

Occupational therapists' perceptions of occupation in practice: An exploratory study.

Abstract

Background: The World Federation of Occupational Therapists' minimum standards state occupation and its relationship with health must be concepts covered in occupational therapy education. Therefore, it is assumed that Australian graduates have sound knowledge of the principles of occupation-based practice. In some practice settings, the link to occupation may not be explicit and graduates could face challenges to being occupation-based. The aims of this pilot study were to explore graduates' perceptions of occupation in their practice and to investigate whether graduates felt sufficiently prepared for occupation-based practice.

Methods: Two focus groups with eight therapists in total were employed to uncover experiences and perceptions of occupation. Themes were synthesised using Braun and Clarke's method of thematic analysis, where line by line coding was employed to inductively build themes.

Results: Participants believed that occupation-based practice was important but did not necessarily need to be implemented as a means of intervention. From the participants' perspective, simply striving for occupation as the end goal of therapy was acceptable. A strong focus on impairment-based practice hindered some therapists from exploring the use of occupation-based practice. For recent graduates, workplace culture was pervasive and inhibited the use of occupation. Additionally, participants felt university educators did not provide an integrated or consistent approach when teaching how to apply occupation in practice.

Conclusion: Workplace expectations and limited power to influence practice are impeding graduates from authentically applying occupation in practice. Insights from recently graduated therapists about occupation have the potential to inform future directions of occupation-based practice.

Key Words: curriculum, occupational therapy, professional practice, qualitative research, teaching

Introduction

Numerous authors (Molineux, 2004; Reilly, 1962; Wilcock, 2000) agree that the unique contribution that occupational therapy can bring to health care is a profound understanding of occupation. Occupation can be defined as a “culturally and personally meaningful activity that an individual engages in over a period of time” (Mackey & Nancarrow, 2006, p. 12). Occupational therapists should utilise their knowledge of occupation to enable occupational performance and in turn impact the health and wellbeing of the people with whom they work (Gray, 1998).

However, throughout history and especially in recent times, it is evident that a focus on enabling occupation and its use in therapy has not always been central to practice (Bryden & McColl, 2003; Wilding & Whiteford, 2007). In recent decades, the dominance of the medical model meant the need to implement empirical justifications for practice which focused on remediating impairments, and moved away from a central focus on occupation (Wilding & Whiteford, 2007). Fisher (2009) stressed that occupational therapy should be about occupation and encouraged therapists to focus less on remediation, impairments and performance capacities, and instead focus on enabling people to perform all occupations.

Occupation-based practice utilises a client’s engagement in occupations throughout the occupational therapy process but in particular the intervention and evaluation stages whereby occupation is used as “the therapeutic agent of change” (Fisher, 2013, p. 164). Molineux, in a Keynote address at the 2010 New Zealand Association of Occupation Therapy Conference, detailed his views on the need for occupational therapists to reclaim occupation in therapy and not simply justify our practice with occupation as an end goal (Molineux, 2011). Other leading occupational therapists have used the platform of the Sylvia Docker, Eleanor Clarke Slagle Lectures and the Elizabeth Casson Memorial Lectures to urge occupational therapists to ensure they look to the future and be creative about what occupational therapy could be in the coming decades (Ballinger, 2012; Barker, 1984; Jacobs, 2012). Commentary by Fortune (2000), Gillen and Greber (2014), and Twinley and Morris (2014), demonstrate there is available evidence and a need for occupational therapists to implement occupation-based practice.

Further confounding implementation of occupation-based practice is the lack of explicit and consistent guidelines. Specifically, Occupational Therapy Australia’s *National Code of Ethics* (2001), the *Australian Minimum Competency Standards for New Graduate Occupational Therapists* (2010), and the Occupational Therapy Board of Australia’s *Occupational Therapy Continuing Professional Development Registration Standard* (2012) do not contain overt reference to the implementation of occupation-based practice as the core of occupational therapy services.

Occupation and its relationship to health and wellbeing are concepts covered in university occupational therapy programmes (World Federation of Occupational Therapists, 2008). In

2002, the World Federation of Occupational Therapists' (WFOT) *Revised Minimum Standards for the Education of Occupational Therapists* stipulated significant changes to ensure university courses explicitly articulated an occupational perspective of health. All Australian accredited occupational therapy programmes must adhere to these standards (WFOT, 2002). This implies that all Australian recent and newly registered graduates have an adequate understanding of and appreciation for occupation and occupation-based practice. However it has been argued that in some settings it can be challenging for graduates to align their learning with the realities of practice (Wilding & Whiteford 2008).

