Community-based occupational therapy in Norway: Content, dilemmas, and priorities

Abstract

Aim: Profound changes in municipal health services call for new models in community–based occupational therapy services. The aim of the study was to explore and describe characteristics of community-based occupational therapy practice in Norway, and how therapists position themselves toward the tasks delivered.

Method: Focus group interviews with ten community-working occupational therapists were conducted. Systematic text condensation was used in the data analysis.

Results: Four ideal types emerged, which can be described as features of and dilemmas that characterize community-based occupational therapy practice in Norway: being 'an all-rounder', 'a provider of assistive device', 'a fire extinguisher', or 'an innovator'.

Conclusions: Community-working occupational therapists must position themselves between 'traditional' occupational therapy tasks and exploring new ways of delivering occupational therapy services. The study demonstrates a rapidly changing practice and further research in the field is required.

Keywords: Primary care, Health care services, Occupational therapy practice, Qualitative study, Assistive devices.

Introduction

Approximately 2.600 occupational therapists worked in community-based services in Norway in 2015 (figures from Statistics Norway (SSB)), representing more than half of all occupational therapists in the country. It is estimated that the number of occupational therapists in community-based health services must triple to meet upcoming health and care

needs (1). A forthcoming change in legislation declares that occupational therapy (OT) will become an obligatory part of community-based services by 2020 (2). Because of this, we can assume that the number of OTs working in community-based services will increase. However, few studies have described what kind of health services OTs provide in the community, which user groups are prioritized, what characterizes their practice, and with whom they collaborate (3). In general, only a handful of international studies investigating the role of community-based OT services have been published (4).

The municipalities in Norway have been given new tasks and have expanded the area of responsibility for the citizens' health care (5). Demographic and technological changes, different user groups, changed needs, and profound changes in community health services call for new models of community-based OT practice. Research has described a generalist role for OTs in a municipality setting, working across the life span with a wide range of client populations providing a variety of interventions (6). The description of diversity of intervention and variation in user groups and arenas of concern may create major challenges upholding quality and continuity in the service delivered. This is especially the case in the community setting, where OT competence in assisting clients seems almost boundless. Access to occupational therapists in Norwegian municipalities is limited (1), which generates dilemmas related to choices and priorities. Various tasks require that community-working therapists must interact in close cooperation with different professions and institutions and across diverse sectors and administrative levels. Research that problematizes what kind of competencies are required and which models should guide professional choices in community-based occupational therapy is lacking (7).

Occupational therapy focuses on people with, or who are at risk of having, activity limitations and participation restrictions in their everyday life (8). The therapy is described as a solution oriented practice promoting participation in daily life through person centred and community

oriented approaches (9). To reduce the gap between the person's ability to participate and the environment's demands, a wide range of professional interventions can be offered: supporting people's performance capacity, adapting and grading specific activities, or adjusting the environment. Providing information, counselling, and teaching are often integral parts of OT support. OTs can work with clients, groups, and social systems, in areas such as health promotion, prevention, treatment, habilitation, and rehabilitation (7).

A systematic review (10) showed that occupational therapy for community dwelling elderly people had a positive effect on functional ability, social participation, and quality of life, especially advising on assistive devices as part of a home hazards assessment. A Norwegian study (11) found stair lift intervention cost-effective for people with disability living at home. Community-based OT services have also been found to be a cost-effective intervention for people with dementia (12, 13), for falls prevention (14, 15), and for stroke patients living at home (16).

A recent study (17) reported that eighty-eight percent of the OTs in the Norwegian municipalities work with assistive devices, and among those the mean estimated time proportion spent working with assistive devices was 51%. This interesting finding seems to be in contrast to the generalist role providing a wide range of interventions, as international studies state (4). The fact that community-working occupational therapists in Norway spend so much time on providing assistive devices seems not in line with international descriptions of OTs' new role in community-based health services (18). Internationally, it has been declared that occupational therapists in the community should provide a faster and more efficient patient recovery after hospital discharge, and deliver more specialized treatment services to community-living patients by improving their living or working skills (18). The aim of the study was to explore and describe characteristics of community-based OT practice and how therapists position themselves toward the tasks delivered.

Methods

Participants

Participants were recruited through a national survey sent to 1767 community-working occupational therapists in Norway (response rate 31%). For practical reasons, the research team decided to conduct focus group interviews during a national conference for occupational therapists. At the end of the electronic questionnaire, those who stated they planned to attend the conference were invited to participate in the interviews. We received confirmation feedback from twenty-one therapists. Eventually, ten of these opted to participate in the study. The reason for drop out was that they did not attend the conference or the set time for the interview did not fit their schedule.

