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Perfectionism in occupational science students: occupational therapy implications

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Abstract
Purpose – The purpose of this study is to categorize perfectionism and determine how perfectionism impacts the occupations and perceived health of students in a Bachelor of Science in Occupational Science program.

Design/methodology/approach – A descriptive study with a survey component was conducted. Participants were categorized as perfectionists or non-perfectionists using the Almost Perfect Scale-Revised (APS-R). Time logs were collected to compare categories of time-use between groups over a one-week period. An online survey was conducted with a sub-sample of the perfectionists.

Findings – More students were categorized as perfectionists ($N = 41$) than non-perfectionists ($N = 3$). Both groups spent similar amounts of time engaged in productive, pleasurable and restorative occupations. Some perfectionists reported that perfectionism supported health, but others reported negative impacts on well-being.

Research limitations/implications – This study included a small sample size limited to one Occupational Science program in the USA.

Originality/value – Results demonstrated positive and negative health impacts because of perfectionism. The majority of participants were identified as perfectionists; rigorous academic programs may attract students with perfectionistic qualities. Findings are relevant for Occupational Therapy, as these students will become future occupational therapists after completing a Master’s program in Occupational Therapy and may be susceptible to negative outcomes associated with perfectionism such as workaholism and poor health.

Keywords Occupational therapy, Occupational science, Health implications, Perfectionism, Occupational science, Perfectionism

Paper type Research paper

Introduction
In autumn of 2015, approximately 20 million students in the USA were expected to begin postsecondary education, and three million students were predicted to begin postgraduate education programs; this number is projected to increase by 21 per cent by the year 2025.
Perfectionism is common among college students, with some previous research including college samples with more than half of participants being classified as perfectionists (Canter, 2003; Grzegorek et al., 2004). Although perfectionism is defined in several ways, it is typically understood that perfectionism is “a personality style characterized by striving for flawlessness and setting excessively high standards for performance accompanied by tendencies for overly critical evaluations of one’s behaviors” (Stoeber and Otto, 2006, p. 2). Perfectionism is commonly classified as adaptive or maladaptive. Adaptive perfectionists have reasonable standards and can feel content with their achievements, despite having a desire to excel. In contrast, maladaptive perfectionists cannot feel satisfaction from their achievements, have unattainable standards and their self-worth is contingent upon their performance (Rice et al., 2014). College students who are perfectionists may exhibit healthy and/or unhealthy behaviors related to their academic performance and other occupational areas of their lives.

Participation in occupation is believed to support health, well-being and social participation in daily life (American Occupational Therapy Association, 2014). Many definitions of occupation are available in the literature from international perspectives. The World Federation of Occupational Therapists (WFOT) (2012) defines occupation as the everyday tasks people complete individually and with others, such as with family members or in communities, that create meaning and provide purpose in our lives. Pierce (2001, p. 139) defines occupation as “a specific individual’s personally constructed, nonrepeatable experience”. Additionally, Pierce divides occupation into three categories to describe how people spend their time: pleasurable, productive and restorative. Pleasurable occupations are focused on the satisfaction an individual gains during enjoyable activities. Conversely, productive occupations are goal driven and are the antithesis of pleasurable occupations. Finally, restorative occupations provide the energy necessary to engage in other daily occupations.

Perfectionism relates to Occupational Science and Occupational Therapy because of its connection to life balance. A balanced lifestyle allows one to meet their basic needs through occupation, and this occupationally balanced state produces the greatest happiness (Matuska, 2010). In Western culture, maintaining a balance between occupations is often challenging because of a high emphasis on productivity. Long work hours coupled with limited time and feeling a lack of control over time-use negatively impacts health and well-being (Zuzanek, 2010). This focus on productivity could result in an over- or under-emphasis on areas of occupation creating occupational imbalance and increasing levels of stress. For perfectionists, achieving balance may be even more difficult because their personalities may guide them to focus more intently on productive occupations and minimizing errors in their work.

**Literature review**

In psychology literature, perfectionism has been studied in relation to procrastination, stress, alcohol abuse and mental health conditions including depression, obsessive-compulsive disorder, as well as eating disorders (Ashby et al., 2006; Bardone-Cone et al., 2007; Chik et al., 2008). Perfectionists may be at greater risk of developing psychosocial problems including psychological disorders because of their increased levels of stress. Current research has shown that prolonged stress alters the brain by spurring the growth of myelin, disrupting the brain’s communication system (Chetty et al., 2014). This process also increases the growth of oligodendrocytes in the hippocampus, which regulates emotions, increasing the risk for anxiety and mood disorders (Chetty et al., 2014). Perfectionism has also been examined in relation to how perfectionists are perceived by others. Adolescents
who are classified as maladaptive perfectionists have been viewed less favorably by their peers than adaptive perfectionists (Gilman et al., 2011). College students who are maladaptive perfectionists may be viewed similarly as the adolescents in this research.

In addition to increasing the risk of psychosocial problems, chronic stress significantly impacts the body’s physiological functioning, especially the heart. Heart disease is the leading cause of death in the USA and continues to be the number one cause of death worldwide (Centers for Disease Control and Prevention, 2016; World Health Organization, 2016). Stress has been found to be a significant risk factor for myocardial infarction as well as making the heart susceptible to other cardiac conditions (Dimsdale, 2008; Huma et al., 2012). Albert et al. (2016) studied the effects of perfectionism on blood pressure after exposing college students to mathematic stressors. Students with higher levels of perfectionism were less likely to experience a drop in blood pressure as the test progressed than those with lower levels of perfectionism. The perfectionists maintained elevated blood pressure levels throughout the testing period. The implications for the cardiovascular health of perfectionistic college students over time in other situations that provoke stress, while unknown, could be detrimental.

Perfectionism in the college student population has been found to influence how students adjust to college, relate to others and also determines whether they remain in school (Lapoint and Soysa, 2014). Maladaptive perfectionism had an inverse relationship between dissatisfaction and attachment to the school, as well as adjustment to others around them (Lapoint and Soysa, 2014). Students who were maladaptive perfectionists had higher dissatisfaction and did not feel connected to their school or to their peers. Students who identify as perfectionists are often less satisfied by their grade point averages (GPAs) and report lowered self-esteem (Grzegorek et al., 2004). Research has also shown that perfectionists are vulnerable to academic burnout. Specifically, students who identify as maladaptive perfectionists are more likely to succumb to exhaustion and feelings of incompetence, while adaptive perfectionists are more likely to be engaged in educational pursuits, displaying more energy, enthusiasm and commitment to academic performance (Zhang et al., 2007). Students who are maladaptive perfectionists have also been found to be more likely to drink alcohol in excess to cope with stress, whereas students who are adaptive perfectionists have lower risks of developing alcohol-related problems (Rice and Van Arsdaile, 2010).

Occupational Science and Occupational Therapy focus on the impact that health conditions, disabilities, context and the environment have on occupation. Despite this focus on health and well-being, publications in these fields about perfectionism are lacking and the closest link available in this literature relates to workaholism. Workaholism is described as a desire or need to work that can cause an overemphasis on work at the expense of social relationships and personal health (Wojdylo et al., 2014). As a result, this overemphasis on work may create a life imbalance that has detrimental social- and health-related consequences (Matuska, 2010). While in the workplace, workaholics may perform somewhat better than their peers and make more use of coping skills; however, this population has poorer overall health than non-workaholics (Shimazu et al., 2010). Further, workaholism has been linked to stress-related conditions ranging from heart disease to mental illnesses (Aziz et al., 2015). In a study of over 16,400 adults, those who identified as workaholics exhibited more symptoms of attention deficit hyperactivity disorder, obsessive-compulsive disorder, anxiety and depression than non-workaholics (Andreassen et al., 2016). Perfectionism has been found to be a common trait among workaholics as presented in psychology literature (Bovornusvakool et al., 2012). Although work has been found to be a meaningful occupation for this population, workaholics have difficulty enjoying time spent in other occupations.
such as leisure (Bovornsvakool et al., 2012). Difficulty enjoying non-productive occupations may impact how perfectionists spend their time daily and how they perceive this time-use. Limited research on the topic from an Occupational Science and Occupational Therapy lens makes it difficult to discern the impact perfectionism can have on occupation, such as whether or not it leads to an occupational imbalance or poor health outcomes.

Occupational Therapy often relies on time-use data as a gauge of health and well-being (Hunt and McKay, 2015). Studies on time-use aid in understanding one’s occupations, the effects of injury, disease or disability and quality of life (Farnworth, 2003). Time-use studies in the Occupational Science and Occupational Therapy literature have increased in recent years and the scholarship contributed represent the USA, Canada, Australia and Scandinavia (Hunt and McKay, 2015). The American Time Use study provides a picture of how Americans spend their time based on 170,000 interviews collected over 12 years. On an average weekday, full-time college students were found to spend more time combined in educational and work activities than in leisure and sports (Bureau of Labor Statistics, 2016). The Irish National Time Use Survey conducted in 2005 found similar results for younger adults of age 18-24 years in that this group spent more time engaged in educational and work pursuits than any other age group category both on weekdays and weekends (McGinnity et al., 2005). This increased time commitment to work and education may represent a time imbalance that could impact overall health and well-being. Understanding how Occupational Science students spend their time and experience their time-use could have health implications for these students as future occupational therapists.

**Purpose**

The aim of this research was to categorize perfectionism and understand how the occupations of Occupational Science students who were identified as perfectionists are impacted by perfectionism. To achieve this purpose, the following research questions were posed:

**RQ1.** Do students who are identified as perfectionists spend more time engaged in productive occupations than those who are not identified as perfectionists?

**RQ2.** In what ways does perfectionism positively or negatively influences one’s occupations and health?

**RQ3.** What stereotypes, if any, about perfectionism have the participants experienced?

**Background of study setting**

This study took place at a regional, public university in the USA that includes a Bachelor’s degree in Occupational Science as a pathway to a Master’s degree in Occupational Therapy. The Bachelor of Science in Occupational Science at the study setting focuses on learning first about the occupations of self and others, and then progresses to using occupation as a means for promoting health and well-being. After students complete the Master of Occupational Therapy program at the study setting, they are eligible to complete the National Board for Certification in Occupational Therapy examination. Passing this exam is required to become certified as an Occupational Therapist in the USA. Additionally, other steps are typically required to obtain and maintain licensure to practice Occupational Therapy, but these guidelines vary by state.
Methods
A descriptive study using a survey component was conducted with undergraduate Occupational Science students during the autumn of 2015 semester. Survey research permits gathering data from a larger number of participants compared to other methods, such as in-depth interviews. Both quantitative and qualitative data were collected and analyzed in this research. Mixed methods research combines both approaches and provides a greater degree of understanding than can be achieved by using a single approach to answer the research question (Creswell, 2014). This study was approved by a University Institutional Review Board (IRB) at the study setting through an expedited review process. Expedited applications are for research that demonstrates no greater than minimal risk for participants and involves non-invasive data collection or research on group characteristics or behavior (US Department of Health and Human Services, 2016). This research category involves review by a subset of the IRB but does not require a full review by the majority of IRB members.

Recruitment
Potential participants were 55 Occupational Science students at a mid-sized public university in the USA. Students had to be between the ages of 18-65 years and be junior Occupational Science majors enrolled in the unit of study entitled OTS 311: Self as an Occupational Being. OTS 311 is taught by an instructor who was not involved in this research study to avoid influencing participants. This course focuses on analyzing occupation and occupational patterns, helping students recognize how this impacts occupation. To recruit participants, the primary researcher visited each section of OTS 311 courses. The purpose, requirements and risks of the study were explained by the primary researcher, and potential participants were given the opportunity to ask questions. Potential participants were notified that participation was voluntary and that grades or status in the Occupational Science program would not be impacted by completing or not completing the study. Contact information for interested students was collected, and students were given a copy of the informed consent document to review and sign. Two weeks later, the primary researcher returned to each section of OTS 311 to collect informed consent verbally and in writing.

Instrumentation
Levels of perfectionism in students were assessed using the Almost Perfect Scale, Revised (APS-R), a questionnaire that measures individual levels of perfectionism using three constructs: standards, order and discrepancy (Rice and Ashby, 2007). Standards refers to high standards of performance, while discrepancy refers to the disconnect between one's standards and determining if those standards were met. Finally, the construct of order relates to one's inclination for organization. Participants were given the APS-R and rated their agreement with each of the 23 questions on a Likert scale from 1 (strongly disagree) to 7 (strongly agree). Each question corresponded to one of the constructs, and all the scores for each construct were tallied. To be classified as a perfectionist, a participant had to score 42 points or higher on the high standards questions. To be further categorized as a maladaptive perfectionist, participants had to score 42 points or higher on the discrepancy questions (Rice and Ashby, 2007). While higher scores for each construct indicate a stronger tendency toward perfectionism, these cutoff scores were determined by Rice and Ashby (2007) to ensure sensitivity and avoid improper categorization of participants using the APS-R.

The APS-R is a valid and reliable measure of perfectionism. Previous research has demonstrated that the APS-R has internal consistency coefficients for its three constructs.
that fall between the 0.85 and 0.92 range and that test-retest reliability is between 0.76 and 0.82 (Rice and Aldea, 2006; Rice and Ashby, 2007). This demonstrates that the scale measures the constructs in which it is proposed to measure and that individuals can be expected to answer similarly on the scale over time. The APS-R has also demonstrated convergent validity with Hewitt and Flett’s Multidimensional Perfectionism Scale and the Frost Multidimensional Perfectionism Scale, indicating that the APS-R is related to measures that are examining similar constructs about perfectionism (Slaney et al., 2001). The APS-R was selected for this study because of its well-established reliability and validity as an assessment tool. In addition, other measures such as Hewitt and Flett’s or Frost’s multidimensional scales were not selected because of the costs of obtaining the assessment tools as well as the advanced training required to administer them.

Procedure
The primary investigator returned to recruit participants for the study near the end of a class session for OTS 311. Students were given the opportunity to leave class early if they did not wish to participate in the research. After providing informed consent, students completed the APS-R during class time that was devoted to the study in this course. This scale was used to classify students as perfectionists and non-perfectionists based on their tallied scores. Participants in the perfectionists sample were further classified as adaptive or maladaptive perfectionists. All students in OTS 311 tracked their daily occupations for 24 hours a day over a week using time logs as part of an already required class assignment in the course; the researchers only had access to analyze time logs from those students who provided consent to participate in the study. Using a random digit table, a sub-sample of 20 perfectionists were selected to receive a follow-up qualitative survey via Survey Monkey. Sample size for qualitative research is typically smaller, as the purpose is not to generalize results to the larger population but to explore the experience of the study participants in a particular sample in great depth (Creswell, 2013). Additionally, only half the sample was chosen to receive a survey because of time constraints of the primary researcher as a full-time undergraduate student. Participants were asked to respond to four demographic and four open-ended questions. Qualitative, open-ended survey items related to the positive and negative effects of perfectionism on health, daily life and social interactions are listed below. Questions for the survey were developed based on information in the literature regarding perfectionism. While time constraints did not allow researchers to review results with all individuals who completed the survey, member checking was conducted with one randomly selected survey participant via email to ensure the accuracy of the themes that were derived from the survey responses and to provide an opportunity for any additional insights. Peer review was completed between the first and second authors to confirm study themes and decisions made throughout the research study.

Open-ended survey questions

Q1. Please describe how perfectionism has impacted or currently impacts your daily life.

Q2. Please describe how perfectionism has positively influenced or currently influences your health.
Q3. Please describe how perfectionism has negatively influenced or currently influences your health.

Q4. Please describe any stereotypes and/or negative experiences you may have encountered as a perfectionist.

