therapy education about alcohol abuse is not commensurate with the scale of the problem' (p356). However, they advocated for a greater acceptance of the value of occupational therapy in this area of practice, including the delivery of brief interventions and representation at future policy development discussions.

Some of the concerns of these authors are voiced more recently in part of the written evidence submitted in 2008 by the College of Occupational Therapists to the policy review *Working together to reduce harm: the substance misuse strategy for Wales 2008-2018*. In this paper, the authors suggested that in the area of prevention 'there is no mention of the important contribution that occupational therapy can make' and that therapists 'could contribute far more than is currently the case in preventing addictive behaviour developing in the first place' (Crowder and Forster 2008, p2). (It is interesting to note that Booth and Mulligan's [1994] comments were made at a time when the UK societal costs attributed to alcohol were lower than those recently calculated for Scotland alone [Scottish Government 2010].)

Alcohol policy development

Current UK policy direction suggests that it may be desirable to change the drinking pattern of the majority of the population if meaningful improvements in health and health-related costs are to be gained. In its response to statistics highlighting the societal and economic costs of alcohol, the Scottish Government (2008) has recently outlined key proposals, including (i) the ending of 'the promotion and loss leading [selling drinks at below cost price] of alcoholic drinks in licensed premises', (ii) the introduction of minimum retail pricing, and (iii) a 'raising [of] the minimum legal purchase age for off-sales to 21'. In addition, (iv) there is a commitment 'to continue to call for a reduction in the drink drive limit from 80 mg to 50 mg per 100 ml of blood'.

The Scottish Government set the NHS in Scotland the target of delivering 149,449 brief interventions on alcohol between April 2008 and March 2011. NHS Health Scotland supports all health boards to meet the HEAT: H4 (Health Efficiency Access and Treatment) target for the delivery of

alcohol brief interventions locally (NHS Scotland 2008). The Scottish Intercollegiate Guidelines Network's Guidelines for the Management of Harmful Drinking and Alcohol Dependence in Primary Care (SIGN 2003) recommend brief and minimal interventions, including helping the patient to weigh up the benefits and disadvantages of his or her drinking pattern. Suggested methods are written media, motivational interviewing and case detection, as opposed to screening for the problem.

Two points are of relevance. First, the potential cost-effectiveness of brief interventions delivered in care settings (National Institute on Alcohol Abuse and Alcoholism 2005, Kaner et al 2009) and, secondly, the recent policy changes within the NHS advocating the development of flexible and collaborative working patterns for health professionals (Department of Health [DH] 2000, 2001, NHS Scotland 2002, 2003). Therefore, the onus, and by implication the potential success of delivering interventions addressing alcohol misuse, may depend on a wider range of health professionals than hitherto.

Education has responded. There has been a move towards shared interdisciplinary teaching within the health professional curricula. The World Health Organisation Study Group on Interprofessional Education and Collaborative Practice endorses and directs interprofessional collaboration in education and practice as an innovative strategy. It views it as being necessary in preparing a 'collaborative practice-ready workforce' (Yan et al 2007). It is stated that effective interprofessional education leads to effective collaborative practice.

The necessity for these ideals to be met by graduating health care professionals in this important area of health policy framed the rationale for the work presented below. The authors set out to survey a large number of medical, nursing and allied health professional students at higher education institutions (HEIs) located within different Scottish cities shortly before they graduated and entered the workforce. Given the large number of students involved, a questionnaire was designed to address the following research questions:

1. What are the levels of knowledge around current UK health advice relating to alcohol use among final year occupational therapy students in Scotland?
2. What are the attitudes of these students in relation to their professional role in the field of alcohol misuse?
3. Do graduating Scottish occupational therapists support, in principle, four key policy proposals put forward by the Scottish Government to address the problems of alcohol misuse?

The findings reported here describe pooled data collected at the three HEIs in Scotland providing occupational therapy education. At each of these, interprofessional education is embedded within the 4-year curriculum. These data are a subset of a larger study, which explored the knowledge and attitudes of graduating allied health professional, nursing and medical students at six universities in Scotland. These results are reported elsewhere (Gill et al 2010).

Method

Participants

The study was conducted during the second semester of the academic year 2008-09 at all three Scottish HEIs offering degree courses in occupational therapy, and invited participation by students due to graduate in July 2009.

Ethics

Favourable ethical opinion was obtained from each HEI. The first page of the questionnaire comprised an information sheet giving details of the study, and assurances of confidentiality and anonymity. Potential participants were assured of their right to decline participation, and informed that the results would be presented at conferences and/or appear in published form. Completion of the questionnaire was taken as informed consent.

Procedure

A paper form of the questionnaire was administered and completed at lectures.

Questionnaire

The questionnaire contained three sections. The first, *Section A*, sought basic demographic data: gender, age, undergraduate year, degree specialisation, drinker/non-drinker classification. (Non-drinkers were defined as drinking no more than '2 glasses of wine, 1-2 pints of beer per year'.) In an attempt to increase participation rates and to comply with ethical committee stipulations, no additional questions relating to personal consumption levels were included.

Section B explored knowledge relating to current UK responsible drinking guidelines for daily consumption (DH 1995) and was shaped by a questionnaire previously employed by two of the authors (Gill and O'May 2007). Accurate recall was recorded as an answer of 3, 3-4 or 4 UK units for men, and 2, 2-3 or 3 units for women (one UK unit is equivalent to 10 ml or 8 g of ethanol). Those who had indicated that they were drinkers were asked to state their preferred drink and the usual volume consumed and to estimate its unit content. From this information, and using manufacturer's product data if required, the unit content was calculated. The estimate provided by the student was then categorised as 'underestimate', 'overestimate' or 'accurate'. (For wine, an alcohol by volume of 12% was assumed.) Non-drinkers, instead, answered a general question relating to the units contained in a typical glass of wine.

Section C was influenced by the questionnaire developed by Happell and Taylor (2001) to explore nurses' attitudes to clients with drug and alcohol problems, and contained 14 statements to which participants were required to respond according to a six-point Likert scale ranging from 'strongly disagree' to 'strongly agree'. The first 10 statements related to professional role and attitude, and the final four to policy change proposals emerging from the Scottish Government's discussion paper (Scottish Government 2008).

Table 1. Summary of student responses (n = 109) to questions relating to UK responsible drinking guidelines

| Responses | Percentage (n) |
|---|---------------------|
| Provided accurate estimate of UK unit content of personally preferred alcoholic drink (amongst drinkers)..... | 47.1% (n = 48)..... |
| Responded 'don't know' when asked the UK unit content of personally preferred alcoholic drink (amongst drinkers)..... | 21.6% (n = 22)..... |
| Provided accurate recall of UK male daily drinking guidelines (all students)..... | 58.7% (n = 64)..... |
| Provided accurate recall of UK female daily drinking guidelines (all students)..... | 67.0% (n = 73)..... |
| Responded 'don't know' when asked to quote male drinking guidelines (all students)..... | 14.7% (n = 16)..... |
| Responded 'don't know' when asked to quote female drinking guidelines (all students)..... | 16.5% (n = 18)..... |

The questionnaire was developed and then piloted with a group of second-year occupational therapy students. In addition, following the pilot phase, content validity was addressed by seeking comments from two practitioners working in clinical departments linked to alcohol misuse within two NHS health boards in Scotland.

Data were analysed using the Statistical Package for the Social Sciences (SPSS) version 16, with the coding and data entry of every seventh questionnaire being cross-checked.

responses related alcohol problems to amount consumed. Very few responses, 13.6%, were linked to the reasons for drinking.

Section C: Professional role/attitude, reaction to proposed Scottish alcohol policy changes

Students were asked to name the profession(s) they thought was best placed to intervene and offer advice when it was suspected that a patient had a problem with alcohol. Their responses are collated in Table 3. It is of

Results

Section A: Basic demographic data

Of those eligible to take part in the study (161 occupational therapy students), 109 students completed the questionnaire (of the 117 who were present at classes on the day of the survey). Therefore, response rates were 68% for matriculated students, and 93% for those present at the timetabled class. No advance warning of the survey was given. The mean age of the sample was 25.9 years (95% CI: 22.58-27.22) and the age range was 21-48 years. Regarding gender distribution, 95.4% of the sample were female, with 6.4% (n = 5) self-reporting as non-drinkers.

Section B: Knowledge

Participants' responses to Section B of the questionnaire, exploring knowledge around UK responsible drinking guidelines, are shown in Table 1.

Amongst drinkers, just over one-fifth (21.6%) did not know the unit content of their personal choice of alcoholic drink. Amongst all students, approximately one-third (33%) did not know, or could not accurately recall, the UK recommended daily limits of consumption for women. For male guidelines, this figure rose to 41%. These findings are, in part, consistent with responses to the later statement, 'I feel I have the appropriate knowledge to advise my patients about responsible drinking advice and the problems associated with alcohol misuse'; over 40% (n = 44) did not agree (see Table 4).

Students' responses to the question, 'How would you define the phrase "someone with alcohol problems"?', are summarised in Table 2. Responses were grouped into three broad categories. Some respondents provided more than one definition and two did not answer this question. The greatest number of responses were in the group relating alcohol problems to the consequences of excessive intake – around half of all responses. However, it is of interest that almost two-fifths of

Table 2. Student responses (n = 109) to the question 'How would you define the phrase "someone with alcohol problems"?' (Note: students could supply more than one definition)

| Categories | Comments | Number of occupational therapy responses | % |
|---|--|--|---------------------------|
| 1. Comments relating to amount or pattern of intake | Drinks every day..... | 20..... | 67.....37.9% |
| | Drinks an excessive amount..... | 21..... | |
| | Does not know limits..... | 1..... | |
| | Drinks more than three times a week..... | 2..... | |
| | Drinks alone..... | 1..... | |
| | Drinks very frequently..... | 11..... | |
| | Drinks more than weekly limit..... | 9..... | |
| | Drinks outside social hours..... | 2..... | |
| 2. Comments relating to reasons for drinking | Drinks to get through the day..... | 12..... | 24.....13.6% |
| | Drinks to get drunk..... | 4..... | |
| | Uses alcohol to solve problems..... | 5..... | |
| | Can't say no to drink..... | 1..... | |
| | Drinks whenever there is an excuse..... | 1..... | |
| | Can't socialise without drink..... | 1..... | |
| 3. Comments suggesting consequences of excessive drinking pattern | Alcoholic..... | 2..... | 86.....48.6% |
| | Dependent on drink..... | 42..... | |
| | Drink has a negative impact on their life..... | 21..... | |
| | Out of control – needs help..... | 7..... | |
| | Becomes ill with drink..... | 4..... | |
| | Addicted..... | 5..... | |
| | Signs of withdrawal..... | 1..... | |
| | Behaviour out of control..... | 1..... | |
| | Always thinking about drink..... | 2..... | |
| | Not aware of problems..... | 2..... | |
| 4. | No answer supplied..... | 2..... | Total.....177..... |
| | | | |

Table 3. Professions identified by students (n = 109) as best placed to intervene when alcohol misuse suspected (students could name more than one profession)

| Profession | Number of students selecting this profession |
|------------------------------------|--|
| Medicine..... | 52..... |
| Nursing..... | 37..... |
| Social work..... | 14..... |
| Dietitian..... | 4..... |
| Psychologist..... | 13..... |
| Counsellor..... | 10..... |
| Occupational therapist..... | 51..... |
| Nutritionist..... | 2..... |
| 'All professions'..... | 18..... |
| Psychiatrist..... | 3..... |
| Therapist..... | 1..... |
| Physiotherapist..... | 0..... |
| Pharmacist..... | 0..... |
| Podiatrist..... | 0..... |
| Speech and language therapist..... | 0..... |
| Don't know..... | 1..... |

interest that occupational therapy was named almost as frequently as the medical profession. Also of note is the fact that 31% of students (n = 34) named only one profession, and for 10% (n = 11) this was occupational therapy. As many as 66% (n = 72) respondents listed more than one profession and 58 of those included themselves (the 'all professions' response has been included in this count).

The following professions were not selected: podiatrists, radiographers and speech and language therapists/audiologists. (It is noteworthy that in the larger study [Gill et al, in preparation] which involved other graduating health professionals including medical students [an additional 418 students], occupational therapy was selected as a response by these future colleagues only 15 times.)

The responses of the occupational therapy students to statements relating to professional role and attitude and to four key proposed changes to alcohol policy in Scotland are presented in Table 4.

A large majority of occupational therapy students agreed that their own profession had a role to play in brief interventions (although, as noted earlier, this view was clearly not shared by some of their future colleagues). A similar number agreed that early intervention was likely to be beneficial and that all professionals had a role in this area. Interestingly, while 92.5% saw a role for their profession, slightly fewer (86.2%) felt that they had the personal qualities required to initiate brief interventions, and only 58.8% felt that they had the appropriate knowledge to offer advice about guidelines. A small number (12.8%) reported possible embarrassment when asking about a patient's alcohol use. Almost a quarter indicated that in their private life they would avoid people whom they suspected had an alcohol problem.

Of the proposed changes to Scottish alcohol policy, only the change suggesting a reduction in the drink driving limit

met with the approval of the majority of these students. Fewer, only around one-third of students, indicated agreement (see Table 4) for policy changes that had an impact on selling price, the banning of below cost price alcohol promotions and the changing of the legal age for off-sales purchases.

Discussion

The responses of this sample of Scottish occupational therapy students to the questionnaire capture an interesting insight into the views of occupational therapy students towards alcohol, their professional practice and the wider political debate around alcohol use in Scotland.

The students' responses concerning their ability to work with people with alcohol problems generally indicate a degree of personal confidence, and a conviction that there is a role for their profession. For example, 92.5% of students believed that occupational therapy has a role to play in brief interventions with patients when alcohol misuse is suspected, with a similar number recognising the important contribution that can be made by fellow professionals working in this area.

Similarly, the study provides evidence of optimism amongst these final year students relating to the potential impact of occupational therapy in this area of practice. The benefits of early intervention (93.6%), a belief that alcohol misusing individuals could be helped before they reached 'rock bottom' (86.1%) and a confidence that alcohol problems were not beyond the control of the person affected (72%) were supported.

Two points emerging from the study are worthy of further debate within the profession. First, while it is encouraging that 92.5% of students believed that their profession had a role in this area of practice, there is, nevertheless, a clear challenge for interprofessional education curricular content and collaborative working, for this confidence was not recognised by the other student professions. Exploration of those factors that have influenced other health professionals' view of the occupational therapist's role is merited, and may offer challenges for the professional body.

Secondly, the recall and understanding of current UK drinking guidelines was relatively poor. Only 58.8% of the occupational therapy students indicated that they had the appropriate knowledge to advise patients about responsible drinking, while 53% of those who drank either did not know, or did not accurately know, the unit content of their choice of alcoholic drink. Despite the high profile afforded to the topic of alcohol and public health within the UK, this finding has resonance with conclusions made 16 years ago by Booth and Mulligan (1994), who highlighted the lack of alcohol teaching within occupational therapy courses.

It could be argued that the newly qualified occupational therapist must be equipped with several skills to work effectively in this area of practice, and not simply have knowledge of the UK sensible drinking message (DH 1995), important as this is. In addition, interpersonal skills, empathy and sensitivity will all be crucial in this very difficult and

Table 4. Students' responses to statements around issues relating to alcohol (n = 109)

| Statement | Strongly disagree | Quite strongly disagree | Disagree | Agree | Quite strongly agree | Strongly agree | Blank (n) | Overall disagree % (n) | Overall agree % (n) |
|--|-------------------|-------------------------|----------|-------|----------------------|----------------|-----------|------------------------|---------------------|
| My own profession has a role to play in brief interventions when alcohol misuse is suspected in a patient | 2 | 3 | 3 | 28 | 35 | 36 | 2 | 7.5% (8) | 92.5% (99) |
| I have the appropriate knowledge to advise my patients about responsible drinking advice and the problems associated with alcohol misuse | 2 | 8 | 34 | 44 | 15 | 4 | 2 | 41.2% (44) | 58.8% (63) |
| Health professionals who identify alcohol problems early can improve the chances of treatment success | 0 | 0 | 7 | 34 | 40 | 27 | 1 | 6.5% (7) | 93.5% (101) |
| All health professionals in the UK share the responsibility of intervening when a patient is suspected of having an alcohol problem | 0 | 1 | 6 | 31 | 26 | 45 | 0 | 6.4% (7) | 93.6% (102) |
| Alcohol problems are beyond the control of the person affected | 11 | 18 | 48 | 21 | 8 | 1 | 2 | 72.0% (77) | 28.0% (30) |
| I have the personal qualities required to initiate brief interventions relating to responsible drinking | 0 | 5 | 10 | 64 | 23 | 7 | 0 | 13.8% (15) | 86.2% (94) |
| In my private life I would avoid people whom I suspect to have problems with alcohol | 16 | 18 | 48 | 24 | 3 | 0 | 0 | 75.2% (82) | 24.8% (27) |
| I would feel embarrassed asking patients about their use of alcohol | 20 | 31 | 44 | 11 | 2 | 1 | 0 | 87.2% (95) | 12.8% (14) |
| People with an alcohol problem can only be effectively treated when they hit 'rock bottom' | 38 | 28 | 27 | 8 | 4 | 3 | 1 | 86.1% (93) | 13.9% (15) |
| People should have the right to use alcohol as they wish within the confines of their own home | 4 | 8 | 18 | 67 | 7 | 5 | 0 | 27.5% (30) | 72.5% (79) |
| Alcohol-related harm will be reduced by banning promotions that sell alcohol at below cost price | 9 | 17 | 41 | 28 | 8 | 5 | 1 | 62.0% (67) | 38.0% (41) |
| The introduction of minimum retail pricing i.e. a minimum price for one unit of alcohol will reduce consumption | 13 | 15 | 45 | 29 | 3 | 2 | 2 | 68.2% (73) | 31.8% (34) |
| The proposal to raise the minimum legal purchase age for off-sales purchases to 21 years will reduce the negative impact of alcohol on communities | 7 | 23 | 41 | 28 | 5 | 4 | 1 | 65.7% (71) | 34.3% (37) |
| It will be beneficial to reduce drink drive limit from 80 mg to 50 mg per 100 ml of blood | 4 | 2 | 15 | 25 | 20 | 41 | 2 | 19.6% (21) | 80.4% (86) |

challenging area of practice. Health care students may differ in their perceptions of the relative importance of the detail of this health message, but nevertheless feel that they have the ability to intervene successfully. This may explain some of the disparity between the responses of the occupational therapy students; only 58.8% believed that they had the appropriate knowledge to advise about responsible drinking while many more, 86.2%, believed that they had the personal qualities to initiate brief interventions.

The alcohol-related content of the curriculum undertaken by all the students who participated in the study is unknown; this may have differed greatly, and it is likely that it explains part of the disparity in knowledge evident in the findings. Similarly, individual students' practice placement experience in relation to alcohol misuse cannot be reported, and it is acknowledged that this is likely to have varied greatly, from minimal to extensive exposure. Nevertheless, the gaps in knowledge revealed by the findings argue for a basic uniform alcohol content within the occupational therapy undergraduate curriculum to meet the demands of this important area of public health policy. Further debate involving educators and practitioners on how best to address knowledge gaps is to be welcomed if the aims of the College of Occupational Therapists are to be met (Crowder and Forster 2008).

Given the complex issues facing the novice occupational therapy graduate in this area, it is interesting that only 12.8% indicated that they would feel embarrassed about asking clients about their use of alcohol. However, almost twice as many (24.8%) indicated that they would avoid such people in their private life. It is difficult to ascertain the beliefs and values that lead to this view, and further study is required to determine the attitudes of occupational therapy students towards people who misuse alcohol. For example, Table 2 indicates a diverse range of views from the occupational therapy students concerning what actually constitutes problem drinking, the reasons for drinking and the consequences. These diverse comments perhaps indicate a lack of detailed information or insight into knowledge of alcohol problems, which inevitably raises issues for curriculum content for occupational therapy education across Scotland.

In relation to current Scottish policy, 62% of the occupational therapy students disagreed that alcohol-related harm would be reduced by banning promotions, for example, and 68.2% disagreed with the need for minimal retail pricing. There is, therefore, a clear disconnection between the views of occupational therapy students in Scotland and the key strategies of the Scottish Government in managing changing attitudes to alcohol. It is not clear if this disparity is due to a lack of engagement or exposure to knowledge about alcohol policy within their professional education. Alternatively, students have not been exposed to the evidence-based debate leading to the development of this alcohol policy.

Perhaps some insight is offered by the statistic that 72.5% of the occupational therapy students felt that people should have the right to use alcohol as they wish within the confines of their own home. A possible reason for this view

may be the philosophy of client-centred practice, which is central to several key conceptual models of practice within occupational therapy, and embedded within the College of Occupational Therapists' (2010) *Code of Ethics and Professional Conduct*. It is, however, disconcerting that a large number of students disagreed with key strategies of Scottish Government policy and seem also to challenge emerging evidence from the general public, which suggests that around 80% linked low price and discounts to an increase in people's drinking (Big Drink Debate 2009).

Any increase to the price of alcohol will have a direct impact on this group, who are identified as having a lack of money due to student loans and funding arrangements. However, these students predominantly belong to age groups linked with high, often potentially hazardous, drinking levels. The possibility of a conflict of interest between personal and professional views, with regard to the impact of an alcohol price increase, should not be ignored.

The study has some obvious strengths. An entire cohort of graduation occupational therapy students in Scotland were approached. Ninety-three per cent of students present at lectures responded, so these results are likely to be representative of Scottish graduating occupational therapy students. No advance warning of the study was given, which arguably could have had a negative impact on attendance. Whilst the gender distribution (95.4% female) is skewed, it is nevertheless closely aligned to the gender distribution of allied health professionals working in Scotland (90% female, 10% male workers; ISD Scotland 2008).

Further research is required to explore in detail the thoughts and views that have influenced the responses of the present cohort, taking a qualitative approach. The extent of exposure to alcohol-related clinical work experience is highly variable, and its influence on knowledge and attitudes is unknown.

Conclusion

This study presents several key messages of relevance to the profession of occupational therapy. This focused questionnaire has revealed key information concerning the knowledge and insight of new occupational therapy graduates entering the workforce in 2009 to issues around the use/misuse of alcohol in Scotland.

There were gaps evident in the knowledge base of these students, particularly around alcohol health guidelines. Given the extent of the current alcohol-related problems within the UK, there is a clear argument suggesting that the content of the present occupational therapy curriculum devoted to alcohol misuse within Scotland be reviewed. While it is encouraging to note the positive attitude of students to the effectiveness of early intervention, the lack of embarrassment when asking patients about their use of alcohol, and a confidence in the importance of the role of their own profession in delivering in this area of clinical practice, this key contribution of occupational therapists was not rated by their fellow allied health professional, nursing, and medical

students. The message for the occupational therapy profession is clear: it must consider how effectively it communicates its role both in academia and in the clinical workplace.

There was a clear disparity between the occupational therapy graduates' views and the key tenets of the Scottish Government's strategy for reducing alcohol-related harm in Scotland. Given the occupational therapy students' age and gender, these findings are perhaps not surprising, but it would be of interest to explore whether these views are maintained once they are practising members of the health care workforce.

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Conflict of interest: None declared.

Key findings

- Final year occupational therapy students exhibited gaps in knowledge base surrounding alcohol health guidelines.
- Belief in professional role was evident, but was not identified by fellow health professional students.