There is a dearth of studies that illuminate the perceptions, opinions and knowledge of occupation-based practice of new or recent graduates. After an extensive search of national and international peer reviewed literature using key words such as 'occupation', 'occupational therapy' 'occupation-based practice', 'practice patterns', 'education', 'curriculum', 'perception' and 'graduates', no articles were located that specifically researched new and recent graduates' perceptions of occupation in practice. It was apparent after this review, that challenges of aligning current educational requirements and the demands of practice have not been fully investigated, nor have potential strategies to overcome this issue been considered.

Considering this, the aims of the pilot study were to test the feasibility of research questions that explore:

1. How occupational therapy graduates perceived the use of occupation in their daily practice.
2. If graduates identified occupation as central to occupational therapy practice.
3. Whether graduates felt adequately prepared by their educational experiences to implement occupation-based practice upon graduating.

Methods

A qualitative research approach was used in this study. An inductive phenomenological design was used to uncover the graduates' perceptions (Denzin & Lincoln, 1994). Phenomenology is a philosophical perspective that assists researchers to explore, uncover and understand everyday experiences without presuming knowledge of those experiences (Crotty, 1998). The use of phenomenology provided the opportunity to uncover the complexity and contextual nature (Denzin & Lincoln, 1994) of the participants' perceptions of occupation in practice and education.

This study was established as a pilot to explore the scope and possibilities for a larger research project. Two focus groups were held, one in the Australian Capital Territory (ACT) and one in Tasmania. These locations were chosen for convenience and pragmatic reasons.

Furthermore, the recruitment process could be easily managed due to the relatively smaller number of new graduates employed. At the time of recruitment, no occupational therapy programme existed in Tasmania, and graduates from the ACT occupational therapy programme were ineligible to participate due to the inclusion criteria relating to year of graduation. Therefore, participants were likely to come from educational programmes in other states of Australia.

Similar recruitment processes were used for both focus groups. Advertisements were placed in each state/territory's Occupational Therapy Australia newsletter and managers at workplaces that employ occupational therapists were contacted.

This study gained ethical approval from University of Canberra's Human Research Ethics Committee (project 14-24). Participants submitted a voluntary consent form prior to each focus group. Pseudonyms have been used to ensure anonymity.

Research Participants

Eight therapists participated in the study, including six females and two males. The participants graduated from a variety of universities in every Australian state that had an occupational therapy programme, except Victoria (see Table 1). One participant transferred from a Victorian university to another in Queensland. In this instance only Queensland was recorded as the state of education. Of the eight participants, six completed undergraduate degrees, and two a Master of Occupational Therapy (graduate entry). All participants worked in traditional occupational therapy roles, where occupational therapists have historically worked such as hospitals or community rehabilitation centres. Table 1 depicts where participants were practising at the time and does not include previous areas of practice. Table 1 also indicates years of practice experience.

Inclusion criteria for participation included completing education between 2007 and 2013, at a WFOT accredited Australian University undergraduate or graduate entry programme. The participants were required to be registered and have work experience as an occupational therapist in Australia. The justification for the years since graduation is tied to the WFOT's *Revised Minimum Standards for the Education of Occupational Therapists* (2002), whereby all graduates from 2007 onwards would have been educated in programmes where these guidelines should have been adopted. This pilot was also to test if the inclusion criteria would be useful in a larger study, particularly relating to the wide range of years post-graduation.

Data Collection

The two focus groups were audiotaped and transcribed verbatim. These transcripts formed the data for analysis. Participants validated the accuracy of the transcription of their focus group session. The participants were asked a mix of open and closed questions about their work experiences and their perceptions of occupation and how and when this construct is utilised in the profession. The participants were also asked whether they felt prepared by their university education to implement an occupation-based plan at work. Topics discussed in the focus groups were decided upon by the authors, based upon current literature and alignment to the research questions.

The focus group design allowed for discussion on and critique of current perspectives in occupational therapy education and practice, in a non-threatening environment and allowed for free flowing discussion. Both focus groups ran for approximately two and a half hours to allow for introductions, in-depth discussion, and debrief, and were facilitated by the first author. Only three participants attended the focus group in the ACT. Kitzinger (1994) stated focus group interviews purposefully use group interactions as part of the method of data collection. Therefore, as there were limited numbers for group interaction another focus group needed to be held and this time five participants attended in Tasmania.