Choosing to include dedicated and committed therapists is a strategic sample. We can assume that those who choose to attend a conference are engaged therapists interested in professional development. Choosing to answer the survey and participate in the focus group interviews, the participants are especially concerned with professional issues and are interested in communicating their experiences and thoughts about community-based occupational therapy.

The ten participants represented different regions of Norway. They were all females of different ages and with different work experiences. Some worked in cities, some in rural areas, and they came from both small and large municipalities (see table 1). Their services were organized in different ways, some worked partly as a leader of the service and some had more defined work areas than others.

Table 1. Participants

Participant	Position	Size of the municipality	Work experience	Education	Number of OT colleagues

1	Department manager and OT	8 000 (rural)	26 years of experience in community health service	Interdisciplinary rehabilitation, universal design, work rehabilitation and management	1
2	OT 50 % (0- 100 years) and 50 % in dementia care	10 000 (rural)	Specialized health services. Small group of OTs have to cover a large geographical area		3,5
3	OT with responsibility for nursing homes, reablement, and persons living at home	11 000 (rural)	Recent graduate		3-4
4	OT	55 000 (urban)	Community health service, adults and elderly, children 0-16, several projects about universal design and accessibility	Knowledge translation, workplace assessment	16
5	Divided between rehabilitation/short time nursing home, palliative unit, and people in all ages living at home	29 000 (rural)	Recent graduate		5
6	Adults and elderly living at home. The references are divided between districts and some content	45 000 (urban)	Work experience from specialized and community health services	Further education on community-based occupational therapy, master	4
7	Children, adults, and elderly, health centre for children, geriatric outpatient clinic, participation in construction projects universal design	14 500 (rural)	Rehabilitation in the specialized health service, day rehabilitation in the municipality, assistive device centre, and community based OT		2,5
8	Health-promoting home visits in development centre for nursing homes and home care	23 000 (urban)	Community based OT in different rural and urban municipalities in Norway, high school teacher in a Scandinavian country	Master	
9	OT	51 000 (urban)	17 years in the specialized health service and 8 years in community health service		20- 25
10	Group leader and OT	51 000 (urban)	Community based OT in different rural municipalities in Norway		20- 25

Focus group interview

Four focus group interviews were conducted. A focus group interview was chosen because it is suitable for the exchange and elaboration of experiences and ideas among professionals (19). Based on features in an ongoing survey about community–based OT services in Norway

(17), an interview guide was prepared and discussed among the authors. The interview guide focused on the content of the service, organization, collaboration, user groups and priorities, dilemmas, opportunities, and thoughts about future occupational therapy. The task of interviewing was distributed among the authors. A mediator and a secretary participated in all interviews. The interview guide helped structure the interview and ensured that key areas were covered. The interviews lasted from 60-90 minutes and were characterized by dialogue and reflection between the participants. All interviews were audio-taped and fully transcribed by the authors.

Analysis

Systematic text condensation was used for analysing the data, and can be described as a descriptive and explorative method for thematic cross-case analysis of different types of qualitative data (20). In the first step, the first author read the entire material, which helped her get a bird's-eye perspective on the data, identify preliminary themes, and find focus areas. The approach was inductive, strove to be open minded, and let the participants' voices lead the analysis. In the second step the first author identified and sorted line by line all the interviews into meaning units, which means text fragments containing statements relevant for the research question. The meaning was thereafter marked with a code, a label that connected related meaning units into a code group. Commonalities and differences within and across the coding groups were investigated within and between the interviews. In the third step, empirical data were reduced to a decontextualized selection of meaning units sorted as thematic code groups. In this phase different ideal types emerged through the analysis. In the last step, the data were reconceptualised by providing stories, patterns, and inequalities that shed light on the different ideal types identified. During a two day workshop, all the authors critically discussed the content of the interviews and the suggested ideal types. These discussions gave important correction and vital input for further analysis.

Ethics

Approval for the study was obtained from the Norwegian Data Protection Official for Research, Norwegian Centre for Research Data (project number 52827). Participants were informed that participation was voluntary and that their responses would be treated in confidence.

Results

Through the analysis, we found that community-based OT practice in Norway could be characterized as four ideal types. Below we will describe ‘the all-rounder’, ‘the provider of assistive devices’, ‘the fire extinguisher’, and ‘the innovator’. All participants described elements of all ideal types, some more than others. The therapists positioned themselves in and between these different ideal types, and below we will show how different dilemmas emerge among the participants.