What the study has added

The study has highlighted a need for alcohol education at undergraduate and post-qualification level, but also students' positive perceptions of the relevance of their role in addressing alcohol misuse.

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Paper 3

The topic of alcohol within the Scottish occupational therapy curricula

Fiona Maclean,¹ Fiona O'May,² and Jan Gill³



Key words:
Alcohol, education.

Introduction: Scotland has witnessed a large rise in all types of alcohol-related illnesses, and in alcohol-related deaths. Despite this escalating problem, previous research in Scotland has demonstrated that gaps exist in the knowledge base of graduate occupational therapists. This study therefore aimed to document the content of alcohol in Scottish occupational therapy curricula.

Method: This study was conducted during 2010–11. A questionnaire was sent to the programme leader of all the Scottish Higher Education Institutes offering a BSc (Hons) degree in occupational therapy, and to the only Further Education College in Scotland offering a Higher National Certificate in occupational therapy. The response rate was 100%.

Findings: There is a lack of cohesive approach to alcohol misuse education within the occupational therapy curricula delivered in Scotland. Key proposals of the Scottish Government targeting alcohol misuse are inadequately addressed.

Conclusion: The topic of alcohol and alcohol misuse is taught to varying degrees within the curricula offered in Scotland and further emphasis needs to be placed on understanding alcohol misuse and associated potential interventions, irrespective of practice context.

Introduction

According to the Scottish Minister for Health, health experts agree that alcohol misuse is the most pressing public health issue facing Scotland (Scottish Government 2009). There has been a rise in all types of alcohol-related illnesses and deaths, and Scotland's liver cirrhosis rate is one of the fastest growing worldwide (Scottish Government 2010). Societal costs associated with alcohol drinking in Scotland have been estimated at 3.6 billion pounds per annum (Scottish Government 2010). It should be noted that adverse consequences of drinking are not confined to the heaviest, dependent drinkers and that the wider population of people drinking at hazardous and harmful levels also experience harm from their alcohol consumption (NICE 2010). Despite the fact that alcohol-related hospital admissions have decreased by two percent from 2010 to 2011, and by six percent over the past five years, during 2011 in Scotland, over 100 people a day were admitted to hospital due to alcohol (ISD 2012). Therefore, Scotland experiences significant health and social problems due to excessive alcohol misuse, indeed more so than in England, Wales, and Northern Ireland (Scottish Government 2008).

There has been an ongoing drive within the National Health Service (NHS) to promote the development of flexible and collaborative working patterns for health professionals (DH 2001, 2000, NHS Scotland 2003, 2002). Consequently, given the extent of alcohol as a problem in Scotland, and recent policy 'drivers' throughout both the United Kingdom (UK) and Scotland advocating a more flexible work force, it is likely that the responsibility for delivering alcohol-related health interventions will depend on a wider range of health professionals. For example, in 2008 the Scottish Government introduced a target for the delivery of nearly 150,000 alcohol brief interventions

¹Senior Lecturer, Queen Margaret University, Division of Occupational Therapy and Arts Therapies, Edinburgh, East Lothian.

²Research Fellow, Queen Margaret University, School of Health Sciences, Edinburgh, East Lothian.

³Reader, Queen Margaret University, Division of Nursing, Edinburgh, East Lothian.

Corresponding author: Fiona Maclean, Senior Lecturer, QMU Drive, Musselburgh, Edinburgh, East Lothian, EH21 6UU, Scotland. Email: fmaclean@qmu.ac.uk Twitter: @MacleanFiona

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(ABIs: short motivational interviews with patients in which the costs and benefits of drinking are discussed), to be delivered over a 3-year period. Traditionally, the remit for the delivery of ABIs and health promotion regarding alcohol misuse has been held by nursing and medical staff, but recently the potential role of other front-line health professionals has been debated (Lock 2004), and McQueen et al (2006) highlighted a role for occupational therapists to work in the area of alcohol misuse. Despite this, the College of Occupational Therapists (COT) presented written evidence to the Alcohol Commission in Scotland and to the Welsh Policy Review regarding substance misuse (Crowder and Forster 2008), noting that in the area of prevention there was 'no mention of the important contribution that occupational therapy can make', and that the occupational therapy profession 'could contribute far more than is currently the case in preventing addictive behaviour developing in the first place (p2).'

The findings by Gill and O'May (2011) suggested other professional groups currently largely ignore the role of the occupational therapist in alcohol misuse, and revealed evidence of role uncertainty in this area of practice. They indicated that this has implications for the content of undergraduate curricula. The current study therefore builds upon past research by aiming to document the content of alcohol education in Scottish occupational therapy curricula.

Literature review

A literature review was conducted using the following search terms: 'student', 'alcohol', 'occupational therapy', 'nursing and allied health professions (AHPs)', and 'undergraduate curriculum'. The inclusion criteria were English language, and published between 1991 and 2011. The databases searched were CINAHL, Medline, PsycINFO, EBSCO, and Google Scholar.

Occupational therapy and alcohol

Recent literature pertaining to occupational therapy and alcohol/substance misuse issues has examined effectiveness and the use of guidelines to structure practice. For example, Stoffel and Moyers (2004) identified brief interventions, cognitive behavioural therapy, motivational strategies, and 12-step programmes as effective interventions for adults and adolescents. They also indicated a lack of occupational therapy studies examining the efficacy and effectiveness of interventions for persons with substance misuse disorders. Corvinelli (2005) considered guidelines for occupational therapists when working with young men who misuse alcohol (amongst other substances). In addition, McQueen et al (2006) examined the feasibility of brief motivational counselling as an intervention for use by occupational therapists in general hospitals. Whilst this was described as a pilot study, the conclusion was that this intervention could be useful within a medical setting.

The literature surrounding occupational therapy and alcohol is striking in relation to both the increasing areas of practice in which alcohol-related misuse is considered and the evolving

role of occupational therapy. Prior to 1991, literature had a tendency to consider predominantly alcohol-dependent adults (for example, Cassidy 1988, Nixon 1988, Stone 1985), whereas contemporary American occupational therapy practice included work by Jirikowic (2008), encompassing intervention strategies and tools suited to support children affected by prenatal alcohol from infancy to adolescence. A survey of 1,000 licensed occupational therapists in the United States (USA) (response rate 20%) conducted by Rudeen et al (2007) documented that those who participated possessed a good general knowledge of fetal alcohol syndrome (FAS) and risky use of alcohol during pregnancy. In the UK, a recent report (Alcohol Concern 2010) recommended mandatory social care training, to help professionals advising children on a practical and emotional level on how to deal with their parents' drinking, providing another illustration of the ways alcohol misuse can impact on children.

Conversely, towards the end of the life span, literature (generally from outside the occupational therapy field) recognizes the growing concern of care workers and health services surrounding alcohol misuse amongst older people (Alcohol Concern 2002). From the documented statistics surrounding the prevalence of alcohol misuse within the UK, Wallace et al (2010) indicated that nurses working in hospital and community settings will, at some point, have cared for an older adult who misuses alcohol. Their call for an integrated assessment of older adults who misuse alcohol has implications for occupational therapists working with older adults, as they acknowledged the need to adopt a shared, team vision of health (and social care where appropriate) in the context of substance misuse. O'Connell et al (2003) noted that due to the ageing population worldwide, the absolute numbers of older people with alcohol misuse disorders is on the increase. These authors further argued that alcohol disorders in older people tend to be under-detected, and often misdiagnosed, due to a variety of reasons that include the fact that healthcare workers have a lower degree of awareness when assessing older people. Given the documented scope of the potential consequences of alcohol across the life span, Riley et al (1998) asserted that, regardless of practice area, occupational therapy practitioners need to be well informed about substance misuse and methods of treatment.

Occupational therapy, alcohol, and education

The evolving range of practice settings impacted by alcohol misuse indicates a growing need for occupational therapists to be cognizant of alcohol as a factor to consider, irrespective of practice context. As such, Gill et al (2011) indicate that the potential success of delivering interventions addressing alcohol misuse is likely to depend on a wider range of health professionals than in the past. It has previously been identified within nursing literature, for example, that a higher priority should be given to care of the alcohol patient in the general practice area during pre-registration nursing training (Clark 2005). Within occupational therapy, Booth

and Mulligan (1994) noted that practicing occupational therapists were aware of basic health information concerning alcohol, but lacked confidence and were reluctant to engage in screening assessments or basic treatment with problem drinkers. They argued that enhanced training in alcohol and substance misuse would underpin their involvement with these clients. Despite this, little subsequent research appears evident in the occupational therapy literature surrounding alcohol curriculum content. This is surprising, as studies conducted within occupational therapy have identified areas of concern in relation to knowledge and understanding associated with alcohol. For example, Rudeen et al (2007) noted that many of the American occupational therapists they surveyed had both limited training and knowledge deficiencies in areas of prevention, diagnosis, treatment, and intervention in relation to fetal alcohol syndrome (FAS). The USA-based Fetal Alcohol Spectrum Disorder (FASD) Regional Training Centers Consortium (2007) conducted a survey of educational curricula, which in part encompassed a report of current efforts to address FASDs in medical and allied health curricula. One conclusion reached was that existing efforts to educate health professionals about FASDs were inconsistent and inadequate.

Thompson (2007) conducted a web-based survey of occupational therapy practitioners from all areas of practice and from all regions across the USA. Of the 128 respondents, it was apparent that mental health practitioners were most likely to assess clients for substance misuse. Practitioners in other areas assessed clients for substance misuse less than 5% of the time. The most frequent reason for not addressing this disorder (26.5%) was that the practitioners did not feel it fell within the scope of occupational therapy practice in their setting. The conclusion drawn was that despite occupational therapists encountering clients with substance misuse disorders, many are unlikely to address this issue in treatment. Whilst these results must be viewed within the context of a small response rate, and from an American perspective, they raise questions as to why occupational therapists, especially outside mental health practice, feel less comfortable or less inclined to deal with substance misuse (including alcohol).

The only comparable research identified within this review of the literature in a UK context is that of Gill et al (2011), who surveyed occupational therapy graduates across Scotland in 2009. They discovered gaps in the knowledge base of those students, particularly around alcohol health guidelines. Despite these gaps, however, 92.5% of students felt that their profession had a role to play in working with alcohol misuse, specifically in implementing alcohol brief interventions.

Whilst the preponderance of survey work investigating the knowledge and attitudes of occupational therapists and occupational therapy students towards alcohol misuse originates from the USA, it is of note that, in 2006, excessive drinking was calculated to cost \$746 for every man, woman, and child in America (Centers for Disease Control and Prevention 2011). As already mentioned, in Scotland,

2007 data showed the societal cost to the country to be approximately £3.56 billion (Scottish Government 2010), equating to a per capita figure of £698, based on General Register Office for Scotland (2008) population data. These costs further demonstrate the urgent need to understand the extent to which occupational therapy is both able and educationally prepared to work with alcohol misuse, specifically in Scotland.

Consequently, the need to review current occupational therapy curricula in Scotland, and the extent to which they are addressing alcohol misuse, has been guided by the relative shortage of established research originating from Scotland and the UK surrounding alcohol misuse, the COT's recognition that the profession could contribute far more in preventing addictive behaviours (Crowder and Forster 2008), and the finding from Gill et al's (2011) work identifying gaps in the knowledge base of occupational therapy graduates.

Method

The findings of the literature review framed the rationale for the development and implementation of the study. The research aim was to document the current extent and content of alcohol use/misuse teaching within both BSc (Hons) and Higher National Certificate (HNC) occupational therapy programmes in Scotland, with the objectives to: (1) investigate the extent to which alcohol misuse as a subject is taught within Scottish occupational therapy programmes; (2) determine the scope and content of the alcohol teaching within Scottish occupational therapy programmes; and (3) investigate potential barriers to the delivery of alcohol teaching within Scottish occupational therapy programmes. A questionnaire was designed to explore these.

Sample and recruitment

The study was conducted during 2010–11 across all the Scottish Higher Education Institutes (HEIs) offering undergraduate BSc (Hons) in Occupational Therapy, and the one Further Education College (FEC) in Scotland offering an HNC in Occupational Therapy. (In Scotland, an honours degree comprises four years of study and each 'level' within a programme equates to a year of study.)

Each of the HEIs and the FEC taking part provided a favourable ethical opinion concerning the study. The first page of the questionnaire comprised an information sheet giving details of the study, and assurances of confidentiality and anonymity. Potential participants were assured of their right to decline participation in the study at any stage, and were informed that the results would be presented at conferences and/or appear in published form. Completion of the questionnaire was taken as informed consent. A copy of the questionnaire was emailed to the identified programme leader of each of the participating institutions, followed up by a paper copy sent by post. The questionnaire was returned to the first author either via email or as a paper copy.

Table 1. Intake of occupational therapy students to Level 1

| Institution | Level 1 intake (n) |
|-------------|--------------------|
| 1 (HEI) | 68 |
| 2 (FEC) | 16–20 |
| 3 (HEI) | 58 |
| 4 (HEI) | 36 |

Table 2. Curriculum level at which alcohol use/misuse taught

| Institution | Level 1 | Level 2 | Level 3 | Level 4 |
|-------------|---------|---------|---------|---------|
| 1 (HEI) | Yes | Yes | Yes | Yes |
| 2 (FEC) | N/A | N/A | N/A | N/A |
| 3 (HEI) | Yes | Yes | No | Yes |
| 4 (HEI) | Yes | Yes | Yes | Yes |

Questionnaire structure

The questionnaire consisted of four sections and contained both open and closed questions.

- **Section 1** requested course characteristics, such as annual student intake numbers and type of course offered.
- **Section 2** explored alcohol-related curriculum content in detail, such as the amount of time spent within each course exploring alcohol-related issues, the type of teaching methods used to explore this topic, and the aspects of alcohol-related curricula content that were discussed and explored throughout the occupational therapy programme(s). The examples of alcohol-related content used within the questionnaire were influenced in part by the findings of Gill et al (2011), and by Scottish Government policy proposals (2008). Participants were asked to indicate what topics were included within the curriculum and to identify what these were.
- **Section 3** was completed by participants whose course did not teach alcohol-related curriculum content, and explored the potential reasons for this.
- **Section 4** explored any potential barriers to the inclusion of alcohol-related curriculum content within the participating institutions and considered the value placed on this topic. Additionally, Gill et al's (2011) findings, highlighting the failure of other AHPs and nursing students to identify the profession of occupational therapy as 'key' when working with alcohol use/misuse, were investigated further.

The questionnaire was developed and piloted on two occupational therapy lecturing staff and one non-occupational therapy academic, working outside the areas to be included in this study. Following the pilot, content validity was addressed by incorporating their feedback in to the final version of the questionnaire.

Data analysis

Descriptive statistics were used and analysed using Excel for Mac 2011, version 14.3.9. The Findings section that follows mirrors the structure of the questionnaire, as outlined above.

Findings

Section 1

The questionnaires were sent to the identified programme leaders of each of the participating institutions, although none was completed by a named programme leader. The job titles given in each questionnaire included Course Co-ordinator, Lecturer, Senior Lecturer, and Subject Lead in Occupational Therapy.

The annual intake of occupational therapy students to Level 1 during the data collection period is shown in Table 1.

Section 2

This section explored the way in which the alcohol content of the courses was taught. One participating institution indicated that alcohol use/misuse was not taught within their programme (Institution 2). Three of the participating institutions reported teaching alcohol use/misuse as an integrated topic. Examples included occupational therapy modules on topics such as occupational performance, pathophysiology, and health and wellbeing. Two institutions noted that alcohol was a topic that could be selected for further elective study, either within an independent learning module or as an honours-level project. Additionally, one institution reported teaching alcohol use/misuse within addictions. Two institutions indicated that practice placements offered an opportunity to learn about alcohol use/misuse. Table 2 indicates the level at which the topic of alcohol use/misuse was taught (Table 2).

The areas of alcohol-related content and visiting lecturer (VL) input, where applicable, are shown in Table 3.

In addition to these identified topics, Institution 4 delivered strategic commissioning of services, partnership working, and research audit content through a visiting lecturer. Institution 3 employed a physiologist to support learning and teaching of alcohol-related content, including some limited discussion of FAS. Institution 4 invited input from a range of professionals, including occupational therapists, service users, drug and alcohol professionals based within addiction services, and the local drug and alcohol partnership.

With regard to the number of lecturer/student direct contact hours dedicated exclusively to alcohol use/misuse education, two participating institutions gave details, and for one this was not applicable (see Table 4).

One respondent (Institution 1) stated that there was potential for exposure to alcohol use/misuse issues during professional practice placements at all four levels. It is likely, although not stated, that students attending Institutions 3 and 4 also had exposure to alcohol use/misuse through practice placements. Institution 2 stated that some of their students may go on placement within an addictions service, consequently sharing their experiences during group work with other students, but that no dedicated direct contact hours were offered.

Institution 4 commented that it was difficult to define specific dedicated hours, as alcohol was taught as an integrated topic across a number of modules and linked to wider aspects of health, social, and cultural issues, and to policy.

Table 3. Alcohol-related content taught

| Alcohol-related content | Institution 1 (HEI) | Institution 3 (HEI) | Institution 4 (HEI) |
|--|--|------------------------|------------------------|
| Pharmacology/physiology of alcohol | ✓ | ✓ and VL* | ✓ |
| Alcohol and mental health | ✓ | ✓ | ✓ and VL |
| Alcohol and the older adult | ✓ | | ✓ |
| Binge drinking | Minimal | | ✓ |
| Unit awareness | ✓ | | ✓ |
| Role of the occupational therapist and alcohol | ✓ | | ✓ |
| Current Scottish Government policy and alcohol | ✓ | ✓ and VL | ✓ and VL |
| Alcohol policy and the workplace | No (unless within independent learning/research project) | | Being developed |
| Alcohol brief interventions | ✓ | | ✓ and VL |
| Scottish culture and alcohol | ✓ | | ✓ and VL |
| Other | ✓ | ✓ | VL |

*Visiting lecturer.

Table 4. Number of lecturer/student direct content hours specifically devoted to alcohol education

| Institution | Level 1 | Level 2 | Level 3 | Level 4 |
|-------------|------------|------------|------------|---|
| 1 (HEI) | 3 hours | 1 hour | 1 hour | 1 (more if supervised independent learning or research project) |
| 2 (FEC) | N/A | N/A | N/A | N/A |
| 3 (HEI) | 1.5 hours | 1.5 hours | 0 | 0 (more if supervised independent learning or research project) |
| 4 (HEI) | Not stated | Not stated | Not stated | Not stated |

With independent/self-directed study, it proved difficult to quantify specific hours, with the exception of Institution 1, which stated that 2 hours were allocated to studying alcohol use/misuse at Level 2. For other levels, no specific hours were allocated to this topic; however, in Level 4, if alcohol was selected as an independent learning or research project, approximately 200–400 hours of study would be undertaken.

In view of Scottish Government proposals, participants were asked which of these were discussed within their programme. Only one respondent, Institution 3, addressed just one of the Scottish Government proposals, relating to the ending of promotions in licensed premises. The remaining three proposals, relating to minimum price retailing, the raising of the minimum legal purchase age for off-sales, and a commitment to call for a reduction in the drink drive limit, were not covered.

Section 3

This section was only completed by Institution 2 (the HNC programme), as it related to reasons for alcohol use/misuse not being taught within the occupational therapy programme. Institution 2 responded that the programme was:

... structured as a generic course designed to equip students with the values, skills and knowledge to work in a wide variety of settings. Alcohol use/misuse is touched on in a number of ways — during topics relating to legislation, demographic factors, and factors that influence the provision of occupational therapy, and specific projects within sociology

and psychology. We often also have visiting occupational therapists who may cover this in presentations (Institution 2).

When asked whether it was planned to implement alcohol teaching in the future, the response was:

... this is a 1-year programme, and although we feel it is an increasingly important issue, we are unlikely to be able to devote a unit of study to this subject (Institution 2).

Section 4

Question 1 of this section explored any barriers to the development and implementation of alcohol use/misuse teaching within occupational therapy programmes.

Institution 4 did not respond to this question. With regard to other identified barriers, all three other institutions identified 'lack of time' and Institution 1 indicated 'other'. No institutions identified a lack of training, awareness or understanding of legislation, or knowledge as to where to get support and information to develop teaching in the area. Institution 1 reported they previously delivered a substance misuse module with practice placement hours attached; however, student uptake was low and there was insufficient staff capacity to sustain this input; consequently, the module had been withdrawn.

When asked whether there was a need to include alcohol teaching within their respective programmes, Institutions 1, 3, and 4 agreed that this was the case:

Table 5. Reasons suggested by institutions why AHPs and nursing students failed to identify occupational therapy as 'key' when working with alcohol use/misuse in practice

| Institution | Reasons suggested |
|-------------|--|
| 1 (HEI) | <ul style="list-style-type: none"> ■ Depending on service, the occupational therapist might not be 'key'. ■ Within some services, occupational therapy posts in substance misuse are being frozen, with no intention of being replaced. If this happens in one area [substance misuse], it will question the need in other substance misuse services. ■ Not seen as a front-line service. ■ Lack of understanding of the range of knowledge and skills of occupational therapists. ■ Generic work in this area, so do not see unique value of occupational therapy. ■ Misusers can recover without the assistance of professionals. ■ Gatekeeping is often undertaken by psychologists, so perhaps protecting their own jobs. ■ There is a lack of evidence-base to support occupational therapy interventions in this area — research specific to occupational therapy is needed. |
| 2 (FEC) | <ul style="list-style-type: none"> ■ Is alcohol use/misuse different from any other area of practice? |
| 3 (HEI) | <ul style="list-style-type: none"> ■ Not enough material within the curriculum. ■ Not many jobs where occupational therapists work in specialized alcohol services, in comparison to other services within mental health. |
| 4 (HEI) | <ul style="list-style-type: none"> ■ No response. |

I think this area is hugely important, I value it and ensure it is taught within my modules. It would be nice to have an entire module on the topic of substance misuse (Institution 3).

Already do it, national issue, huge client caseloads with substance misuse issues, growing trends in particular populations, particular issue in [local area of Scotland] a chronic health and social care issue (Institution 1).

The teaching regarding alcohol is an important aspect, and believe this is reflected in the content of the curriculum (Institution 4).

Institution 2 indicated that they were not sure, saying that they:

... try to cover as many areas of occupational therapy as possible. At this level of study it is difficult to balance it with overall aims of the course and needs of students (Institution 2).

Question 2 identified recent research (Gill et al 2011) that showed other AHPs and nursing students failed to identify occupational therapy as 'key' when working with alcohol use/misuse in practice. Asked to give reasons why this might be the case, three of the four institutions responded (Table 5).

Lastly, participants were asked for any further comments regarding alcohol teaching within their programmes. One responded:

... the content you have highlighted will help to inform the ongoing development of our teaching content (Institution 4).

Discussion

The response rate for this survey was 100% across the geographical area identified within the inclusion criteria. This survey, therefore, represents the first comprehensive review of alcohol education in undergraduate and HNC-level occupational therapy in Scotland.