Data analysis
Following data collection, analysis of the quantitative and qualitative data was completed separately. Completed time logs from all four samples (all perfectionists, adaptive perfectionists, maladaptive perfectionists and non-perfectionists) were examined for differences in time spent in pleasurable, productive and restorative occupations. Areas of occupation were color-coded on the time logs to reflect these different categories by student participants as part of their class assignment requirement. Students were educated by the same instructor regarding Pierce’s categorization of occupation in OTS 311, supporting similar knowledge and understanding of these categories across participants. Descriptive statistics and two tailed t-tests were used to review the differences in time spent in each area of occupation between the perfectionists and non-perfectionists, as well as the adaptive and maladaptive perfectionists. Descriptive statistics included the mean or average amount of time each group spent engaged in Pierce’s categories of occupation, as well as the standard deviation for time-use. Two tailed t-tests were used for inferential statistics to determine whether or not there was a true difference in the average amount of time participants from each group spent engaged in Pierce’s three categories of occupation. Thematic analysis was used to derive meaning from qualitative survey responses by the primary researcher, which involved identifying several broad themes or units of information to reflect the main essence of participants’ responses (Creswell, 2013). Constructivism was used broadly by the researchers as a theory to recognize multiple realities and perceptions related to perfectionism that might exist among participants, as well as to support the emergent nature of findings from the qualitative responses on the survey (Creswell, 2013). A written document of all open-ended survey responses was compiled. The primary researcher completed memoing after reading the responses fully and recording initial impressions related to the data. The next steps involved highlighting important statements relevant to the study topics, followed by placing these important statements into related categories and then further collapsing these statements into the final study themes. Study themes emerged directly from participants’ words and experiences.

Results
Participants
Of 55 potential participants, 44 students completed the APS-R questionnaires resulting in a response rate of 80 per cent. Of those participants, 41 were identified as perfectionists (93.2 per cent), while 3 participants were identified as non-perfectionists (6.8 per cent). Within the perfectionist sample, 22 participants (53.7 per cent) were identified as adaptive perfectionists and 19 participants (46.3 per cent) were found to be maladaptive perfectionists.

Surveys were sent to ten participants classified as adaptive perfectionists and ten participants classified as maladaptive perfectionists. All participants were sent the same email and their categorization as an adaptive or maladaptive perfectionist was not disclosed to avoid potentially influencing the respondents’ answers. All participants within this survey sample identified their age to be in the 18-24 category in the demographic section of the survey. While the inclusion criteria for the study was broader to allow older, non-traditional students to take part in the study, the current students in
the Occupational Science program at the time of this research were all younger, traditional college students. From the perfectionist survey sample \( n = 20 \), 19 responses were collected, resulting in a 95 per cent response rate. There were 15 female participants (78.9 per cent) and 4 male participants (21.1 per cent). Roughly half the sample, 11 participants, considered themselves perfectionists before the study and 8 did not. When asked if others considered them to be perfectionists, 14 participants (73.7 per cent) indicated others did, while 5 participants (26.3 per cent) responded that peers had not previously identified them as a perfectionist.

### Quantitative analysis

From the APS-R, participants were classified into three groups: perfectionists who were further classified as adaptive perfectionists and maladaptive perfectionists and non-perfectionists. Using these classifications, time logs were analyzed using descriptive analysis. The first analysis that was conducted solely relied upon the averages of time-use between the groups to compare the percentage of time that each group spent in productive, pleasurable and restorative occupations. One non-perfectionist chose not to participate in the time log analysis, reducing the non-perfectionist sample size from three to two participants. One person from the maladaptive group and one person from the adaptive group also failed to turn in their time logs, reducing each sample by one participant for time log analysis. Students reported time use in percentages on the time logs, and the averages that were calculated were reported in this same format as percentages. It was found that there was a slight difference between the time-use of the perfectionists and non-perfectionists using Pierce’s classifications of occupation.

The initial analysis of the averages compared the perfectionists’ and non-perfectionists’ time use spent in pleasurable, productive and restorative occupations. The results are presented below in Figure 1, including standard deviations with additional detail in Table I.

Standard deviations are also presented in Table I. Two sample \( t \)-tests were conducted using a significance level of 0.05 and the results were found to not be statistically significant (Table I). These results would indicate no true difference in time-use among perfectionists and non-perfectionists.

![Figure 1. Average time-use for perfectionists and non-perfectionists](image-url)
Using the same process, further data analysis was conducted comparing the adaptive perfectionists and maladaptive perfectionists. Results are presented below in Figure 2, including standard deviations with additional detail in Table II.

The outcomes of the two sample t-tests, tested at a significance level of 0.05, showed that the results were not statistically significant (Table II). This would indicate no true difference in time-use between adaptive and maladaptive perfectionists.

Qualitative findings
From the coding process, the following four main themes emerged from the data: prioritizing and neglecting one’s health, achievement promoting self-confidence, people thinking I am a show-off and organizing time-use. Quotations are presented verbatim from the participants and may include grammatical and spelling errors. Participants were given numbers to protect anonymity.

Prioritizing and neglecting one’s health
Throughout the survey responses, 15 of the 19 participants consistently discussed how perfectionism positively or negatively impacted their physical and mental health.

<table>
<thead>
<tr>
<th>Table I. Perfectionists and non-perfectionists’ data results</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Population</strong></td>
</tr>
<tr>
<td>Pleasurable occupations</td>
</tr>
<tr>
<td>Perfectionists</td>
</tr>
<tr>
<td>Non-perfectionists</td>
</tr>
<tr>
<td>Productive occupations</td>
</tr>
<tr>
<td>Perfectionists</td>
</tr>
<tr>
<td>Non-perfectionists</td>
</tr>
<tr>
<td>Restorative occupations</td>
</tr>
<tr>
<td>Perfectionists</td>
</tr>
<tr>
<td>Non-perfectionist</td>
</tr>
</tbody>
</table>

Figure 2.
Average time-use for adaptive and maladaptive perfectionists
benefits included spending more time engaging in exercise or working out, making more of an effort to select healthy food choices and making one’s health a priority. As a result of these behaviors, participants felt that perfectionism positively influenced their body image and stress levels. The overall consensus from the participants was as one respondent described:

Being a perfectionist has allowed me to make my health a priority (P18).

Conversely, not all respondents felt that their perfectionism had a positive impact on their health. Several responses referenced the toll that perfectionism had on their physical well-being. Because of a need to achieve perfection in aspects of their life, especially education-related assignments, participants described neglecting their health by undereating or overeating, avoiding exercise, staying up late and spending copious amounts of time on school work. Along with the physical impacts, half of participants mentioned some form of stress such as worry, pressure to perform or being overwhelmed as a result of their perfectionism. One participant’s response encompassed the thoughts that had been discussed by the majority of respondents who found perfectionism to have a negative health impact:

I do feel guilty for not taking better care of myself by exercising more and eating healthier food. Yet, the time restraints that I have because I spend so much time trying to do school assignments and other tasks to my satisfaction causes me to eat quick, unhealthy meals, and not get much exercise besides walking to class and the farm work […] It has also caused me to stay stressed on a daily basis and constantly think about what I need to get done and when I don’t get much rest and I don’t have much of a social life because of the time constraints I place on myself (P4).

**Achievement promoting self-confidence**

Several participants expressed that perfectionism was a source of confidence and drove them to perform to the best of their abilities. Six respondents acknowledged that because they were perfectionists, they were successful in school and that success in academics improved their self-esteem. One participant even attributed their admission into the Occupational Science program to perfectionism, while others discussed how perfectionism provided them with pragmatic study skills that prevented procrastination:

Perfectionism has its perks. For example, I got an A on a paper because I did not procrastinate and researched extensively. This was great for my self-confidence and health (P16).

<table>
<thead>
<tr>
<th>Population</th>
<th>Sample size (N)</th>
<th>Sample mean (X)</th>
<th>Standard deviation (S)</th>
<th>t-score</th>
<th>p-value</th>
<th>α value</th>
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</thead>
<tbody>
<tr>
<td><strong>Pleasurable occupations</strong></td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Maladaptive perfectionists</td>
<td>18</td>
<td>16.97</td>
<td>15.429</td>
<td>−0.329</td>
<td>0.744</td>
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<tr>
<td>Adaptive perfectionists</td>
<td>21</td>
<td>15.637</td>
<td>8.077</td>
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<tr>
<td><strong>Productive occupations</strong></td>
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<td></td>
<td></td>
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</tr>
<tr>
<td>Maladaptive perfectionists</td>
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<td>34.666</td>
<td>9.414</td>
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<td>10.098</td>
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<tr>
<td><strong>Restorative occupations</strong></td>
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<tr>
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<td>46.570</td>
<td>4.886</td>
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</tbody>
</table>

Table II. Adaptive perfectionists and maladaptive perfectionists’ data results
In reviewing the survey responses, it became clear that there was a social component to perfectionism. Participants’ responses demonstrated that perfectionism was noticed by peers and also affected interactions with others. Some individuals described that perfectionists were thought to be all knowing and infallible. As a result, the perfectionists did not receive the same assistance related to assignments and projects that other students received:

Asking others that know me, for assistance and/or feedback on an assignment often results in them dismissing my request or concerns because they assume that I’ve done well on the assignment and don’t need help (P4).

There also appeared to be a disconnect between the intentions of the perfectionists and how they were perceived by their peers. Respondents listed names that they had been called or judgments that had been made about them based on their perfectionism. In attempting to do their personal bests, some perfectionists were thought to be domineering rather than helpful:

I have been called a Suck up, nerd, OCD, anal and bossy (P6).

Organizing and time-use
Time was a commonality among the majority of the responses. Participants described spending more time involved in school- or work-related endeavors than other students that took time away from leisure-based occupations. Participants attributed overemphasis in time spent in specific occupations to attempting to achieve perfection:

It is time consuming and stressful to make everything perfect (P15).

While the majority of participants focused on the lack of time they experienced in their responses, a few participants discussed how they liked to keep organized and how it gave life structure:

Being organized and on top of my school work is leading me towards where I want to be (P15).

Discussion
More perfectionists (n = 41) than non-perfectionists (n = 3) were identified in the study sample. The data reflect no difference in time spent in productive, pleasurable and restorative occupations between perfectionist and non-perfectionist Occupational Science students for this study’s participants. These results held true for the adaptive and maladaptive perfectionists. While no true time differences were found in this study, it is possible that time-use may be perceived differently among these groups. For example, previous research has shown that when perfectionists exhibit workaholism, they have difficulty enjoying time spent in non-productive tasks (Bovornsvakool et al., 2012). Even if perfectionists spend a similar amount of time in occupations that are non-productive, such as leisure and restoration, this time may not be fully experienced as enjoyable or relaxing by perfectionists. Future research should examine how perfectionists perceive time spent in categories of occupation compared to non-perfectionists, as experience of time-use could be more meaningful for health and well-being than actual amount of time spent in various occupations.

While quantitative data demonstrates a need for further research, the qualitative survey responses provided an authentic perspective of how perfectionism impacted the participants’ occupations, health, daily life and social interactions. It became apparent in
reviewing the participants’ answers that students expressed feeling a need for more or less time to engage in various occupations demonstrating a perceived lack of occupational balance. For example, many students discussed a perceived lack of time for non-productive activities such as eating and socializing because of needing to spend a significant amount of time in productive tasks related to their roles as college students. When considering the impact that perfectionism had on health, it was evident that health and occupation were interconnected. While some respondents considered perfectionism to have positively influenced their health through diet and exercise choices, more respondents discussed the adverse effects they experienced, such as poor diet, exercise and sleeping habits as well as increased stress and anxiety.

Despite often being construed as negative, perfectionism has also been shown to be linked to positive traits such as increased conscientiousness, extraversion and life satisfaction with adaptive perfectionism being further linked to decreased procrastination and reduced anxiety/depression (Stoeber and Otto, 2006). While it is conceivable that perfectionism could benefit these students in future academic endeavors because of these traits, it is important to also consider the potential negative impacts of actual or perceived occupational imbalance over time. For those who spend too much time in educational or other productive occupations, this behavior could manifest itself as workaholism in adulthood which has been linked to perfectionism in previous research (Wojdylo et al., 2014). Multiple participants in this study discussed spending too much time completing academic assignments and the accompanying negative health consequences, such as exhaustion, lack of sleep and stress. Of these health effects, stress has been commonly reported among perfectionists in previous literature (Matuska, 2010). This is significant because chronic stress is a serious hazard to both mental and physical health (Chetty et al., 2014; Huma et al., 2012). Perfectionists in this study sample also reported further concerning health behaviors, such as lack of exercise, that have been associated with chronic physical and mental conditions such as cancer, heart disease, stroke and depression (Booth et al., 2012).

In addition to impacting health, perfectionism also played a role in how students were perceived and treated by peers for participants in this study. Students reported that peers sometimes held negative views of them, such as that they were bossy or domineering. Peers were also less willing to help perfectionists when they asked questions or needed feedback because it was assumed that perfectionists did not need assistance from others to be successful. While peer perception of perfectionists has not been studied previously in college students, it has been examined in adolescents. Adolescent maladaptive perfectionists have been viewed less favorably by their same-age peers than adaptive perfectionists (Gilman et al., 2011). It is perceivable that college students who are classified as maladaptive perfectionists could also be viewed less favorably by their peers. These perceptions could negatively impact current interpersonal relationships with others and potentially impact future relationships with co-workers as well. Perfectionist students who become occupational therapists may find that their requests for feedback from peers to improve their clinical practice are dismissed or that co-workers have negative opinions about their character related to perfectionism.

Students in Occupational Science and Occupational Therapy programs are in competitive programs and may be more prone to perfectionist traits. As future healthcare practitioners, maintaining a balance among occupations becomes significant, as healthcare workers fall into a high-risk category for burnout and job stress associated with productive occupations. Occupational therapists are not immune to experiencing burnout, and this can lead to decreased satisfaction and performance in one’s job (Edwards and Dirette, 2010). Striving for perfection may give the future occupational therapists from this study or
current occupational therapists, unrealistic expectations of their own abilities and may also impact how they experience time spent in non-productive tasks such as leisure. Because perfectionism has been linked to job burnout, students who meet criteria to be classified as perfectionists may be more prone to experience burnout later in their Occupational Therapy careers (Huo-Tsan et al., 2016).

Occupational Therapy educators should educate students on potential negative health and career impacts of perfectionism. Requiring class assignments such as keeping track of one’s time-use can help students identify their own imbalance to make healthy changes in their use of time, such as scheduling time daily for exercise and relaxation to avoid burnout. Instructors can also use teaching approaches that deemphasize high-stake graded assignments to allow students to focus more on learning. Offering multiple-graded assignments throughout the semester rather than just test grades, as well as providing feedback at multiple points in time for graded and non-graded assignments may help to shift the focus to learning for the sake of learning. Students who are grade-oriented rather than learning-oriented often exhibit poorer academic performance and view classroom content as a means to an end rather than as learning for a future purpose (Vallade et al., 2014). Instructors should emphasize the importance of class concepts and link these to students’ future practice, as occupational therapists to help shift students’ views away from grades toward how course content will be important in the future beyond the classroom.

Limitations
The study’s small sample recruited through convenience limits the ability to generalize this information to outside Occupational Science programs, both in the USA or internationally, as well as to other educational programs. Participants’ prior knowledge of Occupational Science could have impacted the way students responded on survey items. Persons with perfectionistic traits may be more likely to engage in research activities than non-perfectionists, and the remaining 11 potential participants who did not complete the APS-R could belong to the non-perfectionist category which may have impacted the study’s results. Because of time restraints, survey responses were used in place of a more in-depth interview process. Another limitation was the inclusion of participants’ time logs, which were subjective in nature regarding how students categorized their occupations. Even though participants received instruction regarding Pierce’s categories of occupation from the same professor, students still may have categorized their occupations differently. In addition, time logs reflected only a week of data; if students experienced an atypical week of occupations, then this could have skewed results regarding time-use. Finally, the disparity between the number of participants in each group and the small size of the non-perfectionist group may have impacted statistical analysis results. However, de Winter (2013) argues that paired $t$-tests can be used effectively in sample sizes as small as $N = 2$, which is the same as the size of the participating non-perfectionist group in this study. de Winter (2013) examined small sample sizes from $N = 2$ to $N = 5$ through a simulation study and concluded that there were no principle objections to using a $t$-test for statistical analyses in these very small sample sizes.