The all-rounder

A consistent feature in the material is that many participants position themselves as all-rounders: they related to a wide range of users, in different arenas, and with different issues. One says, "You must be a bit of an all-rounder," while another mentions, "I worked in a small municipality where it was just me, then I had responsibility for everything and everyone" and concretizes "it is about being a coordinator for a child with CP and to follow up at school, the home service that wants assistance to see how [best] to perform care, to deliver assistive devices, do hand exercising ... so everything.” Participant 7 says:

> We are expected to cover both health centres and geriatric outpatient clinic. We do dementia assessments, and work with children and adults ... we are involved in construction projects with universal design in the municipality, we cover the whole area.

The all-rounder role also includes distributing their tasks between patients at the institution and at home. Participant 5 says, "I'm working in a rehabilitation ward, i.e., a ‘short-term’ department in a nursing home. I work in a palliative ward, in addition I do home visits.” Participant 3 says, "I spend a lot of time at the nursing home, at times I also spend more time on reablement service, so I'm very flexible. In addition, I do regular (laughter) occupational therapy tasks.”

Participants associate the value of their work as a community OT, particularly to the role of being an all-rounder. Various user groups and diversity of tasks is highlighted as particularly important. Participant 9 says:

> That you get everything and meet everyone, you get to know people over time, not like in hospitals that they come in for a short while and disappear again …. that you can follow them in everyday life and at school and at work, in all things they are involved in. This is what has been fun working in the municipality.

The ability to assist clients in their everyday life and follow-up over time sets the premises for versatility. As an important side of the all-rounder role, some also emphasize their degree of involvement. Participant 7 says:

> In the hospital I was much involved in the patients, complex processes day after day after day after day. ... At the assistive technology centre [where I worked], I was very much an advisor and just briefly in touch with the users. In the municipality I find a good balance of involvement, and that suits me very well.

The all-rounder role is linked to the width of practice, but also to what is denoted as a high degree of autonomy, independence, freedom, and flexible frameworks. Participant 8 says, "I think we are very free to decide for ourselves," and participant 9 relies on flexibility and freedom of user involvement, "both I and the client are quite free to decide what to do, to set goals…. when it is a motivated client, I spend a lot of time, if there is someone just needing a shower chair, I deliver that, and then you're done.”

Being an all-rounder raises several dilemmas. The first is linked to competence, the second to time and capacity, and the third to the priority. It becomes a question of being generalists and to what extent specialization is needed. In larger municipalities, a division of tasks and a higher degree of specialization develop. Participant 10 says;

> There are many occupational therapists in the municipality and some have special interest in psychiatry, some in neurology, some in ME [myalgic encephalopathy] ... that's how we can organize it in a big municipality, a form of specialization.

Participant 2 supports this statement, "You become such a 'small specialist' in our municipal system, I think it's really satisfying." Participants working in a small municipality describe themselves as generalists. The professional self-perception may be understood as participant 8 describes it, "I'm a little good and a little bad (laughter) [in what I do]." Participant 7 explains that, "... we are not expected to be specialists, but on the other hand it is said that we know the patient best and in that regard, we are specialists ...."

Specific work methods are developed as all-rounders, "You must be good at using people around you, call them up and ask for advice." They describe that they Google and talk to others to get knowledge about the topics they are working on. The participants describe that they rarely use research-based knowledge or do systematic searches. The all-rounder role is also about being a coordinator in relation to the individual plan. That competence requires, as one said, in particular, "knowledge of the municipality, system knowledge, and coordination competence."

In the all-rounder role, time is emphasized as a limited resource. They describe long waiting lists and bad consciences about not reaching everyone. When asked about what characterizes their practice, participant 7 spontaneously utters, "Set limits for work tasks", and another says, "to prioritize - to make it go around." Priorities are marked by coincidences, but some also describe how they take different steps to handle the 'time squeeze' and to provide the right

client with the optimal services at the right time. One informant described the value of defining goals with the client as a strategy that delineates and clarifies the follow-up,"... once you have reached the goal you set on your first home visit, you can afford to terminate and go on with new tasks." In that regard, others describe that they work according to ‘prioritization keys’, and some streamline practices through systematization and guidelines.

In sum, we may say that all-rounders relate to a wide range of clients and issues. The all-rounder role is appreciated, but is also described as demanding. The role generates dilemmas like degree of specialization, capacity, and prioritization.

