Generalist, specialist and generic positions experienced by occupational therapists in Norwegian municipalities

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Abstract

Purpose – Reforms in the health-care system may impact how health-care professionals perceive and enact their roles. This study aims to examine the way in which occupational therapists experience and describe their roles in municipalities after the implementation of a health reform (the Coordination Act) in Norway.

Design/methodology/approach – This qualitative study was designed within the perspectives of social constructivism. Data was collected through focus group interviews with 10 community-working occupational therapists. A thematic framework analysis was used to examine the participants' experiences.

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Findings – The following four themes emerged: external factors that framed and shaped the occupational therapists' roles in municipalities; the strengths and dilemmas of the generalist; the problematic generic position and the strengths; and dilemmas of the specialist.

Originality/value – The study suggests that occupational therapy practitioners should identify new opportunities and adapt to health reform changes. They also need to renegotiate their roles as the health reforms require more specialized competences. Greater emphasis must be placed on the core knowledge and competences of occupational therapists to strengthen their professional identity in the municipalities.

Keywords Health-care, Community-based occupational therapy practice, Generalist, Specialist, Generic role, Core knowledge

Paper type Research paper

Introduction

The public health system in Norway is built on the principle of equal access to health services for all citizens, regardless of socioeconomic status, ethnicity and area of residence. Everyone is entitled to essential medical and care services. The health-care system is organised within two main sectors: primary and long-term health-care and hospitals and specialized services. These health services include both public ownership and operation and are financed through governmental grants (Ministry of Health and Care Services, 2012).

In Norway, as in Ireland, health reforms such as the Coordination Act (Department of Health, 2008/2009) and The Irish Health System in Transition (McDaid *et al.*, 2009), aim to make the health-system more primary and community-driven. These reforms are meant to meet demographic and technological changes in the health services and bear resemblance to health-care reforms in other countries, for instance, England (Bauld *et al.*, 2005) and Scotland (Freeman, 2008). Furthermore, they focus on how public sector fragments can unify, and how more emphasis can be placed on health-care policy interactions (Grimsmo *et al.*, 2015). Such health-care-policy require that health-providers in the municipality redirect their focus, roles, priorities and competencies, as they have been given more specialized tasks and have expanded the scope of responsibility for citizens' health-care (Roberts *et al.*, 2014; Horghagen *et al.*, 2015). Because of health-reforms in primary care, occupational therapy providers have seized opportunities in primary care. However, primary health-care continues to develop and change, and occupational therapy practitioners must identify new opportunities and adapt to these ongoing changes (Halle *et al.*, 2018).

More emphasis on occupational therapy in the municipalities in Norway is a logical consequence of the change in legislation as occupational therapy services became a mandatory part of community-based services in January 2020. The municipalities are the employment agencies for over half of Norway's 4,855 used occupational therapists (Statistics Norway, 2018), and there is great variation in public access to occupational therapists used by municipalities. The diversity in user groups and types of interventions may raise dilemmas according to the roles, priorities and competences of the occupational therapists, especially in the rural areas (Arntzen *et al.*, 2019; Ness and Horghagen, 2020).

Occupational therapy focuses on the role of occupation in people's everyday life. This professional knowledge and competence are valuable when implementing the health-reforms in the municipalities. Knowledge of occupation is essential for occupational therapists (Zemke, 2004). They are concerned with supporting clients in the activities that occupy their time, enabling clients to construct identity through doing and provide meaning to clients' lives (Zemke, 2004; Hasselkus, 2006). The desired outcomes of occupational therapy interventions in the municipalities are that people will live their lives engaged in

occupations that foster self-sustenance, support their health and foster involvement in their social world (Davis and McClure, 2019; Schell *et al.*, 2018).