The results are encouraging in the sense that all the institutions surveyed valued and considered alcohol within their curriculum. Whilst the HNC-awarding institution indicated that it did not cover alcohol as a topic, the responses in section 3 demonstrated that this was still 'touched on' by visiting lecturers. Given the current societal costs associated with alcohol in Scotland, it is encouraging that occupational therapy education in Scotland is responding to this issue although, given the importance of alcohol and the emphasis placed on addressing it by the Scottish Government within its legislation and policy developments, it is interesting to note that alcohol is not taught as a 'stand-alone' topic within the curriculum content of any of the courses surveyed. All institutions stated that alcohol was taught as an integrated topic within different modules, meaning it was difficult for the institutions surveyed to provide accurate hours in response to direct teaching associated with alcohol. Despite this, it was reported by Institution 1 that a total of 6 hours was used directly to address alcohol across all educational levels, Institution 3 reported a total of 3 hours across all levels, and Institution 4 did not give a figure. Whilst it was indicated that students could further develop their learning and understanding of alcohol through independent study modules, Level 4 projects, and exposure to alcohol misuse on practice placements, it is striking that these results suggest that many students potentially graduate from university with very little direct teaching content associated with alcohol, despite the significance of this topic as a public health issue in Scotland.

In addition to the teaching hours indicated, one HEI and the FEC responded that they did not directly discuss the role of the occupational therapist in alcohol misuse. The absence of this discussion may suggest that occupational therapy graduates are less able to articulate or clearly define their role within this area, reducing the profession's ability to promote itself in this role. It is therefore perhaps unsurprising that

other AHPs and nurses fail to identify the profession as 'key', as found in the study by Gill et al (2011).

Whilst relevant aspects of curriculum content were covered by all three HEIs, an interesting disconnect is evident. Although all three HEIs stated that current Scottish Government policy developments were taught (Table 3), further investigation of this aspect of curriculum content found that only Institution 3 addressed one of the four 'key' planks of Scottish Government policy in response to alcohol use in Scotland. In many ways this is a surprising finding in that it illustrates the lack of discussion associated with health-related policy aimed at managing changing attitudes to alcohol. This research confirms that alcohol curricula within Scottish HEIs largely ignore the current ongoing debate surrounding minimum unit of pricing and its possible impact on health within Scotland. This may explain the finding by Gill et al (2011) that the majority of occupational therapy graduates in 2009 were against the minimum-pricing proposal (soon to be implemented in Scotland), while their medical student counterparts were in favour of this policy initiative. Potentially, this may relate to the revision of the alcohol-related curriculum content in at least one Scottish medical school, which has shown benefits in terms of student knowledge (Steed et al 2010). Gill and O'May (2011) noted that in England a newly accredited curriculum (Ghodse 2007) on substance misuse has now been recommended to all English medical schools. This example, set by medicine, may indicate that greater discussion of the curricular content devoted to alcohol misuse is needed by Scottish policy makers, professional bodies, and the universities. The effect of this absence of policy context within undergraduate occupational therapy curricula in Scotland is of relevance, as it is difficult to see how graduates, and by extension the profession, can embrace the demands and changing expectations of this area of public health policy.

Whilst the literature review highlighted examples of discussion surrounding the intervention strategies and tools associated with FAS (Jirikowic 2008, Rudeen et al 2007), the findings from this survey indicate that very limited discussion is evident within curricula regarding this topic. Only one institution (Institution 3) specifically stated that they undertook limited discussion of this topic. This would appear to indicate that the conclusion drawn in the USA by the FASD Regional Training Centers Consortium (2007), that education concerning FASDs in AHP curricula is inconsistent and inadequate, might also be the case in Scotland. Whilst independent study projects and practice placements may provide opportunities for students to consider FASDs, there would appear to be a lack of consistent approach dealing with this area of practice, embedded within the curricula in Scotland.

In order to support the curriculum content offered by the institutions providing occupational therapy education, a variety of visiting lecturers are used to 'scaffold' student learning. This includes a range of expertise from the underpinning pharmacology/physiology of alcohol misuse to addiction services, research, and audit. This external input

appeared to be seen as a positive feature of the curricula surveyed, but was reliant on the availability of lecturing staff, and thus could be inconsistent from year to year.

In relation to the final question in the survey, an implicit message appeared to emerge when participants were asked why they thought occupational therapists as a profession were not regarded as 'key' (Gill et al 2011) within alcohol misuse. The responses to this question outlined that there were few posts for occupational therapists within addiction services, the profession was not seen as a front-line service, and posts in addiction services were being 'frozen'. Aspects of these responses seems compatible with the view of Riley et al (1998), who noted that, regardless of practice area, occupational therapists need to understand and work with substance use disorders. The emphasis on largely addiction services in response to this question suggests initiatives from the Department of Health (DH 2001, 2000) and NHS Scotland (2003, 2002) promoting a flexible workforce to embrace the responsibility of a variety of health interventions to target alcohol by a range of health professionals, does not seem to be addressed by curricula. The message — that occupational therapists need to understand alcohol and interventions associated with alcohol use, irrespective of where they work, and not just within services established for alcohol dependency — would seem to need further emphasis.

This survey has indicated gaps in the alcohol curriculum content of the HEIs and FEC participating; however, this needs to be set within the context that all institutions noted lack of time as a barrier to further discussion of alcohol misuse. The FEC also felt that this topic was not currently a priority for their course. One institution noted that due to low student uptake a module on addictions had been withdrawn; it is not possible to identify from this study why students did not see this as an important topic.

Limitations

Whilst this survey has attempted to highlight the current alcohol teaching content of occupational therapy curricula in Scotland, some limitations to this work exist. The experience of students on professional practice placements in relation to alcohol is unknown and, therefore, the extent of knowledge they gain from this is unclear. Whilst practice placement experience is likely to be diverse, these results still appear to indicate that it is possible to complete a programme of occupational therapy education in Scotland with limited exposure to alcohol misuse. Although the survey elicited a 100% response rate, respondents omitted some questions. The scope of this work did not include postgraduate level education in Scotland, which would be a valuable area to include in future research.

Conclusion

The topic of alcohol misuse is taught to varying degrees within the undergraduate and HNC-level occupational therapy

curriculum in Scotland, ranging from tangential/ad hoc coverage (possibly obtained through student placements) to strategic input from a range of professions and organizations.

Given the extent of current alcohol-related issues in Scotland, and the development of flexible and collaborative working patterns for health professionals, it would seem opportune for the profession to 'up-skill' its future workforce accordingly. This study indicates that debate is needed between the curricula providers in Scotland and the COT, as the professional body for occupational therapy, to examine how alcohol teaching can be revised to take into account both the scale of the problem and related Scottish government policy initiatives.

Key findings

- There is a lack of a cohesive approach to alcohol misuse education within the occupational therapy curricula delivered in Scotland.
- Occupational therapists need to understand alcohol misuse and potential interventions associated with alcohol use, irrespective of practice context.

What the study has added

As curricula are revised in Scotland, it is important that the range of practice settings where alcohol misuse is indicated is recognized in occupational therapy education.

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Book reviews

A guide to psychological understanding of people with learning disabilities. Jenny Webb. Routledge, 2014. £22.99. 240pp. ISBN: 978-0-415-60115-3

This excellent book opens by identifying the psychological context of people with learning disabilities, progressing to describing the historical background of this complex area of specialist interest. The coherent and cogent discussion lends ease to the reading experience, despite the book not being based in occupational therapy.

Issues of capacity and consent are addressed in the legal context of mental capacity, with suggestions made for developing an individual's ability to achieve decision making. Communication, time, approach, and contextual evidence, with advice when consent cannot be achieved, are all discussed. Most practitioners could use these skills for developing their expertise while still addressing issues of confidentiality.

Eight domains of interest are then described with clarity and conciseness in separate chapters, each of which can be read separately or in conjunction with the rest as part of a wider whole. The evidence-base is clearly stated and allows knowledge to sit well alongside the theories, which are presented through practice. The domains used in psychological practice and how to work with them

within the boundaries of practice are made apparent. Three stories are told to describe making sense of these theories, and to provide familiar processes for practice and for investigating routes of intervention.

The book is recommended as a useful text from which to seek evidence for practitioners already working with people with learning disabilities. The theory presented provides support in developing work-based interventions and is a useful contribution to the bookshelf. It is also recommended for anyone embarking on a career working with people with learning disabilities, especially early practitioners seeking practical and theoretical foundation knowledge.

Sara John,
Senior Occupational Therapist and Clinical Specialist in Learning Disabilities, Wokingham Community Team for People with a Learning Disability (CTPLD), Berkshire.

Psychoanalytic thinking in occupational therapy. Lindsey Nicholls, Julie Cunningham Piergrossi, Carolina de Sena Gibertoni, Margaret Daniel. Wiley-Blackwell, 2013. £34.99. 244pp. ISBN: 978-0-4706-5586-3

This book provides an introduction to the theories behind psychoanalytic thinking, and manages to intertwine them with occupational therapy. It draws on experiences from an international team of authors yet also recognizes the current economic and political climates that occupational therapists work in.

The book is divided into three sections covering theory, application, and research. The first section sets psychoanalytic thinking within occupational therapy. It introduces the work of various theorists (Freud, Klein, Bion, Winnicott, and others) and makes good use of case vignettes to bring theory to life. The second section takes us through a clear description of the Vivaio (MOVI) model of psychoanalytic occupational therapy – a unique model given its consideration of the use of the therapist within the patient–occupation relationship. The third section describes research that has interwoven psychoanalytic thinking and occupational therapy. It provides us with a range of examples of developments within the field and helps us to think about the way we interact with patients.

This is a valuable book in stimulating our thinking around psychoanalytic theory and how this can be embraced into occupational therapy practice. It provides many references to seminal materials and the reader should explore these for a greater breadth of understanding. The book achieves its aim to reawaken occupational therapists' interests in psychoanalytic thinking, although it is recognized that this is only an introduction and significant training is required to develop this approach within practice.

Hazel Parker,
Advanced Practitioner/Occupational Therapist, Tees, Esk and Wear Valleys NHS Foundation Trust.

Paper 4

Alcohol use amongst older adults: Knowledge and beliefs of occupational therapists working in physical health care settings

Fiona Maclean¹, Jan Gill², Fiona O'May³ and Jenna Breckenridge⁴

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Abstract

Introduction: There is little discussion in the United Kingdom occupational therapy literature surrounding the topic of older people and alcohol, despite the growing prevalence of alcohol-related health problems in older adults resulting from an ageing population and changing patterns of consumption. Occupational therapists in physical health care settings are likely to work with older people whose drinking pattern may not be alcohol dependent, but may put their physical or psychological health at risk.

Method: A survey methodology was employed using open and closed questions, recruiting occupational therapists (band 5 to 9) ($n = 122$) working with older people (65+ years) in physical health care settings across all, except one, National Health Service Regional Health Boards in Scotland.

Results: Responses highlight gaps in occupational therapists' knowledge around alternative 'safe limits' of alcohol intake for older people. Belief in professional role was evident, but the perception was that this was not supported by undergraduate education. Occupation focused theory and assessment were not prioritized when considering alcohol in the older adult.

Conclusion: This study has highlighted a need to develop pre- and post-qualification education for occupational therapists, to enhance understanding of theory, assessment and knowledge of alcohol with older adults in physical health care settings.

Keywords

Theory, assessment, education, alcohol use, older people, physical health care

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Introduction

The harmful use of alcohol is a global problem, resulting in 2.5 million deaths each year (World Health Organization, 2013). In Europe, harmful drinking is the second leading risk factor for premature mortality, disability and loss of health (World Health Organization, 2013). In the United Kingdom (UK) it is widely acknowledged that physical harm related to alcohol has increased over the past three decades (British Psychological Society and Royal College of Psychiatrists, 2011); however, Scotland, in comparison to the rest of the UK, appears to have a particularly unbalanced relationship with alcohol (Scottish Government, 2013). For example, per adult sales of alcohol in Scotland have been 19–21% higher than in England and Wales over the past five years (Beeston et al., 2013).

Set within this context is the growing recognition that, whilst older people generally drink less than younger generations, the prevalence of alcohol-related problems in older people is increasing due to the ageing population and changing patterns of alcohol consumption (Livingston and Galvani, 2012). In Scotland, approximately one in four alcohol-related discharges from hospitals between 2006/7 and 2010/11 involved an elderly patient (Institute of Alcohol Studies (IAS), 2013).

Alcohol Concern (2013) in England examined the trends in hospital admissions for older people with mental and behavioural disorders, secondary to the use of alcohol over a ten-year period (2002 to 2012). This indicated a 150% increase in admissions (age 60 to 74 years). Whilst this illustrates some of the 'known' alcohol-related challenges associated with older people's drinking, Mortimer (2011) has suggested that older adults who misuse alcohol continue to be an invisible group that is larger than policy makers and service providers in the UK assume.

There is growing recognition that the relationship between older people and alcohol needs to be redefined (O'Connell et al., 2003) and that there should be an increased role for nursing and allied health professionals (AHP) in alcohol disorders (Gill and O'May, 2011). These priorities underpinned this research which aimed to

¹Senior Lecturer, Queen Margaret University, Edinburgh, UK

²Reader, Queen Margaret University, Edinburgh, UK

³Research Fellow, Queen Margaret University, Edinburgh, UK

⁴Postdoctoral Researcher, Dundee University, Dundee, UK

Corresponding author:

Fiona Maclean, Senior Lecturer, Queen Margaret University, School of Health Sciences, Queen Margaret University Drive, Musselburgh, Edinburgh EH21 6UU, UK.
Email: fmaclean@qmu.ac.uk

investigate alcohol-related current knowledge, beliefs, underpinning theory and assessments used by occupational therapists working with older adults in physical health care settings in the National Health Service (NHS) Scotland.

Literature review

A literature review was conducted using the search terms; older adults/people; elderly; alcohol; occupational therapy; drinking; nursing and allied health professions. The inclusion criteria were English language, published between 2000 and 2013. The databases searched were CINAHL, Medline, PsycInfo, EBSCO and Google Scholar.

Alcohol and older adults

The Scottish Government intends to tackle alcohol misuse across all age groups through policy (Scottish Government, 2008). Knott et al. (2013) have argued that public policy tends to focus on the behaviours of younger drinkers, with limited attention to the problematic consumption of older populations. There has been a steady increase in the amount of alcohol consumed by older age groups in recent years, and these consumption patterns suggest that the 'baby-boomer' cohort is likely to have higher levels of alcohol consumption in old age than previous cohorts (Simmill-Binning et al., 2009). Alcohol Policy UK (2012) have indicated that 20% of men and 10% of women aged 65+ exceed recommended drinking guidelines, and 3% of men and 0.6% of women aged 65–74 are alcohol dependent.

Whilst alcohol use can decline with age, a significant number of older people consume alcohol at dangerous levels (Royal College of Psychiatrists, 2011). IAS data (2013) reveal that the proportion of 65+ year-old males drinking on five or more days in the last week was 24% in 2011, 8 percentage points above the average for all age groups (16%). For females (65+ years) this figure was 13%, 4 percentage points above the average for all female groups (9%). Whilst Wilson et al. (2013) conducted qualitative interviews with 24 participants in the UK, seeking to explore the views of older people aged 50 and over concerning alcohol consumption, health and wellbeing. One participant (aged 70, female) noted she consumed a bottle of wine (9 units) a day, but described her consumption as 'minimal' due to the percentage of alcohol in the wine she drank and her perceived 'self-control', stressing that she always knew what she was doing and would not be found inebriated.

This pattern of alcohol consumption in older adults is of concern, because the normal ageing process can exacerbate the potential for harm (International Center for Alcohol Policies, 2013). The biological, psychological and social changes accompanying the ageing process can make older people vulnerable to the effects of alcohol misuse (Alcohol Research UK, 2011). Despite this, a diagnosis of substance misuse in the older population can be

missed due to the increased incidence of anxiety, depression, dementing illness and physical illness (Crome and Bloor, 2005). Ageist attitudes and a lack of knowledge and awareness amongst health professionals can also contribute towards missed diagnoses and may prevent some older people from receiving appropriate treatment (Ward et al., 2011). O'Connell et al. (2003) have indicated that alcohol use disorders in older people relate to physical, psychological, social and cognitive health challenges. From an occupational perspective, substance misuse in older people has been linked to impaired function, resulting from injury, self-neglect or social isolation (Lancaster and Chacksfield, 2008).

Currently, the recommended weekly 'safe limits' for the adult population in the UK are 21 units of alcohol for men and 14 units of alcohol for women (Department of Health, 1995). One unit of alcohol equals 10 ml or 8 g of pure alcohol. As a result of the physiological and metabolic changes associated with ageing, and the fact that current 'safe limits' for alcohol consumption are based on younger adults, the Royal College of Psychiatrists (2011) have supported alternative 'safe limits' for older people. They have advised an upper 'safe limit' for older people of 1.5 units of alcohol per day, or 11 units per week. Binge (or sessional) drinking would be defined as >4.5 units in one session for men and >3 units for women. In younger adults binge drinking is consumption of 8 or more units in a single session for men, and 6 or more units for women.

Relevance to occupational therapy in physical health care settings

Scotland's population continues to age, with a 50% increase in the population of over 60s predicted by 2033 (Scottish Government, 2010). In part due to this ageing population, Mortimer (2011) has highlighted that greater numbers of older drinkers will be seen in settings designed for a generic older population. O'Connell et al. (2003) have suggested that whilst these older drinkers may not necessarily fulfil the criteria for alcohol misuse or dependence, their drinking patterns may still be putting their physical or psychological health at risk. While older people consume fewer units than younger people, they are more likely to drink on an almost daily basis over the course of a week (IAS, 2013). Given this pattern of drinking and the rising number of alcohol-related admissions/discharges in the UK among those aged 65 years and over (IAS, 2013), it is essential that healthcare workers in all settings should understand the role of alcohol in the presentation of older people with physical and psychiatric illness, cognitive impairment, and social problems (O'Connell et al., 2003).

Literature associated with alcohol and occupational therapy is evident in the UK (McQueen et al., 2006); however, occupational therapy literature that discusses alcohol use in older people is sparse. In one example, Waldron and McGrath (2012) undertook a cross-sectional postal survey of healthcare professionals in Ireland ($n=157$) to explore knowledge of alcohol disorders in older adults.

Their findings indicated that psychologists ($n = 13$) had a significantly higher level of knowledge in relation to alcohol in comparison to occupational therapists ($n = 55$, Mann–Whitney U test, $p = 0.006$). Whilst not specifically related to older people, Thompson (2007) surveyed occupational therapists ($n = 128$) across all areas of practice in America. He concluded that mental health occupational therapists were most likely to assess clients for substance misuse over other settings.

In Scotland, research by Gill et al. (2011) has highlighted gaps in the knowledge base of graduating occupational therapy students around current recommended alcohol health guidelines. Additionally, Maclean et al. (2014) found a lack of cohesive approach to alcohol education in Scottish undergraduate and higher national certificate occupational therapy education. For example, one institute indicated that no discussion of alcohol and older adults in the curriculum content of their programme took place. In order to identify the care and service needs of older people who use alcohol, Wallace et al. (2010) have stressed that healthcare professionals require knowledge of theory and relevant assessment skills, set within the context of ageing and alcohol misuse. Although Wallace et al. (2010) refer specifically to nurses, this is also an important concern for occupational therapists.

Stoffell and Moyers (2004) have suggested that substance misuse disorders need to be considered in the context of interactions between the person, environment and the activity, in order to support understanding of the complex aspects of prevention and recovery. This implies that occupational therapists need a good understanding of theory to support practice in the field of alcohol misuse. This principle therefore, set within wider literature, framed the rationale for the development and implementation of the study outlined here. A questionnaire was designed to explore the following research aim and objectives:

Research aim

To investigate current knowledge, beliefs, underpinning theory and assessment used by occupational therapists working with older adults in physical health care settings in the NHS Scotland, in relation to alcohol use.

Research objectives

- To record levels of knowledge amongst occupational therapists working with older people concerning current UK health advice relating to alcohol use.
- To document the beliefs of occupational therapists relating to alcohol use and older people in a physical health care setting.
- To document the theory and assessment skills used by occupational therapists working with older adults in physical health care settings to support practice and understanding of issues associated with alcohol.

Method

Ethics

Ethical approval was first obtained from Queen Margaret University, Edinburgh. Contact was then made with the South East Scotland Research Ethics Service. As the study included only NHS staff, there was no requirement (policy-wise or legally) for NHS ethical review. This did not negate the requirement for research and development (R&D) approval.

R&D approval was therefore sought for every NHS Board in Scotland, and was coordinated through the NHS Research Scotland Permissions Coordinating Centre in Aberdeen (NRS Permissions CC). Of the 14 regional NHS boards in Scotland, 13 granted R&D approval. One NHS board (NHS Western Isles) did not respond despite two follow up contacts via NRS Permissions CC. Occupational therapy staff working in this board could not be included in the study.

Participants

Data collection was conducted from January 2013 to June 2013 and targeted occupational therapists from band 5 to band 9, working in physical health care settings employed by NHS Scotland. This included all NHS physical health care settings, rather than services specifically designed for older people.

Literature highlights the broad scope of potential physical harm associated with alcohol misuse in older people, suggesting that health care workers will work with older people utilising a range of NHS services, not necessarily designed specifically for older people. Moreover, the reporting of chronic conditions increases rapidly with age: 29% of those aged 65 to 74 report two or more long-standing illnesses; approximately one third of men and a quarter of women between 65 and 74 report a long-term condition associated with the heart or circulatory system; and 22% of men aged 65 to 74, and 34% for women of the same age, report musculoskeletal conditions (Scottish Government, 2005). Consequently, older people are likely to be seen by occupational therapists in multiple physical health care settings in NHS Scotland.

The total population of occupational therapists, band 5 to 9, working in NHS Scotland (per headcount, excluding NHS Western Isles), filtered from Information Services Division (ISD) data (2012), is 1904. It is not possible to split this data further to indicate the headcount of occupational therapists associated with each practice specialty.

Older people in this study were defined as aged 65 or older.

Procedure

Contact with AHP Leads responsible for physical health care settings in Scotland was undertaken initially through the Allied Health Professions Directors Scotland Group (ADSG). ADSG supported the identification of the appropriate AHP Lead for the 13 participating NHS Boards.

In each of the 13 participating NHS Boards, permission was sought from the relevant AHP Lead, to contact the appropriate head/lead occupational therapists responsible for occupational therapy staff in physical health care settings. Contact was then made with head/lead occupational therapists and following discussion, an electronic, paper copy, or both, of the questionnaire was sent for distribution to occupational therapists via the head/lead. Where permission from head/lead occupational therapists was obtained, the lead researcher attended occupational therapy team meetings to distribute the questionnaire. Four visits were made in total: two sites in NHS Lothian, one in NHS Tayside and one in NHS Forth Valley. Further contact was made to appropriate participants using the practice educators' database used by Queen Margaret University (QMU), Edinburgh, for arranging occupational therapy student practice placements.

Questionnaire

The questionnaire contained four sections, utilizing open and closed questions. Elements of the questionnaire were adapted from Gill et al. (2011).

Section 1 - Context. This sought to identify participant characteristics, e.g. range of experience, area of work and NHS Board.

Section 2 - Occupational therapists' knowledge of alcohol. This explored therapist knowledge around recommended limits of drinking for men and women. Also, knowledge of guidelines associated with older people, how older people who drink are defined and participant's knowledge of current Scottish Government policy. No questions associated with personal levels of consumption were asked, as per R&D approval. It was hoped by not asking questions concerning personal consumption, participation would be encouraged.

Section 3 - Occupational therapists' beliefs in relation to alcohol. This explored occupational therapists' beliefs towards older people and alcohol, and potential health professional involvement, and was influenced by the questionnaire developed by Happell and Taylor (2001) to explore nurses' attitudes to clients with drug and alcohol problems. This adapted version contained 10 statements to which participants were required to respond according to a six-point Likert scale ranging from 'strongly disagree' to 'strongly agree'. The first seven statements related to professional role and attitude, two emerged from current Scottish Government policy (Scottish Government, 2008), related to alcohol brief interventions (ABIs), which are defined by the Scottish Intercollegiate Guidelines Network (2004) as 'a short, evidenced-based, structured and non-confrontational conversation about alcohol consumption'. The last statement emerged from research (Maclean et al., in press) surrounding alcohol content in undergraduate curricula in Scotland.