The provider of assistive devices

An interesting finding is that when participants talked about common or traditional occupational therapy tasks, this was linked to assistive devices and physical adaptation. Participant 1 says: "... most people still associate occupational therapists with assistive devices." A paradox in the material is that the participants, on the one hand, describe a clinical practice in the municipality with flexibility, diversity, and variety; on the other hand, they show a practice that seems to be dominated by delimited and highly externally controlled tasks. This duality in the narratives is a continuous feature of the material.

The role of providing assistive devices appears quite distinctly in the material, and here the participants position themselves differently. For some, delivery of assistive devices representing a particular skill in the municipality, providing clear positioning towards other professionals, while for others it is only regarded as one of several possible interventions. Participant 9 explains that she had little competency on assistive devices when she joined the municipality. At the hospital she worked at for 17 years she was rarely tasked with providing assistive devices, and during education to become an OT there was little focus on assistive device delivery. "When I started in the municipality, I knew hardly anything about assistive

devices. So that was a steep learning curve." One of the participants clearly positions themselves in the role of an expert on assistive devices and physical adaptation and considers it as their central role. Participant 1 says:

> I get involved in the most complex cases where there is a lot of adaptation and the tasks that occupational therapists traditionally work with, related to functional assessments, like car and housing [….] and some workplace adaptations.

Most participants stand out of the traditional role of auxiliary agents, such as participant 2:

> ... it's no longer that rewarding, if you've been involved in delivering assistive devices for 10 years, maybe it's not where I feel like, YES, now I really feel like I am contributing to making a difference, because in my heart, the area of my professional interests is different…

Interest, competence, and experience also appear to guide the way the municipality therapists position themselves in relation to assistive devices. Participant 8 says:

> I was fed up, I guess it was too much assistive devices. Spending a lot of time writing applications, cooperating with the assistive technology centre, and more and more bureaucracy ... so I earned a master's degree in health promotion and then I found out I would not work like that anymore.

The participants experienced strong external pressure and met distinct expectations from other collaborators or employers to work with assistive devices. Participant 6 says, "Assistive devices are like the major issue in the municipality, it is so visible, it is so physical", continuing, "assistive devices have been such a mantra during all these years…." The role of 'provider of assistive devices' is maintained by the managers' perception of occupational therapy. Participant 3 says:

> ... one of my colleagues told me that she had been talking with her manager in relation to dementia-friendly communities, and the manager just says - yes, but you [OTs] are so good at providing assistive devices, that's what you need to focus on. But – actually – we do quite a lot of assessments, as well as things other than assistive devices.

One aspect related to the role of 'provider of assistive devices' is the contrast in the way the collaborators and the OTs professionally contextualize the assistive device practice. Many therapists experience getting referrals for a specific type of device: "Yes please, you can apply for this [particular aid]." Such references harmonize badly with the OTs' working methods and self-perception, "It is all about the assessment skills and follow-up skills needed afterwards."

External pressure allows OTs to easily end up in an ‘ordering function’ that goes beyond their professional integrity. Participant 1 says:

> …there is a difference between the professional groups when it comes to delivering assistive devices ... It is important to maintain high quality, that it is a professional task and not just a technical solution ... I have stopped applying for assistive devices on behalf of others [professionals].

In summary, we may say that the material shows that therapists in the municipality are linked to providing assistive devices and many references are about specific orders. They are under pressure from the outside, where professional autonomy is threatened. Occupational therapists consider the provision of assistive devices as one of several solutions to client’s activity and participation challenges. Quality in the delivery of assistive device-service links the OT to assessment and follow-up expertise, which seems to be noticed or recognized to only a limited degree by collaborating partners.

The fire extinguisher

The third ideal type that characterizes the community-based OT practice in Norway can be described as 'the fire extinguisher.' The feature of this practice is that the therapists becomes involved late in the client’s pathway and the measures are often limited. The ´fire extinguisher' does not follow the clients over time or carry out tasks that require continuity and comprehensive involvement. Coincidences and lack of priority planning are part of this

practice; "We get these phone requests that slurs in before others [waiting lists], because maybe it's so easy to answer it right away and so on ... without having a whole plan." Fire extinguishers provides limited assistance to a wide range of users. Participant 4 says:

> ... you cut some corners - that I wish I did not let happen ... filter away something that you would have taken care of if you had more time. For example, if you visit a client for the first time, and do an assessment, for example, you might be a bit rough about prioritizing what you initiate. The ethics are absolutely questionable.