Conclusion
The intent of this research was to examine how time-use and human occupation were influenced by perfectionism for a class of junior Occupational Science students. More students were identified as perfectionists than non-perfectionists within the study sample. Perfectionists spent a similar amount of time engaged in productive, pleasurable and restorative occupations compared to students who were identified as non-perfectionists.
Similarly, no significant differences in time-use were found between adaptive and maladaptive perfectionists. Perfectionists expressed both positive and negative health consequences related to their perfectionism. Identifying how perfectionists and non-perfectionists experience time-use could have important implications for health and well-being. Continued research on this topic would be of interest to occupational scientists and occupational therapists, as the implications for these students moving forward directly relates to their health and future success in the Occupational Therapy profession.

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Practices and roles of Irish occupational therapists’ with adults with intellectual disabilities who access supported employment services

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Abstract

Purpose – Work is good for one’s health and well-being. Work for people with disabilities should be encouraged because it is therapeutic and improves participation in the society, leading to better health outcomes. It develops interpersonal relationships and enhances life quality. Work is an aspiration for many people with intellectual disability. Within research literature, there appears to be a lack of research into the experience of occupational therapists in Ireland who refer adults with intellectual disabilities to supported employment services. The purpose of this paper was to explore the experience of Irish occupational therapists who refer adults with intellectual disabilities to supported employment services.

Design/methodology/approach – Semi-structured, in-depth interviews were conducted with four occupational therapists recruited through the Association of Occupational Therapists of Ireland (AOTI). Data were analysed using thematic analysis.

Findings – Themes that emerged were as follows: occupational therapy participants did not directly refer adults to supported employment but received referrals; occupational therapy roles included assessments, task analysis and development of client’s skills are major components of current practice; pragmatics involved factors that facilitate and challenge; and future roles.

Originality/value – This paper contributes to occupational therapy practice knowledge by providing a perspective on supported employment in Ireland. Occupational therapists should continue to work in the area of supported employment to support social inclusion and enable participation. Further research with occupational therapists working in this field is required to inform practice.

Keywords Intellectual disability, Supported employment, Occupational therapist

Paper type Research paper
Introduction/literature review

Work, employment and intellectual disability

Many descriptions of work and/or employment and its benefits exist within occupational therapy literature. Work involves the application of physical or mental effort, skills, knowledge or other personal resources (Warr, 1987), including activities needed for engaging in remunerative employment or volunteer activities (Mosey, 1996) (cited in American Occupational Therapy Association, 2008). Besides employment being a right (UN General Assembly, 1948), employment is a source of meaning in people’s lives (Saunders and Nedelec, 2014). In relation to rights for people with disabilities, Inclusion Europe (2001) highlight that employment is important, and the 2005 Disability Act (Houses of the Oireachtas, 2005) endorses this right in Section 37(b). Within the social model of disability, Oliver (1996) emphasises the importance of rights, access, choice and control for individuals with intellectual disabilities.

Various gains are associated with work/employment and occupation for people with disabilities. Evidence suggests work is beneficial to health and well-being (Dickie, 2003; Bond, 2004). Work for people with disabilities should be encouraged because it is therapeutic, improves participation in the society, leads to better health outcomes, develops interpersonal relationships and enhances life quality (West et al., 2005; Waddell & Burton, 2006). For many people with an intellectual disability, work is an aspiration (Jahoda et al., 2008) and an important goal for improving the quality of life (Siperstein et al., 2013). Hall and Wilton (2011) state that work is a key route to social inclusion for people with a disability. Employment and work have the potential to contribute to addressing social exclusion. Harrison and Sellers (2008) refer to social exclusion as being where individuals have limited opportunities to participate in activities such as work.

Despite knowing positive benefits of work/employment, available statistics indicate that people with disabilities are under-represented in employment. They are half as likely to be in employment as others of working age (Government of Ireland, 2015) with less than 10 per cent of people with intellectual disabilities employed (McConkey and Mezza, 2001 cited in Hensel et al., 2007). Additionally, Rose et al. (2005) maintain that people with intellectual disability are amongst those in the society with the lowest employment rate. In Ireland, there are approximately 27,000 people with an intellectual disability on the register of the National Intellectual Disability Database (Inclusion Ireland, 2008).

Supported employment in Ireland

Supported employment is a current practice in Ireland with a number of services nationally. Individuals with intellectual disabilities form part of the cohort of individuals who access these services. Supported employment enables people with intellectual disabilities to enter employment (Wilson, 2003). Ireland has a history in supported employment going back to 1988 (Nic Suibhne and Finnerty, 2014). There are a number of agencies that provide supported employment services to employers and employees in Ireland, and the Irish Association for Supported Employment (IASE) support these agencies. IASE represents almost 900 members who work with almost 5,000 individuals (Nic Suibhne and Finnerty, 2014), including individuals with intellectual disabilities. There are various models associated with supported employment. For example, the Individual Placement and Support (IPS) (Bond et al., 2001) model which has been used most commonly with individuals with severe mental health difficulties in the USA. In Ireland, “place and train” (Turner, 2009) is a method used, and more recently, in Ireland, the Job Shadow Initiative (JSI) from IASE has been providing individuals with the opportunity to experience the world of work, supporting the focus on employment of people with disabilities (Nic Suibhne and Finnerty, 2014).

Nic Suibhne and Finnerty (2014) highlight that assistance should be provided to the employee and the employer before, during and after obtaining a job, and Turner (2009)
supports this concept where “support for the employer as well as the placed employee increases the likelihood of success” (Turner, 2009, p. 17) with regard to supported employment. Support is often provided by a job coach when an individual is receiving the services of supported employment. Job coaches provide individuals with what Nic Suibhne and Finney (2014) describe as individualised support and on-the-job training. Supported employment facilitates the integration of people with disabilities into paid employment in the open labour market, [Foras Aiseanna Saothair (FAS), 2008; European Union of Supported Employment (EUSE), 2010] providing support to assist with this integration process and meeting the labour requirements of employers [Foras Aiseanna Saothair (FAS), 2008]. Best practice advocates that supported employment is driven by the individual [European Union of Supported Employment (EUSE), 2005] with substantial evidence demonstrating the effectiveness of supported employment (Marshall et al., 2014) with reduced discrimination, enhanced financial status, security and self-worth (West et al., 2005; O’Brien et al., 2000). Interestingly, Casper and Carloni (2007) claim that supported employment services are under-utilised, and the rationale used by practitioners to refer individuals to supported employment is not broad enough.

**Literature review**

Much of the available evidence and research on supported employment is from the perspective of service users with mental health difficulties. Findings reported by Strong (1998), Legault and Rebeiro (2001), Kennedy-Jones et al. (2005) and Corrigan et al. (2007) all report on the experience of people with mental health difficulties. They note the positive impact supported employment had on their recovery often discussing such factors such as stigma and barriers to employment.

Less is reported by service users with intellectual disabilities. The evidence that pertains to their experience includes barriers that exist. According to Lemair and Mallik (2008), these barriers include client factors such as inattention, interpersonal problems, literacy difficulties, behaviour problems, inadequate work quality, poor attendance and environmental factors, such as inadequate transportation, risk of losing benefits, limited employment opportunities and mobility issues.

In a small qualitative study, Siporin and Lysack (2004) looked at the quality of life for three service users and found that the service user’s own perceptions of their quality of life was not always in tandem with that of staff or family, but overall, they appeared to prefer their work in supported employment than in the previous setting of sheltered employment. Further research conducted by Jahoda et al. (2008) investigated the socio-emotional impact of work on people with intellectual disabilities and indicated that there is a positive change in levels of autonomy experienced by individuals with intellectual disabilities who are in competitive employment but a lack of perceived social acceptance amongst those with intellectual disabilities in supported employment.

Motivation levels of the client are addressed by Hensel et al. (2007), where they recommend that supported employment services should focus on this aspect of the client when they engage with supported employment services. In their research into psychological factors associated with obtaining employment, they concluded that supported employment agencies should consider using motivation levels of the client as an entry criterion when individuals are entering supported employment. In a retrospective chart review, West et al. (2015) concluded that poor work performance, attendance and punctuality problems, conflicts with the supervisor and social and behavioural issues caused people to cease being in supported employment.
Limited evidence and research exists from the perspective of service providers. Lynch (2002) refers to best practice and inclusive policies to facilitate individuals in leading ordinary lives and having real jobs in regular settings with appropriate support. In the Irish context, the Comprehensive Employment Strategy for people with disabilities (Government of Ireland, 2015) was launched with priorities focused on building skills, capacity and independence; providing co-ordinated supports into work; making work pay; promoting job retention; and engaging employers. Encompassed in this strategy is the concept of individual’s capacity and not an individual’s incapacity. This is in congruence with the World Health Organization (2001) International Classification of Functioning, Disability and Health (ICF), which focus on the level of health and participation for individuals, with a shift from cause of an illness or disability to the impact of it functionally on the individual.

Work has always been a domain of occupational therapy practice, where occupational therapy has a philosophy of seeking to create work for individuals with a lifelong disability (Thurgood and Frank, 2007). College of Occupational Therapists (2006) supports this, stating that employment is a key agenda for occupational therapy.

Against this backdrop of limited research, the need to investigate the experience of occupational therapists when referring adults with intellectual disabilities to supported employment services in Ireland was identified. ‘A consistent finding of reports on the issue of employees with disabilities is that, relative to other equality and diversity issues, there is very little research on the subject either in Ireland or worldwide’ (Alban-Metcalfe, 2004a; Hirst et al., 2004; Murphy et al., 2002 cited in National Disability Authority, 2008). This leads to the question of what are the experiences of occupational therapists who refer adults to supported employment services in Ireland?

The aim of this research was to explore the experience of Irish occupational therapists who refer adults with intellectual disabilities to supported employment services. A secondary aim was to discover what factors may assist and what barriers may exist for occupational therapists when working in this area of practice.

Methodology

Research design
A qualitative approach was used for this study. Within the area being researched, there was minimal published information from the viewpoint of Irish occupational therapists who refer adults with intellectual disabilities to supported employment services. In this research project, the authors wanted to establish the experience of occupational therapists in an aspect of programme delivery. Spencer et al. (2003) purport that qualitative data are useful and appropriate as a method when identifying factors that contribute to programme delivery and as a method to analyse policies and verify outcomes.

The authors’ rationale for using a qualitative approach for this research include that it is, as Carpenter and Suto (2008) describe, interpretive, flexible and a method of gaining in-depth information on the individual’s experience. Semi-structured interviews were used by the author because of the nature of them being what Miller and Crabtree (2004) describe as a method of gathering focused, specific information in partnership with participants with a motive to generate themes.

Sample selection
Only occupational therapists, working in Ireland, who specifically worked with adults with intellectual disability, or had adults with intellectual disabilities on their caseload, were included. Participants were sought through the Association of Occupational Therapists of Ireland (AOTI) Intellectual Disability Advisory Group.
Data collection

In-depth, semi-structured interviews were conducted with four participants, and all interviews were audio-taped and transcribed verbatim.

Data analysis

The results were analysed using thematic analysis (Braun and Clarke, 2006). The first author commenced manual analysis following the completion and transcription of the first interview. Initially, line-by-line coding on the written transcripts was conducted, which advanced onto focused coding, conducted in a manner advised by Charmaz (2004) where the recurring codes that emerged in the line-by-line coding were grouped together into more focused coding. The first author made memos throughout the analyses to assist the development of themes. Concepts that emerged from the coding were continuously compared with all available data and the other themes as they emerged. Concepts that represented similar phenomena were grouped together to create the four emergent themes.

Ethical considerations

Ethical approval was granted by the University of Limerick ethics board to conduct this research and ethical guidelines cited in the University of Limerick Research Ethics Committee (ULREC) Guidelines for completion of Application Form (2008) were adhered to. Participation was voluntary and participants were free to withdraw at anytime, and there are no benefits, financial or otherwise for participants. Confidentiality was strictly adhered to and nothing to identify the participants or where they work is included in this paper.

Trustworthiness

The authors adhered to the concept of “reflexivity” cited in Finlay (2006) and reflected on their own thoughts at different stages during the research keeping a reflective diary to supplement what Finlay (2006) describes as an “audit trail”. There was multiple coding to produce the highest quality themes possible and within the limited time-span the authors worked on identifying themes to the point of data saturation.

Findings

Following in-depth analysis of the data, the following themes emerged about the experiences of Irish occupational therapists who work with adults with intellectual disabilities who access supported employment:

Referrals are received by occupational therapists in contrast to occupational therapists referring adults to supported employment

This was highlighted by all the participants who stated the following:

Participant 1: “the job coach actually refers the clients to me”.

Participant 2: “we would sit down together and look for the most appropriate service for the client and that would include into supported employment so I wouldn’t refer them directly myself”.

Occupational therapy roles

All participants spoke about the different roles that they play in working with individual’s availing of supported employment or transitioning to supported employment. Within this
role, the major themes that arose were assessments, task analysis, supporting clients and the development of client skills.

Assessment. All four participants spoke of different assessments that they conduct with individuals who are either considering commencing supported employment or were in supported employment. This was highlighted by Participant 1 who reported:

Participant 1: (receive referral for) “assessment because I undertake pre-vocational assessments and I use standardized assessments. I use the Jacobs Pre-Vocational assessment, I use the Cognitive Assessment of Minnesota and I use the AMPS”.

Participant 3: “You would be asked to do an assessment on somebody’s skills. In fact, I recently did the Assessment of Motor and Process Skills”.

Transport safety assessments were described as another aspect of the role of the occupational therapist:

Participant 4: “they (Day service staff) would ask the occupational therapist to come and do a travel safety assessment and that is where I have stepped in”.

Task analysis. Another aspect of the occupational therapy role identified was that of task analysis. This was reported to be completed when the client was in a job and occasionally before the client commencing work:

Participant 1: “when I would meet the employers I will analyse the task. I would then bring the individual to the task, and we will demonstrate what they have to do and break that task down”.

“Supporting the individual” and “developing skills”. Participants reported that they spend time supporting the clients and developing skills such as social skills, life skills, work skills and communication skills:

Participant 1: “I will put in a number of hours supporting the individual”.

Participant 2: “it is to build their skills, build esteem and confidence and everything”.

Pragmatics: factors that facilitate and barriers that challenge
Factors that assist the process and potential barriers were identified by participants.

One participant reported being inspired by client motivation as highlighted here:

Participant 1: “Realistically they want a job, and I think that is an expected normality and all of us, we want to be engaged in something, engaged in something worthwhile and proactive you know and I am just inspired sometimes by their motivation”.

Another participant reported on client motivation stating:

Participant 3: “They’re very motivated and it’s their capacity to be able to do something that will stop them more than their motivation”.

The level of happiness of clients was identified:

Participant 2: “they are just blooming, you can see them once they start, it’s just interacting with others and their communication and social skills, all of that, that you strive to do in sessions, that develops just quickly within the working environment”.

The good will and support of employers was highlighted:
Participant 2: “people with intellectual disability need that extra bit of support with supported employment as well, so it is the good will of the employers as well to take them on”.

