OCCUPATIONAL THERAPY IN PRIMARY HEALTH CARE IN AOTEAROA/NEW ZEALAND: A LITERATURE REVIEW

THE NEW ZEALAND ASSOCIATION OF OCCUPATIONAL THERAPISTS INC.

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1.0 INTRODUCTION

There is no longer any doubt that primary health care is the most significant health reform to occur in Aotearoa/New Zealand in the last seventy years (Crampton, 2004). There remains, however, a significant concern that allied health practitioners, including occupational therapists, are missing out on opportunities to actively contribute to the development of primary health care initiatives, despite clear indicators that there is a recognised need, and mandate, for the provision of quality allied health services within the primary health care context in Aotearoa/New Zealand.

This literature review aims to provide a comprehensive and evidence informed review of the role of occupational therapy, and to some degree allied health, within primary health care, utilizing a range of publication sources, including position statements, online tools and toolkits, peer-reviewed articles, and findings drawn from research and evaluations. This review builds on Tse, Penman, & Simms (2003) review of occupational therapy and primary health care, and Tse, Wilson, Wright St-Clair, & Ford's (2003) personal views, as leaders in the occupational therapy profession in Aotearoa/New Zealand, on the challenges and opportunities for occupational therapy in primary health care organisations. The earlier review (Tse, Penman, & Simms, 2003), based on literature published between 1985 and 2003, determined that there was a discrepancy in the perceived community-based, health promotion philosophy and approach that occupational therapy could offer in primary health care in the United Kingdom (UK), and the more individualised treatment approach evidenced in practice. In the UK it appeared that occupational therapists simply transferred biomechanical and rehabilitative/ compensatory approaches from one community service to another, without careful consideration for the unique primary health care context. As such, the authors challenged occupational therapists, and the occupational therapy profession within Aotearoa/New Zealand, not to replicate existing practice approaches and services, and instead to develop a unique approach to working within the complexities of primary health care, that includes; careful consideration of health and occupation (as opposed to illness and occupational deprivation) as the practice focus; strategies for collaboration with community therapists, primarily through documentation; community and population based practice; and culturally competent practice. In addition, Tse, Penman, & Simms (2003) determined that in order for occupational therapy to be successfully represented in the primary health care environment, partnerships needed to be established with community agencies and population groups; the complex relationships within the MDT team in PHC needed to be explored and strengthened; the change of

practice focus would have significant impact for graduate and post-graduate training; and that occupational therapy needed to be active participants in determining its place and role in primary health care in Aotearoa/New Zealand.

1.1 PROJECT BRIEF

As an essential component of the development of a toolkit for occupational therapists working in primary health care, NZAOT requested a **literature review** of CURRENT (published 2000-2009) literature relating to the role of occupational therapy in primary health services, and evaluations of occupational therapy practice, including primary health care service reviews. The brief also included the development of an **annotated bibliography**, a list of citations to books, articles, and documents with each citation followed by a brief descriptive and evaluative paragraph, the annotation. The purpose of the annotation is to inform the reader of the relevance, accuracy, and quality of the sources cited.

2.1 SEARCH STRATEGY

This literature review involved four steps based around three key stages of **search, assessment, and analysis.**

Step one involved consideration of the purpose of the literature review and the search parameters, specifically related to review parameters (the role of occupational therapy/occupational therapists/ allied health practitioners in primary health care; national and international experiences of occupational therapy/allied health in primary health care; models of service delivery; the primary health care context). Limits were initially placed on the literature search, restricting publications to generic reviews published in English in the last 10 years, and giving priority to publications drawing on the Canadian, Australian and British occupational therapists/allied health practitioners experiences of primary health care, given the social, professional, and contextual similarities with New Zealand. Older publications referred to in relevant publications that met one or more of the above criteria were also sourced.

During step two, the literature was searched using internet search engines (specifically Google and Google Scholar) and electronic databases (specifically CINAHL, Evidence Based Medicine Reviews, PsychINFO), internet-based and publication-based bibliographies, publications sourced and provided by members of the NZAOT Occupational Therapy in Primary Health Care Special Interest Group, and published content from a range of relevant organizations including international occupational therapy

associations and societies; the New Zealand Ministry of Health and Future Workforce sites; and primary health care sites . 60 publications were initially sourced.