Data Analysis

The first author utilised Braun and Clarke's (2006) six step method of thematic analysis and all data were analysed following this method. Line by line coding was initially employed to inductively build codes and then in turn similar coding was grouped together and further refined to develop into themes (Braun & Clarke, 2006). The focus groups were initially coded separately, with no pre-determined codes, and then combined to allow for a systematic approach to data analysis. This approach also ensured that the codes from one focus group's analysis did not impact on the codes that emerged from the second.

Trustworthiness was strengthened by engaging in a systematic process of data collection and analysis, the use of reflective processes, and by discussing themes as they arose with the other authors. The legitimacy of the findings was improved by utilising a rigorous method of analysis where all decisions, assumptions and interpretations made during data analysis and discussions on themes were recorded in a journal by the first author (Braun & Clarke, 2006). As recommended by Watt (2007), a reflective journal allowed the first author to engage in an ongoing personal dialogue to examine assumptions and to thereby consider the data critically.

Results

Three main themes arose from the analysis process. These were the conflict between rhetoric and reality, therapists waiting for permission to become increasingly occupation-based, and the role of educators in selling the message of occupation.

Rhetoric vs Reality

While participants recognised that the theory of occupational therapy and occupation were important, some of the participants had difficulty articulating how they use occupation in practice. Most stated that they first needed to use impairment-based techniques prior to implementing any occupation-based interventions. Although not planned as a topic during the focus groups, the facilitator discussed Gray's (1998) framework of Occupation as Ends versus Occupation as Means as it was useful for categorising how the participants depicted occupation-based interventions. Overwhelmingly, almost all the participants (6 out of 8) felt that they could not use occupation-based interventions as they would like in practice. Some participants recognised that they should be using occupation in practice but others accepted that this could not be achieved and as a secondary measure focused on maintaining their client-centred role.

The participants felt that occupation and utilising occupation in practice were important because as Sophie commented "... it's our profession!" Melissa stated that "I guess I always kind of look at an occupational therapist and you kind of go occupation is your medicine." When questioned whether impairment-based therapy was acceptable as the means of intervention Sophie further elaborated "if that's only what you do, then [yes] that's a problem."

Using occupation-based intervention was often cited as means of motivating clients to participate in therapy. As Louise stated:

I think it's more motivating and it is honing in on the exact skills that that person needs, so yeah, you can focus on hands but until you actually see what they use their hands for [then you know] how much grip strength they need.

Many responses were similar to this, with Jane suggesting that if an occupation-based therapy is "already incorporated into what you are doing then it's easier." William, who works in occupational rehabilitation, described that he had seen many of his clients experience reduced pain once re-engaged with work: "the pain is there, but it's in the back of their mind."

Some participants stated that occupation-based practice encompassing an “Occupation as Means” (Gray, 1998, p. 357) approach is their preferred style of occupational therapy practice. In reality, however, many of the participants were content that this was unattainable in their own practice. As Louise described “I feel my interventions and assessments are always based on occupation but I don’t get to use occupation as a therapy tool on a regular basis...” Notably one participant felt that by having conversation about occupations would suffice:

In some aspects we advocate for [clients] to use that occupation to help their health and wellbeing... I don’t actually have the capacity to actually practise that activity... but actually having that discussion with them and telling them that that is actually a meaningful and purposeful role and through doing it you are promoting your health and wellbeing. I would say having that discussion [is important when]... you can’t, actually physically [complete an intervention]. (Anna)

When questioned on how the participants would go about implementing occupation-based intervention in practice Kristy answered:

...lots of strength training and dexterity training tasks, and in terms of occupation it’s really hard in a hospital setting but I try, like whether it’s getting to fold some towels up or reach for a cup, pouring tasks, boiling the kettle and using the kettle.

There was a general consensus by the participants that this was acceptable and constituted adequate occupation-based practice in most settings. Other participants who did not work in a hospital also stated that “primarily, personal care, managing their finances, medication management, get back to using a computer or any occupation” (Kristy) or “when prescribing wheelchairs, the therapy is actually getting the right piece of equipment” could all be occupation-based practice (Sophie). As Kristy commented “maybe when someone’s not ready to be launched into an occupation straight away but maybe that occupation could be a goal at the end for the person. So you do little things to build up to it.” Melissa also agrees “it might be doing shoulder arcs constantly but in the end that’s going to lead to someone

being able to return to work again.” These statements demonstrate that some participants do not always use Occupation as Means as the form of intervention in their practice.