In contrast to the factors that facilitate, barriers that exist were identified such as low client expectations, and this was also described as an area to develop with clients to raise expectations as exemplified by Participant 1:

Participant 1: “I find with intellectual disability their expectations is very limited [...] [...] the limitation of their knowledge because that’s just the work experience they got, because that’s the common work experience, to the likes of Dunnes or big supermarkets and bring boxes from the store and stack shelves. That’s the limitations; it’s hard for them to think beyond that”.

The barrier of transport in a rural areas was highlighted as was the area of information and having the relevant information on services:

Participant 3: “transport and things like that cause problems too, because we are reliant on family as well as we don’t have, say, public transport”.

Participant 2: “Information, it’s not, you really have to dig as a therapist to find out which service is which, which takes a lot of time. The information isn’t there all the time”.

Another barrier identified was of funding and the current economic climate:

Participant 1: “Funding is a big issue, always a big issue”.

Participant 2: “Funding is a nightmare, no getting away from it”.

Participant 4: “economically in the current climate now we are going to be the worst hit people and unless they are very much into a job and have it secured, but if there’s other people in the community who can do that job who don’t have an intellectual disability, I am very sorry, that is the reality, they will probably be accepted for work”.

Participant 1: “It has been extremely difficult (placing clients in work) with the climate at the moment because of the recession in Ireland and the limitation of the jobs and the way a number of employers have been hit financially”.

Associated with funding, the area of client’s benefits was discussed by participants:

Participant 1: “they normally don’t do more hours than to affect their benefits. [...] so keeping within a certain amount so not to interfere with benefits”.

Participant 2: “There are only a certain amount of hours that they are officially allowed to work that won’t affect their benefits”.

“Future role”

When asked about the future role of occupational therapy in the area of supported employment, the following information emerged:

Participant 1: “I think as OTs we have to be pro-active and we have to put ourselves forward, that we can do this because I think that our training, we have the best training to make us very competent in assessing an individual’s abilities and to analysing the task and breaking the task down, making it something the individual can perform in the work environment so I think we are the best placed people to carry this forward”.
Participant 2: “I think there is a huge role. I think it is, an area that will be developed and I think there is a role for OTs working within that area”.

When asked about working with different agencies in the future:

Participant 2: “I suppose more working together in the future would be beneficial”.

Participant 4: “OT see things a bit differently maybe than other services, it’s just the way, that is just our profession as well, so I think we could bring lots to groups and developing their skills and getting people ready for supported employment but at the moment there are just so few of us”.

Discussion

Referrals are received by occupational therapists in contrast to occupational therapists referring adults to supported employment

Interestingly, the participants reported that they actually received referrals rather than refer people to supported employment. It would be beneficial to explore this phenomenon further to ascertain if other occupational therapists are referring individuals with intellectual disability to supported employment services. Especially, as evidence from other countries such as the USA indicate that there may be what Casper and Carloni (2007) claim to be an underutilisation of supported employment services. Siperstein et al. (2013) warn that “the employment outlook for adults with intellectual disability will continue to be bleak until new ways are found to meaningfully incorporate this population in the labor force” (Siperstein et al., 2013, p. 157). Watson (2006) suggests that in relation to employment in its broadest sense, occupational therapists currently play a marginal role in this area. Kelsall (2009) supports this suggestion when claiming that few occupational therapy services are taking the challenge and investing their specialist skills in the area of employment (Kelsall, 2009, p. 120). Additionally, it would be useful to explore why occupational therapists are not referring adults with intellectual disabilities to supported employment.

Occupational therapy roles

The role that occupational therapists play in assessment was highlighted in the data collected from all participants. Participants indicated that they used a range of assessments, and these were important to get a functional profile of the person in supported employment or about to enter into supported employment. Law and Baum (2005) assert that occupational therapists use assessments and measurements to improve decisions regarding clients. When reporting on case studies of job support by occupational therapists for people with developmental disabilities, Arikawa et al. (2013) highlighted occupational therapists help by assessing the occupational performance of the individual and the work environment. The present findings from the participants concur with this aspect of occupational therapy practice where occupational performance and the work environment are assessed.

The importance of task analysis to support clients in, or entering, supported employment was highlighted by the participants. It was described as a current role for occupational therapists working in this area of practice. According to O’Brien (2013), activity analysis is central to occupational therapy practice. Braveman (2006) states that occupational therapists are well aware of the importance of the fit between the individual and their environment, with research by Fillary and Pernice (2006) recommending that employment support staff provide “a desirable person/work match” (Fillary and Pernice, 2006, p. 36). Additionally, Crepeau and Boyt Schell (2009) state that occupational therapists “are concerned with the specific situation of the client and therefore must understand the specific occupations the person wants or needs to do” (Crepeau and Boyt Schell, 2009, p. 360).
Skill development for clients was identified as a role by the participants, as was providing support for clients. Research shows that occupational therapists play an important role in the development of client skills. Vila et al. (2007) reported that training and monitoring of the individual in supported employment contributed to the support of these individuals. Fillary and Pernice (2006) recommended that people in supported employment were given effective on job support. Test (2004) further recommended that individuals with disabilities could be taught self-determination skills to prepare them for work situations. The evidence highlighted suggests that what the participants are currently doing is congruent to practice within supported employment.

Pragmatics: factors that facilitate and barriers that challenge

Client motivation was an area highlighted by the participants. In relation to the theme of client motivation, research shows that individual characteristics such as motivation are factors in determining the possibility of individuals with intellectual disability finding employment or not (McConkey and Mezza, 2001; Rose et al., 2005).

The sub-theme of limited expectations for clients is in congruence with Kelsall (2009), who stated that many people with intellectual disability have limited opportunity to gain experience in employment opportunities. Kelsall (2009) further indicated that occupational therapists have a role in facilitating individuals with intellectual disability to explore employment opportunities. This role may be to raise client expectations to provide clients with a wider range of vocational exploration because as Townsend et al. (2007) highlight “with support from occupational therapists, clients visions of possibility may energise them to imagine a life that may not be expected of them and they may have not expected” (Townsend et al., 2007, p. 102).

Inadequate transport was highlighted by participants as a challenge. Research conducted by Conley and Taylor (2003) highlighted inadequate transport as a barrier for individuals to access supported employment. The Disability Federation of Ireland (DFI) (2015) assert in their submission to the Department of Social Protection in Ireland that transport has always been a major barrier to the participation in work for people with disabilities. They further assert that “inadequate public transport, and unaffordability or non-viability of personal transport prevent people taking up employment opportunities” [Disability Federation of Ireland (DFI), 2015, p. 5].

Funding and the economic climate in Ireland were highlighted as barriers in supported employment. This is also considered internationally. In a study on the slowing momentum of supported employment services in the USA, Cimera (2006) highlighted the impact that lack of funding may place on the services provided.

Financial disincentives within the benefits system for people with a learning disability were described by Kelsall (2009). Furthermore, Bond et al. (2008) assert that there may be a fear amongst some individuals who access supported employment that they may lose health insurance, and the number of hours worked per week may be influenced by rules relating to disability payments and medical aid eligibility. This was also a theme that emerged from the participants. Provision of reliable, accessible benefits advice was advised by Wistow and Schneider (2006), with Schneider (2007) reporting a lack of confidence amongst professionals working in supported employment in dealing with benefits issues.

Future role of occupational therapists in supported employment

The participants identified future roles for occupational therapists in the area of supported employment. Current theory such as that of Townsend et al. (2007) support this. “Occupational Therapists are encouraged to generate the courage and supports to enable individual and social change, thereby advancing opportunities for client empowerment and
participation in society” (Townsend et al., 2007, p. 103). This idea is further developed by Finlayson and Braveman (2006), who stated occupational therapists were challenged to offer the best and most effective interventions possible.

In occupational therapy practice, Pettigrew (2010) asserted that there are many exciting emerging areas of practice on the horizon. Occupational therapy has the potential to play a greater role in the area of supported employment. Occupational therapists contribute to closing the gap between the impairment of individuals with developmental disabilities and the complex demands of supported employment (Siporin and Lysack, 2004). King and Olson (2009) further support this by claiming that occupational therapists are ideally positioned to include motor skill function, cognitive function, social skills, activities of daily living and adaptive equipment as part of treatment programmes in the area of supported employment.

It is important that occupational therapists continue to work in and develop this area of practice. However, in relation to employment in its broadest sense, Watson (2006) suggests that occupational therapists currently play a marginal role in this area. Kelsall (2009) supports this suggestion claiming that “few occupational therapy services are taking the challenge and investing their specialist skills in this area” (Kelsall, 2009, p. 120), highlighting the role that occupational therapists could take in this area of practice.

A review of relevant Irish policy identified four pillars which will underpin services for people with disabilities in Ireland into the future: the rights of people with disabilities; the delivery of person-centred services; the mainstreaming of service provision; and service quality (Finnerty, 2013). Consequently, occupational therapists are ideally placed to support these aspects of service delivery.

Limitations of study
The authors acknowledge that it would be more advantageous to have a larger number of participants to have a greater representation of occupational therapists’ views on this particular area of practice. Currently, there is no official database of occupational therapists in Ireland working in the area of intellectual disability; therefore, recruitment of participants was difficult. The limited time-span for completion of this research was also considered when considering limitations of the study.

Conclusion
This study demonstrated that researching occupational therapists’ experiences provide an important perspective on supported employment services in Ireland. This research set out to explore the experience of Irish occupational therapists who refer adults with intellectual disabilities to supported employment services. A key finding from the participants was that they received referrals for individuals instead of referring individuals to supported employment. They appeared to work in an inter-agency collaborative method where they worked closely with job coaches, staff of day services and clients. However, it would be advantageous to further investigate whether other occupational therapists in Ireland are referring individuals to supported employment and establish the reasons that occupational therapists may or may not be referring individuals.

The areas that the participants reported to have most involvement in were the areas of assessment, client support, client skill development and task analysis. These areas are traditionally part of the occupational therapy process, and as literature suggests, this is one of the unique aspects of the profession of occupational therapy.

Various pragmatics around the area of occupational therapists working with individuals with intellectual disabilities in supported employment were highlighted. Client motivation and the good will of employers were identified as facilitators, while barriers identified
included funding, transport and limited client expectations. All participants felt that there was a future role for occupational therapists working in this area. Possible roles may include raising expectations of individuals with intellectual disability within the area of work and vocational exploration and supporting social inclusion, thus enabling participation.

However, therapist’s workloads and a lack of resources and funding may impact on the service they provide, and they may have to prioritise other areas of intellectual disability service provision, such as equipment provision or sensory integration over supported employment.

Acknowledgments
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References


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Progressing recovery-oriented care in psychiatric inpatient units

Occupational therapy’s role in supporting a stronger peer workforce

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Abstract

Purpose – Initiated by the service user movement, recovery-oriented practices are one of the keystones of modern mental health care. Over the past two decades, substantial gains have been made with introducing recovery-oriented practice in many areas of mental health practice, but there remain areas where progress is delayed, notably, the psychiatric inpatient environment. The peer support workforce can play a pivotal role in progressing recovery-oriented practices. The purpose of this paper is to provide a pragmatic consideration of how occupational therapists can influence mental health systems to work proactively with a peer workforce.

Design/methodology/approach – The authors reviewed current literature and considered practical approaches to building a peer workforce in collaboration with occupational therapists.

Findings – It is suggested that the peer support workforce should be consciously enhanced in the inpatient setting to support culture change as a matter of priority. Occupational therapists working on inpatient units should play a key role in promoting and supporting the growth in the peer support workforce. Doing so will enrich the Occupational Therapy profession as well as improving service user outcomes.

Originality/value – This paper seeks to provide a pragmatic consideration of how occupational therapists can influence mental health systems to work proactively with a peer workforce.

Keywords Recovery, Mental illness, Peer Workforce, Psychiatric hospitalisation

Paper type Viewpoint

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Introduction
Since the first published literature over 20 years ago, the recovery paradigm has evolved and grown. Recovery-orientated practice is now seen as one of the core tenets of good mental health service delivery (Slade et al., 2014). At the core of the recovery paradigm is the preservation of an individual’s hope and right to self-determination. Recovery-orientated practice is creating real change in health providers’ attitudes (Slade et al., 2014). Despite this, there remain areas of mental health care where progress in recovery-oriented reforms has been harder to achieve.

The inpatient environment is one such setting. Peer workers are individuals with a lived experience of mental illness who identify themselves as such and who use their lived experience to support their peers during recovery (Tse et al., 2013; Vilic et al., 2016). Peer workers can play a pivotal role in progressing recovery-oriented practice reform. This is recognised in the Fourth National Mental Health Plan (Commonwealth of Australia, 2009) with peer workforce identified as key areas of three of the five priority areas and as part of the vision for mental health care reform in Ireland [Department of Health (Ireland), 2006]. Being an occupational therapist does not inherently make a practitioner recovery-oriented. The underlying philosophies of the profession, however, do provide a solid platform for occupational therapists working on inpatient units to form a natural alliance with peer support workers to help advocate and support recovery-oriented practice reforms (Lloyd et al., 2004).

While occupational therapists have been actively engaged in research on and with peer workers, there is minimal published literature addressing how the peer workforce and Occupational Therapy can work in collaboration in the clinical setting to achieve better mental health care. This article seeks to encourage occupational therapists to be active advocates in research and clinical practice for the development of a strong peer workforce working in collaboration with occupational therapists.

Recovery in mental health
The ideas behind recovery practices emerged out of the service user, or survivor, movement and, thus, outside the traditional mental health arena. The service user movement emphasises that mental illness must be understood from the perspective of those directly affected and draws on the recovery values of hope and use of knowledge gained from lived experience to help each other (Deegan, 1992). As such, it seems logical that those with a lived experience are the most appropriate people to facilitate culture change towards a recovery-orientated approach. Recovery refers to wellness as a work-in-progress rather than one side of a binary structure of exclusive states of health, which is the absence or presence of illness. In the UK, recovery outcomes are described as:

A greater ability to manage one’s own life, stronger social relationships, a greater sense of purpose, the skills needed for living and working, improved chances in education, better employment rates and a suitable and stable place to live (Her Majesty’s Government, 2011, p. 6).

The recovery paradigm represents sets of values and principles, informing changes to practices and healthcare systems, based on accumulated research and debates from more than two decades (Slade et al., 2014). In Australia, recovery is defined as ‘being able to create and live a meaningful and contributing life in a community of choice with or without the presence of mental health issues’ (Commonwealth of Australia, 2013, p. 2). It seems most now agree what recovery-orientated services look like. The question remains ‘how best to shift traditional approaches in well-established institutions like inpatient psychiatric units further towards recovery-orientated practice?’
Lawn et al. (2008), in reviewing the impact of peer workers as part of an early discharge support service, found that where adequate supports were available, overall staff, service users, carers and peer workers themselves reported positive experiences with the peer worker role. Peer worker roles have the potential to impact the experience of service users accessing psychiatric inpatient units and help drive the culture of inpatient units towards a true recovery framework.

The inpatient context
Inpatient mental health units are undoubtedly one of the most challenging environments in which to introduce recovery-oriented practice. The processes of managing a busy acute mental health ward can involve the use of compulsory hospitalisation and result in a perceived, and at times real, lack of choices about medication, freedom to leave the ward and even simply meal choices can cause frustrations for the service user (Walsh & Boyle, 2009). While there are positive examples, overall a negative picture of the inpatient unit is portrayed with boredom on the units, poor communication with staff, lack of information and perceived valuing of hospital routines over service user needs being evident (Hyde et al., 2014; Walsh & Boyle, 2009). In addition, they may have little knowledge about what is available in the community, as there is little encouragement for service users to re-engage with neighbours and others in the community with similar interests (Cleary et al., 2013; Walsh & Boyle, 2009).