In the third step, the publications were reviewed and filtered for those that best met the established criteria for the review. These publications were then reviewed again, annotated, and key themes and findings drawn from the literature were identified, in preparation for the final step, compilation of this report. The development of the report included providing an overview of findings and themes drawn from the literature, and providing recommendations for best practice occupational therapy within the primary health care practice environment. This step also included requesting feedback from the NZAOT Occupational Therapy in Primary Health Care Special Interest Group on the draft report.

1.2 LIMITATIONS

Limitations to this review include search limitations, such as access to full-text journal publications; the general paucity of rigorous, independent evaluation research, specifically around outcomes associated with occupational therapy practice in the primary health care context; and the general lack of New Zealand reporting around evidence for occupational therapy, and indeed allied health, practice in the primary health care context. An additional limitation is related to the timeframe for completion of this potentially extensive and exhaustive review, which may have resulted in important publications or findings being missed.

2.0 THE PRIMARY HEALTH CARE CONTEXT

While Tse, Penman & Simms (2003) have comprehensively described the history of the primary health care movement in Aotearoa/New Zealand, it is worth reviewing that the concept of "primary health care" was initially introduced by the World Health Organization in the Declaration of Alma Ata (World Health Organization, 1978). The WHO included a number of key principles within the Declaration based around intersectoral collaboration; health promotion; community health; and comprehensive care (Wevick, n.d.; Fong, n.d.). The Manitoba Society of Occupational Therapists cautions against using the terms "primary health care" and "primary care" interchangeably arguing that primary care services are those that address diagnosis, treatment and management of illness, while "primary health care" addresses the broader determinants of health among populations that are influenced not only by the health care system but by other sectors as well" (2005, p. 6). In addition to the Alma Ata report, Stewart & Haswell (2007) in their review of the challenges and opportunities for physiotherapists within primary health care in Aotearoa/New Zealand, also include the Ottawa Charter for Health Promotion (World Health Organization, 1986) as a significant milestone in the development of a social concept of health, a key premise of the primary health care movement. The Charter advocates that in order for health promotion initiatives to be effective they must address the underlying determinants of ill-health at all levels, which requires an integrated approach to change at policy, environmental, community, personal, and service delivery levels (Wass, 1998). The Charter's framework is based on five fundamental change strategies: building health public policy; creating supportive environments; strengthening community action; developing personal skills (health education); and reorienting health services.

In Aotearoa/New Zealand, the Primary Health Care Strategy, published by the Ministry of Health in 2001, set the direction for the delivery of primary health services. The Strategy determines that primary health care is essential evidence based, socially and culturally appropriate healthcare, that is universally acceptable, situated in community participation, integral to and an essential function of the Aotearoa/New Zealand healthcare system, and the first point to access into the health system (p.1). The model for Primary Health Care developed by the Ministry of Health (2002) requires a philosophical shift away from a primary care medical model, to a boarder "population health" perspective, including health promotion, community development and prevention, alongside integrated first level services (Ministry of Health, 2001). As such, the model also advocates for effective primary health care being delivered by

a “collaborative, multidisciplinary approach” (Ministry of Health, 2008), which, of course, includes and values the contribution of allied health practitioners, including occupational therapists.

2.1. GP’S + PRACTICE NURSES +PHARMACISTS = THE PRIMARY HEALTH CARE WORKFORCE?

In terms of the primary health care workforce in Aotearoa/New Zealand, it’s fairly evident that General Practitioners, nurses and pharmacists have long cornered the primary health care job market, with GPs being particularly vocal about their desire to continue to be seen as “captain of the team” (Carryer, 2004). While perhaps more relevant to GPs and nurses, Branson, Badger, & Dobbs (2003) reviewed the literature (60 articles) relating to patient’s satisfaction, preference and needs, of the skill mix of clinical staff available in primary health care settings. Despite the usual barrage of methodological issues, the authors determined that patient satisfaction tends to be driven by knowledge and expectations of the health services; the age of the patient; health status; and socio-economic indicators – with the key finding, relevant to this review of the role of occupational therapists in primary health care, being that when patients present to the GP, they often expect to see a professional they’ve always seen - a doctor or a nurse. Despite this, the authors also determined that communication, time available, continuity of care, the competence of health professionals, education and information provision, and the location of services are also key priorities for patients, and that access to a wide range of services and professionals tends to be important to a number of patients, when they’re eventually offered a choice. This finding indicates that a potentially effective strategy for ensuring that occupational therapists are able to be accessed as part of primary health care, and primary health care teams, may be to encourage patients to ask for services that are not currently available to them in this context.