Kristy went on to qualify that occupation-based interventions could only be implemented once impairment-based therapy was completed as “it’s only when you get in some strength, and function, and ability for a patient to carry out an occupation that you can be really occupation-focused.” Completing components of occupation rather than incorporating the entire occupation was also a popular strategy:

...if people understand that you are doing this for your bigger goal and you are doing a sub-part of that goal they can see the connection so they’re more likely to do it. If you just tell them to wiggle their fingers cause you know at the end of the day that’s [going to] get you doing this goal over here, then I think that might connect it. (Anna)

At times, it seemed that being impairment-based and using components of occupation could be substituted for occupation-based practice in the participants’ opinions. This perspective was discussed as acceptable practice in both focus groups.

There were numerous times in the focus groups when the participants felt occupation-based interventions could not be implemented. However, this was not deemed problematic, as the participants felt it was more important in the first instance to be client-centred rather than occupation-based. As Anna offered an example of her practice:

I felt that I’d, yeah [I was] client-centred...but at the same time it wasn’t really occupationally-focused. So I could have been a nurse, I could have been a physio[therapist]... I didn’t feel like I was an OT at that time [be]cause they weren’t ready for me to have that conversation about occupations.

Jane concluded at the end of the focus group that most of the practices of traditional occupational therapy were not occupation-based, “ultimately we don’t think it’s occupation-focused but at the end of the day it is to enable [clients] to live safely.” It is troubling that this response was from a new graduate, who easily dismissed occupation and allow mechanistic forms of intervention to be at the fore of her practice.

Occupation-based practice: Waiting for permission

At times throughout the focus groups the participants expressed that they would like their practice to be more overtly focused on occupation. However they often felt that they were not able to implement this in practice because of their status as a newer graduate, as Kristy remarked: "I think I have to be more occupation-focused but I think with more experience the clinical reasoning would be better." Direct supervisors and line managers were perceived to have a direct role in fostering occupation-based practice of the participants, as Melissa explained "supervision would be really important for implementing that." Therefore, it seems, for graduates' final decisions as to how they practice are heavily reliant on the senior clinicians and supervisors in their workplace.

Many participants said that to be occupation-based the workplace would need to be first supportive. As Louise offered "we don't actually get to deliver intervention that is occupationally based... I focus on [impairments] because that's what I have to focus on, on the ward."

Jane also supports this view, as she is now based on a rehabilitation ward:

You can engage people in and do interventions based on occupation a lot more than say on the [medical] wards, where you're just doing the bare minimum really. My view of what OTs can offer is pretty different in community to when I first moved to the [medical] wards. I was kind of thinking: do I just give out equipment?

Peter who works for a private sector company offered:

I think it's all well and good to have those assessment skills and to look at the broad picture but your intervention is often guided by where you work and what the outcomes need to be rather than what [the client or therapist want].

In this passage Peter highlights that outcomes that are best for the client and perhaps align to favourable occupational outcomes can be dismissed if it is in opposition to what the company or workplace dictates. It is concerning that

workplace expectation pervades and can strongly direct clinical reasoning and alter practice outcomes for recent graduates.

Many participants based their clinical reasoning and practice decisions on what pragmatically and historically had been offered at a workplace in the past. Peter felt that new and recent graduates “are stuck in the middle of that system.” Some participants felt there was no choice but to accept that the historical means of practising in a particular setting:

My setting, it was more what [clients] needed to do to safely return home because that’s where I’m based. So I guess we have things that we are looking for to make sure that [clients] are safe in terms of they are not a falls risk, that they have got appropriate support and things in place, and with my clients that particular day I didn’t get to achieve really exploring any of those occupations that were impacting on their ability to go home. (Anna)

One participant lamented that:

It would help if everyone else had an idea of what we did, like the medical team for instance in my setting. If they actually knew what we did, maybe we could be a bit more occupation-focused where you get referrals in a timely manner and they actually consider the bigger picture but that doesn’t really happen. (Louise)

Educators: Selling the message?

All but one participant cited that they had first learned of occupation and the core philosophies of occupational therapy at university lectures given by occupational therapy educators. However, many participants in this study believed lecturers had downplayed the importance of occupation and increased their uncertainty of the concept. For example, Melissa offered that one of her university lecturers in first year said that explaining the concept of occupation was so complicated that it was easier to say and think that “it’s just

doing”, and therefore Melissa adopted this definition, however then in her fourth year of study another lecturer described “it’s not activities of daily living or doing but try and just use the proper OT language.” These mixed messages made it hard for Melissa to feel confident about her understanding of the concept of occupation.