The same Likert scale format was used to explore reasons for admission prompting consideration of alcohol use, and finally the extent to which occupational therapists explore alcohol with older people in a health-promoting role.

Section 4 - Implementation of practice. This final section explored the extent to which conceptual models of practice, frames of reference and assessment used in occupational therapy influenced the consideration of alcohol and older people.

The questionnaire was reviewed by three academic staff; two from QMU (part of the project team), one external to the university. Two members of the questionnaire review team had knowledge of, and expertise in, alcohol issues. Feedback from this process was used to refine the development of the questionnaire. Finally, an occupational therapy practitioner working in mental health (therefore not meeting the inclusion criteria) completed the questionnaire, offering feedback. The questionnaire took approximately 15 minutes to complete.

Data analysis

This study attempted to recruit a representative sample of occupational therapists working in physical health care settings, with older people, across NHS Scotland, allowing inferences to be made to the wider population. In practice, it was challenging to accurately identify the population of interest in terms of occupational therapist headcount associated with physical health care settings, in order to determine a precise sample size. Consequently, descriptive statistical analysis has been undertaken.

Microsoft Excel for Mac 2011, version 14.3.6 was used to analyse the data.

The qualitative responses were transcribed and the transcription checked by a second researcher. The qualitative data were then analysed using enumerative content analysis, favouring word and category frequency, as discussed by Grbich (2013). This involved searching for key words (and related synonyms) in the data, recording their frequency and grouping similar words into categories. Categories were then labelled, defined and comparisons made, allowing similar categories to be collapsed into one another, filtering the initial list of categories into themes. These themes were discussed and agreed amongst the research team.

Results

Section 1: Context

In total, 125 questionnaires were returned, three were excluded (one was completed by a mental health specialist and two by non-occupational therapists), providing 122 useable questionnaires. The mean number of years' experience, post qualification of the sample, was 11.8 years (median = 10 years). The sample contained 93.4% of

occupational therapists employed at band 5, 6 and 7 (band 5: 33.6%, band 6: 38.5%, band 7: 21.3%).

According to ISD (2012), 1949 occupational therapists between band 5 and 9, are employed in NHS settings across Scotland, with 1904 employed in the NHS Board areas participating in this study. This latter data would indicate a response rate of 6.4%. However, as this study only sought to recruit occupational therapists working in physical healthcare settings where older people may be admitted, the true response rate is likely to be much higher.

For example, in one NHS board (NHS Forth Valley) more detailed data was available (personal communication). Of the 93 occupational therapists employed across all practice settings (ISD, 2012), 44 occupational therapists worked in physical healthcare settings where older people may be admitted. These data suggest board-specific response rates of 24.7% and 52.3% respectively.

The number of participants from each NHS Board in Scotland is represented in Figure 1, which indicates just less than three quarters of the sample (73.1%), are encompassed by four NHS Boards (NHS Forth Valley, Greater Glasgow & Clyde, Lothian and Tayside). In terms of percentage response rate using the ISD (2012) data, NHS Shetland had the highest response rate (50.0%), and NHS Lanarkshire the lowest (0.5%).

A broad range of NHS physical health care settings were indicated, with 23.1% describing their practice area as older people/elderly care, and 40.2% describing their practice setting as medical, neurology or orthopaedics.

Section 2: Knowledge

Responses exploring knowledge around UK recommended drinking guidelines demonstrated 61.5% of

participants ($n=75$) correctly recalled the daily limit of alcohol for men and 68.8% ($n=84$) correctly recalled the daily limit of alcohol for women.

Knowledge of alternative 'safe limits' of alcohol unit intake for people aged 65+ demonstrated that 16.4% ($n=20$) of participants were aware of the recommended guidelines; however, of this number, only two respondents worked in practice settings described as elderly/older people.

These findings are consistent with responses to the later statement, 'I do feel I have the appropriate knowledge where alcohol is an issue for an older person', where 68.0% ($n=83$) did not agree with this statement (see Table 2).

How participants defined an older person with alcohol problems were grouped into the two themes presented in Table 1.

In response to knowledge of current Scottish Government policy associated with alcohol misuse, 69.0% could not identify any aspect of policy.

Section 3: Beliefs

Responses of participants to statements relating to professional role and beliefs about older people and alcohol are presented in Table 2.

Table 2 demonstrates that a majority of occupational therapists working in physical health care settings agreed that alcohol was an issue with older people, and a similar percentage (95.1%) recognized that older people can have alcohol related issues. Nevertheless, 67.2% of participants indicated that older people had the right to use alcohol as they wished.

Interestingly, whilst 88.5% of respondents agreed occupational therapy has a role to play in ABIs when alcohol

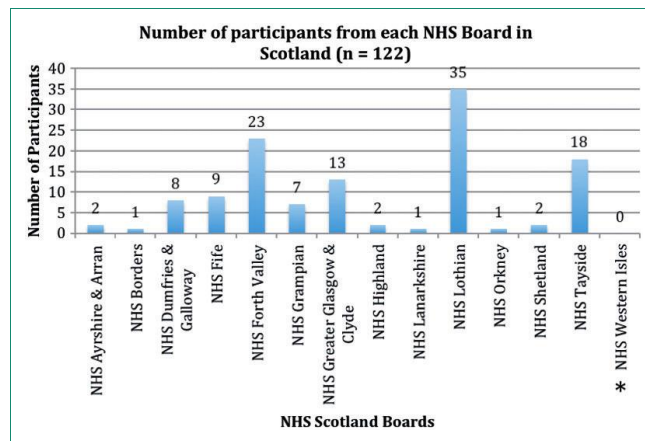


Figure 1. Number of participants from each NHS Board in Scotland ($n = 122$).
 *R&D approval not attained.

Table 1. Participant responses ($n = 122$) to the question ‘How would you define an older person with alcohol problems?’ (Note: participants could provide more than one definition).

| Categories | Comments | Number of participant responses |
|---|--|---------------------------------|
| 1. Comments relating to pattern of alcohol consumption | History of drinking | 7 |
| | Binge drinking | 4 |
| | Dependent on alcohol | 28 |
| | Drinks in excess of recommended unit intake | 63 |
| 2. Comments relating to impact of alcohol | Ability to perform ADL's impaired | 51 |
| | Problems with relationships | 11 |
| | Causes problems in life | 12 |
| | Results in physical injury | 7 |
| | Causes health problems (medical & mental health) | 40 |

Table 2. Participants’ responses to statements around issues relating to alcohol and older people ($n = 122$).

| Statement | Quite strongly disagree | | Disagree | | Agree | | Quite strongly agree | | Strongly agree | | Overall agree | | Overall disagree | | Neither agree or disagree | |
|---|-------------------------|-----|----------|-----|-------|-----|----------------------|-----|----------------|-----|---------------|-----|------------------|-----|---------------------------|--|
| | (n) | (n) | (n) | (n) | (n) | (n) | (n) | (n) | (n) | (n) | (n) | (n) | (n) | (n) | (n) | |
| Alcohol is not an issue with older adults. | 53 | 17 | 44 | 1 | 3 | 2 | 4.9% | 6 | 93.4% | 114 | 1.6% | 2 | | | | |
| There is not enough time to consider alcohol with older adults. | 23 | 8 | 51 | 27 | 4 | 7 | 31.1% | 38 | 67.2% | 82 | 1.6% | 2 | | | | |
| I would feel embarrassed asking patients about their alcohol intake. | 25 | 18 | 56 | 20 | 1 | 0 | 17.2% | 21 | 81.1% | 99 | 1.6% | 2 | | | | |
| People have the right to use alcohol as they wish. | 3 | 2 | 21 | 73 | 3 | 6 | 67.2% | 82 | 21.3% | 26 | 11.5% | 14 | | | | |
| I do not feel I have the appropriate skills to intervene where alcohol is an issue with older people. | 5 | 19 | 54 | 25 | 6 | 3 | 27.9% | 34 | 63.9% | 78 | 8.2% | 10 | | | | |
| I do feel I have the appropriate knowledge where alcohol is an issue for an older person. | 5 | 18 | 60 | 25 | 6 | 1 | 26.2% | 32 | 68.0% | 83 | 5.7% | 7 | | | | |
| Older people do not tend to have alcohol related issues. | 53 | 28 | 35 | 2 | 1 | 0 | 2.5% | 3 | 95.1% | 116 | 2.5% | 3 | | | | |
| My own profession has a role to play in brief interventions when alcohol misuse is suspected in an older adult. | 0 | 1 | 7 | 68 | 21 | 19 | 88.5% | 108 | 6.6% | 8 | 4.9% | 6 | | | | |
| I have the skills and knowledge required to initiate brief interventions relating to responsible drinking. | 3 | 16 | 56 | 32 | 7 | 4 | 35.2% | 43 | 61.5% | 75 | 3.3% | 4 | | | | |
| My own undergraduate education prepared me for working with older people who misuse alcohol. | 40 | 20 | 45 | 6 | 1 | 2 | 7.4% | 9 | 86.1% | 105 | 6.6% | 8 | | | | |

misuse is suspected in an older adult, 61.5% did not feel they had the skills or appropriate knowledge to initiate ABIs. A similar percentage (68.0%) did not feel they possessed appropriate knowledge where alcohol was identified as an issue for an older person. The majority of respondents (86.1%) did not feel their undergraduate occupational

therapy education had prepared them for working with older adults and alcohol misuse (Table 2).

Types of admission criteria where participants reported they would consider alcohol as a factor in older adults in physical health care settings included, falls (91.8%), confusion (82.0%) and fractures (80.3%). Fewer indicated

Table 3. Use of underpinning theory and assessment with older people in physical health care settings (Note: respondents could choose more than one theory and assessment).

| | | Years post-qualification experience | | |
|--|---|-------------------------------------|---------------|--------------------------|
| | | ≤10 (n = 67) | > 10 (n = 55) | All experience (n = 122) |
| Conceptual Models of practice | MOHO | 22.4% | 20.0% | 21.3% |
| | CMOP-E | 41.8% | 21.8% | 32.8% |
| | PEOM | 46.3% | 38.2% | 42.6% |
| | KAWA | 4.5% | 3.6% | 4.1% |
| | Other | 1.5% | 0.0% | 0.8% |
| Frames of reference | Biomechanical | 59.7% | 54.5% | 57.4% |
| | Client-centred | 88.1% | 80.0% | 84.4% |
| | Neurodevelopmental | 29.9% | 30.9% | 30.3% |
| | Rehabilitative | 76.1% | 70.9% | 73.8% |
| | Other | 9.0% | 14.5% | 11.5% |
| Occupational therapy standardised assessment | COTNAB ^a | 6.0% | 12.7% | 9.0% |
| | OSOT ^b | 1.5% | 1.8% | 1.6% |
| | LOTCA-G ^c & LOTCA ^d | 1.5% | 3.6% | 2.5% |
| | COPM ^e | 3.0% | 5.5% | 4.1% |
| | Rivermead ^f | 11.9% | 16.4% | 13.9% |

^aCOTNAB: Chessington Occupational Therapy Neurological Assessment Battery.
^bOSOT: Ontario Society of Occupational Therapists Perceptual Evaluation.
^cLOTCA-G: Loewenstein Occupational Therapy Cognitive Assessment – Geriatric.
^dLOTCA: Loewenstein Occupational Therapy Assessment.
^eCOPM: Canadian Occupational Performance Measure.
^fRivermead: Rivermead Perceptual Assessment Battery.

alcohol would be a factor to consider where pain (33.6%) or medication (50.8%) was specified, whilst 86.9% would consider alcohol where there were recurrent admissions.

Respondents (76.2%) agreed occupational therapists in physical health care settings should routinely promote current health messages surrounding alcohol with older people. Of those who responded ‘no’ to this question, the majority felt this was due to lack of time, or health promotion messages could be delivered, not routinely, but by individual need and circumstance.

Section 4: Implementation

As part of the occupational therapy initial assessment, 57.4% stated they would occasionally ask older adults about alcohol intake, 33.6% stated they would never ask and 9.0% ‘always’ asked. Of the 9.0% who always asked there appeared to be no association across practice setting, ranging from elderly, neurology, intermediate care, medical and orthopaedics. The majority of those who ‘always’ asked (n = 7) had two years or less practice experience.

Where conceptual models of practice were used to guide practice in physical health care settings and older people (Table 3), 42.6% of respondents stated they referred to the Person Environment Occupation Model (PEO Model). Respondents also indicated the use of CMOP-E (32.8%), with the frequency of use in those ≤10 years’ experience (41.8%), almost double that of respondents with >10 years’ experience (21.8%) (Table 3).

Table 3 also indicates the strong use of frames of reference to underpin conceptual models of practice, with

84.4% of respondents stating they used a client-centred frame of reference.

Whilst 80.0% of the sample used standardised assessments in practice, none of the respondents used a standardised assessment specifically designed to assess alcohol intake. Just over half of this sample reported use of between one and two standardised assessments, of which 86.3% focused on cognition.

Of the occupational therapy specific standardised assessments named, 4.1% used a standardised assessment associated with occupation focused conceptual models of practice.

When respondents were asked to consider alcohol in the context of underpinning theoretical knowledge, 71.3% stated they would not use an occupational therapy conceptual model of practice. Of this sample, 65.5% provided no reason for this. Table 4 illustrates reasons why the remainder of this sample felt occupation focused conceptual models of practice were not useful when considering alcohol and older people.

Conversely, conceptual models of practice were seen to support occupational therapists in addressing alcohol use with older people by 28.7% of the sample (Table 4). Just under half of these respondents worked in settings described as older people/elderly or stroke rehabilitation.

Discussion

This is the first study of its kind to be conducted in Scotland and the first comprehensive survey of occupational therapy knowledge and beliefs in relation to older

Table 4. Reasons given why occupational therapy conceptual models of practice were not useful in physical health care settings.

| Themes why conceptual models are <u>not</u> used to consider alcohol in physical health care settings (71.3% of sample) | | Themes why conceptual models are <u>used</u> to consider alcohol in physical health care settings (28.7% of sample) | |
|---|-----------------------|--|-----------------------|
| Theme | Number of respondents | Theme | Number of respondents |
| Conceptual models of practice in occupational therapy not designed to address alcohol. | 4 | The use of conceptual models promotes holistic occupation centred practice, which would consider alcohol. | 11 |
| Frames of reference are predominant in physical health care settings. | 4 | The inter-relationship of person/environment/occupation (use of PEO Model) in physical health care settings supports consideration of alcohol use. | 5 |
| A lack of confidence & reliance on experience instead | 12 | Conceptual models of practice frame clinical reasoning to support the identification of alcohol use. | 4 |
| Alcohol is not an issue addressed in physical health care settings. | 3 | Conceptual models incorporating client centred practice supports the identification and discussion of alcohol. | 4 |
| A lack of awareness of conceptual models. | 2 | Conceptual models of practice, regardless of setting support the identification of alcohol use. | 1 |
| It is the patients' responsibility to address this. | 3 | The use of the Canadian Occupational Performance Measure (COPM) used with older people, highlights alcohol use. | 1 |
| The use of conceptual models in acute physical health care settings is disjointed. | 2 | MOHO considers volition, which is connected to alcohol use. | 1 |
| No comment, unsure | 57 | No comment, unsure | 8 |
| Total | 87 | Total | 35 |

people and alcohol misuse in physical health care settings in the UK. A range of practice settings were captured and, as the majority of those responding (93.4%) were employed as band 5, 6 or 7 therapists, there is a degree of confidence that this study successfully engaged occupational therapists with clinical caseloads. Only one NHS Board out of 14 did not respond.

The participants' responses indicate a conviction that occupational therapy has a role to play with older people and alcohol misuse, supporting the view of Lancaster and Chacksfield (2008) of the need for occupational therapists in all fields of practice to understand an occupational perspective associated with alcohol. An overwhelming number of respondents (95.1%) felt that alcohol misuse can be an issue with older people and 88.5% believed that their profession has a role in brief interventions when alcohol misuse is suspected in an older adult. This is in spite of the limited literature surrounding alcohol misuse and older people in occupational therapy literature itself; potentially indicating clinical caseloads are informing this belief.

Although confident that occupational therapy has a role to play in alcohol misuse and older people, respondents also recognized a lack of skills and knowledge required to initiate, for example, brief interventions (61.5%). Whilst it is encouraging 76.2% of respondents felt they should routinely promote health messages surrounding alcohol with older adults, a majority (84.0%) did not have knowledge of the alternative 'safe limits' of

unit alcohol intake for people aged 65+, as recommended by the Royal College of Psychiatrists (2011). Indeed those respondents who described their practice setting as older people/elderly, scored worse in their knowledge of alternative 'safe limits', compared to occupational therapists working in other practice settings.

Whilst respondents were broadly able to accurately recall the current recommended daily unit of alcohol for men (61.0%) and women (69.0%), 69.0% of respondents were unable to identify Scottish Government policies associated with alcohol misuse. This is in spite of the relatively high profile of media coverage of alcohol and public health throughout the UK and, in particular, Scotland over recent years. It may be of significance that a number of respondents (67.2%) felt older adults have the right to use alcohol as they wish in their own home. This belief could be informed by their own drinking habits or alternatively grounded by the widespread adoption of a client-centred frame of reference by respondents in this study.

This is in contrast to Scottish Government policy encouraging the use of ABIs, in order to support people to change their drinking behaviour to reduce alcohol related problems. Consequently, the right of older adults to use alcohol as they wish in their own homes should be an informed decision framed within current knowledge of 'safe limits' of unit intake for older adults. Gaps in knowledge identified here suggest that occupational therapists may not adequately support older people in making this

informed decision. It is of note that participants were not asked about personal consumption or their attitudes to this.

Interestingly, 86.1% of occupational therapists disagreed with the statement that their undergraduate education had prepared them for working with older people who misuse alcohol. In many respects this finding is unsurprising. Waldron and McGrath (2012) noted detection of alcohol disorders among older people is compounded by the lack of attention paid to this topic in initial and continuing education of healthcare workers in Europe. Gill et al. (2011) have argued there is a need for basic uniform alcohol content within occupational therapy undergraduate curricula in Scotland. The Royal College of Psychiatrists (2011) advocate that health professionals, including allied professions, must be suitably trained and have adequate knowledge of substance misuse in older people.

In terms of practice, just over half the sample stated that they would occasionally ask older adults about their pattern of alcohol intake. Just 9.0% of respondents would always ask this question. In addition, none of the occupational therapists surveyed used any form of standardised assessment associated with alcohol. Livingston and Galvani (2012) note there is good evidence to support the use of standardised assessments in order to explore the positive and negative aspects of drinking, and when used with health information, can help to initiate change in older adults and alcohol intake.

Detailed reasons why occupational therapists are reluctant to assess alcohol intake are unclear, however it may link to the view expressed by respondents that health promotion of alcohol should be considered in the context of individual circumstances, as opposed to routine promotion. Paradoxically, relevant individual circumstances would seem difficult to judge if questions concerning alcohol are not being asked. Clough et al. (2004) have argued questions concerning alcohol use with older adults should become as fixed and uncontroversial as questions concerning smoking habits. Consequently, it may be desirable to alter occupational therapy practice to routinely engage older people in discussion surrounding alcohol intake.

Whilst respondents indicated a willingness to refer to occupation-focused conceptual models of practice, this was not reflected when asked if they would consider using a conceptual model with older people and alcohol. Reasons for this have been outlined in table 4, however for the small percentage (28.7%) who indicated they would consider a conceptual model, the PEO Model was favoured. The value of this model in physical health care settings has been explored by Maclean et al. (2012), and this finding here lends support to the view of Stoffell and Moyers (2004) of the need to examine interactions among person, environment, and activity in prevention and recovery of substance misuse.

Of respondents using a standardised assessment associated specifically with occupational therapy (31.1%), only 4.1% used an assessment linked to a conceptual model of practice. This may explain why, when defining an older person with alcohol problems, the greatest number of

respondents associated their definition on the impact of alcohol with no reference to occupation. The assessment of cognition (86.3%) far outweighs assessment of occupation.

Limitations of this study exist. Notably the response rate of this study is a limitation, however identifying the size of population as defined by the inclusion criteria proved to be challenging. The overall response rate using the ISD (2012) data was poor (6.4%), however the likelihood is that the true response rate for this study is much higher across the participating NHS Boards. The example of NHS Forth Valley illustrates this point. Nevertheless, care must be taken when making inferences from this study concerning the wider population of occupational therapists working with older people in physical health care settings, due ultimately to its small sample size and lack of probability sampling.

Conclusion

This study presents several key messages of relevance to the profession of occupational therapy. Gaps in occupational therapists' knowledge concerning alcohol are evident, particularly health guidelines for older people. It is positive that occupational therapists identify a clear role for themselves when working with older people and alcohol. There appears however to be a lack of educational and continuing professional support to enable the profession to effectively address gaps in knowledge and, by extension, limits ability to build professional confidence when working with older people and alcohol.

Key findings

1. Occupational therapists working with older adults exhibit gaps in knowledge surrounding appropriate alcohol health guidelines.
2. Participants identified a belief that alcohol is an issue when working with older people and the profession has a role in this area, but that this role is not supported by undergraduate education.
3. Occupation-focused theory and assessment were not prioritized when considering alcohol and the older adult.

What the study has added

This study has highlighted a need to develop pre- and post-qualification education for occupational therapists, in order to enhance understanding of theory, assessment and knowledge of alcohol with older adults.

Ethics

Favourable ethical approval was first obtained from Queen Margaret University, Edinburgh.

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Conflict of interest

None declared.

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Paper 5

Use of occupation-focused language by occupational therapists in physical health care settings when considering older people and alcohol use

Fiona Maclean¹ and Jenna Breckenridge²

Abstract

Statement of context: There is ongoing debate about therapists' use of occupation-focused language in practice. Through practice language analysis we explored how conceptual models influence therapists' word choice by re-analysing qualitative data from a survey of occupational therapists' knowledge and beliefs about alcohol use amongst older people.

Critical reflection on practice: We used word clouds to analyse practitioners' responses about whether they used conceptual models in practice. We reflect on three themes: theories that mirror the realities of practice; shaping theories in action; and 'considered' practice.

Implications for practice: Conceptual models shape, and are shaped by, the language of practice. This provides insight into the relationship between models, language and professional identity.

Keywords

Occupation, language

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Statement of context

In a recent opinion piece, Gillen and Greber (2014) outlined practical steps for keeping occupation at the centre of the profession. Their paper was a catalyst for debate, calling on therapists to identify barriers and solutions for actualising occupation-focused practice. One of the solutions Gillen and Greber (2014) suggest is that therapists should be more articulate in the way they describe and discuss occupation, encouraging conversation between colleagues to support reasoning in occupational terms. Wider professional debate also reflects the need to 'anchor' practice in occupation (Kielhofner, 2004). Various theories and conceptual models over the last few decades have sought to assist practitioners in operationalising and articulating their unique occupation focus (Turpin and Iwama, 2011). Despite these theoretical advancements, however, it seems that therapists still have difficulties articulating practice in occupational terms (Gillen and Greber, 2014).