There have been debates about the dilemma of being in a generalist, specialist or a generic position in municipality health-care teams and the challenges of role-blending with other disciplines (Foto, 1996; Donnelly *et al.*, 2014). *The generic* role is described as interventions that any professional who has been suitably trained within a municipality health team can carry out (Cook and Cook, 2003). *The generalist* role for occupational therapists in the municipality setting is described as working throughout peoples' life spans within a wide range of client populations to provide many types of interventions (Donnelly *et al.*, 2014). *The specialist* role is described as one who specializes in a specific impairment group (Foto, 1996), and one who conducts interventions that cannot be delivered by all the team members (Cook and Cook, 2003). It might be a challenge for occupational therapists to provide a specialist role and define their core knowledge (Halle *et al.*, 2018; Ness and Horghagen, 2020). These challenges are exacerbated if practitioners find it difficult to provide a rationale for why they use occupation as a therapeutic medium (Ashby *et al.*, 2013). This might challenge their professional identity. A recent study of occupational therapists working in municipalities who provided assessments of clients with cognitive impairments concluded that the therapists valued an occupation-based process, but used impairment-based screening tools even if they questioned the usefulness of the results (Stigen *et al.*, 2019). A review from an Irish study in the field of recovery in mental health found that the dominance of the biomedical models of care continues to be pervasive (Lloyd *et al.*, 2017). Turner and Knight (2015) explored what could reinforce the occupational therapists' professional identity and found that they could do that through a shared understanding of the profession's internalized beliefs, values and knowledge about the positive effects of occupation on health and well-being.

The occupational therapy profession has never been static in terms of their own disciplinary boundaries or in its role or status in society (Halle *et al.*, 2018; Ness and Horghagen, 2020). A Norwegian study showed that political and educational regulations, technology, inter-professional relationships and the purchaser-provider model have shaped and changed the profession (Vabø, 2012) in addition to research and development within health professions. There are debates between the ways in which therapists should position themselves within the changed health-political contexts of the municipality health-care teams (Halle *et al.*, 2018; Stigen *et al.*, 2019). Health reforms call for more advanced practice in municipality services (McDaid *et al.*, 2009; Department of Health, 2008/2009). Nevertheless, there is limited empirical research about this issue. Following the above-mentioned health-reforms, updates are needed to examine how occupational therapists position themselves in the municipalities. Therefore, the aim of the study was to explore the way in which community-based occupational therapists in Norway experience and describe their roles after the implementation of the Coordination Act.

Methods

Chosen design and methodology

This qualitative study was designed within the perspectives of social constructivism, that explores human experiences related to a social context, namely, occupational therapists working in health-care contexts in Norway (Green and Thorogood, 2004). A purposive sampling of participants was chosen, and focus-group interviews (Rabiee, 2004) were used to collect the data. One of the advantages of focus-groups interviews is the group dynamic, which often results in richer and deeper data compared to data derived from one-on-one interviews (Rabiee, 2004).

Participants

This study was a part of a larger study of occupational therapy in community health care contexts in Norway (Bonsaksen *et al.*, 2019). The research group designed a national survey that was sent to 1,767 community-based occupational therapists in Norway. At the end of the electronic questionnaire, those who stated that they planned to attend the National conference for occupational therapists, which took place in Trondheim in late autumn 2017, were invited to participate in the focus-group interviews. Confirmation was received from 21 therapists and 10 of the respondents participated in the study. In total, 11 of the respondents did not attend the conference. Because the time for the interviews had been planned around the conference programme, it was decided to follow this plan. The participants were not able to change the time for their participation as organised around these times were presentations and attendees at this conference.

The 10 participants represented different regions of Norway. They were all women between 20 and 60 years, with both long and short work experiences. The participants had experiences from diverse patient groups and services. Some worked in urban areas, others in rural areas and they came from both small and large municipalities. Their services were organised in various ways as some had combined positions as leaders and therapists while others had more defined work areas. For details about the participants (Table 1).

Focus group interviews

The participants were divided into three groups and were strategically placed to ensure a variation of experience. Although the sample size for the focus groups was smaller than planned, the discussions that emerged among the participants generated rich data related to the research-aim. The interview-guide was based upon the features from the national study material and focused on the content of the service, organisation, competency, innovation, collaboration, user groups, priorities, dilemmas, opportunities and thoughts about future occupational therapy. The interview-guide helped structure the interviews and ensured that the key areas were discussed in all the groups. The first and the last authors organised the interviews, but all authors participated in the interviews. Based on the participants' preference, the conversations and discussions were actively moderated and facilitated. The interviews lasted approximately 90 min. All the interviews were audiotaped and transcribed by the authors.