The dominance of the biomedical and legal models of care continues to be pervasive (Hyde et al., 2014). Medication is the main form of treatment given to people on inpatient wards, and participants in Hughes et al. (2009) study reviewing involuntary inpatient care expressed strongly negative views about how this treatment was administered. Walsh and Boyle (2009) also revealed consensus amongst study participants with the way medication was administered in the inpatient setting. Interestingly, a significant number of participants in Walsh and Boyle (2009) did report finding medication helpful as a treatment. There is a continuing emphasis on custodial measures, such as the use of seclusion and the use of medication that are both characteristics of a biomedical model. Seclusion and restraint practices, used to manage people who are a risk to themselves or others, remain commonly used to help maintain short-term safety despite the current knowledge that these practices are known to be traumatic to the individual experiencing them (Muskett, 2014). This is despite well-established evidence that alternative approaches to seclusion such as the use of sensory approaches are more effective in creating a place of safety that is less harmful in the long term to the individual (Ashcraft et al., 2012; Lloyd et al., 2014). Coercion has been reported by inpatients as being extremely distressing and impacts negatively on people’s sense of self-efficacy and self-worth as well as perpetuating cycles of conflict (Hughes et al., 2009). Attempts have been made to improve the clinical interventions in individual inpatient psychiatric environments with some success. Overall, however, the picture remains one where progress to more recovery-oriented systems is slow at best.

Peer workers on an inpatient unit
Davidson et al. (2012) report that increasing/introducing a peer workforce in a mental health setting is complicated but can support significant cultural change. The introduction of peer workers into the acute inpatient psychiatric setting can be a powerful tool in moving these settings closer to true recovery-orientated systems. By working closely with peer workers, occupational therapists may find allies in establishing inpatient units that are health promoting venues that uphold the tenets of recovery-oriented practice. Occupational therapists have long promoted the development of the recovery approach for people with a
mental illness (Lloyd et al., 2004) and have advocated for the active participation of service users.

Peer workers have assisted in developing an environment of hope, a sense of self and belonging and determination to recovery (Davidson et al., 2012; Vilic et al., 2016). They provide social and emotional support coupled with instrumental support to others sharing a similar mental health condition to bring about a desired social or personal change (Landers & Zhou, 2011). The peer worker can share their knowledge from a lived experience with both service users and staff. It is a twofold effect that, in turn, reduces stigma and provides the opportunity for the person to commence their individual recovery journey.

Peer workers can provide input to the day-to-day operations of a ward through group work, individual sessions and/or participating in ward meetings (handover, case review). Inpatient groups facilitated by peer workers focus on discussing recovery and how to manage early warning signs and offering referrals to community-based clinical and peer support workers after discharge (Vilic et al., 2016). Alternatively, individual sessions may occur allowing discussions between two people with lived experience around strategies that may help service users to manage symptoms. Peer workers are able to draw on their personal experiences, sharing strategies of what they have utilised/use that may assist service users on the inpatient ward. Sledge et al. (2011) found peer support to be effective in reducing readmissions of people with multiple psychiatric hospitalisations. Likewise, Lawn et al. (2008) found that peer workers’ role in supporting early discharge facilitated reducing readmission rates. This demonstrates the value of peer support programmes in assisting service users to identify resources and supports to accomplish recovery goals and with assisting systems to engage with service users.

A less tangible benefit of a strong peer workforce can be the impact this has on the culture of a service. An example of this is the work by Foxlewin (2012) in influencing seclusion and restraint practices. To be successful, it is clear that a healthy peer model requires strong leadership, supervision and support (Davidson et al., 2012; Vilic et al., 2016). Gillard et al. (2015) acknowledge that there are many barriers when introducing peer workers into established structured environments (such as inpatient units); however, when supported by the organisation and introduced as equal members of the team culture, change can be sustained. Strategies on the ground need to be put in place that address the role of the peer worker, the unique needs of the worker and overall workplace environment to enable peer workers to provide meaningful psychosocial, emotional and practical support to inpatients (Moran et al., 2013). Training is required for peer worker supervisors to ensure that they understand the policies and practices with respect to confidentiality, role definition/scope and are equipped to set them in place and enforce them amongst their staff (Gates & Akabas, 2007; Vilic et al., 2016). It is absolutely necessary that regular supervision be provided to peer staff to ensure they are receiving the support and accommodation that they need to best meet their job requirements (Gates & Akabas, 2007), and a senior peer worker or external peer supervisor is appointed to provide professional supervision (Vilic et al., 2016). It is important that peer worker roles are clear, and they are able to optimise their expertise.

**Occupational therapy and peer workers**

Occupational therapists working on inpatient units usually are in sole positions and have a role where they may be responsible for the group programme (Duffy & Nolan, 2005; Lloyd & Williams, 2010). In addition, a part of their role may include assessing people’s activities of daily living and making recommendations about discharge (Lloyd & Williams, 2010).
Nowadays, with the advent of peer workers on inpatient units, there is an opportunity for occupational therapists to rethink their role and to work out ways of working closely with peer workers.

Peer workers are a unique professional group which in many ways is continuing to clarify and define their role (Kemp & Hendersen, 2012). Occupational therapists working with peer workers need to be mindful that as a professional group, peer workers require support and a willingness to understand their unique role (Kemp & Hendersen, 2012). The relationship between the peer worker and the occupational therapist starts with how they work together on a day-to-day basis. The inpatient unit can be an unfriendly place to a newcomer. It is a place where there is much action happening, and yet at the same time, it can be quiet and appear as if nothing is happening. It is a place of contradictions. The occupational therapist has the opportunity to start working on establishing a collegial relationship with the peer worker as a colleague and partner in recovery-based interventions. This may extend from talking to the peer worker, maybe sharing office space together, seeing service users jointly and collaborating (both as lead and supporting facilitator) on the group programme together. Lloyd and Williams (2010) suggested that there were four key elements of practice undertaken by occupational therapists working on inpatient units. In regards to the day-to-day clinical work, occupational therapists may consider working in partnership with peer workers in these practice areas:

- **Assessment** – Occupational therapists should actively pursue opportunities to work collaboratively with peer workers in the assessment processes (mostly informal assessment rather than the use of specific Occupational Therapy assessment tools) to identify the service user’s strengths and assets. Involving the peer worker in this process may provide a much more realistic view of the service user and highlight alternative information more freely shared with the peer worker, enhancing the occupational therapist’s ability to understand and accurately assess the skills, abilities, concerns and hope for the future.

- **Individual work** – When meeting with service users for individual work, the occupational therapist could ask the service user if they would like to see the peer worker as well. This would give a much more rounded approach, and the service user would feel that their concerns were being heard.

- **Group programme** – It may be a good time for the occupational therapist to think about the groups that he/she has been running and see if there is some way to work more closely with the peer worker. Where appropriate, the occupational therapist should support the peer support worker to take the lead facilitator role. These groups could include such things as managing your illness, lifestyle, hope and recovery (Vilic et al., 2016).

- **Discharge planning** – In talking with the service user about discharge, the occupational therapist could involve the peer worker. This may include jointly running a discharge preparation group to seeing the person individually (Table I).

At a broader level, occupational therapists have an opportunity to advocate for system change to support the introduction of peer workers. This can be achieved in organisations in a number of ways:

- **Language** – Language in the work place has a significant impact on staff culture and attitudes. Occupational therapists can support a positive culture identifying positive language (person first language, strengths based).
- **Supervision** – It is commonplace at present for supervision of peer workers to sit with a member of the allied health team. Occupational therapists need to resist the system push to provide supervision to peers and be a clear voice advocating for the requirement to ensure adequate professional supervision is available by a senior peer worker.

- **Workforce development** – Developing a clear role description and workforce development plans that are sensitive to the needs of the professional roles are essential components in the creation of new positions. It should be no different when considering the peer workforce. This cannot occur without the involvement of senior peer workers in this process. Occupational therapists can be advocates within their work system to ensure that peer worker roles are not established and built without the leadership of a senior peer worker.

- **Research** – Simpson (2010) suggested that greater involvement in research that focuses on the role of occupational therapists, their impact on service user experiences and outcomes and the interrelationships with the functions and responsibilities of other staff was essential. Importantly, this would give us opportunities for greater collaboration and a firm background of involvement with service users on the inpatient unit.

### Conclusion

While there have been considerable advances made in inpatient psychiatric care, it is recognised that it remains a challenging environment in which to introduce recovery-oriented practice. However, peer workers are an essential component of comprehensive mental healthcare. Recovery-oriented practices are about evolving a culture of values and principles that support environments and behaviours where service users feel a sense of control, choice and hope in their future. Occupational therapists working on inpatient units are ideally positioned to play a key role in driving the push for recovery-oriented practice. This article contributes to the developing debate on recovery-oriented practices in the inpatient environment by suggesting that the employment of peer workers is both a positive step towards creating recovery-oriented inpatient services in mental healthcare on inpatient psychiatric units and presents an opportunity for the profession of Occupational Therapy to help facilitate culture change in establishing peer workers as a mainstay of inpatient care.

### Table I.

<table>
<thead>
<tr>
<th>Service delivery</th>
<th>Engage peer workers in joint working to enhance:</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Assessments</td>
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<td></td>
<td>Individual work (both Occupational Therapy led and referring for peer worker led)</td>
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<td></td>
<td>Group programmes (as lead and support facilitator as appropriate)</td>
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<tr>
<td></td>
<td>Discharge planning/facilitation process</td>
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<tr>
<td>Peer support</td>
<td>Seek opportunities to engage peer workers as equal colleagues of the multi-disciplinary team</td>
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<tr>
<td></td>
<td>Ensure peer workers have office space available with other allied health team members</td>
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<td></td>
<td>Be sensitive to the language in the workplace</td>
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<tr>
<td>System level</td>
<td>Advocate for appropriate supervision for peer workers</td>
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<tr>
<td></td>
<td>Advocate for clear role descriptions and development plans that are driven by senior peer workers</td>
</tr>
</tbody>
</table>

**Progressing recovery-oriented care**
References


Foxlewin, B. (2012), “What is happening at the seclusion review that makes a difference? – A service user led research study, available at: www.actmhcn.org.au


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Experiences of men with psychosis participating in a community-based football programme

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Abstract
Purpose – Physical activity is associated with both physical and mental health benefits for people with psychosis. However, mental health services have been criticised for failing to adequately promote physical activities. Occupational Therapy, with its focus on meaningful everyday occupations, is well placed to incorporate physical activity interventions. The purpose of this study was to explore the experiences of men with psychosis participating in an Irish community-based football programme.

Design/methodology/approach – Six men with psychosis participated in qualitative interviews. The interviews were audio-recorded and transcribed verbatim. Interview data were analysed thematically.

Findings – Participants identified many benefits of engaging in the programme. Football became a valued part of weekly routines and fostered re-engagement with previously valued roles. Participants identified improvements in social confidence and motor and process skills, as well as a positive impact on their mental and physical health.

Originality/value – This study highlights the value and meaning of participation in football for men with psychosis, as well as demonstrating the longer-term feasibility of football as a therapeutic medium in Occupational Therapy mental health service provision. Findings could help to promote the routine use of sports interventions to mental health services.

Keywords Mental health, Football, Recovery, Psychosis, Physical activity, Model of human occupation

Paper type Research paper

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Introduction
In addition to a range of physical health benefits, physical activities such as football can lead to improvements in psychotic symptoms, mood, alertness and concentration, sleep, self-esteem and the development of a positive identity (Alexandratos et al., 2012; Hutcheson et al., 2010; Mason and Holt, 2012). However, there is limited evidence on how physical activity is actually experienced by people with psychosis (Alexandratos et al., 2012).

Literature review
Physical activity and mental health services
While physical activity can contribute to improved quality of life through social interaction, meaningful use of time and purposeful activity (Alexandratos et al., 2012; Hutcheson et al., 2010), people with psychosis are vulnerable to exclusion from sports because of a number of factors, including weight gain, difficulties with motivation and self-care, lack of routine, social isolation, lack of support, financial difficulties and a perceived lack of opportunities to access community resources (Carter-Morris and Faulkner, 2003; Cole, 2010; Hodgson et al., 2011). The Department of Health’s policy framework, Healthy Ireland (Department of Health, 2013), promotes the development of programmes to encourage vulnerable populations, including those with mental health problems, to engage in physical activity. While the mental health policy A Vision for Change (Department of Health and Children, 2006, p. 41) acknowledges that membership of a sports club or football team conveys “the benefits of physical exercise […] sense of belonging […] social contacts and support”, it does not actively direct mental health services to offer their clients opportunities to engage in sports. Similarly, mental health service providers have been criticised for not devoting enough attention to the promotion of physical activities (Carpiniello et al., 2013), with both staff and service-users reporting a lack of structured and accessible activity (Hutcheson et al., 2010).

Service-users may experience synergistic benefits from physical activity programmes delivered by mental health services working with community-based sports organisations (Hodgson et al., 2011; Nyboe and Lund, 2013; Spandler et al., 2013), with the integration of physical activity into mental health service provision forming a “critical component” of recovery-focused interventions (Richardson et al., 2005, p. 329). There is a need for healthcare professionals using football as an intervention to explore how physical activity is experienced by people with psychosis (Alexandratos et al., 2012), with qualitative research in particular key to furthering understanding of the effects of exercise from the participants’ unique perspectives (Mason and Holt, 2012; Mutrie, 1997). A review by Alexandratos et al. (2012) highlighted a further gap in the literature regarding the feasibility of longer-term physical activity programmes, as most of the included interventions were short term with limited follow-up.

Physical activity as an occupational therapy intervention
Occupational Therapy can facilitate community-based participation for people with mental health problems (Pieris and Craik, 2004) and is well placed to incorporate physical activity interventions into meaningful everyday occupations (Alexandratos et al., 2012; Jones, 2008). Fiona Cole (2010) illustrated the value of the Model of Human Occupation (MOHO) in conceptualising the physical activity experiences of people with mental health problems. MOHO (Kielhofner, 2008) examines how volition, habituation, performance capacity and the environment interact to produce occupational performance or dysfunction. However, Cole’s study focused on people with anxiety or depression and who had expressed an interest in physical activity. The present study builds on this work by including men with psychotic disorders who were actively engaged in physical activity.
The main aim of this qualitative study was to explore the subjective experiences of the participants of a community-based football intervention, the KSRP. A secondary aim was to report the long-term feasibility of this intervention delivered as part of an Occupational Therapy programme.

Methods

The kickstarting recovery programme

The setting for this study was an urban state-funded mental health service in Ireland, consisting of 13 multidisciplinary mental health teams, 3 multidisciplinary rehabilitation and recovery teams and a homeless service. Participants in the Kickstarting Recovery Programme (KSRP) had a diagnosis of psychosis and came from across the service.

The KSRP emanated from a lack of opportunity for service-users to engage in valued sporting activities. Service-users had expressed an interest in playing football but were unable to access existing community resources. KSRP was a joint initiative of the mental health service’s Occupational Therapy department, the Football Association of Ireland (FAI) and the local county council to facilitate participation in football for persons with psychosis.

The aim of this qualitative study was to explore the subjective experiences of participants of a community-based football intervention, the KSRP, from an occupational perspective.

Study design

This qualitative study explored the experiences of men with psychosis participating in a community-based football programme, from an occupational perspective. As the aim of the study was to explore experiences using subjective accounts of participation, a qualitative design was chosen (Cole, 2010; Craik and Pieris, 2006).

Ethical considerations

Ethical approval was sought and granted by the Health Service Executive’s local mental health research ethics committee. All participants provided written, informed consent. Pseudonyms are used throughout this document to preserve anonymity. Because of the nature and content of the interviews, it was not anticipated that interviews would cause distress. However, each participant’s keyworker was informed of their participation and was available in case the need for support arose during or following an interview.