Specific to the Aotearoa/New Zealand context, in 2008, the Workforce Taskforce, initiated by the Ministry of Health and including allied health consultation and representation, released a report which reviewed strategies for overcoming barriers to workforce change and innovation in primary health care. The report details five barriers to workforce effectiveness in primary health care – the funding model; organizational structure and function; professional leadership; training; and quality improvement – and details five key recommendations, and specific solutions, to address the identified barriers, including:

1. Realignment of funding to enable innovation and better support multidisciplinary working in primary health care service delivery

2. Development of an investment strategy that enables investment in workforce expansion, training, and retention
3. Improved professional leadership and clinical governance through the development of evidence based workforce vision, and establishment of effective clinical governance structures and pathways and processes – and the establishment of a MOH Allied Health Advisory role;
4. Training for primary health care, including the establishment of a medical and nursing educational pathway for primary health care, the standardisation of nursing induction and orientation, and preparation for student placements, including access to collaborative learning environments through a multidisciplinary practice model ; and
5. Quality improvement and assessment.

The report clearly advocates for "new ways of working", which matches service delivery with population needs, and recognises that while GPs and nurses will be the main providers of primary health care, no one discipline or practitioner can completely and effectively meet an individual clients needs. Somewhat disappointing, however, is the list of suggested multidisciplinary team members provided by the Taskforce (p. 2) which does not include occupational therapists.

3.0 ALLIED HEALTH AND PRIMARY HEALTH CARE

One of the key ways to address the disparity of the strong medical focus in the primary health care workforce is to determine the "added value" of allied health in primary health care. This is especially important as the Ministry of Health have mandated that Primary Health Organisations must integrate with other services to develop multidisciplinary and interdisciplinary approaches to providing rehabilitation and care to people with chronic health problems and disabilities. In 2009, Future Workforce released a review of allied health innovations in primary health and determined that the potential contribution of allied health to primary health service delivery "remains relatively invisible and underdeveloped" (2009, p. 3). Despite this, and despite the limited response to the stocktake of allied health innovations in primary health primarily deemed to be the result of reduced evaluation and dissemination capacity and capability, the report concluded that allied health practitioners (AHPs) are "involved with and leading a wide range of interventions aimed at reducing inequality, improving access to primary health care, increasing collaboration between primary and secondary services, and reducing ambulatory sensitive admissions" (p. 4). The Future Workforce report outlines the significant contribution that AHPs, and in particular occupational therapists and social workers, make within NGOs and secondary community teams. Additionally, the report recognises the impact that recruitment and retention issues in the primary health care sector (relating specifically to contracting arrangements, the diversity of PHO structures, and models of service delivery that recognize the value of AH to primary health care) have on development of effective interdisciplinary practice in primary health care. The report concludes that it may be the "lack of critical mass" which is one of the key impediments to allied health practice in primary health care (p. 5). Additional insights drawn from the report include the lack of establishment and sustainable funding for staff and physical resources (including the availability of physical space within the current PHOs to accommodate additional staff); the lack of clearly defined corporate and clinical governance standards for allied health practice in primary health; the lack of workforce data and indicators relating to demand, recruitment, retention, and turnover in PHOs and related NGOs; the lack of effective representation for allied health at the level of national policy development; the variability of leadership for allied health at the DHB level; and challenges with translating "models of care" to "models of practice". The Future Workforce report also outlines a number of specific challenges around the education and career development of AHPs, including role re-design and practice development through the defining of primary health focused capabilities and frameworks, integrated across physical, mental, and public health, alongside workforce planning;

ensuring access to career pathways and professional leadership through the local DHB provider arm; and consideration of assistant and advanced practitioner roles and opportunities.