Interview guide

- Can you briefly describe what you work with and where you work?
- Why do you work in the municipality and eventually within the field in which you work?
- What characterizes your work?
- Are your priorities governed by professional assessments or are there other factors that regulate the day and the work tasks?
- Do you experience that users and relatives receive an optimal occupational therapy service from you, elaborate on why/why not?
- What are you particularly good at in your work, and how do you get to use your competences?
- Is your everyday work characterized by learning and innovation? How?
- What will the content of specialization within municipal occupational therapy practice consist of? Does it make a difference?

Table 1.
Participants

Participant	Position	Size of the municipality	Work experience	Education	No. of OT colleagues
1	Department manager and OT	10,000	26 years of experience in community health service	Interdisciplinary rehabilitation, universal design, work rehabilitation and management	1
2	OT 50% (0–100 years) and 50% in dementia care	10,000	Specialized health services Small group of OTs has to cover a large geographical area		3,5
3	OT with responsibility for nursing homes, retirement and persons living at home	10,000	Recent graduate		3–4
4	OT	50,000	Community health service, adults and elderly, children 0–16, several projects about universal design and accessibility	Knowledge translation, workplace assessment	16
5	Divided between rehabilitation/short time nursing home, palliative unit and people of all ages living at home	30,000	Recent graduate		5
6	Adults and elderly living at home. The references are divided between districts and some content	40,000	Work experience from specialized and community health services	Further education on community-based occupational therapy, master	4
7	Children, adults and elderly, health centre for children, geriatric outpatient clinic, participation in construction projects universal design	15,000	Rehabilitation in the specialized health service, day rehabilitation in the municipality, assistive device centre and community-based OT		2, 5
8	Health-promoting home visits in the development centre for nursing homes and home care	25,000	Community-based OT in different rural and urban municipalities in Norway, a high school teacher in a Scandinavian country	Master	
9	OT	50,000	17 years in the specialized health service and 8 years in community health service		20–25
10	Group leader and OT	50,000	Community-based OT in different rural municipalities in Norway		20–25

- Do you experience gaps in competence related to contemporary challenges, describe the eventual gaps and what does it take to close these?
- Do you have professional management? How is it expressed in everyday work?
- Are there topics that you are interested in that we have not been to? What topics?

Data material and analysis

The data material consisted of 152 pages of transcribed interviews and six pages of reflexive observations written by the first and last author. Qualitative data analysis was conducted using guidelines from Rabiee (2004) and Ritchie and Spencer (1994). The process of data analysis started with reflections between the moderators during and after data collection. Furthermore, the first and the last author discussed the impressions of the data. A framework analysis was used, which is an analytical process that involves five key stages, namely, familiarization, using identifying a thematic framework, indexing; charting and mapping and interpretation. The fifth stage is the overall thematic approach, which allows themes to develop both from the research questions and from the narratives of research participants. Even though the key stages were followed, interpretations were made and remade in a spiraling circle, going back and forth, up and down between the empirical data, the reflexive observations and making possible links between them as the analysis developed.

The first author became familiar with the data by reading the transcripts, and observational notes with the aim of obtaining a sense of the interviews before dividing them into parts. The preliminary results were discussed with the last author and via this process; the major themes having different positions in the municipality that are related to contextual factors started to emerge. In the second stage, the first author started to identify a thematic framework. This included writing memos in the margin of the text in the form of short phrases in addition to concepts arising from the text, which provided a way to develop categories. At this stage, all the authors received the preliminary analysis, which was then further sorted. In the third stage, the work related to indexing was to highlight. Quotes were sorted out and comparisons were made between the categories. The fourth stage involved lifting the quotes from their original context and re-arranging them under the newly developed thematic content. For further interpretations of the material, work was done at a higher meta-level in mapping and interpreting the material. To ensure reliability and trustworthiness, the material was carefully examined to look for words, frequency, context, internal consistency and extensiveness and intensity of comments. Additionally, the data material was discussed, and the analysis related to the research aim and to the context for occupational therapists in the municipality after the Coordination Act. The main content of the material was dilemmas around the occupational therapists' roles and how new frameworks challenged their roles, and the terms generalist, specialist and being in a generic position became names of the overall themes of the participants' dilemmas. During a two-day workshop, all the authors discussed and made critical suggestions about the content of the interviews and the suggested positions. These discussions provided correction and vital input for the final analysis that resulted in four themes:

(1) external factors that frame and shape the occupational therapists' everyday role in municipalities;
(2) the generalist position;
(3) the generic position; and
(4) the specialist position.