Molineux (2004) has linked these difficulties to the historical influence of the medical profession over occupational therapy. Occupational therapy was traditionally prescribed by a physician, limiting the profession's scope to make its own professional judgements (Molineux, 2004). Whilst this offers some historical explanation, occupational therapy is now an autonomous research based

profession and should thus have sufficient theoretical basis to guide practice and a specific discourse with which to promote its professional role (Turpin and Iwama, 2011). Indeed, Gillen and Greber (2014: 40) argue that although 'practice must conform to the pragmatic constraints of a service, our potential to think and talk in occupation focused ways is unrestrained'. Research suggests, however, that therapists working in physical settings continue to be constrained by the biomedical contexts in which they work (Wilding and Whiteford, 2008).

In this paper, we offer a practice language analysis that explores the extent to which occupational therapists working in physical healthcare settings use occupation-focused language. We reflect on the theoretical and pragmatic structures that restrain or facilitate the language of practice.

¹Lecturer, Occupational Therapy, Queen Margaret University, Edinburgh, UK
²Postdoctoral Researcher, School of Nursing and Midwifery, Dundee University, Dundee, UK

Corresponding author:

Fiona Maclean, Occupational Therapy, Queen Margaret University, QMU Drive, Musselburgh, Edinburgh, East Lothian EH21 6UU, United Kingdom.
Email: fmaclean@qmu.ac.uk

Practice language analysis

In a recently completed study (Maclean et al., 2015), we surveyed occupational therapists working in physical health care settings about their knowledge and beliefs relating to alcohol misuse amongst older adults (aged 65+). Knowledge of theory and assessment is essential for healthcare professionals working within the context of ageing and alcohol misuse (Wallace et al., 2010). However, there is a notable lack of occupation-focused literature exploring older people and alcohol misuse. One item in our questionnaire therefore asked respondents: 'Are occupation-focused conceptual models of practice of value when considering older people and alcohol use in physical health care settings?' Of the 122 therapists who responded, 57 participants gave a qualitative response to justify their answer (27 said models were of value; 30 said models were not of value). These participants were spread across 11 NHS Boards in Scotland, representing a diverse range of physical health care settings (Table 1). This provided us with an opportunity to 'listen' to the language being used in these practice settings and contribute to the ongoing discussion about occupation-focused practice. Having previously identified themes (Maclean et al., 2015), we returned to our data to look in more detail at therapists' word choice. As the question did not pre-determine a specific conceptual model of practice, we were able to explore more generally the relationship between the language of practice, and the language used by current occupational therapy models.

Our practice language analysis consisted of two phases: 1. content analysis of the responses using word clouds; 2. reflective discussion on the similarities and differences in word choice across both groups.

Phase 1. We began our practice language analysis by generating word clouds of therapists' responses in each group. Word clouds organise text into a visual format; the

frequency of each word is represented by its prominence and size within the cloud (McNaught and Lam, 2010). This is a useful approach in explorative qualitative research, quickly highlighting key words and areas of interest (McNaught and Lam, 2010). Presenting data visually also facilitates comparison between data sets, pinpointing similarities and differences between groups (McNaught and Lam, 2010). Word clouds have been used to support learning and reflection (Baralt et al., 2011) and were thus aptly suited to our practice language analysis. Our word clouds are presented in Figures 1 and 2.

To create the word clouds, questionnaire responses were entered into word cloud software (Tagxedo.com, 2014). Guided by McNaught and Lam (2010), we 'cleaned' the data by removing conjunctions (for example 'a', 'the') and conversation fillers (for example 'you know'), corrected spelling and combined plural and singular words. Parameters were set to display the fifty most frequently used words and the generated word clouds were checked against the enumerative content analysis of the original transcript (Maclean et al., 2015) to ensure consistency. We recognise that frequency does not necessarily equate to importance, however, by focusing on word choice we were able to compare the use of occupational language between those therapists who did, and did not, claim to use conceptual models in their practice.

Phase 2. The second phase involved critical reflection on the word clouds. Both authors reflected on the word clouds independently, each writing a list of the similarities, differences and inconsistencies between clouds. We compared and contrasted our initial impressions to identify preliminary themes, before searching literature within and beyond occupational therapy to relate our themes to wider debate. This collaborative and iterative process of discussing the word clouds and incorporating different

Table 1. Participant responses (*n* = 57) to the question 'Are occupation focussed conceptual models of practice of value when considering older people & alcohol use in physical health care settings?', grouped by NHS Scotland Board with practice contexts noted.

| NHS Scotland Boards (numbered for anonymity) | Number of participants who responded 'No' | Participants' practice contexts | Number of participants who responded 'Yes' | Participants' practice contexts |
|--|---|--|--|--------------------------------------|
| 1 | 0 | | 1 | Neurology |
| 2 | 0 | | 1 | Elderly/older People |
| 3 | 1 | Orthopaedics | 1 | Community |
| 4 | 0 | | 7 | Neurology, orthopaedics, other |
| 5 | 8 | Elderly, medical, community, surgical | 3 | Neurology, surgical |
| 6 | 2 | Burns, neurology | 1 | Acute care |
| 7 | 2 | Orthopaedics, community | 2 | Orthopaedics, acute care |
| 8 | 0 | | 1 | Acute care |
| 9 | 11 | Neurology, elderly/older people, community, orthopaedics, medical, other | 7 | Medical, elderly/older people, other |
| 10 | 1 | Community | 0 | |
| 11 | 5 | Medical, orthopaedics, neurology | 3 | Elderly/older people, acute care |
| TOTAL | 30 | | 27 | |

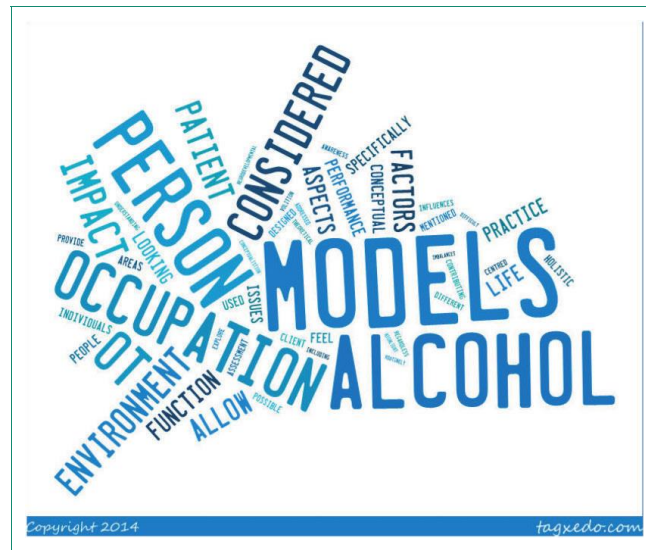


Figure 1. Word cloud representing the 50 most frequently used words by occupational therapists ($n=27$) where occupation-focused models of practice were viewed as valuable, when considering older people and alcohol in physical health care settings.



Figure 2. Word cloud representing the 50 most frequently used words by occupational therapists ($n=30$), where occupation-focused models of practice were not viewed as valuable, when considering older people and alcohol in physical health care settings.

perspectives from the literature generated three final themes about how and why the use of occupational language might differ between therapists who do and do not use conceptual models in their practice.

Critical reflection

Theme 1: Theories that mirror the realities of practice

A striking difference between the two word clouds is the frequency of the words 'occupation', 'person' and 'environment'. For practitioners who valued the use of conceptual models (Figure 1) these terms were highly prominent. Comparatively, practitioners who said they did not use conceptual models used these words less frequently (Figure 2). The word 'occupation' was rarely mentioned by this group and it is surprising that these therapists did not use the term more often. Word choice does not necessarily reflect core values and we cannot conclude that these respondents lacked an occupation focus in their practice. However, this finding could support Gillen and Greber's (2014) claim that therapists' struggle to articulate practice in occupational terms.

One possible explanation for this is that there might be a lack of synergy between the language of conceptual models and the practice contexts in which therapists' work. According to Cornelissen (2000), research is often initiated for academic understanding in the pursuit of building theories. Accordingly, from a practitioner perspective, academic knowledge can be considered abstract and too conceptual in nature; it may not necessarily mirror practice realities. Despite the documented advantages behind the use of conceptual models, it is clear there are barriers to their use in practice. However, debate about how academic theories develop, rather than how they can be integrated in to practice, is scarce in occupational therapy literature.

Theme 2: Therapists' language shapes theories in action

Biomedical words such as 'patient' and 'function' feature in both word clouds. This suggests that, although conceptual models can influence the language of practice, therapists' word choice is still shaped to a significant extent by the practice contexts in which they work. The use of generic biomedical lexicon (for example 'patient', 'acute', 'intake') may demonstrate that therapists have moulded the occupational language of conceptual models to suit the predominant medical model approach within their own practice settings. Wilding (2010) similarly identified that therapists in acute settings favoured the word 'function' because they feared 'occupation' would be misunderstood.

It would be easy to assume that translation of theory into practice is one directional or, as Bryant (1991: 178) puts it: 'science speaks and practice listens'. However, conceptual models are rarely used in practice without being

altered in some way by practitioners (Cornelissen, 2000). Therapists' use of language, and the extent to which they alter occupational terminology, has the potential to shape the development of theory in practice. Therefore, rather than viewing conceptual models as the application of academic knowledge to practice, Cornelissen (2000) suggests that we must think of models as translational, that is, they undergo an active process of transformation as they are used and altered by knowledgeable, reflective professionals in the practice setting.

The language of occupational therapy is dual directional: conceptual models can and do shape therapists' language but, when those theories do not closely mirror their practice realities, practitioners transform models through alterations to their language. This poses an important dilemma about how much practitioners can change the language of occupational therapy models without compromising core concepts and thereby professional identity. Wilding (2010) has voiced concerns that the incorporation of too much biomedical lexicon within practice can reduce the broad concept of occupation to performance components only. She argues that the use of occupational terminology boosts professional identity, supports how we explain what we do and crystallises the link between occupation and enabling health, well-being and life satisfaction.

Theme 3: Complex decision making and considered practice

The words 'consider' and 'considered' feature prominently in both word clouds, suggesting that both groups of therapists underpin their practice with complex reasoning processes. This commonality of language implies that the value placed on conceptual models of practice does not alter therapists' recognition of the need to be cognisant of and anchor practice with sound reasoning. Indeed, Rogers (2010) suggests that all therapists use a systematic process of occupational reasoning to support quality thinking in relation to assessment and intervention. The other notable word that features prominently across both word clouds is 'alcohol'; however, this is understandable given that our practice language analysis was based upon a segment of data from a larger survey of occupational therapists' knowledge and beliefs about alcohol use amongst older people. For more information, we direct the reader to the full presentation of our findings in Maclean et al. (2015).

Our practice language analysis suggests that therapists are active agents in the modification and creation of theory expressed through their use of words and language, influenced by practice settings. This infers that in order to refine and enhance theory underpinning practice, there is value going forward in spending more time simply 'listening' to therapist conversations. We need to understand how these conversations actively shape, inform and translate existing theory in order to support the implementation of occupation-focused services. This offers an interesting point of departure relative to existing research that can

have a tendency to predetermine and apply the use of a particular conceptual model of practice, rather than embrace the complexity of this process. There is a need to understand these processes more clearly which is beyond the scope of this paper, but our understanding of how theory is developed and informed by practice is clearly an issue of relevance to the profession.

Conclusion

This practice language analysis offers a glimpse into the words used by occupational therapists in physical health care settings. For therapists to embrace occupational lexicon in practice, as advocated by Gillen and Greber (2014), they must see this as meaningful and relevant to their practice settings. Our practice language analysis shows that conceptual models may facilitate the use of occupational lexicon in the contexts of those who participated in our study, however we also recognise that models not only shape but *are shaped* by practice language. Although our analysis is based upon a discrete practice area, and our limited data made in depth-analysis difficult, we hope our reflections highlight the complexity surrounding the use of occupational language in physical settings. We offer this paper as a foundation for further research and, as we move forward with this debate, we want to highlight the importance of 'listening' to the language of practice, through detailed discourse analysis in future.

Key messages

- Occupation-focused language must be meaningful to be used in practice.
- Models are altered as therapists mould them to practice contexts.
- Practice language should inform future theoretical developments.

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Research ethics

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Declaration of conflicting interests

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Appendix 2

Search Strategy and Critical Summary of Gap Analysis Papers Related to Occupational Therapy

Table 1: Search strategy examining the use of gap analysis in occupational therapy.

| Date of search: 16.02.15 | | |
|--------------------------|---|---|
| Database searched | Key words used | Number of 'hits' |
| CINAHL | "gap analysis" + "occupational therap*" | 2 (1 excluded as a duplicate article) Antony D & Brooks N (2001) |
| PsycINFO | "gap analysis" + "occupational therap*" | 5 (all excluded as 'hits' not related to a gap analysis) |
| Medline | "gap analysis" + "occupational therap*" | 1 (Battye KM & McTaggart K, 2003) |
| Google Scholar | gap analysis + occupational therapy | 1 (CAOT, 2003) |

Table 2: Critical Summary of Gap Analysis Papers Related to Occupational Therapy

| Reference | Aim(s) | Design | Sample | Results & Conclusions | Strengths | Limitations |
|---|--|--|--|--|--|--|
| ANTHONY, D., and BROOKS, N., 2001. Clinical guidelines in community hospitals. <i>Nursing Times Research. Vol. 6 (5)</i> , pp. 839-851. | <p>What clinical guidelines do nurses and therapists use?</p> <p>Do nurses and therapists consider clinical guidelines to be helpful?</p> <p>What problems can clinical guidelines cause?</p> <p>Are there areas of nursing practice for which no clinical guidelines are available?</p> <p>What barriers are there to using clinical guidelines?</p> <p>What bridges might be employed to encourage the use of clinical guidelines?</p> <p>How aware are nurses and</p> | <p>Descriptive design, using qualitative interviews.</p> <p>Content analysis was undertaken, condensed to produce themes, further analysed for relationships amongst themes.</p> | <p>Sampling strategy unexplained: 19 F & G grade nurses, 1 practice development nurse, 2 physiotherapists, 2 occupational therapists</p> | <p>Clinical guidelines: confusion over what constitutes a clinical guideline</p> <p>Need for clinical guidelines: need for clinical guidelines agreed, however the areas of need not included in discussion</p> <p>Barriers & bridges: Multi-professional involvement in development of clinical guidelines seen as important and education of importance.</p> | <p>Synergy between findings and wider literature apparent.</p> <p>Clearly identified research questions.</p> | <p>Gap analysis mentioned as a tool used in methodology in abstract, but no further mention of gap analysis or how this was implemented in the methods section (or elsewhere) in article.</p> <p>Sampling strategy unidentified.</p> <p>Analysis of data poorly defined.</p> |

| Reference | Aim(s) | Design | Sample | Results & Conclusions | Strengths | Limitations |
|---------------------------------------|---|--|--|---|---|---|
| | <p>therapists of the sources of clinical guidelines?</p> <p>What is the best method of disseminating to clinical nurses and therapists information about clinical guidelines, systematic reviews, and other relevant sources of evidence-based practice?</p> <p>How relevant are national clinical guidelines to local practice?</p> <p>What are the most important clinical guidelines to implement?</p> | | | | | |
| BATTYE, KM., and McTAGGART, K., 2003. | The aim of this study was to develop an outreach model of | Development of the outreach Model of service delivery occurred | 11 remote communities in the Northern Queensland | The development of revised allied health delivery service using a | Clearly identified purpose, identification of | Evaluation of model still to be undertaken. |

| Reference | Aim(s) | Design | Sample | Results & Conclusions | Strengths | Limitations |
|---|--|---|--|---|---|--|
| Development of a model for sustainable delivery of outreach allied health services to remote north-west Queensland, Australia <i>Rural and Remote Health 3 (online) (5)</i> , pp. 1-14. | allied health service delivery operating in the primary healthcare paradigm. | over 4 stages; 1.Development of a planning matrix 2.Environmental scan (mapping and gap analysis of existing allied health services) 3.Desktop analysis of previous research relevant to the study 4.Synthesis of information to develop a model. | Rural Division of General Practice | hub and spoke model. AHPs based in Mt Isa (the hub), serving three geographically separate areas (the spokes): (i) the Gulf precinct (ii) the Highway precinct (iii) the Mt Isa precinct. | concerns related to existing delivery of AHP services which engaged local communities, community input in to the development of revised allied health delivery, sustainability strategies embedded in to model. | Only six allied health professions included in service delivery (1.5 FTE occupational therapy post). |
| PARKER-TAILLON & ASSOCIATES, on behalf of CAOT. 2003. | To provide an overview of the sources of workforce data in occupational | The overall approach used was a “gap analysis”, which involved an | Sources of workforce data for the profession of occupational | Four key recommendations were outlined; 1.Leadership and partnerships | Comprehensive report clearly indicating in detail the current state of | Future steps in developing HHRP dependent on the |

| Reference | Aim(s) | Design | Sample | Results & Conclusions | Strengths | Limitations |
|---|---|--|----------|---|--|--|
| Background Paper on Occupational Therapy Human Resource Data: Sources, Utilization, and Interpretative Capacity. CAOT | therapy, its utilization and the interpretative capacity across jurisdictions, as well as recommendations for the future. | inventory of occupational therapy human resource data, a review of health human resource planning literature, a gap analysis, and development of the background paper and recommendations. | therapy. | 2.Information needs for HHRP 3.Data requirements for comparability and harmonization 4.Next steps for HHRP in occupational therapy. | HHRP in occupational therapy in Canada. Diversity in data sources linked to workforce including, occupational therapy regulators, occupational therapy professional organizations, occupational therapy academic (university) programs and education programs for support personnel in occupational therapy. Clearly | development of a centralised agency of essential (identified) partners to provide internal leadership and strategic direction. |

| Reference | Aim(s) | Design | Sample | Results & Conclusions | Strengths | Limitations |
|-----------|--------|--------|--------|-----------------------|--|-------------|
| | | | | | identified steps outlined connected to the 'future state'. | |

Appendix 3

Tables of Existing Knowledge and Beliefs: Occupation Focused Critical Introspection (Quadrant 1 & 2)

Table 1: Occupation-focused, critical introspection of the 'current state' of findings associated with knowledge in Maclean et al (2012) The usefulness of the Person-Environment-Occupation Model in an acute physical health care setting *British Journal of Occupational Therapy*, 75(12), p555-562.

| The 'current state' – Key findings from research | Introspection | Occupation Focus (Person-Environment-Occupation) | Knowledge 'guide post' reconciling the current 'state' of professional knowledge to theory proposed in professional literature |
|---|--|---|---|
| Elements of the PEO Model used subconsciously by participants in practice | An interesting internal perspective from participants. I wonder if this links to complexity theory in learning & practice e.g. using PEO as a subconscious 'filter' and 'organizer' to support understanding of occupational complexity and the variables surrounding occupational performance in context? Occupational complexity subconsciously arranged and organised into an overall system that changes according to variations in the person or environment. | Person-Occupation | Connects to Chapparo & Ranka, (2005) as part of a theory building process within the science of occupation & the practice of occupational therapy |
| Use of the PEO Model as a framework helping therapists move beyond ADL, to address coping & meaning for the client in the environment | This may indicate a willingness by participants in this study to move beyond viewing disability as an individual problem in order to contribute also to a non-disabling society. In other words, wider consideration of the person other than just within the hospital environment. | Person-Environment | Theories are also part of the political environment (theorizing about others is never politically neutral) (Whalley Hammell, 2003) |
| Continuum of complexity | Is this to some extent associated with the depth of knowledge participants have around the model? For | Person | The importance of occupational |

| The 'current state' – Key findings from research | Introspection | Occupation Focus (Person-Environment-Occupation) | Knowledge 'guide post' reconciling the current 'state' of professional knowledge to theory proposed in professional literature |
|--|--|--|---|
| associated with PEO Model in physical health care settings | example, the idea of the passage of time explained in the model illustrated through self-care. A woman during adolescence may take more care with self-care as an occupation as this is may be of more personal importance due to peer groups/belonging. Perhaps less importance for the same woman during family life, and perhaps further refine/simplify these during ageing. In other words the complexity of the PEO model starts with our own understanding of underpinning professional knowledge. Complexity therefore is guided by the person's occupational needs, not the perceived complexity of the theory underpinning the model. The view expressed by participants regarding a lack of complexity/theoretical detail of the model seems 'back to front' to me. | | performance must be stressed as the starting point for any occupational therapy intervention (Letts et al, 2003) |
| The challenge of delivering patient-centred care in acute medical settings | To what extent do existing conceptual models of occupational therapy practice reflect the realities of practice in physical health care settings in the UK? "It's really not about patient goals". Is client-centred practice in this context disconnected from the realities of what therapists are expected to achieve? Can we re-configure/re-shape how we think about what we do, without losing the centrality of the people we work with | Person-Environment | Aldrich (2008) considers the value of transactionalism that talks about "ends-in-view" rather than goals. Ends-in-view reinforce the idea that the person-context relationship exists before, |

| The 'current state' – Key findings from research | Introspection | Occupation Focus (Person- Environment- Occupation) | Knowledge 'guide post' reconciling the current 'state' of professional knowledge to theory proposed in professional literature |
|---|--|---|---|
| | and for? | | during and through transaction, the aim of which is functional co-ordination. Explores conditions as a product of the relationship between the habits and contexts of experience. History, current conditions and uncertainty of future are all interwoven. |
| Education influences choice of model in practice but also forces choices to be made between models. | Do we? "Essay questions about which model you think best, why, it almost sets them up against each other". This has 'jarred' with me ever since and I am deeply concerned that it may be perceived we present a competition between professional models in our teaching. It leads me to ask how do we teach theory in our curricula, and/or do the leading proponents of models influence this view in their discourse surrounding underpinning theory? Makes me feel uncomfortable. | Person-Environment | Criticism of the 'conceptual model' is the implied presumption that science and academic research will necessarily enlighten practitioners, and favours a one-way relationship between science and practice (Cornelissen, 2000). Translational models embrace an active |

| The 'current state' – Key findings from research | Introspection | Occupation Focus (Person- Environment- Occupation) | Knowledge 'guide post' reconciling the current 'state' of professional knowledge to theory proposed in professional literature |
|--|---------------|---|---|
| | | | process of interpretation and reframing by practitioners within the context of professional knowledge, in other words the 'push' tendency of conceptual models v's the 'pull' model of the translational model (Cornelissen, 2000). |

Table 2: Occupation-focused, critical introspection of the 'current state' of findings associated with knowledge in Gill et al (2011) Occupational therapy graduates of 2009: knowledge and attitudes relating to their role in the area of alcohol misuse *British Journal of Occupational Therapy*, 74(4), p168-175.