Several describe that they are late getting involved with the clients and say that there could be greater utility if they worked more preventively. One says, "working more preventively we would have more opportunities, but there is not enough time for it. There is a lot of fire extinguishing." Participant 7 says, "I think we should really focus more on the children ... but I do not have the time." Several describe that there are not enough OTs in the municipality to which to distribute referrals, which contributes to the fire extinguisher problem.

For the fire extinguishers, it's easy to become absorbed in daily practice, which makes it difficult, as participant 1 says, "to stop and take a step to the side and look at how we work, and what we are doing … you just drive on like a train."

New services and changed user groups are also a reason for maintaining the role of fire extinguisher:

> ... those who have good cognitive function, those who are motivated (laughter) - they are going to the reablement services. This affects our waiting list, because they [that come to us] are now worse and they may not be that easy to 'get rehabilitated'. In those cases, an assistive device will often be the best, right?

For the fire extinguishers, rehabilitation tasks are difficult to prioritise. Many describe information exchange with other professionals, but the practice they refer to does not seem to be characterized by close interdisciplinary collaboration over time with clients. Several emphasize that private physiotherapists are difficult to get hold of and that they do not

prioritise collaboration and meetings. Collaboration requires time, continuity, and hence a strong priority of someone rather than others. For fire extinguishers, it becomes difficult to be involved in binding teamwork.

Areas in which several of the participants believe they should prioritize more are especially related to functional training and hand exercises for stroke patients. For the fire extinguishers, expectations from the specialist health service following up with long-term needs becomes problematic. Participant 1 says:

> I sometimes think it is somewhat unclear what kind of expectations the specialist health service has for the municipality sector regarding follow-up of some patients. In relation to stroke patients …. with focus on follow-up of hand function and the more cognitive challenges they have ... we really do not have the possibility to [deliver what is sufficient]. We neither (laughter) have resources nor competence ...

The lack of follow-up of people with cognitive challenges is thematised and linked to a lack of competence and shortness of time. For the fire extinguishers, follow-up with this patient group is limited to providing cognitive devices, such as cookers, calendars, and other reminder aids. Participant 5 says, "The work toward people with cognitive limitations is especially related to an electric wheelchair and driver license. We do a lot of tests in relation to cognitive functions."

Some describe how they have taken action to get out of the role of fire extinguishers by making active choices and priorities. Participant 8 says:

> For over a year, we have worked preventively with young people with chronic disorders ... they have met once a week and done different activities together. We try to work preventively, both OTs and physios. This, in addition to reablement. But, of course, we have the potential to get better.

In summary, we can say that a characteristic of the role of municipal therapist is to be a fire extinguisher. It is an unsatisfactory role and threatens professional integrity. It is about giving

little to many. This characteristic includes active choices and group priorities, and tasks are, to a small extent, provided. For fire extinguishers, defined tasks are prioritized rather than health promotion and rehabilitation tasks, which require continuity and close monitoring of clients, relatives, and collaborators.

The innovator

This ideal type is about developing new incentive models in community-based occupational therapy. It is about redefining the role from acting on behalf of other professionals' requests to more fully experiencing professional autonomy. Participant 8 says, "I'm working on changing the practice of being a secretary in delivering assistive devices to perform occupational therapy, such as providing early follow-up, person centred-goal formulation, and ADL-training." Participant 5 says that "it is expected that we take care of assistive devices first! We are working to change this every single day. Change takes time."

Participants describe that they are now experiencing time shifting, in which their and others' understanding of municipal OT is changing. This is about how the participants position themselves as actors and premise providers in the process of change. Participant 10 says there are "very exciting times to come ... very positive now, it's a possibility, and I think that's what I have to take responsibility for locally." New demands also facilitate changed performances; "In the future we need to have fierce priorities. We cannot go in the same rhythm as before… You must always reflect on what you are doing" (participant 2). New services also help increase the demand of occupational therapists and referrals change character. Participant 10 says:

> ... in the past few years a lot has happened in the municipality, we got a memory team, we have reablement, there are more satellites out there who see [the needs] and refer to us. We have a huge increase in the number of referrals.

Several also describe that the user group is changing, which is of importance for the changing practice. Participant 7 says:

> Earlier, there were a lot of arthritis patients and that's almost not on the lists anymore, there was a lot of fibromyalgia, which we rarely see. Now there is an increase in this hypermobility syndrome, Ehlers-Danlos and ME. And, we still get surprised when we check the average age of our clients, because it's 57 years, there are many young people.