Ethical and methodological considerations and limitations

Approval regarding ethical and confidential protection of participants was obtained from the Norwegian Social Science Data Services (NSD) (project number 52827). The audiotapes were kept in a locked cabinet in a locked room until the transcriptions were done and were then destroyed. The transcriptions were retained and will be deleted when the article is published, in line with the regulations from NSD. Participants were informed that participation was voluntary and that their responses would be confidential. After the group discussions, the participants reaffirmed that they felt confident in participating in the research. As the study had a focus-group design (an open design), unexpected results were obtained. The sample size was smaller than planned, and larger sample size would have strengthened the study. Men were not represented. However, the sample represented a variety of rural and urban areas, the four health regions in Norway, age and work experience and many of the same issues were discussed in all the groups. The findings present the occupational therapists' dilemmas related to shaping their role in community-based practice.

Results

External factors that frame the occupational therapists' everyday role in municipalities

The occupational therapists described how external factors such as the Coordination Act framed and shaped their roles in the municipalities. Firstly, they described the way in which structural changes from health-related reforms changed the content of their work to be more specialized:

> Clients are discharged from hospitals earlier than before. This forces us to be more specialized [. . .] without being trained in specialized competences. We experience this as a pressure, even though we wish to embrace the new challenges and the possibilities it gives.

The therapists described the pressure of being more specialized without receiving the resources needed to improve their competencies. They wanted to do their best and be a part of health reforms, new initiatives and future challenges, but they struggled to handle the external frame expectations. They described that generally, municipality leaders wanted the professionals to have more expertise in dedicated areas. "Think smarter is a mantra in my municipality", one participant stated. They experienced dilemmas about the way in which to handle new tasks in addition to their usual tasks and said that there were too few occupational therapists to handle all the challenges and explain why it is effective to invest in more occupational therapists.

Secondly, some therapists described the way in which their leaders framed and shaped the focus of their practice, and the way in which it could lead to conflicts when leaders' ideas of occupational therapy were not in line with the occupational therapists' knowledge of occupational therapy:

> It is problematic when our leader has a different opinion on occupational therapy than we do. When we as occupational therapists want to work with a dementia-friendly society, my leader asks me to write applications for assistive technology. The competences of the leaders set limits for my professional work and devaluate the profile of my competences. I want to do occupational therapy by making evaluations, do functional training, setting goals, working with goals and do intensive follow up of the clients.

When their leaders defined occupational therapy differently than they themselves did, the therapists discussed and problematized not being given the possibilities to practice in line with their professional identity. Their professional contours faded under those conditions.

They reflected that their leaders organised more projects than before and asked them to reorganise the services to be able to take part in interprofessional projects.

Thirdly, they explained the way in which geographical conditions, population sizes and the number of occupational therapists in the municipalities shaped the form and content of their practice. This practice included economic principles or systems for prioritizing tasks, which had different frameworks in rural municipalities than urban municipalities with larger populations and more occupational therapy employees. The occupational therapists working in small rural municipalities seemed to have more impact on administrating the waiting lists. They described that they had to handle the whole field of services, including the entire lifespan, children, youth, adults, elderly, health-care and geriatric clinics, dementia assessment, universal design, building projects and facilitating the clients' homes:

> We are generalists for better or worse [. . .] it is exciting but also a dilemma when it comes to priorities. We have a lot of areas to cover even though there are few therapists. It is a challenge what to prioritize with only 3 ½ occupational therapy positions in the municipality. We must be capable to handle everyone.

They described the economic principles for priorities as a factor influencing their professional practice and consequently the number of occupational therapy employees. A topic that they all agreed on was the way in which time constraints were stressful and might threaten the quality of service delivery:

> There are more tasks to do than I can handle. Therefore, I delegate a lot. Sometimes this frustrates me; shall I delegate – source out – my whole profession? The lack of time is a huge challenge.