Programme delivery

The KSRP was initially piloted in September 2012 for four weeks, with a weekly one-hour session in a local community centre facilitated by an experienced FAI coach. All service-users received clearance from a medical doctor before participation. There have been 12 cycles of training sessions to date (January 2016), with each cycle initially lasting four to six weeks. In 2015, the programme ran for the majority of the year, breaking for eight weeks over the summer and finishing in early December. The number of participants per session ranged from 3 to 18, with a mean of 8.7 participants (SD = 3.1). In all, 74 individuals have taken part (71 male; 3 female), the majority of whom were diagnosed with a psychotic disorder (76 per cent). At least one occupational therapist also participated in each training session and provided grading and adaptation of instructions and exercises when necessary. Activities were, thus, tailored to each individual’s level of ability (Cole, 2010; Creek, 2003). Each session began with a warm-up, continued with skill drills and finished with a match, followed by refreshments in a coffee shop.
Participants
Service-users were eligible to participate if they had attended at least one full cycle of training (4-6 sessions) and were considered by a mental health professional to have the capacity to give informed consent and participate in a qualitative interview. In all, 12 potential participants, all with diagnoses of psychotic disorders, were personally invited to participate by the first author at the end of a training session. Six agreed to take part. All participants were single Irish Caucasian males, with a mean age of 32.8 years (range 20-49). All participants were prescribed atypical anti-psychotics in combination with other psychiatric medications (Table I).

Qualitative interviews
Semi-structured qualitative interviews were used to explore the subjective experiences of participation in KSRP from an occupational perspective. Qualitative interviews are particularly suitable for exploring participants’ engagement in sports (Carless and Sparkes, 2008) and provide an opportunity for detailed investigation of personal perspectives and in-depth understanding of the personal context within which research phenomena are located (Ritchie et al., 2003; Spencer et al., 2003). Each interview began with a set of warm-up questions regarding participants’ hobbies and routines (“what do you do to enjoy yourself in your spare time?”) and explored their interest in football (“do you support a team?”, “would you watch football on TV?”). The remainder of the interview schedule was structured around MOHO (Kielhofner, 2008) exploring volition, habituation, performance capacity and environment (see Table II for sample questions).

Semi-structured interviews were conducted between February and July 2014 by an occupational therapist external to the programme. Interviews were conducted in quiet locations chosen with the participants, lasted between 30 and 50 minutes and were audio-recorded and transcribed verbatim.

Data analysis
Thematic analysis followed two key stages identified by Ritchie et al. (2003): managing the data and making sense of it through descriptive accounts. Data management began by sorting and reducing the data. Initially, a set of 20 codes was devised, based on the research aims, interview schedule and data from the first four interviews. To ensure rigour and trustworthiness and to promote dependability (Pope et al., 2000; Smith and Firth, 2011), each transcript was then coded independently by two researchers. At this stage of the analysis, a number of codes were combined because of considerable overlaps, resulting in a final

<table>
<thead>
<tr>
<th>Demographic and health variables</th>
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<tr>
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<td>Diagnosis</td>
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<td>Supported independent Living</td>
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<td>Quetiapine</td>
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<tr>
<td>Age (mean, range)</td>
<td>32.8, 20-49</td>
</tr>
<tr>
<td>Marital status</td>
<td></td>
</tr>
<tr>
<td>Single</td>
<td>6</td>
</tr>
</tbody>
</table>

Table I. Participant demographic information
number of 14 codes (Braun and Clarke, 2006). The coded material was then synthesised and summarised into descriptive accounts, identifying key dimensions and mapping the range and diversity of each phenomenon while reducing the volume of verbatim quotes from respondents (Spencer et al., 2003; Ritchie et al., 2003).

The next stage was to identify ways in which the codes could be grouped into fewer, broader categories or themes (Ritchie et al., 2003). As we were particularly interested in exploring the participants’ experiences of the programme from an occupational perspective, we identified themes in a theoretical, deductive manner (Braun and Clarke, 2006), ensuring they were not unduly influenced by our theoretical interest in the Model of Human Occupation. Four main themes emerged: positive experiences of playing football; football as part of a weekly routine; improvements in skills; and environmental factors.

Trustworthiness
To minimise potential bias at both the data generation and data analysis stages of the study, participants were interviewed by an occupational therapist external to the programme, with data coded independently by two researchers. Codes were initially developed inductively (Cole, 2010). This open coding ensured that all data items received equal attention in a thorough, inclusive and comprehensive coding process (Braun and Clarke, 2006). This also guaranteed the accurate representation of the full range of participants’ accounts and ensured that the concepts included in the findings were fully grounded in the data (Lewis et al., 2014).

Findings
The findings will be discussed under each of the four themes: positive experiences; football as part of a weekly routine; improvements in skills; and environmental factors.

Positive experiences of playing football
All participants identified participation in KSRP as a positive experience that enhanced their sense of competence and effectiveness. Feelings of accomplishment and “doing a good day’s work” (Frank) were highlighted:

After I do my training […] I feel like I accomplished something […] I went in and I played football and I scored a goal and I contributed to scoring a few goals, you know, and I feel good about myself (Alan).
Through KSRP, playing football became a useful strategy for coping with mental health symptoms: “football does, you know, it helps me cope with life [...] I [look] forward to the football [...] so that’s something to kind of keep me preoccupied with” (Alan). Richie and Tony similarly described football as a useful distraction technique from unhelpful thoughts:

Because I used to get very paranoid when I wasn’t playing football or since I’m now playing football now it’s kind of taking my mind off things [...] get the touch of the football and do the little skills, and it would keep my mind going as well like it would keep all them negative thoughts, and get rid of them negative thoughts (Richie).

Participants described their experience of engaging in KSRP and “the fun of playing with a football at your feet” (Tony) very positively:

You get a much better buzz playing football [...] I can’t say anything bad about playing football, nothing bad (Alan).

I love my football [...] I love just running around on the pitch because I love burning out my energy (Richie).

The value of KSRP to participants was further highlighted by the fact that all participants wanted to encourage other mental health services and service-users to get involved in similar programmes:

I would advise to people that are out there like and they are sitting around doing nothing or lying in their bed to go to their healthcare professional worker and ask for Kickstart Football in their location (Peter).

Alan’s description of himself as “somebody who has got chronic schizophrenia” illustrates how his sense of identity was linked to an internalisation of his role as a patient. Alan appeared to experience a significant role shift as a result of participation in KSRP, from somebody with schizophrenia to “a member of a team”:

After I do my training [...] I feel I’m a person, I’m somebody who matters, so it’s a good feeling [...] I’m a member of a team and I’m a player on a team [...] it just makes me feel good about life (Alan).

These excerpts highlight the value and importance of KSRP to the participants, who identified feelings of achievement, effectiveness, satisfaction and enjoyment as a result of engaging with the programme. This was further solidified when all participants sought to encourage others to share their positive experiences by participating in the training sessions. KSRP facilitated the forging of a new identity for one participant, moving away from a “sick role” towards a more inclusive “member of a team”.

Football as part of a weekly routine
Participants reported varying levels of activity throughout their week, ranging from “very boring” (Alan) to “busy” (Richie). Routines were either leisure and home-based or focused on health-centre activities, such as getting a depot injection or participating in an activity group:

I go to [clubhouse] three times a week [...] I just do my washing, clean up my room and just get everything ready for the next week I do (Peter).
The importance of football and KSRP to participants was evident from descriptions of their weekly routines:

I play football once a week I do [...] I like playing football (Peter).

I love my football, I mean even it starts on a Wednesday but come Monday, Monday morning, Tuesday I will be looking forward to the football for being on, on Wednesday (Alan).

Mark articulated the benefits of KSRP becoming part of his routine:

Well it’s healthy cause it’s something to do in the afternoons, it gets me out of me flat.

Participation in the training sessions “gives you something else to do [...] a different outlet” (Tony):

I’m getting used to the football now because if I hadn’t been going to the football I probably would have been just sitting around like and I would have been probably doing nothing (Richie).

These accounts illustrate the importance and value the participants placed on engaging in football as part of their weekly routine – having somewhere to go, having something to look forward to and having an alternative to just “sitting around”.

*Improvements in skills*

Participants’ awareness of their performance capacity was evident in descriptions of their skills and abilities. Improvements in process and motor skills related to football were noted by participants. Tony described how his “passing has improved”, while Alan highlighted improvements in his overall abilities: “I just feel like I can, I can play better than I used to [...] I’m more hungry to score goals”. Mark noted the return of motor and process skills that he had once possessed:

I just feel [skills] coming back a small bit, like [...] Well controlling the football when you are running with it and being able to dribble past the people, pass the ball and [...] giving little flicks [...] and all that [...] I’m getting back skills that I had (Mark).

Mark also highlighted that his attention was better than usual while playing football:

Other times I could be sitting at home watching the news and me mind would just drift off but when I’m playing football me eh concentration is 100 per cent [...] I’m fully focused on the game (Mark).

Participants also noted physical benefits of participation in the programme, including improved fitness levels, weight loss, having more energy, sleeping better and feeling healthier and more active: “I feel great I do since I started playing football, I just feel more fitter and I lose the weight” (Peter).

The relevance of interpersonal and communication skills was particularly evident when participants described the teamwork element of playing football, such as giving “tips to your teammates and all that” (Mark). Social benefits of participating in KSRP included making new social connections and providing a topic for conversation, which facilitated improvements in social skills and confidence:

I have met a lot of people who I get on very well with and all that because of the football [...] I kind of feel I can talk to people about football [...] and sometimes you meet people and you are a bit stuck for conversation and you talk about the weather or whatever and [...] it’s good to be able to kind of branch out and talk to people about different things (Alan).
Richie described how, at the beginning of his involvement in KSRP, he used to sit:

[...]

Participants identified subjective improvements in various aspects of physical and mental well-being, including improved football and social skills, more focused attention, increased fitness and energy levels and improved weight management and sleeping patterns.

**Environmental factors (physical and social)**

Participants were positive about the physical environment in which the football sessions took place, reporting that the location and facilities were “lovely”:

It’s a nice area [...] it’s a lovely spot, outdoor astro and if there is good weather like this or on a summer’s day I might play outdoors but if it’s bad weather, if it’s a bit cloudy or cold we play indoors in the hall (Richie).

Couldn’t be better, brilliant. It’s in the middle, it’s between here and town so it’s convenient to get to (Alan).

The involvement of professional FAI coaches provided an important resource that facilitated participation and performance, described by Frank as “good motivation”. Participants highlighted the coaches’ professionalism and the support they provided: “I think that’s good yeah, it brings more in-depth training to the, that I mightn’t get elsewhere [...] the exercises or the drills are more professional” (Tony). Peter also described the occupational therapists and coaches as “very supportive”:

They encourage us [...] they are very professional as well, so the two of them work hand-in-hand they do (Peter).

The social environment was highlighted frequently by all participants as being an important aspect of their engagement with KSRP. This included a “cup of coffee” after training and people to talk to:

We all have good craic [fun] we do and we all have a laugh and a joke after then. We all sit there and have a cup of coffee or tea or soft drinks or ice pops and we all have a good chat after (Richie).

**Discussion**

The aim of this qualitative study was to explore the subjective experiences of men with psychosis participating in a community-based football programme, from an occupational perspective. Football became an enjoyable and valued part of participants’ weekly routines and not only fostered re-engagement with previously valued roles, but also the development of new roles and identities. Participants identified improvements in social confidence and motor and process skills related to playing football, as well as experiencing a positive impact on their mental and physical health.

**Football as a valued occupation**

Participants clearly described how playing football became an important and valued part of their weekly routines, something they looked forward to. The integration of leisure activities into individuals’ routines has previously been noted as an important factor facilitating continued participation (Piersis and Craik, 2004). A valuable and meaningful weekly routine is an important part of the recovery process, as well as in shaping who we
are and how we identify and interact with the world (Forsyth and Kielhofner, 2006). Jones (2008) proposed that with the right encouragement and support from occupational therapists and technical instructors, individuals with psychosis could experience and interpret physical activity in a positive light and anticipate future sessions through the volitional cycle (Jones, 2008; Kielhofner, 2008). This is supported by the present study, as participants described how they looked forward to training each week.

Re-engagement with previously valued roles is another key aspect of recovery and was a clear benefit of participation in KSRP. One participant was actually able to forge a new role and identity as a result of his participation, as a “member of a team [...] somebody who matters” (Alan). This is consistent with a previous study of a football programme for people with mental health problems, which found that playing football offered participants a reconnection with a pre-illness identity and was associated with enjoyment and a positive sense of self (Mason and Holt, 2012).

All participants reported that participation in KSRP had a positive impact on their mental health, highlighting that football helped them cope with their illness and provided hope that they could recover. Participants also described how participation in the programme provided a distraction from psychotic symptoms, led to improvements in concentration and alertness and improvements in self-esteem. These findings are consistent with previous research (Alexandratos et al., 2012). KSRP offered men with psychosis the opportunity for social interaction in the context of a normalising activity, thereby helping to reduce social isolation for individuals who are particularly vulnerable to becoming socially excluded from the society (Mason and Holt, 2012; Department of Health and Children, 2006; Hodgson et al., 2011). Indeed, participants identified improvements in social confidence as a result of involvement in KSRP and reported that having a common interest improved their ability to interact with others.

A partnership approach to mental health recovery

Irish health policy promotes the use of collaborative community partnerships, encouraging mental health services to use a community development model to embrace the synergistic effects that can be achieved through multi-agency working (Department of Health, 2013). The KSRP achieved this synergy through the use of community resources and facilities, coupled with the professional experience and expertise from participating FAI coaches and occupational therapists. Participants themselves wanted to encourage other services and service-users to recognise the value of KSRP and to adopt it in their own services. Building closer links with community resources can facilitate continued participation as well as fostering social inclusion (Hutcheson et al., 2010; Jones, 2008), and participants were positive about both the physical and social environment in which the football sessions took place.

Feasibility of Kickstarting Recovery Programme

The KSRP has been running successfully since 2012 and continues to attract an average of eight participants per session, with a total of 74 individuals having attended overall (up to January 2016).

This study adds to the growing body of evidence supporting the use of football as an intervention in mental health. Occupational therapists are in an ideal position to promote the use of sports and physical activity, as well as to facilitate community-based participation for people with mental health problems (Alexandratos et al., 2012; Jones, 2008; Pieris and Craik, 2004). This study illustrates the longer-term feasibility of incorporating football into an Occupational Therapy programme, as well as its acceptability and value to a vulnerable, hard to reach population. The programme has since been adopted by a further seven mental
health services throughout Ireland. The continued success of KSRP, both in terms of sustained interest and participation from service-users, underlines the importance of culturally meaningful, age- and sex-appropriate activity that is of interest to participants (Cole, 2010).

Limitations and strengths
A number of limitations should be noted. Only a sub-sample of participants from the programme were interviewed, and it is possible that the views of non-respondents may differ from those who were selected and chose to take part (Mason and Holt, 2012). The difficulty of recruiting participants with severe and enduring mental health problems has been noted by previous studies (Jones, 2008; Beebe, 2007), with sample sizes ranging from 2 to 12 participants in a review by Alexandratos et al. (2012). While it is not possible to make claims regarding representativeness based on the intensive study of a small number of cases (Denscombe, 2010), nevertheless insights into the experiences of participants in the KSRP might encourage other occupational therapists to consider a similar programme as part of their service delivery. This study provided a unique opportunity to explore the value and feasibility of a community-based football programme, generating an interpretation of existing research from the views and personal experiences of people with psychosis themselves (Alexandratos et al., 2012; Pieris and Craik, 2004).