The Future Workforce report details six key recommendations, and 18 specific recommendations. The recommendations include:

1. Improving the understanding of the Allied Health contribution to primary health care (through a national commitment to identification and evaluation of AH initiatives supported in implementation of the Primary Health Care Strategy, including the provision of an online reporting template through DHBs; and improving evaluation capability);
2. Improving structure and collaboration within primary health and across the continuum (through clarification of the PH vision; the MOH and DHBs taking a more active role in ensuring the PHOs provide AH support; improving access to AHPs; the development of clearly defined models of inter-provider practice and integrated clinical pathways; encouraging cross-continuum collaboration through AH Professional Leader appointments, student placements; inter-provider orientations, educational opportunities, joint appointments and secondments);
3. Addressing material and financial barriers to innovation (through the enablement of capital investment in primary health and ensuring the AHPs have access to innovation funding);
4. Improving management and clinical governance related to Allied health services (through the standardization of a tool to measure management/leadership structures for AHPs in primary health services; ensuring that clinical governance processes are designed to support quality inter-disciplinary service delivery; representation of AH at primary health clinical governance forums; and development of an appropriate strategy to collect and analyze allied health, primary health workforce indicators);
5. Ensuring appropriate leadership and development of professional practice
6. Facilitating education and career development

3.2 PHYSIOTHERAPY AND PRIMARY HEALTH CARE

The physiotherapy profession appears to be experiencing similar challenges with attempts to articulate and develop a role and place within primary health care. Specific to both a physiotherapy and Aotearoa/New Zealand perspective, Stewart & Haswell (2007) recognize that while the physiotherapy profession has the potential to make a significant contribution to primary health care, this will require

physiotherapists to “extend their skills and knowledge beyond those required for the treatment of disorders” (p. 51), a challenge that occupational therapists will undoubtedly find all too familiar (Tse, Penman, & Simms, 2003). Stewart & Haswell’s assertion that a move away from a predominantly medical paradigm and a drive to strengthen the physical-scientific foundations of practice through increased research and evaluation activities has not been matched by an attempt to incorporate social and psychological sciences (and equally, social and ecological models of health) into core physiotherapy knowledge. Stewart & Haswell are adamant that this omission has been to the detriment of the physiotherapy profession’s attempts to contribute effectively to the goals of primary health care and strongly suggest that academia needs to “turn their attention to preparing physiotherapists for this new health-work environment” (p. 51, 2003). Despite this challenge, Stewart & Haswell urge current physiotherapy practitioners to contribute constructively to primary health care reform in Aotearoa/New Zealand by **Becoming informed** (about local communities/populations and primary health organisations; through reading the Primary Health Care Strategy); **Becoming involved** (being visible and building relationships within primary health organisations and with other allied health professionals); and **Becoming educated** (participating in relevant continuing education opportunities and post-graduate study). Stewart & Haswell (2003) also suggest that physiotherapy needs to be prepared for a primary health care workforce by determining the core attributes and competencies of physiotherapists working in the area – the authors are under no illusion that there will be a significant demand for community oriented physiotherapists with a broad perspective of health, and current health issues, and the ability to integrate clinical skills with expertise in health promotion, rehabilitation and teamwork (p. 52). Additionally, the authors are clear that primary health care needs to be integral to physiotherapy practice, and not one of its many specialties (p. 52).

3.0 OCCUPATIONAL THERAPY AND PRIMARY HEALTH CARE

In arguably one of the more well constructed discussions on the topic, Scriven & Atwal (2004) confidently situate occupational therapy alongside health promotion, articulating the historical connection between the two, through the work of West (1960s), AOTA (1980s), CAOT (1990s), the British College of Occupational Therapists (2002) and Wilcock (1998, 2000). The authors, in their review of the opportunities and barriers for occupational therapists as primary health promoters, provide a comprehensive overview of health promotion, and critique a range of strategies for implementation of the recent recommendation made by the UK College of Occupational Therapists to align the professional development of primary health care occupational therapists with the five key principles of the Ottawa Charter. Heavily discussed within the health promotion and primary health care academic literature and policy documents, and pivotal to the perceived place of occupational therapy in the primary health care context, is the notion of "upstream thinking" (Scriven & Atwal, 2004; Manitoba Society of Occupational Therapists, 2005), which, as the name suggests, requires a refocusing of resources, planning and action with the "well population" before people become unwell and access secondary and tertiary medical care. Scriven & Atwal suggest that if a shift in practice to an upstream preventative role is intended for the occupational therapy profession, this will have wide-ranging implications, particularly around workforce capacity and competency. The authors also suggest that urgent and more "traditional" work within the secondary and tertiary services may need to be prioritized, before the profession makes a "paradigm and praxis shift to more preventative upstream activities" (p. 427). Jones-Phipps & Craik (2008), in their survey of second-year occupational therapy student's views of health promotion, determined that, while occupational therapy, and occupational therapists, assert that there is a clear relationship between the profession and health promotion, only two studies have rigorously explored the views of occupational therapists regarding the topic: Seymour (1999) who surveyed 100 occupational therapists in Wales, and Flannery & Barry (2003), who surveyed 240 members of the Irish Association of Occupational Therapists. Both studies determined that while many occupational therapists recognize the demand for a role within primary health care/health promotion, much fewer report that health promotion is a professional, or individual, priority. Barriers identified by both studies (Seymour, 1999; Flannery & Barry, 2003) include time, staffing levels, support from managers and doctors, a lack of resources, and a lack of knowledge and training – as such, findings drawn from Seymour (1999) suggest that health promotion should be included in the occupational therapy undergraduate curricula.