Another common dilemma that challenged the participants upon graduating university was that they never felt prepared to implement occupation-based practice in the current health care environment. Jane mistakenly thought:

I think at [university] in my head, I had a vision of myself going into people’s houses and helping Bill to go fishing again with his grandkids to get back to his meaningful roles, but now I’m just making sure Bill can get up and down, you know, get on and off the toilet...and do the simple meal [preparation] he needs to do.

Many participants in the focus groups also did not feel prepared to implement occupation-based perspectives upon leaving university. As evidenced by this statement by Louise, “I feel like [lecturers] go on about [occupation] so much but they didn’t actually teach you the skills to deliver occupation-based practice and within a variety of settings...” she continues that “just learning some of those skills would have been much more useful than all of those anatomy subjects.” Melissa had a similar experience:

I guess I kind of got mixed messages with some things at [university]. Like I remember we did specific workshops with dexterity tests and things like that, which was just picking up small objects. But then there was a lot of talk about [occupation] that would make you feel very inspired about using occupation in your therapy.

From the participants’ experiences, even after graduating, confusion about what constituted occupation-based practice hindered them from applying this confidently in the workplace.

Discussion

This exploratory study was designed to not only elicit understandings from graduates about their perceptions of occupation, and ascertain if occupation was central to their practice, but also to determine if they felt prepared to implement occupation-based perspectives upon graduating. Participants highlighted contrasting views between their beliefs about the importance of an occupation-base to occupational therapy and when to implement this in practice. Many participants favoured impairment-based interventions despite stating occupation-based practice was highly motivating for clients. Statements on client-centredness provide insights into the marginal status of occupation to the participants' clinical reasoning. Education is the main avenue where occupational therapists learn about occupation however inconsistencies between the theory and the implementation in university teaching appear to be compounding the difficulties of confidently implementing occupation-based practice. In addition to uncertainty arising from their educational experiences, other factors including power differentials between junior and senior staff and workplace culture are inhibiting new graduates from applying occupation in practice.

The impact of workplace culture

The pervasive nature of workplace culture was raised in the focus groups. Participants expressed that their choices for practice were driven by workplace efficiency or the outcomes expected by their colleagues. Some participants unknowingly conformed to workplace expectations. However, as illuminated by Peter in the findings (pg. 10), some participants intentionally conformed to their colleagues' expectations and dismissed the key tenet's of occupational therapy in the process.

Conforming to workplace culture, especially a medically-dominated workplace can be damaging to profession-specific reasoning for healthcare workers subscribing to a social model of health, as Miles (2008) found through an investigation of midwifery students' experiences of fieldwork. Miles discovered that students and practitioners alike conformed to the existing culture and adapted their way of thinking to fit. Also, Wilding and Whiteford's 2008 study of acute hospital practice found occupational therapists conformed to the dominant biomedical culture and this adversely affected the therapists' ability to think and talk about occupational therapy-specific values. This study adds to the growing body of literature and commentary on the need for examination of individual and workplace beliefs on implementing an occupational approach to practice (Gillen & Greber, 2014; Molineux, 2011).

Occupation as Means or Occupation as Ends

“Occupation as Ends” where therapists justify their clinical decisions with occupation as the end point of therapy (Gray, 1998, p.357) is ultimately still favoured by the participants, as indicated by findings in this study. Many participants stated that they would be unable to use occupation in practice without first remediating impairments. Nevertheless, it was apparent most participants recognised the importance of and acknowledged the need to continue to reflect upon and implement the founding philosophies of the profession. This resonates with the sentiments of Reilly (1962) who called acquiring knowledge of occupation-based practice an “obligation” for all in the profession (p.2). Given the complexities the findings in this study illuminate, implementing occupation-based practice across the profession could be challenging but a challenge worth striving for.

The general consensus among the two focus groups was if an occupational therapist is working towards a client’s occupations solely as the end goal of therapy, then this still constituted occupation-based practice. It was clear the participants had diverse definitions of occupation-based practice. However, despite a push in recent decades for occupation therapy to re-embrace its founding philosophies, it seems the participants still did not fully understand what constituted and how to implement occupation-based practice. Fisher’s 2013 paper about the differences between occupation-centred, occupation-based and occupation-based practice may help to elucidate the terminology for some. However, occupational therapists and university educators alike should increase awareness of the differences between striving for occupation as an end goal of therapy and using occupation as the intervention. Deliberately deciding to practice in an occupation-based manner may make it easier for new graduates given the overriding culture and power divide.