Future studies
Future studies could explore participation in other forms of physical activity, including those that may be of greater interest to women. We hope that our findings will inspire other mental health services to prioritise physical activity interventions equally with activities of daily living and productivity (Jones, 2008).

Conclusion
This study has highlighted the value and meaning of participation in football for men with psychosis, as well as demonstrating the longer-term feasibility of football as a therapeutic medium in Occupational Therapy mental health service provision. These findings may help to promote the routine use of football and sports interventions to other mental health services.

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Factors that influence hand hygiene practice amongst occupational therapy students

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Abstract

Purpose – Hand hygiene is the single most important intervention to reduce the risk of acquiring infection. All healthcare workers and healthcare students have a responsibility to prevent transmission of infection. The purpose of this study is to investigate students’ attitudes to hand hygiene following university-based education and practice placement. Students attended a lecture, completed an e-learning module, participated in a practical session using a ultra-violet light hand inspection cabinet and engaged in clinical placement.

Design/methodology/approach – In all, 64 students participated in a multimodal hand hygiene education programme before clinical placement, with each student completing an in-class questionnaire after placement. Data were analysed using descriptive and comparative statistics. Students rated educational methods that had most influence on them. Their preference was for a practical hand hygiene education session. Students were also influenced by the therapist they were on placement with. They were least influenced by the didactic college presentation.

Findings – This study highlights that students may be influenced by different methods of education at different stages in their course and that placement may be an important influencing factor in the earlier years of occupational therapy education.

Research limitations/implications – This study highlights the importance of the availability of a multimodal educational approach and clinical placement to promote increased compliance with hand hygiene amongst students.

Practical implications – University healthcare course curricula should include multimodal approaches to the education of hand hygiene. While hand hygiene e-learning modules are beneficial, they should be used in conjunction with a multimodal educational strategy that incorporates practical elements. The influence of the therapist on a students’ behaviour should be utilised to improve both student and professionals hand hygiene adherence.

Originality/value – Original piece of work that is not widely discussed in Occupational Therapy literature.

Keywords Education, University, Behaviour, Students, Hand hygiene

Paper type Research paper

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The authors are grateful to all students for their time taken to complete the survey and for the prompt return of the surveys.
Introduction
Hand hygiene is recognised as the single most effective action to reduce and control the spread of infection (Pittet et al., 2000; Whitby et al., 2007). However, compliance is not always optimal. The challenge of affecting change in the behaviours of healthcare workers and healthcare students towards maintaining compliance with hand hygiene guidelines is well-documented (Whitby et al., 2006).

Although hand hygiene prevents cross-infection, successful adherence is unacceptably low (Institute for Healthcare Improvement, 2006). Knowledge needs to be enhanced and changed to improve compliance (Kim et al., 2013). Education is an integral part of hand hygiene improvement strategies (Mathai et al., 2010). Kaur et al. (2014) suggest that poor hand hygiene compliance by medical students is because of a lack of knowledge, misconceptions and poor hand hygiene practices by role models. Negative influences of poor role models further emphasises the significance of good clinical practice by those who teach students (Hunt et al., 2005). The influence of others and the need for positive role modelling is vital for successful hand hygiene compliance (Polacco et al., 2015). In occupational therapy practice, practicing occupational therapists are the main role models for students in the traditional one-to-one placement model.

To plan interventions that are most likely to succeed, it is vital to understand both the barriers and motivators for that behaviour (Collins McLaughlin and Walsh, 2012). Compliance with hand hygiene remains a challenge (Smiddy et al., 2015). Education is a key component of hand hygiene training for all team members. Hand hygiene education for healthcare workers and students can be delivered using a number of pedagogical approaches including traditional didactic lecture, e-learning, demonstration, interaction and discussion (World Health Organization 2009). In the last published research related to hand hygiene education for occupational therapy students, it was reported that occupational therapy educational programmes did not provide sufficient information on hand-washing techniques to students (Marcil, 1993).

This study was undertaken to explore the educational methods that were most effective in terms of delivering hand hygiene information. The aim of the study was to inform improvement of teaching practices and, thus, positively influence students hand hygiene knowledge and skills.

The study provides an insight into the impact of different educational methods and an exploration of perceived factors influencing hand hygiene compliance amongst undergraduate occupational therapy students.

Methods
Research design
This is a descriptive cross-sectional study of undergraduate occupational therapy students who attended a four-year degree programme in an Irish university.

Participant selection
The study population were a convenience sample of undergraduate students studying occupational therapy. Students from Years 2 to 4 (n = 78) were asked to partake. All students had completed clinical placements. Students in Year 1 were excluded because of a lack of clinical experience.
Procedures
In the 2014-2015 academic year, students received four different methods of hand hygiene education before going on placement:

(1) All students completed the Irish Health Service Executive Learning and Development Hand Hygiene for Clinical Staff e-learning module. This module included an online assessment which students had to pass to generate a certificate of completion.

(2) All students received a practical session in college before commencing their clinical placement. This session in college involved students engaging in hand hygiene and then using an ultra violet (UV) light hand hygiene inspection cabinet to check technique.

(3) All students attended a didactic lecture in college and were prompted to discuss hand hygiene.

(4) All students were asked to peer check their fellow student to check for hand hygiene readiness (to check for any barriers to engaging in successful hand hygiene).

Students checked and commented to each other regarding barriers to hand hygiene compliance, for example: hand/wrist jewellery, sleeve length, nail polish, nail condition and skin condition.

Once this multimodal hand hygiene education was complete, the students engaged in their placements. When students returned to college post-placement, they completed a paper-based questionnaire (Appendix). The same procedure was followed for all academic years that were involved in the study.

Data collection
The paper-based questionnaire was developed by the author to capture factors influencing students’ hand hygiene practices. Sections of the questionnaire (Questions 2 and 3) were developed, with permission, based on a previously published study (Collins McLaughlin and Walsh, 2012).

Questionnaires were provided to students on return to college after the completion of clinical placement. All participants were provided with a research participant information sheet. Participation was voluntary and consent obtained. Completion of surveys was facilitated immediately at the end of teaching sessions to maximise response rate and to reduce the possibility for students to check information or communicate with each other. Completion of the questionnaire took approximately five minutes. Participant’s anonymity was assured throughout the survey distribution, collection and analysis. Data were categorised according to the specific academic year.

Statistical analysis
Descriptive and comparative statistics were performed using Stata IC, version 13.

Ethical approval
Ethical approval was obtained from the university Clinical Research Ethics Committee before the commencement of the study.
Results

Demographics
There were 78 students eligible to engage in the research. All students were invited to participate. In all, 64 students were recruited, from second year ($n = 23$), third year ($n = 21$) and fourth year ($n = 20$). This equated to an 82 per cent response rate.

Reasons for hand hygiene compliance and non-compliance

Students were asked to rank a list of statements about the influences on their hand hygiene on clinical placements (Appendix). The highest ranked factor for engaging in hand hygiene practices was that students believed that engaging in hand hygiene practices prevents the spread of diseases (39 per cent [95 per cent CI 0.27-0.52]). Second to this, students identified that they engaged in hand hygiene, as it was what they were taught to do (19 per cent [95 per cent CI 0.11-0.32]). Other reasons the students ranked included, soap dispenser was located conveniently and planning on touching someone. In some instances, students suggested that they used alcohol-based hand-rub on placement rather than hand washing. Additional reasons for non-compliance with hand hygiene practices were that it was not important on placement, they forgot, the therapist they were working with did not wash their hands and they did not deem patients to be a risk to them.

Educational methods

Students rated multimodal influencing factors, as detailed in Table I. The majority of students (72 per cent [95 per cent CI 0.60-0.80]) rated the practical session in college using the ultra-violet light hand hygiene inspection cabinet as having most influence on their practice. Over 90 per cent (95 per cent CI 0.68-0.93) of third-year students and 80 per cent (95 per cent CI 0.56-0.93) of fourth-year students rated this as having the most influence on their hand hygiene behaviour.

Association between the year the student was in and the reported influence the practical session in college had on their hand hygiene behaviour was tested using a chi-squared test. A significant association was identified, $\chi^2 (1, N = 64) = 18.33, p = 0.02$.

The comparison between second years and fourth years with regards to the influence of the therapist on their hand hygiene behaviour was studied. The level of influence was

<table>
<thead>
<tr>
<th>Year</th>
<th>Practical (with UV light)</th>
<th>Therapist (O.T.)</th>
<th>Other healthcare workers</th>
<th>Online learning (e-learning)</th>
<th>Peer checking</th>
<th>Didactic presentation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Second years (%) ($n = 23$)</td>
<td>48</td>
<td>61</td>
<td>30</td>
<td>22</td>
<td>18</td>
<td>0</td>
</tr>
<tr>
<td>Third years (%) ($n = 21$)</td>
<td>0.27-0.70</td>
<td>0.39-0.80</td>
<td>0.14-0.53</td>
<td>0.08-0.44</td>
<td>0.06-0.40</td>
<td>0</td>
</tr>
<tr>
<td>Fourth years (%) ($n = 20$)</td>
<td>0.68-0.93</td>
<td>0.12-0.52</td>
<td>0.06-0.43</td>
<td>0.12-0.52</td>
<td>0.04-0.37</td>
<td>0</td>
</tr>
<tr>
<td>All students (%) ($n = 64$)</td>
<td>0.56-0.93</td>
<td>0.10-0.49</td>
<td>0.13-0.54</td>
<td>0.10-0.49</td>
<td>0.07-0.44</td>
<td>0</td>
</tr>
</tbody>
</table>

$\chi^2$ value: 18.34
$P$ value: 0.02
divided into most influence and not most influence. Because of a small sample \((n = 64)\), a Fisher’s Exact test was used to establish the level of influence of the therapist on student hand hygiene. In all, 14 second-year students rated the level of influence of the therapist as “most”, whereas only five fourth-year students rated the level of influence of the therapist as “most”, indicating a significant difference regarding the influence of the therapist on these groups, \(p = 0.03\). 

Discussion

This study adds to the existing literature regarding hand hygiene educational strategies. The concept of practical sessions was also explored in a study by Porzig-Drummond et al. (2009), where their findings suggested that even brief disgust-based interventions may have a successful place in promoting hand hygiene compliance. Their findings suggest that an emotional link to disease may be more important to prompt hand hygiene than a cognitive link. Similarly, Vanyolos et al. (2015) advocate that introducing a ultra-violet test into graduate medical education may help to improve hand hygiene compliance, as it gives immediate visual feedback to medical students.

The majority of third- and fourth-year students in this study strongly favoured the influence of practical education (using a ultra-violet light hand hygiene inspection cabinet) on their hand hygiene behaviour, whereas the majority of second-year students rated the therapist they were on placement with as most influential to their practice. There could be many influencing factors for this difference. One could be that second years had just completed their first block placement of eight weeks, so they rated the therapist as more influential. This may be that more junior students (second years) are influenced more by those working in clinical practice, whereas more senior students (third and fourth years) have established their own hand hygiene habits by this stage. Tompson and Ryan (1996) discuss the professional socialisation of students and state that there is a shifting focus in placements. By the time students reach fourth year, the supervision model is one of consolidation, whereas in the second year, the model is one of students becoming familiar with their role and more reliant on the therapist for direct teaching. This would suggest that education before students going on placements would provide more junior students with increased capability and motivation to enable them to practice appropriate hand hygiene behaviour while on placement (Michie et al., 2014). Future research in this area would be beneficial to explore the therapists influence on students and the need for ongoing education of therapists to make them explicitly aware of their influence.

Online approaches are advocated for inclusion when teaching hand hygiene to medical students (Kaur et al., 2015). This study adds another dimension to those findings, as only 25 per cent (95 per cent CI 0.15-0.38) of students in this study found the e-learning hand hygiene module to have most influence on their practice. In Ireland, at present, the recommendation is made that an e-learning programme may be used in isolation to educate regarding hand hygiene (The Royal College of Physicians of Ireland, 2015). This study would caution the use of solely using online learning and suggest that wholly online approaches would miss vital opportunities to teach face-to-face and that because of the different learning styles of students various educational methods need to be used to target different learners. For example, over 90 per cent (95 per cent CI 0.68-0.93) of third-year students rated the practical session in college using the ultra-violet light hand inspection cabinet as having the most influence on their practice.
Students also stated that one of the influencing factors for not engaging in hand hygiene practices was that it was not perceived as important on clinical placement. This links with other studies regarding role models and the importance of having good role models for hand hygiene on sites to champion hand hygiene for others (Jang et al., 2010, Dixit et al., 2012). Feather et al. (2000) found that medical students were modelling the poor hand hygiene practices of medical personnel. Likewise, this study found that occupational therapy students were influenced by their educator/therapist and others on the site. Role modelling on site has been rated as important, and for future clinical placements, this knowledge could be harnessed to improve hand hygiene practices.

Forgetting to engage in hand hygiene, while on practice was a common reason cited for non-compliance. Efficacy of visual cues effecting improved hand hygiene practice is debatable (Wearn et al., 2015, Nevo et al., 2010). Use of visual reminders is a component of the Five Moments for Hand Hygiene multimodal hand hygiene improvement strategy (World Health Organization, 2009) and is promoted as the cue for healthcare workers to engage in hand hygiene (Luangasanatip et al., 2015). As practice sites vary considerably, the issue of reminders and prompts needs to be discussed at local level in conjunction with a hand hygiene behavioural strategy to see what would impact most with regards to increasing student compliance. A national focus via inter-professional regulatory bodies to obtain consensus on an educational approach needs to be considered. Comprehensive collaborative approaches in universities are required to increase the profile of hand hygiene education within undergraduate healthcare student programmes.

Using a hand sanitizer instead of washing hands was chosen as a reason in Collins, McLaughlin and Walsh’s (2012) study for why people did not wash their hands. They identified that a hand sanitizer was a method of hand hygiene. In this study, students stated that the most frequent reason for not engaging in hand hygiene was that they used an alcohol-based hand rub (ABHR) instead. As they were engaging in hand hygiene by using the ABHR, it is unknown whether the students understood this. Further research would need to be conducted to check did the students understand that hand hygiene included using ABHR as well as hand washing.

Future research needs to consider the influence the students on the hand hygiene practices of the therapists/educators who facilitate the clinical placements. From another perspective, Almaguer-Leyva et al. (2014) suggest that medical students can successfully be used as covert observers in the evaluation of hand hygiene compliance. Their incorporation of medical students into their hand hygiene programme revealed a discrepancy between covert observers and infection control observers. They suggest that using medical students in this role leads to no Hawthorne effect. However, there are ethical issues with this approach. Irish occupational therapy students have not been used in this role previously, and it could be a novel suggestion for increasing hand hygiene audit in primary care settings and on home visits, where traditionally an audit of hand hygiene compliance has been impossible.

This study provides important information regarding hand hygiene behavioural perceptions of a group of healthcare students who previously were not highlighted in Irish or international student-related hand hygiene research and literature.

- University healthcare course curricula should include multimodal approaches to the education of hand hygiene.
- While hand hygiene e-learning modules are beneficial, they should be used in conjunction with a multimodal educational strategy that incorporates practical elements.
The influence of the therapist on a students’ behaviour should be utilised to improve both student and professionals hand hygiene adherence.

Limitations
This small-scale study was carried out with a limited sample size ($n = 64$), yet response rates were high. The fact this was a one-site study may reduce generalisability to the wider occupational therapy student population; however, the findings are important, as they impact on the teaching in the undergraduate occupational therapy course and highlight areas for future research. The entire sample that was available was sampled; therefore, there was no selection bias. This study looked at students’ perceptions of what influenced their behaviour rather than observation of their actual hand hygiene practices. Future direction for this research would be to replicate this intervention in other healthcare-related courses and also take into account the views of teaching staff regarding hand hygiene education in various healthcare-related undergraduate courses.