Another key document, also deemed pivotal to the discussion around a potential role for occupational therapy in primary health care, is the Manitoba Society of Occupational Therapists publication entitled "Occupational Therapists in Primary Health Care" (2005). As well as providing a comprehensive review of the primary health care history and context, and that of occupational therapy profession, in Manitoba and Canada, the authors clearly and confidently articulate a justification for the value of occupational therapy in primary health care, based around shared philosophies; the evidence-based relationship between occupation and health; and occupational therapists' expert knowledge and training in occupational performance and the impact that this has on health and wellness – the occupational therapy equivalent of "becoming informed and educated" (Stewart & Haswell, 2003). In addition, the report provides occupational therapists with a platform for active and continued participation in primary health care, through the provision of specific examples of occupational therapy practice in the area, and a review of the evidence around specific interventions and specific populations. These interventions and populations include community interventions and post-discharge home visiting with the elderly; management of chronic illness, and the provision of injury prevention programmes in the workplace; skill building approaches with people who are homeless; mental health; maternal and infant health; and working with children and youth, primarily in educational settings. The authors are optimistic about the "added value" of occupational therapy in primary health care while also realistic about the challenges the profession faces in ensuring that the public and other health care providers are aware of the relationship between occupation, health and wellbeing, and indeed that occupational therapists are competent in providing a health promotion and prevention perspective. Other challenges identified include existing health care funding models which limit access to publically funded occupational therapy services; strategies to enhance effective and equitable interdisciplinary collaboration; and the development of a more comprehensive evidence base for community based occupational therapy practice.

A number of international position statements on occupational therapy in primary health care, such as those published by the Canadian Association and the Saskatchewan Society of Occupational therapists (2003) and the British College of Occupational Therapists echo the key messages of the Manitoba report. While it is not within the parameters of this project to summarize these position statements, the New Zealand Association of Occupational Therapists (NZAOT) recently endorsed their position statement on the topic. The NZAOT statement is directly linked to the Alma-Ata report (1978), international position

statements and papers, and the New Zealand Health Ministers discussion paper (Ryall, 2007) which proposes devolving more care and responsibility for population and community health to the primary sector, and advocates for the increased utilization of allied health professionals; moving services closer to home; and coordinating chronic care and support, to ensure better, sooner, and more convenient primary care. The statement promotes the "added value" of occupational therapists in primary health care and determines that primary health care occupational therapists improve, maintain and restore health through participation in occupation; lead and participate in community development and health promotion initiatives that have occupation as the means to or the intended outcome; co-ordinate between and across services and work within a collaborative interprofessional team to ensure continuity of care; actively contribute to primary health organisations by participating in establishment, management and governance processes; evaluate the effectiveness and outcomes of programmes and interventions from an occupational perspective; inform stakeholders including consumers, health leaders, and policy makers about occupation as a determinant of health; advocate for access to occupational therapy services in primary health care for individuals, populations, and communities; and advocate for funding for resources and employment opportunities to provide quality occupational therapy services in primary health care (p. 1-2).

The statement draws on the work of Mace (2008) who presents a comprehensive review of the "added value" that occupational therapy can bring to primary health care in Aotearoa/New Zealand, and provides details of a number of specific and existing innovations being provided by occupational therapists, nationally and internationally, across three identified primary health care domains: **Improving health**; **Maintaining health**; and **Restoring health**. Mace presents a number of evidence based interventions within each of these domains including lifestyle redesign, goal setting and positive psychology/coaching models, positive parenting, environmental access audits, inclusive design, stress management and occupational balance programmes, community gardening, and consultation to improve people's health; through to assessment and rehabilitation, housing modifications and equipment provision, and rapid response to restore people's health.