No power to influence practice

In the past two decades, literature has been published on power differential between students on placement and their supervisors (Crist, 2007; Pfeifer, Kranz & Scoggin, 2008). The authors of this paper contend that power disparity is not unique to occupational therapy students. This study revealed that new graduates feel similar pressure to conform to expectations of a workplace due to the perceived power disparity between themselves and senior therapists.

Many participants in the study stated that they would be unable to use occupation-based practice in their daily work due to the existing practice patterns of their senior colleagues. Surprisingly, this assertion was made by therapists with less than one year of experience but also by graduates with more than five years of experience. Pressure to conform and be seen as competent was generally regarded as more important than using occupation in practice. This conscious conformity is not a new concept for occupational therapy students (Di Tommaso & Wilding, 2014) and therapists (Wilding & Whiteford, 2007) who may choose to conform to the existing culture of a workplace, rather than take a different stance.

However, it seems that to become truly occupational in practice, changes must be made to influence the profession's future. Questioning historical means of practising could revive a focus for occupation in practice.

Implications for further research

Initiating conversations with colleagues about the importance placed upon occupation-based practice was a strategy recommended by participants. This strategy has also been endorsed in the literature (Gillen & Greber, 2014). Therefore an examination of and conversations about current practice could be a useful exercise for change towards more meaningful occupation-based practice. Despite the power gap, new graduates and less experienced therapists should be encouraged to have input into these conversations, as they are likely to have the most up-to-date knowledge from university. As supervisors and managers were seen to play integral parts for graduates to implement occupation-based practice, it is important to examine their views on the topic.

It could be helpful for therapists who graduated prior to university curricula reflecting the significant changes made by the WFOT's *Revised Minimum Standards for the Education of Occupational Therapists* in 2002 to increase or review their knowledge of occupation-based practice. This study highlights the need for professional development to more strongly focus on occupation and the occupation for health message. Therefore the opportunity for professional development within and outside the workplace to foster these perspectives is necessary if occupation-based practice is to be a reality of practice.

From this study, we know a small number of graduates from universities across Australia did not feel prepared to implement the central tenets of the profession. Therefore examining and discussing teaching practices and content to meet this shortcoming could be useful. This reinforces the work already completed in this area by educators in Australia such as Wilcock (2000) and more recently Gustafsson, Molineux and Bennett (2014) and Fortune and Kennedy-Jones (2014). Repositioning occupation to be central in university curriculum is not only being examined in Australia, with educators from the United States also investigating and developing an increased focus on occupation in curricula (Hooper et al., 2015). A new edition of the *Minimum Standards for the Education of Occupational Therapists* could be an opportunity for educators to examine how they are currently informing students of occupation-based perspectives. Revising guidelines to have an explicit occupational focus could assist universities and industry to work together to deliver outcomes that are consistent to the philosophies of occupational therapy, thereby increasing the likelihood of occupation-based practice becoming a priority for the future.

Limitations

This was a very small study designed to explore the usefulness of the research questions for a larger study, and to potentially uncover some perceptions of and challenges faced by new graduates in Australia.

Conclusion

The findings from this study indicate that the research questions are feasible for a larger study to illuminate the perceptions of how graduates use and value occupation in their practice. In addition findings have generated insights as to why occupation might not be at the forefront of practice in Australia. Despite participants in this study having practice experience ranging from one to six years, there were no obvious differences in their perceptions of occupation when used in practice, nor when discussing the centrality of occupation in the profession. Further research in this area is necessary.

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Table 1 Australian state where graduates trained, years since graduation, and current area of practice

Participant (pseudonyms used)	State	Years since graduation	Area of Practice
Anna	WA	5	Acute Hospital- Medical
Jane	WA	3	Acute Hospital- Aged Care
Kristy	NSW	<1	Acute Hospital- Rehabilitation
Louise	QLD	<1	Acute Hospital- Medical
Melissa	NSW	4	Community Mental Health
Peter	NSW	6	Occupational Rehabilitation
Sophie	NSW	5	Community Paediatrics
William	SA	3	Occupational Rehabilitation