| The 'current state' – Key findings from research | Introspection | Occupation Focus (Person-Environment-Occupation) | 'Guide post' reconciling existing professional knowledge to theory proposed in professional literature |
|--|---|---|---|
| 21.6% of participants did not know their unit content of personal alcoholic drink, 33% did not know or could not recall UK recommended daily limits for women, rising to 41% in men. | Surprise at numbers! Given the extent to which alcohol is discussed & considered in the media over the last 10 years, surprised that education in schools and our professional undergraduate curricula does not address what I would regard as basic underpinning knowledge to practice in a range of health care contexts. | Person | Area identified for further research (Maclean et al, 2014), however training of healthcare professionals in general associated with substance misuse given minimal attention (Happell et al, 2002, Rassool, 2004, Cape et al, 2006) |
| Occupational therapy students' definition of 'someone with an alcohol problem', described for the first time in research in UK. | Cautious acknowledgments to myself here that the examples contained within the categories are all negative. Are all the issues/reasons around 'someone with an alcohol problem' negative? I wonder if we jumped in to 'another person's shoes', if we would answer that question, to some extent, differently? In other words there must be some value for the person in their drinking behaviour? Is there a need to recognise this? | Person | Addiction has been reported to aid connectedness, as well as isolation (Wasmuth et al, 2014). Further themes of identity, promoted through addiction, and coping also emerge through Wasmuth's et al (2014) |

| The 'current state' – Key findings from research | Introspection | Occupation Focus (Person-Environment-Occupation) | 'Guide post' reconciling existing professional knowledge to theory proposed in professional literature |
|---|--|--|---|
| | | | work, leading to addiction-as-occupation. This indicates greater complexity of understanding around the categories defined by the student participants. |
| Change in drink driving limit only proposal (at date of publication) Scottish Government policy approved by majority of participants. | Again surprise...I was expecting a higher response rate from students in favour of minimum retail pricing, banning promotions etc. Discussion in class with students indicated their disquiet that these proposals would disadvantage the poor in society, whilst higher earners would still be able to drink what they like, when they like....a reflection on society? I do not agree with this view but very interested in the potential connection to policy and the wider impact on society, advantages/disadvantages dependent on social groups. | Person | Possible synergy here with the view of Hocking (2014) suggesting in the UK we could/should practise 'social occupational therapy' that makes a point of attending to occupational injustices associated with poverty, unemployment, homelessness. |
| Students value their role in working with alcohol (naming their profession as best placed to intervene and offer advice | Our own value of what we (occupational therapy) can offer very often poorly viewed from outwith the profession of occupational therapy. Participants here seem to have a strong sense of their professional identity and valued role, not necessarily matched by our professional colleagues. Frustrating, but can we clearly | Person-Environment | Anecdotal view of Gillen & Greber (2014) that therapist should be more articulate in the way they describe and discuss occupation. |

| The 'current state' – Key findings from research | Introspection | Occupation Focus (Person- Environment- Occupation) | 'Guide post' reconciling existing professional knowledge to theory proposed in professional literature |
|--|---|---|--|
| n=51), versus professional colleagues who named occupational therapy 15 times. | articulate what we do and how we do it? | | |

Table 3: Occupation-focused, critical introspection of the 'current state' of findings associated with knowledge in Maclean et al (2014) The topic of alcohol within the Scottish occupational therapy curricula *British Journal of Occupational Therapy* 77(4) p205-212.

| The 'current state' – Key findings from research | Introspection | Occupation Focus (Person-Environment-Occupation) | 'Guide post' reconciling existing professional knowledge to theory proposed in professional literature |
|--|---|---|--|
| The three institutions that teach alcohol as part of their curricula do so as an integrated topic. | I feel uneasy concerning an integrated approach...although this is very much the approach we would use to teach many conditions as part of our curricula. A little surprised that a defined focus is not given to alcohol, given the extent of the issue. | Environment | Uneasiness expressed perhaps not misplaced as Clark (2005) notes in nursing research that where the focus of alcohol use is not made explicit in nursing pre-registration education, the opportunity to learn how to cope with patients who have alcohol related issues might be lost. |
| Limited value placed on Scottish Government policy connected to alcohol. | An explanation potentially as to why our previous research (Gill et al 2011) indicated graduating occupational therapists only held a majority view in favour of the drink/driving policy change. Why are we not addressing important policy proposals/changes associated with health in our undergraduate pre-registration curricula in Scotland? Answers one question but raises others...lack of time? Competing priorities? Lack of interest? Important if therapists are | Person-Environment | The Association for Medical Education and Research in Substance Abuse (AMERSA) is a multi-disciplinary organisation committed to health professional development of substance abuse, the |

| The 'current state' – Key findings from research | Introspection | Occupation Focus (Person-Environment-Occupation) | 'Guide post' reconciling existing professional knowledge to theory proposed in professional literature |
|--|--|--|--|
| | to support a conversation with people associated with alcohol. | | only MDT in the US with this explicit educational mission (Samet et al, 2006). Value in replicating this in the UK? |
| Difficulties in quantifying the number of hours students are exposed to professional knowledge teaching involving alcohol. | Should it matter that across Scotland as a profession we are unable to state with a degree of precision, the number of hours each student is exposed to alcohol teaching? The numbers of hours noted in this research are wide ranging from 5 hours, to 1.5 hours to between 200-400 hours if studying as level 4 projects. I feel frustrated at the lack of clarity around this and therefore unsurprised at some of the findings noted throughout our research journey concerning occupational therapist knowledge associated with alcohol. Might be useful to survey students themselves regarding their exposure to alcohol education. | Person-Environment | Findings are in keeping with wider research such as Rassool et al (2007), the results of their study indicating a lack of adequate educational preparation of undergraduate nursing students in alcohol and drugs. |
| Diverse reasons for suggestions from HEI's/FEI why profession not regarded as 'key' by our professional colleagues. | Concern, disquiet...reasons for this lack of consensus, appear to be flippant in places "is alcohol use/misuse different from any other area of practice", only one response refers to occupation. This is key...where is the evidence and theoretical basis in the profession of occupational therapy to support working with people who misuse alcohol, irrespective of practice area? Do | Person-Environment | In response to the delivery of ABI's in a general hospital setting, occupational therapists role in delivering these interventions now beginning to be |

| The 'current state' – Key findings from research | Introspection | Occupation Focus (Person-Environment-Occupation) | 'Guide post' reconciling existing professional knowledge to theory proposed in professional literature |
|--|---|--|---|
| | <p>the responses indicate the scope and range of practice areas impacted by alcohol misuse, such as physical health care settings (100 people admitted to hospital each day in Scotland due to alcohol)? I feel a narrow focus of understanding is implicit in these responses.</p> | | <p>recognised (McQueen, 2013), but there is a need for more emphasis on alcohol in undergraduate (& post graduate) education (McQueen, 2013). Is this an example here of the 'pull' of the translational model (Cornelissen, 2000) in action?</p> |

Table 4: Occupation-focused, critical introspection of the ‘current state’ of findings associated with knowledge in Maclean et al (2015) Alcohol use amongst older adults: Knowledge and beliefs of occupational therapists working in physical health care settings *British Journal of Occupational Therapy* (in press).

| The ‘current state’ – Key findings from research | Introspection | Occupation Focus (Person-Environment-Occupation) | ‘Guide post’ reconciling existing professional knowledge to theory proposed in professional literature |
|--|--|---|--|
| 61.5% of participants correctly recalled the daily limit of alcohol for men and 68.8% correctly recalled this for women. | Improved scores here in comparison to the graduating occupational therapists from our previous work (Gill et al, 2011). Good news but these could/need still to be improved further. | Person | Difficulty benchmarking this finding against professional literature as limited research (other than our own) exploring this aspect of occupational therapist knowledge. |
| Majority (95.1%) recognize that older people can have alcohol related problems. | Surprised that a majority of therapists recognise this as a potential issue, yet pleased that practice acknowledges this, despite the paucity of research/discussion in the professional literature associated with older people and alcohol. | Person | Synergy here with the findings of Waldron & McGrath (2012) who identified overall high levels of healthcare knowledge associated with awareness of alcohol issues in older people. |
| Majority (88.5%) agreed occupational therapy has a role to play in ABIs. | Interesting finding here as offers support in physical health care settings (general hospital environments) of the growing recognition of ABI’s in the profession, despite limited literature associated with this. Supports the view of McQueen (2013). Again, is this an example | Person | An example here of the ‘pull’ of the translational model (Cornelissen, 2000) in action? |

| The 'current state' – Key findings from research | Introspection | Occupation Focus (Person-Environment-Occupation) | 'Guide post' reconciling existing professional knowledge to theory proposed in professional literature |
|---|--|--|---|
| | of the 'pull' of translational knowledge from practice, waiting to be adopted in to theory? | | |
| Majority (76.2%) agreed occupational therapists should routinely promote current health messages surrounding alcohol with older people. | Really positive message here as it would appear to chime with the idea that health promotion is of value, part of the occupational therapists' remit and supports Wilcock's (2006) view the of the importance of health promotion as a process of enabling people to increase control over, and to improve, their health | Person | Alcohol, as part of the public health agenda and health promotion (Scottish Government 2008), need also connect with the conceptualization of occupation as a powerful influence on health requiring an extension of the profession's domains of concern to include all people (Wilcock, 2006). Through occupational science, for example, occupational therapy can become better positioned to stake a claim in the prevention arena (Clark & Lawlor, 2009). |
| 42.6% of respondents stated | This is interesting as it provides an evidence-based example, which supports Strong et al (1999) anecdotal | Person-Environment | This supports the findings from Strong et al (1999), |

| The 'current state' – Key findings from research | Introspection | Occupation Focus (Person-Environment-Occupation) | 'Guide post' reconciling existing professional knowledge to theory proposed in professional literature |
|---|--|--|--|
| they referred to the PEO Model when working with older people in physical health care settings. | view that the PEO Model is of value in hospital settings. In addition, this provides further evidence, in concert with Maclean et al (2012), of the potential value of using the PEO Model as an underpinning theory in physical health care settings. What is not clear is from this finding is how the PEO Model is translated in to practice, why this appears to be a model of value (some indication of this from previous research work) and to what extent it helps to support occupation focused delivery of service. I feel there is a real need to look at this further, in relation to the design and delivery of occupation-focused services in physical health care settings. | | however also supports the findings from Maclean et al (2012) and indicates a rationale for using the PEO Model as the occupation lens through which to guide the gap analysis. |

Table 5: Occupation-focused, critical introspection of the ‘current state’ of findings associated with knowledge in Maclean et al (2015) A practice language analysis of the use of occupation-focused language by occupational therapists in physical health care settings when considering older people and alcohol *British Journal of Occupational Therapy* (in press).

| The ‘current state’ – Key findings from research | Introspection | Occupation Focus (Person- Environment- Occupation) | ‘Guide post’ reconciling existing professional knowledge to theory proposed in professional literature |
|--|--|---|---|
| Frequency of the use of words between word clouds ‘occupation’, ‘person’ & ‘environment’ | I feel this is a really valuable insight to occupational therapists ‘words in action’, potentially offering an uncomfortable insight in to practice. Out of interest, I went back to the qualitative transcript of those occupational therapists that stated they did not value occupational therapy conceptual models of practice when considering alcohol with older people, and the word occupation was used once, throughout the 30 qualitative transcripts. Is occupation as a term controversial in physical health care settings, is that why we don’t use it? Literature suggests it may be (Molineux 2010, Wilding 2010)? Are we actually practising as occupational therapists in physical health care in the NHS, if we do not view certain health issues (alcohol) as valuable intervention for therapy, informed by underpinning occupation-based theory? Are we losing our holistic approach? Have we lost our occupation focus, or, if we value the PEO Model does this support delivery of occupation-focused services sub-consciously (Maclean et al, 2012), but experience difficulty articulating practice, as argued by Gillen & | Person- Environment | Education has an important role here. Kinn & Aas (2008) recommend a clearer link between occupational therapy philosophy, theory & practice, which educational programs should be focusing more on. They argue that because occupational therapists work in MDT, they need to substantiate a common sense & occupation-based approach, but what therapists think and do is in line with professional paradigms. The problems arise they argue, when they are about to articulate their actions. |

| The 'current state' – Key findings from research | Introspection | Occupation Focus (Person- Environment- Occupation) | 'Guide post' reconciling existing professional knowledge to theory proposed in professional literature |
|--|---|---|---|
| | Greber (2014)? Or are we at a cross roads in the UK, where our practice in the NHS (physical setting) no longer has parallels with wider debate within professional literature connecting the practice of 'social occupational therapy' argued by Wilcock (2014) versus our focus on self-care in acute practice areas (Griffen & McConnell, 2001), with increasing pressure to discharge patients (Crennan & MacRae, 2010)? | | This seems to support the need for a clearer articulation of philosophy, to theory, influencing practice. |
| Use of generic words such as 'patient', 'acute', 'intake'. | This touches on much historical discussion in the literature...for example, Townsend (1998) maintained that occupational therapists often claim that they define practice in medical terms in order to communicate with audiences and receive funding from sources that are directed towards medical care. Interesting though that Lundgren Pierre (2001) reflects if a "language of occupation" exists in Swedish occupational therapy and whether such a language is current in the biomedical world or not? So...would a change in how we articulate our practice associated with alcohol, older people and physical health care settings even be of value IF our colleagues do not recognise occupational therapy and note us as a 'key' service in working with alcohol (Gill et al, 2011)? In | Person- Environment | Kinn & Aas (2008) recommend a clearer link between occupational therapy philosophy, theory & practice, which educational programs should be focusing more on. |

| The 'current state' – Key findings from research | Introspection | Occupation Focus (Person-Environment-Occupation) | 'Guide post' reconciling existing professional knowledge to theory proposed in professional literature |
|---|---|--|--|
| | <p>other words, is the language of occupation not 'current' even if we articulate practice with an occupation focus, or by not using an occupation-focus do we diminish its currency/value? It is impossible to say which of these two possibilities is true, but perhaps we need to 'drive' towards building occupation-focused discussion around alcohol in physical health care settings through clearer articulation of philosophy, connected to theory, influencing practice.</p> | | |
| <p>Rather than thinking about conceptual models, where academic knowledge is applied <i>to</i> practice, Cornelissen (2000) suggests that we must think of models as translational.</p> | <p>I am beginning to be persuaded of the flaws in creating conceptual models of practice in occupational therapy. The very definition of a conceptual model implies its flaw <i>related to</i> practice. It assumes a one-way relationship from science to practice; practice is regarded as a passive receiver of rationalised knowledge and expertise, thus utilization has traditionally been conceptualised in terms of the "diffusion of knowledge" (Cornelissen, 2000). In other words it 'pushes' a pre-defined set of ideas in to practice, receiving feedback from practice on the already existing ideas. The existing ideas become ever further refined through practice feedback, but what are the mechanism of 'coming up for air'? What</p> | <p>Person-environment</p> | <p>Occupational science – originally intended to provide knowledge that could be used to theoretically inform, and thereby refine and develop, occupational therapy interventions (Clark & Lawlor, 2009). Further, in addressing a wide variety of topics that are relevant to the general population, occupational science can broaden occupational</p> |

| The 'current state' – Key findings from research | Introspection | Occupation Focus (Person- Environment- Occupation) | 'Guide post' reconciling existing professional knowledge to theory proposed in professional literature |
|---|---|---|---|
| | <p>if the iterative refinement of existing theory does not mirror practice, or is ill fitting, clunky? Where do influences from outwith occupational therapy that could usefully 'shape' our philosophy fit with a conceptual model already in existence? How can existential shifts in thinking inform what we do and how we do it, for example, connected to alcohol?</p> | | <p>therapy's professional jurisdiction...[and]....become better positioned to stake a claim in the prevention arena (Clark & Lawlor, 2009).</p> |

Appendix 4

Tables of Knowledge and Belief Gaps: Occupation Focused Critical Introspection (Quadrant 3)

Table 1: Occupation-focused critical introspective gap analysis associated with knowledge findings in Maclean et al (2012) The usefulness of the Person-Environment-Occupation Model in an acute physical health care setting *British Journal of Occupational Therapy*, 75(12), p555-562.

| Gaps | Introspection | Occupation Focus (Person-Environment-Occupation) | Alertness to Opportunities |
|---|--|---|---|
| <p>The 'transactive' nature of the PEO Model missing from findings.</p> | <p>No mention here of the "transactive" nature of the PEO Model, representing the person and environment as interdependent and that a person's behaviour cannot be separated from the context in which it occurs. According to Turpin & Iwama (2011), occupational performance is context-, person-, and an occupation-specific process. Here emphasis seems to be placed on the person's environment, in terms of getting them home as a pressure was noted to get people "in and out" as quickly as possible. The focus on the use of the PEO Model in physical health care settings appears to separate out three entities of person, environment and occupation. Thus, the occupation focus of the 'event', which led the person to hospital, leads to only the observable features of the environment considered in assessment, excluding consideration of the meaning of the 'event' to people. Potentially I think this restricts our focus in assessment and intervention to 'what is in front of us', rather than considering the wider perspectives of health & well-being. Perhaps explains why therapists are reluctant to ask about and consider alcohol such as asking routine questions concerning alcohol intake in older people</p> | <p>Occupation</p> | <p>Opportunity to re-consider underpinning theory. It may be that the use of the PEO Model requires further consideration in implementation in physical health care settings to prompt wider consideration of both the context and meaning of the environment to the person. BUT also, the use of the PEO Model seems to limit therapists to consider an occupation focus associated with the patient admitted. Wider concerns linked to participation and meaning of alcohol within the person's</p> |

| Gaps | Introspection | Occupation Focus (Person-Environment-Occupation) | Alertness to Opportunities |
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| | (Maclean 2015)? | | environment/community may help to support the interconnectedness of a person's behaviour and the wider environment. Perhaps elements of occupational science, connected to understanding of communities and populations can support this. |
| Person | The challenges around delivering client-centeredness are alluded to, however a deeper disconnect with the understanding of person appears evident. Whilst the features of a person that can be observed are alluded to, the subjective experience of the person appears largely ignored here. The changing nature of subjective experience and views of self is central to understanding this model (Turpin & Iwama, 2011), but this core idea is largely ignored, as is the notion of the environment which surrounds the person shapes their sense of self. Deeper understanding of the person in the context of their environment seems missing. | Person-Environment | "Attention to how occupations are shaped, negotiated and experienced by individuals and collectives requires attention to not only macro-elements of contexts, but also individual lives" (Rudman, 2012, p111). This perspective contributes to a wider understanding of |

| Gaps | Introspection | Occupation Focus (Person-Environment-Occupation) | Alertness to Opportunities |
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| | | | the need to explore the personal narratives of how people's experiences are shaped by personal circumstance. This understanding may better 'signal' role of alcohol in people's lives. |
| Occupation | There seems very limited discussion of occupation. On reflection the theme 'continuum of complexity' misses the focus of what it is the therapists wanted to consider in depth and surely this must be occupation as our core focus. The potential use of a conceptual model of practice may support how we view the person/individual sitting before us, but what is informing our wider occupational understanding of collective experiences shaping who we are? | Occupation | Occupation matters. Opportunity and a need to consider ways in which to support the development of an occupational 'lens' in physical health care settings, to shape understanding of the wider relationship between occupation and healthfulness. |
| Curricula and theoretical understanding of occupation | Participant's discussion around underpinning theory in occupational therapy centred on conceptual models. The power of education is implicitly valued here but narrowness in the scope and potential of wider theory to | Occupation-Environment | Opportunity to consider more widely the transformational nature of occupation (Royeen, |

| Gaps | Introspection | Occupation Focus (Person-Environment-Occupation) | Alertness to Opportunities |
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| | inform practice seems to me to be evident. | | 2002), beyond our current use and understanding of conceptual models in physical health care settings, in order to shape, inform and support occupation focused delivery of services. |

Table 2: Occupation-focused, critical introspective gap analysis associated with knowledge findings in Gill et al (2011) Occupational therapy graduates of 2009: knowledge and attitudes relating to their role in the area of alcohol misuse *British Journal of Occupational Therapy*, 74(4), p168-175.

| Gaps | Introspection | Occupation Focus (Person-Environment-Occupation) | Alertness to opportunities |
|---|--|---|--|
| <p>21.6% of participants did not know their unit content of personal alcoholic drink, 33% did not know or could not recall UK recommended daily limits for women, rising to 41% in men.</p> | <p>Surprise at numbers! Given the extent to which alcohol is discussed & considered in the media over the last 10 years, surprised that education in schools and our professional undergraduate curricula does not address what I would regard as basic underpinning knowledge to practice in a range of health care contexts.</p> | <p>Person</p> | <p>Area identified for further research (Maclean et al, 2014), however training of healthcare professionals in general associated with substance misuse given minimal attention (Happell et al, 2002, Rassool, 2004, Cape et al, 2006)</p> |
| <p>Professional colleagues do not name occupational therapy as 'key' in order to intervene & offer advice when alcohol may be suspected as an issue.</p> | <p>I wonder if there are two reasons why this may be the case;</p> <ol style="list-style-type: none"> 1. Occupational therapy education not discussing an occupation-focus to alcohol (Maclean et al, 2014) 2. Difficulty articulating what we do in terms of an occupation-focus (Maclean et al, in press), in other words our distinct value. <p>This requires the profession of occupational therapy, emerging from education, to look inwards and consider how we discuss, think about and teach occupation and specifically occupation and its relationship with alcohol.</p> | <p>Occupation-Environment</p> | <p>Development opportunity to consider occupation much more widely within the context of occupation focused theory, and how this can help to inform professional knowledge associated with alcohol.</p> |

| Gaps | Introspection | Occupation Focus (Person-Environment-Occupation) | Alertness to opportunities |
|---|--|---|---|
| Occupational therapy graduates did not agree with 3 of the 4 Scottish Government policies, connected to minimum retail pricing, banning promotions that sell alcohol at below cost price, raise the minimum legal purchase for alcohol to 21 years. | Barbara & Whiteford (2005) suggest that viewing the occupational therapy profession, as a political entity is a concept many practitioners are not familiar or comfortable with, reluctant to engage with the political influences that can shape policy and practice. What is interesting here is the extent to which they disagreed (68% linked to minimum retail pricing), perhaps indicating that this finding does not indicate a reluctance to engage with policy. Perhaps it implicitly connects with the anecdotal views of students expressed in the classroom of the perceived injustice this policy (minimum retail pricing) would have on poorer members of society, making alcohol less affordable. I may not necessarily agree with this position associated with alcohol and minimum retail pricing, but perhaps it captures the essence of what is important and matters to occupational therapists? | Occupation-Environment | This may resonate with ideas around occupational injustice and the suggestion of 'social occupational therapy' (Hocking, 2014). |
| Gaps in knowledge guidelines | Education may be lacking associated with what we teach and how we teach recommended alcohol unit intake guidelines. Can be a confusing message...we don't sell alcohol by the unit for example. | Person | Enhance educational curricula to explain recommended alcohol unit intake guidelines |

Table 3: Occupation-focused, introspective gap analysis associated with knowledge findings in Maclean et al (2014) The topic of alcohol within the Scottish occupational therapy curricula *British Journal of Occupational Therapy* 77(4) p205-212.

| Gaps | Introspection | Occupation Focus (Person-Environment-Occupation) | Alertness to opportunities |
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| Occupation-focused theory underpinning alcohol | Alcohol-related content noted in the findings does not include discussion of the occupational nature of alcohol. It seems surprising that the relationship between alcohol and occupation has been largely ignored within Scottish occupational therapy curricula, perhaps explaining the difficulties in articulating this role in practice (Maclean & Breckenridge, in press). As a consequence if we do not teach/understand this relationship and therefore struggle to articulate this role, it may not be surprising that other professionals do not regard us as 'key' when alcohol is suspected as an issue. | Occupation | Educational need to develop curricula to reflect and consider the relationship between occupation and alcohol. |
| Gaps in education considering alcohol-related policy. | Limited scope and consideration of alcohol-related policy identified. Interesting disconnect here in that Barbara & Whiteford (2005) suggest that consistent efforts have been made to make the profession of occupational therapy more aware of legislative and policy contexts, but, education in Scotland associated with alcohol does not appear to be responding to these efforts | Occupation-environment | Educational need to consider policy associated with alcohol & how this shapes practice. From this platform then engaging occupational therapists to also 'shape' policy, allowing the profession to promote its holistic view of health. |
| Gaps in understanding scope | Relationship of alcohol and mental health settings clearly defined with all three HEIs teaching alcohol | Environment | Educational and professional need to be |

| Gaps | Introspection | Occupation Focus (Person-Environment-Occupation) | Alertness to opportunities |
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| of alcohol across practice contexts. | associated with mental health. No consideration of alcohol and the older adult and an implicit message that alcohol essentially defined through mental health services. The broader scope and role alcohol plays across our society and thus, filtering through to physical health care settings in the NHS and beyond, lacks definition here. | | much more explicit concerning the groups of people influenced by alcohol, and what this means in terms of our professional knowledge. |