In summary, the participants described the way in which they experienced pressure from policymakers, leaders and others. They reflected on strategies of the ways in which they could change the frameworks. They experienced the pressure of having to be more specialized to fulfill the expectations embedded within the Coordination Act without having to obtain further education. Some participants problematized a feeling of losing their professional identity when leaders who were not familiar with the profession defined their competencies. There was no consensus if the answer to these challenges was to strengthen the generalist or the specialist role, but it was not problematized.

The generalist positions

Firstly, some participants described their role as a generalist, which implied having an overview, knowing the organisation and field of practice in addition to being able to decide on overall priorities within the health-care services within the municipality. The strengths of being in a generalist role presented the possibility to have variation and diversity in both tasks and roles, for instance, to be both therapist and adviser for clients of all ages and for both groups and individuals. Working as generalists, they had excellent contact with the clients.

Furthermore, they discussed the generalist's dilemma. A generalist needs to be skilled to manage many cases, but reflective and have insight into different issues. They had not necessarily decided consciously to be a generalist or a specialist. The generalist role as a consequence of working in a country with huge rural areas, in which there was just one position or less for occupational therapists and this therapist then had to embrace everything involved in that area. The participants reflected that the challenges of embracing everything entailed the disappearance of contours of their roles, and some felt they became and did what others on their multi-professional teams were doing. They reflected that this

might be a threat to their professional identity. They questioned what the important competencies of occupational therapists in the municipalities would be:

> I am good at quite a lot, and not that good in other cases. You might say that it is the scourge of the generalist [. . .] know something about everything. On the other hand, we know the patient the best; we know where the shoe pushes. In such a way, we are generalist-specialists!

In summary, both the strengths and challenges of the generalist role appeared. The strengths were the possibility to have variation and diversity in both tasks and roles. They discussed possibilities to develop the generalist into a specialist-generalist or a generalist-expert.

The generic positions

The generic position was discussed by all the focus groups. This position was mostly described as both a challenge and a pitfall, but the participants also highlighted this position's strength. The strengths involved that occupational therapists are skilled to work on interprofessional teams. The pitfall was viewed in a similar manner as the others on the team, receiving the same competencies and not being given possibilities to develop their professional competencies and enrich the others in the team with different perspectives. Some occupational therapists in Norway work in milieu-therapy positions and some stopped calling themselves occupational therapists. One exemplified this with the sentence: "I do not work as an occupational therapist". They explained that this was not necessarily a conscious process, but, in situations in which occupational therapists were working as milieu-therapists, they did not control the way in which to define their competencies and professional profiles. This position might be considered a generic position in which they were doing the same tasks as other health-care professionals. The participants discussed the way in which this could undermine their professional identities but underlined that this was not a general description of all milieu-therapists. Some occupational therapists described that they managed to firmly establish their competences and core knowledge about activity and participation in these positions. They had additional examples that turned their professional identity in a more generic direction:

> It is difficult when I am not allowed to define what I do as an occupational therapist. I get frustrated to be someone's secretary in writing applications about assistive technology. I could do more of the examinations and mappings of the more complicated cases about assistive technology, follow up the people and guide them in use of the aids etcetera.

They agreed that if they worked with several occupational therapists, they felt more empowered to emphasize their skills, competences and treatment ideologies to more clearly define themselves.

In summary, perceived weak differences between professions, working in teams and not being in charge of defining which tasks to do, caused some occupational therapists to state that they do not work as an occupational therapist. We interpreted this finding as the generic individual downplaying their professional roles and not being able to clarify their identities; they were not always able to emphasize the way in which they used their competencies as an occupational therapist in their practice.

The specialist positions

From the participants' discussions, several arguments about the Coordination Act and the need for more specialized knowledge and competencies occurred. Firstly, the therapists discussed whether new health concepts relevant to occupational therapy required more specialized knowledge. They described that the implementation of reablement demanded

more specialized knowledge and competencies. Furthermore, they added the issue of assistive technology as a field that required more competencies, both in examining the needs of the clients and understanding the procedures, in addition to having skills and critical reflections about assistive technology. They discussed the need for becoming more specialized in stroke treatment, rehabilitation and in mapping cognitive function and mobility as a consequence of the Coordination Act. They argued that there could be a need for hand training for clients, as services that are more specialized should be given in the municipalities after the health reform.