3.1 GETTING IT RIGHT: OCCUPATIONAL THERAPY AND PRIMARY MENTAL HEALTH CARE

One of the aspects of primary health care service delivery where occupational therapy appears most visible, and where occupational therapists appear to have a developing a strong presence, is primary mental health care. The relative visibility and success of occupational therapy integration in this area can

be attributed to a number of factors including the existing mental health occupational therapy workforce and the case management/key worker role that many occupational therapists already experience working in secondary and tertiary services, which also appears to be the model of choice being adopted by a number of primary health organisations.

While not exclusively related to occupational therapy, Moulding, Blashki, Gunn, Mihalopolous, Pirkis, Naccarella, & Joubert (2007) reviewed the evidence for delivery of effective psychological treatments for common mental health disorders in the primary health care context in Australia. The report is situated alongside two service delivery frameworks, Better Outcomes (2001) which supports GPs to access to 12 treatment sessions through the Access to Allied Psychological Services initiative, and Better Access (2006) which enabled GPs increased access to registered psychologists, social workers, and occupational therapists for up to 12 sessions of psychological therapy. The authors reviewed the evidence for effectiveness and cost-effectiveness of (i) generalist vs. specialist providers of psychological treatment in primary care and (ii) models of collaboration in providing treatment, as well as the elements of successful collaborative models. Following the review of 69 relevant articles, the authors determined that while there was good evidence for GP delivery of problem solving therapies for people with depression (superior to usual treatment and equivalent to treatment with anti-depressants), and good evidence for allied health (psychologist) provision of psychotherapy (similar to medication for people with depression; superior to usual treatment for people with Major Depressive Disorder and panic disorder) and the cost-effectiveness of psychologist-delivered therapies, best outcomes belonged to collaborative interventions. The authors found that, while there is limited evidence around the cost-effectiveness, there is good evidence that working collaboratively, including a multi-professional approach, structured management plans, scheduled follow up, and enhanced communication, was superior to treatment-as-usual in primary care for people with depression, panic disorder, and generalized anxiety disorder. As such, the authors recommend that Australia continues to support collaborative service incentives; fund additional infrastructure to support the non-psychologist allied health workforce to utilize existing service incentives; continue to support locally developed collaborative models; develop systems that provide GP supervision and support by allied health practitioners; and provide additional support to GPs providing psychological services where specialist assessment and intervention services are not available. In addition, while the authors also recommend that strategic research and evaluation is undertaken around clinical outcomes and cost-effectiveness (of note, no studies were sourced for the review around occupational therapists undertaking psychological

interventions in primary health care), the authors also recommend that the primary health care workforce needs to be better trained in both mental health (assessment, planning, review, problem solving and behavioural treatments, gate-keeping, matching therapists-patients) and working in primary health care, as well as the promotion of approaches that incorporate an emphasis on early inter-professional training, training in primary health care settings, and making explicit a coherent career pathway. Fong & Siu (2007), in determining the undergraduate competencies required for occupational therapists working in primary health care, also suggest that interprofessional collaboration is the cornerstone of effective primary health care. The authors describe the potential involvement and contribution of occupational therapy in primary health care in Hong Kong, and conclude that the contribution that occupational therapy can make involves promoting health, preventing injury, and addressing occupational performance issues to promote holistic wellbeing in physical, mental, emotional, social and spiritual aspects. Additional primary health care roles for occupational therapists, as identified by Fong & Siu (2007), may include assessments of healthy schools, healthy workplaces, and healthy homes (such as safety programmes and retirement planning for seniors, workplace modifications for workers, and handwriting programmes for children) and the prevention of secondary risk and disorder (such as programmes for adolescents using drugs, falls prevention for the elderly, and integration of children with disabilities into mainstream educational environments and settings.

Further to Moulding et. al's (2007) review, Raine, Haines, Sensky, Hutchings, Larkin, & Black (2002) reviewed the evidence for the extrapolation of mental health interventions deemed effective for three common somatic symptoms (chronic fatigue syndrome; irritable bowel syndrome; and chronic back pain), from secondary to primary care. The authors, in reviewing sixty-one relevant studies, determined that, despite a number of identified methodological weaknesses with the studies reviewed (including a lack of research in primary care; inadequate information; lack of data on patient characteristics; limited assessment of outcome; limited power; diverse outcome measurements; and problems with internal validity, p.325), psychological interventions appears to be generally more effective in secondary care, possibly due to different regimens being offered to patients with more severe or chronic illnesses and better supervision. This finding also highlights the tension raised earlier in this review by Tse, Penman, & Simms, 2003 around the perceived community-based, health promotion philosophy and approach that occupational therapy/allied health can offer in primary health care, and the more individualized treatment approaches often evidenced in practice – and the potential challenges and issues with simply

transferring secondary and tertiary care skills and knowledge from one setting to the other, without careful consideration for the unique primary health care context.