Table 4: Occupation-focused, critical introspective gap analysis associated with knowledge findings in Maclean et al (2015) Alcohol use amongst older adults: Knowledge and beliefs of occupational therapists working in physical health care settings *British Journal of Occupational Therapy* (in press).

| Gaps | Introspection | Occupation Focus (Person-Environment-Occupation) | Alertness to opportunities |
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| Where is the occupation-focus in service delivery when considering alcohol and older people? | Genuinely surprised at several key findings here; 86.3% of respondents focused on assessment of cognition rather than occupation, only 4.1% used a standardised assessment connected to occupational therapy conceptual models of practice & 71.3% stated they would not use an occupational therapy conceptual model of practice to conceptualise/consider an older person and alcohol. This represents a clear gap in service delivery associated with an occupation focus and alcohol, but also more broadly, it represents an area of concern connected to wider occupation-focused service. Does the lack of standardised assessment represent a lack of focus on occupation in physical health care settings, and can this lead to a 'narrowing' of therapist concern for wider occupational issues impacting patients? Difficult to determine what our distinct value is, if we are not focusing on occupation. Would underpinning theory, which embraces recognition of wider community, and population challenges associated with occupation support how we think, act and converse with an occupational focus in hospitals? | Occupation | Opportunity here to embrace a conversation with occupational therapists in physical health care settings around their occupation focus and the extent to which they deliver occupation-focused services. If conceptual models concentrate on understanding the individual within the context of the person, environment and occupation, there may be value in encouraging integration of theory that also considers the place of the individual in society, and their communities. In other |

| Gaps | Introspection | Occupation Focus (Person-Environment-Occupation) | Alertness to opportunities |
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| | | | words to support the flourishing of occupation in physical health care settings more broadly, and specifically connected to professional knowledge between alcohol and occupation. Ikiugu (2010) very often a gap exists between every day practice and the theory and research generated by occupational therapy academics. Gaps in occupation evident throughout findings. |
| Lack of engagement with health promoting messages around older people and alcohol. | Only 9% of our sample 'always' asked older people about their alcohol unit intake, a small number and none of the participants used a standardised assessment to consider alcohol with older people Again surprise with this finding. At odds with current literature surrounding older people and alcohol (although most of this literature is from nursing/medicine), at odds also with therapists' beliefs that alcohol is an issue with older adults...so why | Occupation | Clark & Lawlor (2009, p.7) suggest that occupational science, through generating scientific research, can inform the practice of occupational therapy in that it will "demonstrate |

| Gaps | Introspection | Occupation Focus (Person-Environment-Occupation) | Alertness to opportunities |
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| | <p>not ask?</p> <p>Current conceptual models of occupational therapy, in my view, tend to largely ignore the health promoting agenda. Tendency to focus on occupational issues arising from disease, ill health and disability.</p> | | <p>the ways in which health-promoting activity lessens the risk for developing chronic disease or disability, thus occupational therapy will become better positioned to stake a claim in the prevention arena". Andersson et al (2012) cross-sectional study (n=851) exploring women's patterns of alcohol consumption lends support to occupation focus.</p> |
| <p>Lack of preparation from undergraduate curricula when working with older people and alcohol</p> | <p>This feels like an important area for future consideration. The lack of preparation from education can be illustrated in a number of ways; gaps in knowledge of alternative safe limits for older people, gaps in therapist acknowledgment of an occupation focus to service delivery & therapist's belief that education did not prepare them to work with older people and alcohol issues. These examples from practice further supports the findings from Gill et al (2011) and Maclean et al</p> | | <p>An opportunity to advance occupational therapist knowledge in physical health care settings through education, embracing an occupation-focused understanding of alcohol.</p> |

| Gaps | Introspection | Occupation Focus (Person-Environment-Occupation) | Alertness to opportunities |
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| | (2014) of the lack of cohesive approach to alcohol education in Scottish undergraduate curricula. The evidence all points towards an opportunity to enhance alcohol education related to professional knowledge associated with occupation-focused theory and alcohol misuse with older people. | | |

Table 5: Occupation-focused, critical introspective gap analysis associated with knowledge findings in Maclean et al (2015) A practice language analysis of the use of occupation-focused language by occupational therapists in physical health care settings when considering older people and alcohol *British Journal of Occupational Therapy* (in press).

| Gaps | Introspection | Occupation Focus (Person-Environment-Occupation) | Alertness to opportunities |
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| <p>Use of occupation-focused language in physical health care practice when considering alcohol and older people.</p> | <p>The findings here are surprising and fascinating. A real lack of synergy between the language of practice and language used by conceptual models of practice in occupational therapy has been identified. Of real interest in the group of respondents who stated they did not use conceptual models of practice when considering alcohol and older people was the virtual absence (used once) of the word occupation. Current conceptual models of practice do not appear to be influencing therapists working in physical health care settings around issues associated with alcohol misuse. This may be because current conceptual models of occupational therapy do not mirror the realities of practice. This idea represents an emerging advancement of theoretical thinking around occupation which has resonance with a view expressed by, Bonsaksen writing to the BJOT in February 2015. The idea of addiction-as-occupation discussed by Wasmuth (2014), represents a challenge to existing theory in occupational therapy, highlighting challenges associated with our understanding of addiction using MOHO. Bonsaksen (2015) writes, “It is interesting to speculate</p> | <p>Occupation</p> | <p>Consider the opportunity to explore professional knowledge and understanding of alcohol in physical health care settings using occupational science to guide thinking. Kinn & Aas (2009) who argue that a clearer link between philosophy, theory, and practice is recommended, and that educational programs must focus on helping occupational therapists to articulate their knowledge of occupational therapy concepts.</p> |

| Gaps | Introspection | Occupation Focus (Person-Environment-Occupation) | Alertness to opportunities |
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| | <p>how addiction-as-occupation may fit with, or challenge, established conceptual frameworks in the profession. My belief is that the findings of the five prima facie papers presents both indicators and hints which challenge us to explore alcohol beyond the 'traditional' boundaries of theory wrapped within conceptual models of practice and, instead, to explore alcohol using the discipline of occupational science. This thinking parallels Bonsaksen (2015) own thoughts when he states in his letter, "new knowledge about a phenomenon can come from using new concepts to describe it".</p> | | |

Appendix 5

Introspective Transcript

Table 1: Introspective transcript with initial analysis in context of raw data.

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| <p>(i) Introspective data connected to existing knowledge & beliefs</p> <p>An interesting internal perspective from participants. I wonder if this links to complexity theory in learning & practice e.g. using PEO as a subconscious 'filter' and 'organizer' to support understanding of occupational complexity and the variables surrounding occupational performance in context? Occupational complexity subconsciously arranged and organised into an overall system that changes according to variations in the person or environment.</p> <p>This may indicate a willingness by participants in this study to move beyond viewing disability as an individual problem in order to contribute also to a non-disabling society. In other words, wider consideration of the person other than just within the hospital environment.</p> <p>Is this to some extent associated with the depth of knowledge participants have around the model? For example, the idea of the passage of time explained in the model illustrated through self-care. A woman during adolescence may take more care with self-care as an occupation as this is may be of more personal importance due to peer groups/belonging. Perhaps less importance for the same women during family life, and perhaps further refine/simplify these during ageing. In other words the complexity of the PEO model starts with our own understanding of underpinning professional knowledge. Complexity therefore is guided by the person's occupational needs, not the perceived complexity of the theory underpinning the model. The view expressed by participants regarding a</p> | <p>Individual in context of society</p> <p>Depth of knowledge linked to professional understanding of theory</p> <p>Depth of professional knowledge?</p> |
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| <p>lack of complexity/theoretical detail of the model seems 'back to front' to me.</p> <p>To what extent do existing conceptual models of occupational therapy practice reflect the realities of practice in physical health care settings in the UK? "It's really not about patient goals". Is client-centred practice in this context disconnected from the realities of what therapists are expected to achieve? Can we re-configure/re-shape how we think about what we do, without losing the centrality of the people we work with and for?</p> <p>Do we? "Essay questions about which model you think best, why, it almost sets them up against each other".</p> <p>This has 'jarred' with me ever since and I am deeply concerned that it may be perceived we present a competition between professional models in our teaching. It leads me to ask how do we teach theory in our curricula, and/or do the leading proponents of models influence this view in their discourse surrounding underpinning theory? Makes me feel uncomfortable.</p> <p>Surprise at numbers! Given the extent to which alcohol is discussed & considered in the media over the last 10 years, surprised that either through education in schools and our professional undergraduate curricula does not address what I would regard as basic underpinning knowledge to practice in a range of health care contexts.</p> <p>Cautious acknowledgments to myself here that the examples contained within the categories are all negative. Are all the issues/reasons around 'someone with an alcohol problem' negative? I wonder if we jumped in to 'another persons shoes', if we would</p> | <p>Disconnect between theory and practice/client-centred</p> <p>Professional education – how we teach theory ? link to depth of professional knowledge of theory</p> <p>Professional knowledge associated with generic underpinning knowledge Locus of control</p> <p>Negative occupations may be positive Occupation-as-addiction Limits or scope of professional understanding</p> |
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| <p>answer that question, to some extent, differently? In other words there must be some value for the person in their drinking behaviour? Is there a need to recognise this?</p> <p>Again surprise...I was expecting a higher response rate from students in favour of minimum retail pricing, banning promotions etc. Discussion in class with students indicated their disquiet that these proposals would disadvantage the poor in society, whilst higher earners would still be able to drink what they like, when they like....a reflection on society? I do not agree with this view but very interested in the potential connection to policy and the wider impact on society, advantages/disadvantages dependent on social groups</p> <p>Our own value of what we (occupational therapy) can offer very often poorly viewed from outwith the profession of occupational therapy. Participants here seem to have a strong sense of their professional identity and valued role, not necessarily matched by our professional colleagues. Frustrating, but can we clearly articulate what we do and how we do it?</p> <p>I feel uneasy concerning an integrated approach...although this is very much the approach we would use to teach many conditions as part of our curricula. A little surprised that a defined focus is not given to alcohol, given the extent of the issue.</p> <p>An explanation potentially as to why our previous research (Gill et al 2011) indicated graduating occupational therapists only held a majority view in favour of the drink/driving policy change. Why are we not addressing important policy proposals/changes associated with health in our undergraduate pre-registration curricula in Scotland? Answers one</p> | <p>Shared knowledge?</p> <p>Disconnect with policy...don't agree with it or unaware of it?</p> <p>Policy connectors here?</p> <p>Professional identity/ our own and as viewed by others/locus of control</p> <p>Locus of control</p> <p>Educational teaching strategies ? linked to locus of control</p> <p>Policy not discussed in education/? Connector here to policy & occupation/locus of</p> |
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| <p>question but raises others...lack of time? Competing priorities? Lack of interest? Important if therapists are to support a conversation with people associated with alcohol.</p> <p>Should it matter that across Scotland as a profession we are unable to state with a degree of precision, the number of hours each student is exposed to alcohol teaching? The numbers of hours noted in this research are wide ranging from 5 hours, to 1.5 hours to between 200-400 hours if studying as level 4 project. I feel frustrated at the lack of clarity around this and therefore unsurprised at some of the findings noted throughout our research journey concerning occupational therapist knowledge associated with alcohol. Might be useful to survey students themselves regarding their exposure to alcohol education.</p> <p>Concern, disquiet...reasons for this lack of consensus, appear to be flippant in places "is alcohol use/misuse different any other area of practice", only one response refers to occupation. This is key...where is the evidence and theoretical basis in the profession of occupational therapy to support working with people who misuse alcohol, irrespective of practice area? Do the responses indicate the scope and range of practice areas impacted by alcohol misuse, such as physical health care settings (100 people admitted to hospital each day in Scotland due to alcohol)? I feel a narrow focus of understanding is implicit in these responses. Improved scores here in comparison to the graduating occupational therapists from our previous work (Gill et al, 2011). Good news but these could/need still to be improved further.</p> <p>Surprised that a majority of therapists recognise this as</p> | <p>control/engagement with policy</p> <p>Education strategies in teaching</p> <p>Is there belief in what we are teaching and it's importance?</p> <p>Narrow focus of teaching ?generic knowledge</p> <p>Practice informing professional</p> |
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| <p>a potential issue, yet pleased that practice acknowledges this, despite the paucity of research/discussion in the professional literature associated with older people and alcohol.</p> <p>Interesting finding here as offers support in physical health care settings (general hospital environments) of the growing recognition of ABI's in the profession, despite limited literature associated with this. Supports the view of McQueen (2013). Again, is this an example of the 'pull' of translational knowledge from practice, waiting to be adopted in to theory?</p> <p>Really positive message here as it would appear to chime with the idea that health promotion is of value, part of the occupational therapists' remit and supports Wilcock's (2006) view the of the importance of health promotion as a process of enabling people to increase control over, and to improve, their health</p> <p>This is interesting as it provides an evidence-based example, which supports Strong et al (1999) anecdotal view that the PEO Model is of value in hospital settings.</p> <p>In addition, this provides further evidence, in concert with Maclean et al (2012), of the potential value of using the PEO Model as an underpinning theory in physical health care settings. What is not clear is from this finding is how the PEO Model is translated in to practice, why this appears to be a model of value (some indication of this from previous research work) and to what extent it helps to support occupation focused delivery of service. I feel there is a real need to look at this further, in relation to the design and delivery of occupation-focused services in physical health care settings.</p> <p>I feel this is a really valuable insight to occupational</p> | <p>belief/professional role?</p> <p>Generic/shared knowledge</p> <p>Prevention Professional identity</p> <p>Value placed on the PEO Model but ? restricting person?</p> <p>Restricting the person & what about occupation/a gap or occupation dissipating?</p> <p>Is practice informing theory? Is there a</p> |
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| <p>therapists 'words in action', potentially offering an uncomfortable insight in to practice. Out of interest, I went back to the qualitative transcript of those occupational therapists that stated they did not value occupational therapy conceptual models of practice when considering alcohol with older people, and the word occupation was used once, throughout the 30 qualitative transcripts. Is occupation as a term controversial in physical health care settings, is that why we don't use it? Literature suggests it may be (Molineux 2010, Wilding 2010)? Are we actually practicing as occupational therapists in physical health care in the NHS, if we do not view certain health issues (alcohol) as valuable intervention for therapy, informed by underpinning occupation-based theory? Are we losing our holistic approach? Have we lost our occupation focus, or, if we value the PEO Model does this support delivery of occupation-focused services sub-consciously (Maclean et al, 2012), but experience difficulty articulating practice, as argued by Gillen & Greber (2014)? Or are we at a cross roads in the UK, where our practice in the NHS (physical setting) no longer has parallels with wider debate within professional literature connecting the practice of 'social occupational therapy' argued by Wilcock (2014) v's our focus on self-care in acute practice areas (Griffen & McConnell, 2001), with increasing pressure to discharge patients (Crennan & MacRae, 2010)?</p> <p>This touches on much historical discussion in the literature...for example, Townsend (1998) maintained that occupational therapists often claim that they define practice in medical terms in order to communicate with audiences and receive funding from sources that are</p> | <p>message here that theory is not supporting practice, or understanding of alcohol? Lack of occupation. Where is occupation as focus of therapy?</p> <p>Narrow focus/understanding of alcohol. Barriers to delivery of occupation focus. Is it a sub-conscious understanding of occupation. Practice v's theory disconnect? Reality?</p> <p>Practice v's theory disconnect. Occupation focus unclear, perspectives re alcohol Contradictions</p> |
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directed towards medical care. Interesting though that Lundgren Pierre (2001) reflects if a “language of occupation” exists in Swedish occupational therapy and whether such a language is current in the biomedical world or not? So...would a change in how we articulate our practice associated with alcohol, older people and physical health care settings even be of value IF our colleagues do not recognise occupational therapy and note us as a ‘key’ service in working with alcohol (Gill et al, 2011)? In other words, is the language of occupation not ‘current’ even if we articulate practice with an occupation focus, or by not using an occupation-focus do we diminish its currency/value? It is impossible to say which of these two possibilities is true, but perhaps we need to ‘drive’ towards building occupation-focused discussion around alcohol in physical health care settings through clearer articulation of philosophy, connected to theory, influencing practice.

I am beginning to be persuaded of the flaws in creating conceptual models of practice in occupational therapy. The very definition of a conceptual model implies its flaw *related to practice*. It assumes a one-way relationship from science to practice; practice is regarded as a passive receiver of rationalised knowledge and expertise, thus utilization has traditionally been conceptualised in terms of the “diffusion of knowledge” (Cornelissen, 2000). In other words it ‘pushes’ a pre-defined set of ideas in to practice, receiving feedback from practice on the already existing ideas. The existing ideas become ever further refined through practice feedback, but what are the mechanism of ‘coming up for air’? What if the

The person in the environment linked to alcohol...no occupation either. Professional identity unclear

Professional identity linked to policy. Narrowing again of role and value placed on this

Occupation gap, theory practice disconnect

Theory/practice disconnect and challenges within theory. Narrowing of theory in practice and therefore relevancy.

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| <p>iterative refinement of existing theory does not mirror practice, or is ill fitting, clunky? Where do influences from outwith occupational therapy that could usefully 'shape' our philosophy fit with a conceptual model already in existence? How can existential shifts in thinking inform what we do and how we do it, for example, connected to alcohol?</p> <p>(ii) Introspective data connected to gaps in knowledge No mention here of the "transactive" nature of the PEO Model, representing the person and environment as interdependent and that a person's behaviour cannot be separated from the context in which it occurs.</p> <p>According to Turpin & Iwama (2011), occupational performance is context-, person-, and an occupation-specific process. Here emphasis seems to be placed on the person's environment, in terms of getting them home as a pressure was noted to get people "in and out" as quickly as possible. The focus on the use of the PEO Model in physical health care settings appears to separate out three entities of person, environment and occupation. Thus, the occupation focus of the 'event', which led the person to hospital, leads to only the observable features of the environment considered in assessment, excluding consideration of the meaning of the 'event' to people. Potentially I think this constricts our focus in assessment and intervention to 'what is in front of us', rather than considering the wider perspectives of health & well-being. Perhaps explains why therapists are reluctant to ask about and consider alcohol such as asking routine questions concerning alcohol intake in older people (Maclean 2015)? The challenges around delivering client-centredness</p> | <p>Are there issues with depth of professional knowledge, disconnect, occupation, links to wider theory & policy Are there delimiters to professional knowledge? External forces shaping theory.</p> <p>The person restricted or narrowed. Transaction avoided</p> <p>Barriers to practice: practice context forcing separation of key elements.</p> <p>Loss of patient focus Is emphasis on person? Narrow focus & where is occupation</p> <p>Barriers to health and an occupation focus here</p> |
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| <p>are alluded to, however a deeper disconnect with the understanding of person appears evident. Whilst the features of a person that can be observed is alluded to, the subjective experience of the person appears largely ignored here. The changing nature of subjective experience and views of self is central to understanding this model (Turpin & Iwama, 2011), but this core idea is largely ignored, as is the notion of the environment which surrounds the person shapes their sense of self. Deeper understanding of the person in the context of their environment seems missing.</p> <p>There seems very limited discussion of occupation. On reflection the theme 'continuum of complexity' misses the focus of what it is the therapists wanted to consider in depth and surely this must be occupation as our core focus. The potential use of a conceptual model of practice may support how we view the person/individual sitting before us, but what is informing our wider occupational understanding of collective experiences shaping who we are?</p> <p>Participant's discussion around underpinning theory in occupational therapy centred around conceptual models. The power of education is implicitly valued here but narrowness in the scope and potential of wider education.</p> <p>Surprise at numbers! Given the extent to which alcohol is discussed & considered in the media over the last 10 years, surprised that either through education in schools and our professional undergraduate curricula does not address what I would regard as basic underpinning knowledge to practice in a range of health care contexts.</p> <p>I wonder if there are two reasons why this may be the</p> | <p>Is there a loss of patient focus, separating out the person from the environment</p> <p>Superficial view of the person in their context</p> <p>Absence of occupation/narrow focus of understanding the person in context of environment.</p> <p>Narrowness of education</p> <p>Shared/generic Knowledge/ Connector to policy in Scottish Government.</p> |
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| <p>case;</p> <ol style="list-style-type: none"> 1. Occupational therapy education not discussing an occupation-focus to alcohol (Maclean et al, 2014) 2. Difficulty articulating what we do in terms of an occupation-focus (Maclean et al, in press), in other words our distinct value. <p>This requires the profession of occupational therapy, emerging from education, to look inwards and consider how we discuss, think about and teach occupation and specifically occupation and its relationship with alcohol.</p> <p>Barbara & Whiteford (2005) suggest that viewing the occupational therapy profession, as a political entity is a concept many practitioners are not familiar or comfortable with, reluctant to engage with the political influences that can shape policy and practice. What is interesting here is the extent to which they disagreed (68% linked to minimum retail pricing), perhaps indicating that this finding does not indicate a reluctance to engage with policy. Perhaps it implicitly connects with the anecdotal views of students expressed in the classroom of the perceived injustice this policy (minimum retail pricing) would have on poorer members of society, making alcohol less affordable. I may not necessarily agree with this position associated with alcohol and minimum retail pricing, but perhaps it captures the essence of what is important and matters</p> <p>Education may be lacking associated with what we teach and how we teach recommended alcohol unit intake guidelines. Can be a confusing message...we don't sell alcohol by the unit for example.</p> <p>Alcohol-related content noted in the findings does not</p> | <p>? Occupation focus</p> <p>Occupation focus & Professional identity</p> <p>Occupation focus but also locus of educational control.</p> <p>How does education consider alcohol & occupation? Engagement with policy lacking/missing? A social injustice/ Occupational injustices & a perspective on connecting to policy Sharing knowledge and perspectives.</p> <p>Sharing knowledge through policy and connecting this with occupation.</p> <p>Absence of occupation</p> |
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| <p>include discussion of the occupational nature of alcohol. It seems surprising that the relationship between alcohol and occupation has been largely ignored within Scottish occupational therapy curricula, perhaps explaining the difficulties in articulating this role in practice (Maclean & Breckenridge, in press). As a consequence if we do not teach/understand this relationship and therefore struggle to articulate this role, it may not be surprising that other professionals do not regard us as 'key' when alcohol is suspected as an issue.</p> <p>Limited scope and consideration of alcohol-related policy identified. Interesting disconnect here in that Barbara & Whiteford (2005) suggest that consistent efforts have been made to make the profession of occupational therapy more aware of legislative and policy contexts, but, education in Scotland associated with alcohol does not appear to be responding to these efforts</p> <p>Relationship of alcohol and mental health settings clearly defined with all three HEIs teaching alcohol associated with mental health. No consideration of alcohol and the older adult and an implicit message that alcohol essentially defined through mental health services. The broader scope and role alcohol plays across our society and thus, filtering through to physical health care settings in the NHS and beyond, lacks definition here.</p> <p>Genuinely surprised at several key findings here; 86.3% of respondents focused on assessment of cognition rather than occupation, only 4.1% used a standardised assessment connected to occupational therapy conceptual models of practice & 71.3% stated</p> | <p>Difficulty talking about occupation Occupational focus missing in education, linked to professional identity</p> <p>Disconnect between Theory/practice/ Policy/education</p> <p>Is this everyone's business</p> <p>Locus of control Narrow focus of education</p> <p>Occupation focus missing Disconnect between theory & practice Professional identity Practice v's theory</p> |
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| <p>they would not use an occupational therapy conceptual model of practice to conceptualise/consider an older person and alcohol. This represents a clear gap in service delivery associated with an occupation focus and alcohol, but also more broadly, it represents an area of concern connected to wider occupation-focused service. Does the lack of standardised assessment represent a lack of focus on occupation in physical health care settings, and can this lead to a 'narrowing' of therapist concern for wider occupational issues impacting patients? Difficult to determine what our distinct value is, if we are not focusing on occupation. Would underpinning theory, which embraces recognition of wider community, and population challenges associated with occupation support how we think, act and converse with an occupational focus in hospitals?</p> <p>Only 9% of our sample 'always' asked older people about their alcohol unit intake, a small number and none of the participants used a standardised assessment to consider alcohol with older people Again surprise with this finding. At odds with current literature surrounding older people and alcohol (although most of this literature is from nursing/medicine), at odds also with therapist's beliefs that alcohol is an issue with older adults...so why not ask?</p> <p>Current conceptual models of occupational therapy, in my view, tend to largely ignore the health promoting agenda. Tendency to focus on occupational issues arising from disease, ill health and disability.</p> <p>This feels like an important area for future consideration. The lack of preparation from education</p> | <p>Occupation focus missing Disconnect between theory & practice Professional identity Practice v's theory</p> <p>Narrowing of understanding the person</p> <p>Or where is the person/occupation</p> <p>Policy connecting to person/education</p> <p>Where is occupation in the context of conceptual models: a contradiction?</p> <p>Narrow focus of education</p> |
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| <p>can be illustrated in a number of ways; gaps in knowledge of alternative safe limits for older people, gaps in therapist acknowledgment of an occupation focus to service delivery & therapist's belief that education did not prepare them to work with older people and alcohol issues. These examples from practice further supports the findings from Gill et al (2011) and Maclean et al (2014) of the lack of cohesive approach to alcohol education in Scottish undergraduate curricula. The evidence all points towards an opportunity to enhance alcohol education related to professional knowledge associated with occupation-focused theory and alcohol misuse with older people.</p> <p>The findings here are surprising and fascinating. A real lack of synergy between the language of practice and language used by conceptual models of practice in occupational therapy has been identified. Of real interest in the group of respondents who stated they did not use conceptual models of practice when considering alcohol and older people was the virtual absence (used once) of the word occupation. Current conceptual models of practice do not appear to be influencing therapists working in physical health care settings around issues associated with alcohol misuse. This may be because current conceptual models of occupational therapy do not mirror the realities of practice. This idea represents an emerging advancement of theoretical thinking around occupation which has resonance with a view expressed by , Bonsaksen writing to the BJOT in February 2015. The idea of addiction-as-occupation discussed by Wasmuth (2014), represents a challenge to existing theory in</p> | <p>Locus of control here.</p> <p>Occupation focus/education & alcohol misuse</p> <p>Theory to practice disconnect. What is our focus?</p> <p>Absence of occupation</p> <p>Theory practice disconnect but also with policy. Focus of occupation</p> <p>Theory to practice disconnect</p> |
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| <p>occupational therapy, highlighting challenges associated with our understanding of addiction using MOHO. Bonsaksen (2015) writes, “It is interesting to speculate how addiction-as-occupation may fit with, or challenge, established conceptual frameworks in the profession.</p> <p>My belief is that the findings of the five prima facie papers presents both indicators and hints which challenge us to explore alcohol beyond the ‘traditional’ boundaries of theory wrapped within conceptual models of practice and, instead, to explore alcohol using the discipline of occupational science. This thinking parallels Bonsaksen (2015) own thoughts when he states in his letter, “new knowledge about a phenomenon can come from using new concepts to describe it”.</p> | <p>May fit with a renewed focus on occupation/depth of professional practice</p> |
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Appendix 6