Conclusion
The findings indicate that the introduction of hand hygiene educational methods into the curriculum enhanced students’ knowledge and also impacted on their perceived hand hygiene behaviour and practices. Practical education (using ultra-violet light hand hygiene inspection cabinet) and role modelling (from the therapist and others on site) influenced student behaviour more than other educational approaches. This study highlights that students may be influenced by different methods of hand hygiene education at different stages in their course and that while on placement the therapist may be an important influencing factor in the earlier years of occupational therapy education.

References


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## Hand hygiene questionnaire

**Preliminary piece to read and if agreeable please tick the box**
If you consent to completing this questionnaire on hand hygiene and if you are aware that the results may be published but there will be no identifying features to identify you personally please tick this box.

<table>
<thead>
<tr>
<th>Question 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Please circle what year of your programme you are currently in:</td>
</tr>
<tr>
<td>Year 1</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Question 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Please pick three items from this list below and rate the following from 1 to 3:</td>
</tr>
<tr>
<td>1 = the most frequent reason I carried out hand hygiene practices</td>
</tr>
<tr>
<td>2 = the second most frequent reason for carrying out hand hygiene practices</td>
</tr>
<tr>
<td>3 = the third most frequent reason for carrying out hand hygiene practices</td>
</tr>
<tr>
<td>Reasons for carrying out hand hygiene on practice experience:</td>
</tr>
<tr>
<td>Had plenty of time</td>
</tr>
<tr>
<td>Soap/dispenser was located conveniently</td>
</tr>
<tr>
<td>My hands were visibly dirty</td>
</tr>
<tr>
<td>The client had an infection</td>
</tr>
<tr>
<td>I washed my hands when I did not have an alcohol based hand rub instead</td>
</tr>
<tr>
<td>I believe hand washing prevents the spread of diseases</td>
</tr>
<tr>
<td>The team member I was with washed his/her hands</td>
</tr>
<tr>
<td>Because that is what I was taught to do</td>
</tr>
<tr>
<td>I never wash my hands before an activity</td>
</tr>
<tr>
<td>Dispenser full or product was available</td>
</tr>
<tr>
<td>I washed my hands when I remembered to do it</td>
</tr>
<tr>
<td>I washed my hands when I believed my hands were dirty</td>
</tr>
<tr>
<td>Returning to an activity where hands would stay clean</td>
</tr>
<tr>
<td>Planning on touching someone</td>
</tr>
<tr>
<td>I washed my hands when my educator washed his/her hands</td>
</tr>
<tr>
<td>I care if my hands are dirty</td>
</tr>
<tr>
<td>Other (please specify)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Question 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Please pick three items from this list below and rate the following from 1 to 3:</td>
</tr>
<tr>
<td>1 = the most frequent reason I did not carry out hand hygiene practices</td>
</tr>
<tr>
<td>2 = the second most frequent reason I did not carry out hand hygiene practices</td>
</tr>
<tr>
<td>3 = the third most frequent reason I did not carry out hand hygiene practices</td>
</tr>
<tr>
<td>Reasons for not carrying out hand hygiene on practice experience:</td>
</tr>
<tr>
<td>Too busy</td>
</tr>
<tr>
<td>Soap dispenser empty</td>
</tr>
<tr>
<td>I did not believe my hands were dirty</td>
</tr>
<tr>
<td>I was not dealing with patients that were a risk to me</td>
</tr>
<tr>
<td>I was not planning on touching anyone</td>
</tr>
<tr>
<td>The team member I was with did not wash his/her hands</td>
</tr>
<tr>
<td>If I washed my hands it would have interfered with patient care</td>
</tr>
<tr>
<td>It did not seem like it was important on my placement</td>
</tr>
<tr>
<td>I always wash my hands before an activity</td>
</tr>
<tr>
<td>It never crossed my mind to wash them</td>
</tr>
<tr>
<td>I did not wash my hands because I had nothing to dry my hands afterwards</td>
</tr>
<tr>
<td>Touching anything in (location) seemed dirtier than not washing my hands</td>
</tr>
<tr>
<td>Hands were not visibly dirty</td>
</tr>
<tr>
<td>I have a skin sensitivity so I did not wash my hands</td>
</tr>
<tr>
<td>I don’t believe hand washing prevents the spread of diseases</td>
</tr>
<tr>
<td>Soap/dispenser was too far away</td>
</tr>
<tr>
<td>My educator did not wash his/her hands</td>
</tr>
<tr>
<td>The client did not have an infection</td>
</tr>
<tr>
<td>I simply forgot</td>
</tr>
<tr>
<td>I used gloves instead</td>
</tr>
<tr>
<td>Other (please specify)</td>
</tr>
</tbody>
</table>

(continued)
### Question 4

Can you please rate the influence each of the following three methods of hand hygiene education had on your hand hygiene practices by ticking one box per method?

<table>
<thead>
<tr>
<th>Method</th>
<th>1 = Most influence on my practice</th>
<th>2 = Some influence on my practice</th>
<th>3 = Neither agree or disagree</th>
<th>4 = Little influence on my practice</th>
<th>5 = Least influence on my practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>1  HSE LanD online hand hygiene for clinical staff course</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2  Practical session in pre linking learning using the “glow box”? hand hygiene inspection cabinet</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3  PowerPoint session in pre linking learning</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4  Peer checking fellow students to check if hand hygiene ready</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Question 5

Can you please rate the influence each of the following had on your hand hygiene practices by ticking one box per item?

<table>
<thead>
<tr>
<th>Statement</th>
<th>1 = Most influence on my practice</th>
<th>2 = Some influence on my practice</th>
<th>3 = Neither agree or disagree</th>
<th>4 = Little influence on my practice</th>
<th>5 = Least influence on my practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>The hand hygiene practices of others on site</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The hand hygiene practices of my therapist/educator</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Question 6

Any further comments?

________________________________________________________

________________________________________________________

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Occupational Therapy embraces the National #Littlethings mental health and wellbeing campaign in Offaly via an Operation Transformation Programme

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Community Mental Health Team, Tullamore, Ireland

Abstract
Purpose – In early 2015, an Occupational Therapy led Operation Transformation healthy eating and exercise programme produced results suggestive of the value and need to promote and integrate physical activity interventions into mental health services.

Design/methodology/approach – In all, 41 clients with various mental illness diagnoses participated in the eight-week Operation Transformation programme. The outcome measures involved weekly weigh-ins and an end of programme evaluation form.

Findings – The quantifiable benefits – a total weight loss of nine stone ten and a half pounds – were mirrored in equally impressive qualitative impacts. Participants’ feedback via anonymous evaluation forms, echoed the findings of the articles appraised in the literature, including improvements in mood and energy levels, better sleep and increased motivation.

Practical implications – The organisers will benefit from lessons learned in this first experience, including overcoming logistical and organisational difficulties experienced in enabling clients’ full participation.

Originality/value – The evidence base points to the successful benefits of physical activity in promoting positive mental health. Occupational Therapists have a unique opportunity to drive forward the message of promoting physical activity via meaningful occupations.

Keywords Mental health, Occupational therapy, Operation transformation

Paper type Viewpoint

Background
In October 2014, The Health Services Executive (HSE) National Office for Suicide Prevention and over 25 partner organisations launched the #Littlethings mental health and well-being campaign (www.yourmentalhealth.ie) (yourmentalhealth.ie, 2015). The campaign aims to highlight that we will all experience challenges in our lives, and when we do, there are some

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simple, evidence-based steps we can take that can make a big difference to how we feel. Our challenge as Occupational Therapists working in the area of mental health is how best to incorporate the messages of the national campaign at a local level, which was an expectation of the HSE National Health Service Plan 2015. “The more you move the better your mood” is only one of the eight messages that the Little Things campaign promotes, but it is a message that presents Occupational Therapists with a significant opportunity to promote exercise and physical activities as meaningful occupations. Exercise can be broken down into many potentially personally meaningful occupations depending on an individual’s interests and abilities. What is particularly important for Occupational Therapists is that physical activity can be incorporated into leisure pursuits, such as dancing, hiking or gardening; transportation activities, such as cycling and walking; instrumental activities of daily living, like vacuuming; as well as planned exercise and sports. For Occupational Therapists, the national campaign highlighted a unique opportunity to drive forward the message of promoting physical activity through our clinical practice. Lloyd (2003) (Jones, 2008, p. 499) “stated that occupational therapists are well placed in mental health, with their focus on occupations to improve health, to play a pivotal role in promoting fitness-oriented physical activity”.

There is a significant evidence base to support the positive impact of exercise on mental health, and more recently, there appears to be a greater emphasis on the potential benefits of exercise on the mental health of those with severe and enduring mental illness. A systematic review and meta-analysis by Rosenbaum et al. (2014) including 39 randomised controlled trials of adults with a confirmed mental illness concluded that physical activity reduced both depressive symptoms and symptoms of schizophrenia while also improving the quality of life of people with mental illness. Blumenthal et al. (2000) writes that depression can be as effectively treated with exercise as with medication and vice versa with clients embracing regular exercise for over six months being much less likely to relapse into depression. However, also acknowledged is that exercise can do what medication cannot: it offers an opportunity to empower people to take personal control of their recovery and develop a new sense of self in doing so.

The challenge for us now is how best to support those with mental illness to appreciate the value of physical activity in their own recovery and well-being. It has been our experience as Occupational Therapists that those enduring mental illness often find it difficult to engage in exercise because of symptoms like poor sleep patterns, low energy levels and poor motivation as well as a lack of interest. Richardson et al. (2005, p. 328) writes “In fact, individuals with serious mental illness often face substantial illness-related barriers to physical activity that healthier individuals do not face”; nonetheless, those with mental illness tend to value physical activities. Taking this into account, Richardson et al goes on to state that there are a number of important reasons for integrating physical activity specifically into mental health services including having staff trained to be sensitive to such illness-related barriers. It is also acknowledged that regular reinforcement of positive health behaviours by the professionals that individuals with mental illness are most regularly in contact with can play a critical role in successful long-term changes.

**Operation transformation – the programme**

Operation Transformation was an Occupational Therapy-led programme to support clients to embrace personal lifestyle changes that would aim to promote positive mental health. A precursor to the organisation of the Operation Transformation programme was a “Couch to 5km” pilot exercise programme, which ran in late 2014 in conjunction with Offaly Sports Partnership. This small-scale programme involved eight clients and ran over six weeks, with three community-based exercise sessions per week. What we learned from running this
programme fed into the development of the Operation Transformation programme. Operation Transformation was an eight-week Occupational Therapy-led healthy eating and exercise programme which was carried out in January and February 2015 with a total of 41 clients with various diagnoses attending the community mental health team. The roll out of the programme involved invitations being sent out to potential participants with GP clearance forms, which had to be completed for all individuals who wished to participate in the fitness programme. Funding was obtained from Offaly Sports Partnership for staffing two of the three one-hour exercise classes (walking/jogging) run per week. The exercise classes included a 10-minute warm-up, 40-minute walk intermittent with jogging for those more physically fit and then a 10-minute cool down. All warm-up and cool-down exercises were demonstrated by staff to prevent possible injury. Community amenities, such as the local town park and local athletics club, were used as venues for the exercise sessions. It was important as local amenities were used to promote community integration while considering long-term ease of accessibility. Funding was also sourced from the local Vocational Education Committee (VEC) for one of the two healthy eating classes run per week. The healthy eating classes focused on meal preparation incorporating the menu plans from the actual RTE Television series, Operation Transformation. In addition to the leadership provided by Occupational Therapy, there was also a strong involvement of the nursing and healthcare staff at the community mental health centre. Participants were also advised to tune into the Operation Transformation television programme twice per week, so that they could feel that they were involved in a countrywide effort. Participants were weighed on a weekly basis. They were also provided with an educational session from nursing staff on medication and weight management. In the final week, the local VEC provided funding for a Colour Me Beautiful Consultant to advise clients on what clothing shapes and colours suited them. Similar to the television programme, during the final week, there was an awards ceremony at which all participants received certificates of attendance. On the day of the awards ceremony, participants attended a local hair salon at a reduced rate, staff assisted in grooming such as make-up application; all the clients got dressed up, and there was a healthy food buffet to celebrate their success and encourage lifelong lifestyle changes.

Obstacles and overcoming challenges
Scheduling represented the greatest obstacle to clients’ participation in the programme. Internal scheduling difficulties were overcome through cooperation: before running the group, Occupational Therapy met with nursing staff and agreed that other groups run at the centre during the eight-week period of Operation Transformation would be suspended because of the intensity of the programme. Indeed, from the outset, an important element in the set-up of the programme was the involvement and buy-in of other members of the multidisciplinary team.

Scheduling issues that impacted more directly on the clients were more difficult to overcome. For example, most clients did not have access to their own transport, and at times, it was difficult for the buses that transported them to deliver them to alternate locations, such as the town park and the local running club track. Set dinner times are deeply ingrained in the culture of the community mental health centre: the meals are cooked outside the centre and delivered there within a set timescale, which resulted in staff often rushing back, so that clients could receive their meals. What might have been thought to be a significant barrier to participation – the weather – proved less so, with clients persevering even though the programme started at the coldest time of the year. Organisers of the programme were conscious that participants would also have to overcome a culture of external locus of control that would more usually encourage clients to refrain from over exertion. As the programme progressed, clients evinced a greater confidence in their own resolve and
determination. The physical achievement of meeting defined exercise goals was being mirrored in a sense of psychological strength and achievement, mirroring effects noted in a review by Mason and Holt (2012), which found a high degree of congruence in support of the themes of social interaction and social support; feeling safe; improved symptoms; a sense of meaning, purpose and achievement; identity and the role of the facilitating personnel.

Feedback and looking forward: implications for practice
Quantitatively, the total weight loss was nine stone ten and a half pounds. All participants were asked to complete an evaluation form at the end of the eight weeks, and a focus group was organised to brainstorm potential future exercise-based groups that could be facilitated by Occupational Therapy. Feedback included participants feeling brighter, having more energy, feeling motivated and sleeping better, echoing the finding of Alexandratos et al. (2012) that exercise can contribute to improvements in symptoms, including mood. The conclusion of Rosenbaum et al. (2014) that physical activity reduced depressive symptoms in people with mental illness chimed with participants’ observations that they were more active, with improved mood and an overall positive feeling of well-being. Jones (2008, p. 499) writes “the use of physical activity as an intervention fits well with the Model of Human Occupation (MOHO) and is particularly relevant to the concepts of volition and personal causation”. With this in mind, it would be beneficial to consider appropriate MOHO assessment and evaluation tools to measure the success of any future run programmes.

The initiative’s success was apparent not only in the fact that the participants’ testimonies echoed the positive findings of the research into the impact of exercise on mood and well-being, but even more directly in the eagerness of many of them to carry on the exercise and dietary changes once the programme ended. This is reflected in the fact that several participants were inquisitive about and eager for follow-up activities. Participants were encouraged to continue with their exercise and diet plans. Information was provided on local running/walking clubs and following on from Operation Transformation – some of the participants have joined the local Athletics Club and were accompanied there by the Occupational Therapist afterwards to support community integration. Some have now completed 5-km local races. Other participants were encouraged to join the local gym. Our client with the greatest weight loss has kept up the exercise and healthy eating and has now dropped almost seven stone in total. He has also taken up a work programme which was not possible for him because of his size before embarking on the programme.

In addition to the positive effects that participants have experienced from their own efforts and perseverance, there are clear benefits to the Occupational Therapy service. The experience of planning and running this programme leaves this service in a stronger position to overcome or work around some of the practical and organisational obstacles to clients’ participation. Less tangibly, but just as importantly, witnessing the positive outcomes for clients provides organisers with the satisfaction of seeing their own efforts and perseverance rewarded.

References


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