3.2. IMPLICATIONS FOR OCCUPATIONAL THERAPY UNDERGRADUATE EDUCATION

In reviewing the research and theoretical literature to develop this report, it's fairly clear that a move into primary health care will have significant implications for the way that occupational therapists are educated at a pre-registration level. What we know is that simply transferring one set of skills into an entirely new context probably won't work. Fong & Siu's (2007) work in determining the undergraduate competencies required for occupational therapists working in primary health care, suggests that interprofessional collaboration may in fact, be the cornerstone of effective primary health care. Mace (2008) suggests that the two occupational therapy programmes in Aotearoa/New Zealand have worked hard to integrate an occupational science perspective in their undergraduate and postgraduate programmes. However, additional information that occupational therapists will need for the Aotearoa/New Zealand primary health care context, as suggested by Clark, Jackson &Carlson (2004) include:

- The relationship between meaningful occupation, health promotion, and the human experience;
- Dynamic systems theory and the emphasis of therapy occurring in the natural environment;
- Defining occupation beyond disability and the effects of occupation on habits and routines;
- Healthy occupations;
- Occupational justice and social inclusion;
- Client centered care and phenomenology; and
- Creating sustainable communities.

One of the principle challenges to adopting a health promotion paradigm to underpin pre-registration occupational therapy education, especially in a small country like Aotearoa/New Zealand, may be accessing appropriate fieldwork placements. Emerson (2004), in recognising the need for primary [health] care to be better prepared for an influx of undergraduate placements and the importance of interprofessional collaboration practice within the context, reviewed the competency requirements for nursing, medicine, occupational therapy and social work supervisors, to determine the feasibility of developing an integrated interprofessional development and support programme for placement

educators in the UK. Five practice education categories were identified (enabling learning; knowledge of theory and principles of learning; managing the learning environment; imparting a sense of professional responsibility; and knowledge on professional practice and the relevant curricula). As only the last category is profession-specific, a common programme for placement educator development and support in primary [health] care is presented and advocated, following consideration of how to gain cooperation from the different professions to ensure equal ownership; the configuration of the programme; facilitation responsibility; and strategies for updating the programme to include consideration of relevant and current curricula. One source of resources and support may be the Enabling Inter-disciplinary Collaboration in Primary Health Care initiative (www.eicp.ca) which appears well positioned to support and encourage allied health practitioners working in primary health care to address a number of these issues. This comprehensive website provides evidence based, quality online resources and publications, including a toolkit. While the initiative, which aimed to support all health professionals to work together in the most effective and efficient way to produce best health outcomes for patients and providers, was completed in September 2006, the website remains a portal for a wealth of information around interdisciplinary education and collaboration.

Relevant to the Aotearoa/New Zealand context is the evaluation of a pilot interprofessional education project developed between Waitemata District Health Board and AUT University, and undertaken in collaboration with the University of Auckland, and primary health care organsations and primary care providers in the Waitemata District (Ministry of Health, 2008). The project enabled teams of up to seven senior undergraduate students from a range of disciplines to work collaboratively within a primary health or primary care organisation for a specific length of time. Findings from the evaluation identified the value and impact of primary health care organisations, and the community, whanau members and patients, being exposed to the contribution of a broader range of health disciplines. Benefits were identified at the service, team and patient level, as well as benefits for students involved in the project around enhanced understanding of client-centred care and community-centred health care; interprofessional collaboration skills and knowledge; and interest in a future career in primary health care (Ministry of Health, 2008). In addition, tertiary education providers were generally positive about the placements and reported the need for more interprofessional education and primary health care placements for undergraduate students.

Key challenges to adopting a health promotion paradigm within occupational therapy pre-registration education is also the limited literature/evidence base for an occupational therapy role in health promotion, and the potential educational “expense” of prioritizing a health promotion curriculum, when preparing students with the skills and knowledge to work in a diverse range of practice settings, services and contexts.