Tables of Summary and Refined Themes

Table 1: Impressions of introspective analysis, leading to tentative themes.

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| Tentative themes generated from introspective analysis | <ol style="list-style-type: none">1. Depth of therapist professional knowledge2. Theory and practice disconnects3. Professional education4. Generic professional knowledge5. Narrowing of professional knowledge6. Policy and practice disconnect7. Professional identity8. Policy 'connectors' to occupation9. Absence of occupation10. Conceptual contradictions |
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Table 2: Refined themes and sub-themes underpinned by guide posts/opportunities highlighting supporting theory.

| Refined Themes | Sub-Themes | Supporting Introspective Text from Introspective Transcript | Associated 'Guide Posts' & Opportunities |
|--------------------------------------|-----------------------------|--|--|
| Delimiters of Professional Education | Sharing policy perspectives | <p>"I was expecting a higher response rate from students in favour of minimum retail pricing, banning promotions etc." (p. 2)</p> <p>"students indicated their disquiet that [policy] proposals would disadvantage the poor in society, whilst higher earners would still be able to drink what they like, when they like....a reflection on society?" (p. 2)</p> <p>"connection to policy and the wider impact on society, advantages/disadvantages dependent on social groups" (p. 2)</p> <p>"Why are we not addressing important policy proposals/changes associated with health in our undergraduate pre-registration curricula in Scotland?" (p. 2)</p> <p>"growing recognition of ABI's in the profession"</p> <p>"Where do influences from outwith occupational therapy that could usefully 'shape' our philosophy fit?"</p> <p>"The power of education is implicitly valued here but a narrowness in the scope and potential of wider theory to inform practice seems to me to be evident." (p. 7)</p> <p>"perceived injustice this policy (minimum retail</p> | <p>Barbara & Whiteford (2005) suggest that viewing the occupational therapy profession, as a political entity is a concept many practitioners are not familiar or comfortable with, reluctant to engage with the political influences that can shape policy and practice.</p> <p>Possible synergy here with the view of Hocking (2014) suggesting in the UK we could/should practise 'social occupational therapy' that makes a point of attending to occupational injustices associated with poverty, unemployment, homelessness.</p> |

| Refined Themes | Sub-Themes | Supporting Introspective Text from Introspective Transcript | Associated 'Guide Posts' & Opportunities |
|----------------|------------------------------|---|---|
| | Educational locus of control | <p>pricing) would have on poorer members of society, making alcohol less affordable.” (p. 7) “at odds with literature surrounding older people & alcohol, at odds with therapists beliefs that alcohol is an issue with older adults....so why not ask?</p> <p>“professional undergraduate curricula does not address what I would regard as basic underpinning [alcohol-related] knowledge to practice in a range of health care contexts.” (p. 2) “I feel uneasy concerning an integrated approach” (p. 2) “A little surprised that a defined focus is not given to alcohol, given the extent of the issue.” (p. 2) “lack of time? Competing priorities? Lack of interest?” (p. 3) “I feel frustrated at the lack of clarity around this [alcohol-related teaching content] and therefore unsurprised at some of the findings noted throughout our research journey concerning occupational therapist knowledge associated with alcohol.” (p. 3) “Concern, disquiet...reasons for this lack of consensus, appear to be flippant in places” (p. 3) “is alcohol use/misuse different from any other area of practice”, only one response refers to occupation.” (p. 3)</p> | <p>Uneasiness expressed perhaps not misplaced as Clark (2005) notes in nursing research that where the focus of alcohol use is not made explicit in nursing pre-registration education, the opportunity to learn how to cope with patients who have alcohol related issues may be lost.</p> <p>Area identified for further research (Maclean et al, 2014), however training of healthcare professionals in general associated with substance misuse given minimal attention (Happell et al, 2002, Rassool, 2004, Cape et al, 2006) The Association for Medical</p> |

| Refined Themes | Sub-Themes | Supporting Introspective Text from Introspective Transcript | Associated 'Guide Posts' & Opportunities |
|----------------|------------|--|---|
| | | <p>“look inwards and consider how we discuss, think about and teach occupation and specifically occupation and its relationship with alcohol.” (p. 7)</p> <p>“The broader scope and role alcohol plays across our society and thus, filtering through to physical health care settings in the NHS and beyond, lacks definition here” (p. 8)</p> <p>“The lack of preparation from education can be illustrated in a number of ways; gaps in knowledge of alternative safe limits for older people, gaps in therapist acknowledgment of an occupation focus to service delivery & therapist’s belief that education did not prepare them to work with older people and alcohol issues.” (p. 9)</p> | <p>Education and Research in Substance Abuse (AMERSA) is a multi-disciplinary organisation committed to health professional development of substance abuse, the only MDT in the US with this explicit educational mission (Samet et al, 2006). Value in replicating this in the UK?</p> <p>Findings are in keeping with wider research such as Rassool et al (2007), the results of their study indicating a lack of adequate educational preparation of undergraduate nursing students in alcohol and drugs.</p> <p>In response to the delivery of ABI’s in a general hospital setting, occupational therapists role in delivering these interventions now beginning to be recognised (McQueen, 2013), but there</p> |

| Refined Themes | Sub-Themes | Supporting Introspective Text from Introspective Transcript | Associated 'Guide Posts' & Opportunities |
|---------------------------|----------------------------|--|---|
| | | | <p>is a need for more emphasis on alcohol in undergraduate (& post graduate) education (McQueen, 2013). Educational need to consider policy associated with alcohol & how this shapes practice. From this platform then engaging occupational therapists to also 'shape' policy, allowing the profession to promote its holistic view of health. Linking to conceptual contradictions....</p> |
| Conceptual Contradictions | Partitioning of the Person | <p>"PEO as a subconscious 'filter' and 'organizer' to support understanding of occupational complexity and the variables surrounding occupational performance in context?" (p. 1) "supports Strong et al (1999) anecdotal view that the PEO Model is of value in hospital settings. In addition, this provides further evidence, in concert with Maclean et al (2012), of the potential value of using the PEO Model as an underpinning theory in physical health care settings." (p. 4) "What is not clear is from this finding is how the PEO Model is translated in to practice, why this</p> | <p>This supports the findings from Strong et al (1999), however also supports the findings from Maclean et al (2012) and indicates a rationale for using the PEO Model as the occupation lens through which to guide the gap analysis. "Attention to how occupations are shaped, negotiated and experienced by individuals</p> |

| Refined Themes | Sub-Themes | Supporting Introspective Text from Introspective Transcript | Associated 'Guide Posts' & Opportunities |
|----------------|------------|--|--|
| | | <p>appears to be a model of value" (p. 4)</p> <p>"No mention here of the "transactive" nature of the PEO Model, representing the person and environment as interdependent and that a person's behaviour cannot be separated from the context in which it occurs." (p. 6)</p> <p>"Here emphasis seems to be placed on the person's environment, in terms of getting them home as a pressure was noted to get people "in and out" as quickly as possible." (p. 6)</p> <p>"The focus on the use of the PEO Model in physical health care settings appears to separate out three entities of person, environment and occupation." (p. 6)</p> <p>"leads to only the observable features of the environment considered in assessment, constricting consideration of the meaning of the 'event' to people." (p. 6)</p> <p>"restricts our focus in assessment and intervention to 'what is in front of us'.... explains why therapists are reluctant to ask about and consider alcohol such as asking routine questions concerning alcohol intake in older people" (p. 6)</p> <p>"Deeper understanding of the person in the context of their environment seems missing." (p. 6)</p> <p>"clearer articulation of philosophy, connected to theory, influencing practice [needed]" (p. 5)</p> | <p>and collectives requires attention to not only macro-elements of contexts, but also individual lives" (Rudman, 2012, p111). This perspective contributes to a wider understanding of the need to explore the personal narratives of how people's experiences are shaped by personal circumstance. This understanding may better 'signal' role of alcohol in people's lives.</p> |

| Refined Themes | Sub-Themes | Supporting Introspective Text from Introspective Transcript | Associated 'Guide Posts' & Opportunities |
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| | Occupational Evaporation | <p>“Occupational therapy education not discussing an occupation-focus to alcohol (Maclean et al, 2014) Difficulty articulating what we do in terms of an occupation-focus (Maclean et al, in press), in other words our distinct value.” (p.7)</p> <p>“This requires the profession of occupational therapy, emerging from education, to look inwards and consider how we discuss, think about and teach occupation and specifically occupation and its relationship with alcohol.” (p.7)</p> <p>“Alcohol-related content noted in the findings does not include discussion of the occupational nature of alcohol. It seems surprising that the relationship between alcohol and occupation has been largely ignored within Scottish occupational therapy” (p.7)</p> <p>“curricula, perhaps explaining the difficulties in articulating this role in practice (Maclean & Breckenridge, in press).</p> <p>“Genuinely surprised at several key findings here; 86.3% of respondents focused on assessment of cognition rather than occupation, only 4.1% used a standardised assessment connected to occupational therapy conceptual models of practice & 71.3% stated they would not use an occupational therapy conceptual model of practice</p> | <p>Ikiugu (2010) very often a gap exists between every day practice and the theory and research generated by occupational therapy academics. Gaps in occupation evident throughout findings.</p> <p>Kinn & Aas (2009) who argue that a clearer link between philosophy, theory, and practice is recommended, and that educational programs must focus on helping occupational therapists to articulate their knowledge of occupational therapy concepts.</p> <p>Andersson et al (2012) cross-sectional study (n=851) exploring women’s patterns of alcohol consumption lends support to this occupational perspective of alcohol.</p> <p>Hocking (2014) proposes that</p> |

| Refined Themes | Sub-Themes | Supporting Introspective Text from Introspective Transcript | Associated 'Guide Posts' & Opportunities |
|----------------|------------|--|--|
| | | <p>to conceptualise/consider an older person and alcohol. This represents a clear gap in service delivery associated with an occupation focus and alcohol, but also more broadly, it represents an area of concern connected to wider occupation-focused service". (p. 8)</p> <p>"Difficult to determine what our distinct value is, if we are not focusing on occupation. Would underpinning theory which embraces recognition of wider community and population challenges associated with occupation support how we think, act and converse with an occupational focus in hospitals?" (p. 8)</p> <p>"The lack of preparation from education can be illustrated in a number of ways; gaps in knowledge of alternative safe limits for older people, gaps in therapist acknowledgment of an occupation focus to service delivery & therapist's belief that education did not prepare them to work with older people and alcohol issues." (p. 9)</p> | <p>all educational programmes state their commitment to societal change, in order to envisage graduate practitioners skilled in recognizing and responding to occupational injustices in every practice context.</p> |

Appendix 7

Researcher Positioning

About me

The most obvious details of who I am includes information such as, I am female, 44, white and British. I was brought up in a village in Scotland and I have lived most of my adult life in Edinburgh. I am married, I have two children and I work part-time as a Senior Lecturer at Queen Margaret University in Occupational Therapy.

Shenton (2005) argues that it is open to question the extent to which consumers of qualitative research need to know about the qualitative researcher. This includes personal information in order to inform a view of how, where and when, 'who' the researcher is may influence the research undertaken. A guiding principle Shenton (2005) suggests is that biographical information supplied should be consistent with the phenomenon under study. Using this guiding principle, it somehow seems appropriate to acknowledge that I drink alcohol.

I enjoy drinking alcohol and I also see its value and role in my occupational routines, primarily at weekends, as I look forward to a glass of wine. Thus I don't believe that alcohol has no valued role in society. It does (for me), but the obvious effects of alcohol misuse are apparent to me also displayed already through my research work, as well as the more subtle realities such as offence caused to others when my husband started to decline the offer of alcohol, following his decision to stop drinking.

My academic experience started through higher education, which I commenced in 1988 when I rejected offers to study politics and geography at University, to start a BSc degree in Occupational Therapy. I completed this in 1991 and went to work in an older people assessment and rehabilitation ward at Woodend hospital in Aberdeen. I met an older lady as part of my basic grade occupational therapy rotation on this ward. She was 82, widowed, had no family and became what we labelled as a 'revolving door' patient. I was struck by her, as in the 6 months I worked on that ward, she was admitted and discharged a total of 5 times, each referral noting 'dizzy turns' and I was involved as part of her discharge process each time.

Each time she would come in to hospital, each time I would do a home visit and each time on our return the Consultant would ask me if she was fit for discharge. Each time I replied "yes", she had managed all the assessed tasks as part of the home visit but, I couldn't quite put my finger on it, I felt she would be admitted again, not able to cope, but I didn't know why. The Consultant agreed. She was admitted a sixth time, three weeks before I finished my rotation and died on the ward. I have thought about her often and I wonder now the extent to which she may have drunk and misused alcohol, and I wonder if I could have done my job differently.

I undertook a basic grade occupational therapy rotation working with older people in Dunfermline, encompassing mainly physical assessment and rehabilitation, as in Aberdeen, but also some mental health. I left to undertake a Scottish Remedial Research Training Fellowship funded by the Chief

Scientist Organisation (CSO) for one year. My research project subsequently published, was an inter-rater reliability study of the Revised Elderly Person's Disability Scale (REPDS).

From this I undertook another study, a quasi-experimental, non-equivalent control group design exploring the functional outcome for the very elderly (aged 75 years and over) when admitted for cataract extraction. This CSO funded study led to me completing my M.Phil.

I returned to practice as a Senior Occupational Therapist working in a physical health care day hospital for older people, with sessional work in the Rheumatology clinic.

I applied and accepted a full-time lecturing post at Queen Margaret University in 1998, becoming part-time at the end of 2001 when my son was born.

How I view myself as a researcher

My research experience until the PEO Model, had all been quantitative research, using both parametric and non-parametric statistical analysis. I enjoyed it. The statistical 'mind set' was methodical, set within distinct parameters which determined either an association of significance or a pre-post change. Clarity, situated within distinct boundaries felt obvious, containable and reasonably straightforward.

The decision to undertake a generic qualitative research design when exploring the PEO Model was, of course, generated by the research question, but also from a personal desire to understand and expose myself to qualitative research. The experience, guided by a former occupational therapy colleague, offered some insight in to qualitative research and I began to see myself as an enthusiastic novice related to this form of enquiry.

This enthusiasm was harnessed by my co-author, Jenna Breckenridge, on the final practice analysis article. I originally wrote the first draft of this article as a quantitative piece of work. Jenna wondered if this was the only way the article could be written. I considered this, and of course came to the conclusion that we could analyse the clouds qualitatively. The purposeful decision to qualitatively analyse the word clouds, to write in the first person and to follow Jenna's suggestion that I write poetry about the clouds (which I declined), began to nudge me forward in terms of confidence in understanding and engaging with qualitative research.

When I reflect on the creation and implementation of this critical appraisal, my perspective is to see a blend and fusion of the research experiences I have enjoyed thus far. I see the step-wise, methodical 'structure' of a research process in terms of the gap analysis and quadrant linear design, allied to the qualitative introspective thinking which has extended my understanding of the creativity and rigour of possibilities linked to qualitative research.

Shifting positions and challenging personal assumptions

The research papers and critical appraisal undertaken have all been conducted over a 5-year period. The process of undertaking the research, shaped also by my history, experiences and culture have all influenced the eventual analysis and interpretation of data as part of this critical appraisal.

Throughout this period I have kept a reflective journal. I have taken some extracts and examples from this journal, illustrated in the table below, to highlight some of the shifting positions and personal assumptions challenged, which may have impacted on the critical appraisal. I have purposefully selected examples that are likely to have resonance in seeking to understand the introspective analysis.

Table 1: Examples of shifting positions and personal assumptions linked to the development of the critical appraisal.

| Shifting Positions | Personal Assumptions | Critical Reflections |
|---|----------------------|---|
| <p>Introspection as a data collection tool moving me from a position of researcher, to a position of being researched</p> | | <p>Extract from journal, 12.03.15: “Feeling uneasy and a little uncomfortable at the prospect of my own thoughts and ideas so exposed in forming a major part of the critical appraisal and introspection. What if I’m wrong, misguided or upset someone?”</p> <p>The shifting meaning and sense of accountability switching from in ‘control’ as the researcher responsible and undertaking the research, to a position of being researched was challenging. The extract suggests an emotional response to the recognition of being researched, demonstrating engagement and also a sense of concern,</p> |

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| | | potentially toward the commitment to ensure rigour and trust of the findings. |
| | The introspective data would identify connections and be reconciled to occupational science. | This was a clear personal assumption prior to the analysis of introspective data that was strongly held. During the initial stages of the analysis of data I felt shocked and amazed that what I thought I had been thinking in relation to my ideas connecting the 'framing' of the findings of the prima facie case papers, were not in fact the case. Whilst tangential links to occupational science could be made, this was not as clear and obvious as I had thought and, indeed, did not inform the interpretation of analysis as much as I had originally expected. This initial personal assumption around occupational science, I think, held back my ability to 'hear' and 'see' the data in the early stages of analysis. |
| | The centrality of occupation to service delivery in physical health care settings. | I think I have always assumed that what we do and how we practice in physical NHS settings reflects occupation. I'm no longer sure that it does. I felt comfortable and assured concerning my own practice in these settings, however I wonder, in comparison to discussions/literature from occupational |

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| | | <p>therapy and mental health settings if this is the case. This shaking of my assumption leads me to believe there is a need to promote further discussion and research in relation to the place of occupation in service delivery in physical health settings.</p> |
| <p>Knowledge linked to alcohol misuse in physical health settings seems to be of less interest connected to wider professional debate. I seem to transition from being passionate and confident in my subject, to less confident and assured in the topic itself.</p> | | <p>Extract from journal, June 2013: “Hardly anyone turned up to my presentation on alcohol misuse at the COT conference. Quite the opposite in terms of response in ENOTHE, Sweden. Feeling disappointed and not sure if this is of value”.</p> <p>Sparse interest from the UK profession in alcohol education and impact on practice seemed to affect me. As my experience and depth of understanding concerning the area of research grew, my confidence in the value of the topic of alcohol misuse seemed to diminish. My confidence as a communicator of valued messages, ‘wobbled’.</p> <p>The introspective analysis, examining my ideas and thoughts in greater depth, linking these to appropriate literature and extending the discourse connected to education, alcohol misuse and physical health care settings has</p> |

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| | | breathed refreshed thinking and confidence both in terms of how I view the importance of alcohol misuse as a topic, and my researcher identity. |
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Lingering questions and reflections on learning

I have tried to place the findings presented as part of this critical appraisal as honestly as I can, situated within many of the recommended qualitative mechanisms that attempt to assure trustworthiness.

I have learned that whilst undertaking qualitative analysis can be challenging, it has also proved to be an enlightening experience of theory I had only until recently read about. In other words, my traditional understanding of what constitutes research, how it is created and interpreted has been deconstructed, altered and curved to embrace the creativity and diversity of ways in which knowledge can be generated.

Nevertheless, lingering questions associated with my work remain. For example;

1. Is the representation of the centrality of occupation to service delivery free of the power, culture and external and internal drivers of the NHS?
2. To what extent does 'my voice' truly represent the educational position linked to alcohol misuse learning and teaching, and how this impacts practice?
3. If I am truly connected to the importance and value of the 'person', where is the service user voice here and what relevance/meaning would they take from this body of work?

I hope I am privileged with the opportunity as part of post-doctoral work to explore aspects of these questions further.