Secondly, they highlighted the value of being considered as a competent occupational therapist by others and by themselves. They explained it as necessary to be an employee with possibilities to develop their own knowledge and competences:

> To have the opportunity to develop myself to be a specialist is my personal perspective, – to experience that I develop, learn, become skilled and get respect from my colleagues. Occupational therapists are concerned about how our clients shall enable everyday life activities [. . .] but it is also important for therapists, – to experience that we master our tasks very well.

They considered working more systematically to obtain the qualification demands for applying to be a specialist. They described applying for courses with the goal of developing their knowledge. They named courses and additional education that they had taken in both leadership, occupational science, rehabilitation, work rehabilitation and universal design.

Thirdly, some argued for coherence between being a specialist and being an innovator to develop the occupational therapy profession. They described it as being a contributor to changing the welfare services from a care-perspective to implementing a retirement perspective in line with occupational therapy values, health reforms and empowerment philosophical concepts. Another discussion was about the importance of marketing occupational therapy. This presented a position as an innovator.

In summary, the discussions about the specialist position presented the participants' dedication to the occupational therapy profession, their clients and that of taking a stand for change, marketing and development within the profession.

Discussion

This study aimed to explore the way in which community-based occupational therapists shape their roles after the implementation of the Coordination Act. The findings show that external factors such as national health reforms, geography, populations and expectations from leaders, challenged community-based occupational therapists to develop their professional role to promote their core knowledge and to view future possibilities about the way in which to enable people to master everyday life. Furthermore, we found that occupational therapists described their position as being at an intersection between a generic, generalist and a specialist. This lack of a clear definition has been a longstanding issue in occupational therapy as in other health professions (Foto, 1996; Fossey, 2001). This issue involves both strengths and unsolved challenges.

Both the findings and results from other studies (Ashby *et al.*, 2013) underline how challenges might arise when health professionals work in interprofessional teams. Challenges might increase if colleagues from other disciplines supervise occupation-based practice without an understanding of its aims and rationale (Ashby *et al.*, 2013).

Table 2 shows that the unresolved challenges are mostly related to the generic position, including the role of blending in with other professions. Role blending has especially been a part of occupational therapy practice in municipality mental health practices (Cook and Cook, 2003), but this study also found that role blending is perceived by occupational

	Strengths	Challenges
Generalist	To have an overview of the field Influence priorities Work with clients for longer periods Variation in tasks and roles Work with clients of all ages Work with both groups and individuals	To be skilled to manage many fields Have insights into all problematics
Specialist	To develop and master is satisfying Have a passion for the profession Being innovators of the profession Are god at marketing OT Promote independent living	To use reablement instruments Be competent with assisted technology Master stroke-rehabilitation Master hand-training Work systematically to become a formalized specialist
Generic	Skilled to work interdisciplinary	Concretize their core knowledge Develop professional competences Enrichen patients and colleagues with their profession's competences To call themselves occupational therapists Handle to work as the only occupational therapists in the community To concretize the differences between occupational therapists, physiotherapists and special pedagogues

Table 2.
Overview of the strengths of the generalist, specialist and the generic positions

therapists in municipality services. Role blending might occur when occupational therapists are working in interprofessional teams or when they must handle many different tasks (Ashby *et al.*, 2013). The findings show that the generic position might develop when leaders that are not familiar with occupational therapy define the profession from their perspectives. Fox (2013) emphasized that a generic position might lead to a therapist who is insecure with defining his/her unique position within an interprofessional team. In the worst cases, such insecurities might affect the clients if the therapists feel unsure about their job as their roles and responsibilities might seem unclear; thus, the generic position can contain many pitfalls. Fossey (2001) emphasized that occupational therapists must be aware of their role within interprofessional teams and that the myth of equality within teams limits the acknowledgement of difference. Teams that value differences are more likely to build effective working relationships with client-centred approaches (Fossey, 2001). It can be easy to become side-tracked and to feel the need to try to fit in with the rest of the team when one is working as the only occupational therapist in the municipality. Interprofessional teams and generic interventions have become the dominant means of providing clients services within a municipality (Vabø, 2012). From this point of view, it seems important to increase occupational therapists' autonomy such that they can provide the best possible service to their clients (Bonsaksen *et al.*, 2018). Related to the findings of this study and results from other studies (Cook and Cook, 2003; Fox, 2013; Fossey, 2001; Lloyd *et al.*, 2017), there seems to be value in examining ways for occupational therapists to describe the unique way in which they contribute to the team. The findings presented the way in which the occupational therapists suggested developing this unique manner, including innovation while use their core knowledge to enable people to engage in everyday life activities (Zemke, 2004; Hasselkus, 2006).