4.0 CONCLUSIONS AND RECOMMENDATIONS

This literature review (and annotated bibliography) aims to provide a current picture of the role/place of occupational therapy in primary health services to support the development of a toolkit for occupational therapists working in, or planning to work in, the primary health care context in Aotearoa/New Zealand. One of the key limitations to this review has been the lack of rigorous research and evaluation relating to the quality and effectiveness of occupational therapy interventions being undertaken in primary health care practice, both nationally and internationally, despite the fact that occupational therapy practice is very definitely occurring in this area. It would be extremely useful if quality examples of primary health care practice were made available to support the preparation of undergraduates and practitioners as the profession diversifies into health promotion, and develops innovative, evidence informed ways of working effectively in this unique practice context.

While Tse, Penman, & Simms (2003) originally set the scene for the potential role of occupational therapy and primary health care, and Scriven & Atwal (2004) confidently situate occupational therapy alongside health promotion, only three publications were accessed that comprehensively and confidently document occupational therapy practice in primary health care - the Manitoba publication (2005), the Future Workforce report on allied health innovations in primary health (2009), and Mace's (2008) article on developing opportunities in primary health care for occupational therapists. The Future Workforce report provides a local review of allied health innovations in primary health (2009) and concludes that allied health practitioners (AHPs) are involved with and leading a wide range of interventions aimed at reducing inequality, improving access to primary health care, increasing collaboration between primary and secondary services, and reducing ambulatory sensitive admissions (p. 4). However, the report also determines that the potential contribution of allied health to primary health service delivery "remains relatively invisible and underdeveloped" (p. 3), a position that is reluctantly, but very definitely, supported by this review.

It is undoubtedly time to move occupational therapy from being considered "invisible and underdeveloped" within the primary health care context, to a more substantial position of action. Recommendations for the occupational therapy profession and in particular the identified Occupational Therapy Key Strategic Stakeholders, drawn from the literature and publications reviewed in this report include:

1. Developing and articulating a health promotion focused, evidence based role for occupational therapy in primary health care to ensure that occupational therapy is well positioned to lead professional practice and innovation;
2. Actively supporting change leadership and management which recognises potential resistance to allied health involvement in primary health care, and primary health organisations, and interprofessional collaboration and educational models;
3. Ensuring that all members of the profession can clearly and confidently articulate the primary health care role and the "added value" that occupational therapy and occupational therapists, bring to primary health care by **becoming informed, educated, and involved**;
4. Developing strategies to effectively address the identified gaps in clinical skills and knowledge for primary health care practice, specifically around health promotion and population/ community-centred health care; interprofessional collaboration; health and occupation (as opposed to illness and occupational deprivation) as the practice focus; documentation; and culturally competent practice;
5. Developing and supporting research and evaluation relating to the quality and effectiveness of occupational therapy interventions being undertaken in primary health care practice to assist with the development of a more comprehensive and contextually relevant evidence base for community based occupational therapy practice;

6. Supporting structural and collaborative improvements and opportunities within primary health care and across the continuum to better include occupational therapy;
7. Supporting strategies to address material and financial barriers to occupational therapy practice and innovation;
8. Improving management and clinical governance related to occupational therapy and allied health services within primary health organisations;
9. Ensuring that occupational therapists working in primary health care have access to quality leadership, clinical governance, and professional practice opportunities;
10. Facilitating access to ongoing and quality professional education opportunities in evdeicne based programmes for **improving, maintaining and restoring health,** such as training in lifestyle redesign, goal setting and positive psychology/coaching models, positive parenting, environmental access auditing, inclusive design, stress management and occupational balance programmes, community gardening, consultation to improve people's health, assessment and

rehabilitation, housing modifications and equipment provision, and rapid response to restore people's health.

It is beyond the scope of this review to determine exactly HOW each of these recommendations will be enacted – this is clearly the jurisdiction of the Occupational Therapy Key Strategic Stakeholders, and in particular the NZAOT Occupational Therapy in Primary Health Care Special Interest Group. However, it is the purpose of this review to determine the immense importance of the primary health care movement, the significant implications that this movement has for both professional practice and undergraduate and professional education, and the paramount importance in ensuring that occupational therapy, and occupational therapists, are well prepared to "leap across the void", lead and develop innovative practice, and add recognised value to effective primary health care service delivery. The opportunity awaits!