The Coordination Act has led to a shift towards more community-based services (Department of Health,2008/2009). There are voices that claim that the purchaser-provider

model leads to a redistribution of resources based on professional accomplishment rather than historical workforce roles (Vabø, 2012). From this, it becomes more usual for professionals to delegate tasks to other disciplinary groups as findings from this study demonstrated. When some of the occupational therapists strive to maintain their professional identity, there are contextual factors that cause their worries. Generic interventions might affect their professional identities and self-efficacy in several professions (Fox, 2013), and these dilemmas might be relevant to other professions. Occupational therapists, who find themselves taking care of pressing needs as defined by others, may tend to see themselves as less influential in their work role (Bonsaksen *et al.*, 2018). Nancarrow and Borthwick (2005) claim that dynamic role boundaries may have the potential to challenge the monopoly of the health-care professions and that the groups at most risk within periods of overall workforce boundary changes are the most specialized ones. At the same time, the professions appear to be safe if they can retain a high level of demand. Feelings of being invisible, misunderstood, stereotyped by traditional images and undervalued by those in related professions, can be a result of being in generic positions (Ashby *et al.*, 2013).

The findings present another way to understand the differences between the generalist and the specialist positions. On one hand, they suggest the occupational therapists suggests that more therapists should become specialists. On the other hand, the occupational therapists discuss the ways to strengthen the role of the generalist. This means that some generalists in the municipality can be specifically skilled to be an all-rounder (Arntzen *et al.*, 2019) in a manner that is parallel to doctors who are specialists in public health. This implies more initiatives from organisations to ensure that occupational therapists with a bachelor's degree in the municipalities obtain more opportunities to undertake further education to develop their competencies as generalist specialists. Furthermore, the overall solution may be to put greater emphasis on the core knowledge and skills of occupational therapy (Zemke, 2004; Hasselkus, 2006), especially with respect to developing the generalist as a specialized generalist. Occupational therapy focuses on the role of occupation in people's everyday life, and this professional knowledge and competence are valuable when implementing the health-reforms in the municipalities. This is underlined in the study of Halle *et al.*, (2018). The results of the study show that this is also transparent with the knowledge and competences of occupational therapists. At the same time, occupational therapists need to be clear to renegotiate and communicate their core knowledge and competences and position themselves in relation to leaders, politicians and other professional groups. They also need to renegotiate, develop and communicate new methods of work that ensure professional autonomy and quality in the municipal occupational therapy service and within interprofessional teams. Occupational therapy exists and develops continuously when practitioners promote occupational participation and adopt inclusive contexts so that people can perceive participation and belonging.

Conclusion

Within the social constructive frame of reference, this study has shown that the role of community-based occupational therapists in Norway after the implementation of the Coordination Act is under pressure. In this study, the challenges and opportunities therapists faces in their daily practice in the intersection between a generic, generalist and specialist position have been addressed. Interestingly, the challenges seem to appear as an individual struggle not properly addressed at the general, structural and policy levels. The challenges should to a higher extent be more explicitly highlighted in the national policy documents and the research literature. The generalist specialist role has to be further developed and implemented in the occupational therapy bachelor and master programmes. The challenges of

the generic position may be resolved by placing greater emphasis on the core knowledge and competences of occupational therapy. Consequently, occupational therapy will further develop as practitioners promote occupational participation and inclusive environments so patients can perceive participation and belong in their communities.

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