Participant 8 says, "Post-polio syndrome is actually something we now see", while participant 10 says, "We also have refugees and immigrants. It is a new experience working with an interpreter and it is challenging working with people from other cultures." Some OTs orient themselves towards new ways to solve tasks, such as participant 11: "In such a large municipality, I think there is also potential for group training, such as hand training."

The innovation role is challenged by others' lack of knowledge regarding community-based OT and their expertise. An important part of the work as innovators is therefore to be marketers of their own profession. One of the participants says, "We must jump into unknown landscapes and convince them that our approach will make a difference and complement services that are well established." Another says, "We have great potential and capacity to handle many users, different diagnosis groups, and issues, but we must be allowed to get hold of it, be allowed to share it, we must get on the track, and we must be heard by politicians." Therapists working with children in the municipality say, "We are actively promoting the service and our competence." Addressing the challenges of communicating competence, participant 7 says, "The challenge is that we are involved in so many levels….in so many activities in daily life… explaining our competence to someone else is challenging."

The innovators describe that they are under great pressure, where different understandings about their practice and priorities take place. However, the participants highlight different opportunities for them as innovators, especially because OTs are defined as key actors in the

development of new services in preventive, health promotion, and rehabilitation efforts in the municipalities. Innovators respond to project work facilitating service development. However, many municipalities rarely invest in OTs, so one challenge for the innovators is that there are often few OTs to include in such work. The participants highlight the dilemma of being involved in developmental work while at the same time taking care of their clients.

In summary, we can say that the biggest threat to innovators is a lack of opportunity to redefine their own role and limited ability to define themselves from the ordering of assistive devices. The threat is also about going out of a professional culture that, over time, becomes self-reinforcing. Participants show that municipal OTs are changing, and they show in different ways how they stand in a tension between the "traditional" and “new” ways of practicing therapy. They all show how they are innovators who actively contribute towards developing new models for OT practice. Innovation is pushed forward from above, from outside sources, and from themselves. The key feature of this work is to promote professional competence, greater awareness for making qualified choices and priorities, and the development of new working methods and services.

Discussion

We find that community-based occupational therapists in Norway can be described as being ‘all-rounders’, ‘providers of assistive device’, ‘fire extinguishers’, and ‘innovators’. A survey (n=157) from Canada also showed that occupational therapists worked as all-rounders, with a wide range of activities in their community practice (4). They found that diversity of services and tasks depended on the nature of the local community, team composition, and client needs (4). In our study, we found that small rural communities produce generalists, while in cities and larger communities with several occupational therapists, the therapists become more specialized. We illustrated that the generalist role is demanding and implies a variety of knowledge and skills. As highlighted in studies of occupational therapy (21), nursing (22),

and physiotherapy (23), it is important to emphasize what will be required of rural practice in the future. When OT becomes a mandatory part of community-based services in Norway starting in 2020 (2), we can assume a significant growth in OT services in rural areas. An Australian study showed that OTs in rural areas need to have well-developed caseload prioritization skills to successfully manage their workload (24, 25). Our study showed that OTs untrained in caseload management often end up working as fire extinguishers, providing limited follow-up and providing services to a large number of patients without clear priorities.

In a Canadian study (26), OTs reported that management and organizational skills were essential for their rural practice. The researchers also found that rural OTs access to online and telehealth resources appeared to have markedly changed the nature of rural practice. Similarly, we found that management and organizational skills, as well as the ability to use technology for professional support, seem crucial for effective community OT services. Others (27) predict that community-based OT services call for broad experience, advanced training, and commitment toward life-long learning. That implies avoiding a situation where community-based OT interventions generally involve only a small number of home visits, as one study showed (28). Occupational therapy educational programs must make students well-equipped for advanced community-based services, including developing skills for rural OT practice.

The focus group interviews were mostly about providing assistive devices and dilemmas in that regard. This is not sensational considering that 88% of community-working OTs in Norway work with assistive technology, and report spending 50% of their time on assistive technology (17). An international survey (4) found that community-working OTs most frequent activity involved equipment prescription (approximately 75%). Gramstad and Nilsen's (3) study of 48 community-working OTs in Norway demonstrated that their expertise was especially linked to assistive devices. In line with their study, we also found that other

professionals did not have the same in-depth understanding of the comprehensive and dynamic process required in providing assistive devices. They found that OTs in the municipality experienced being assigned the role of 'orderers' without considering the professional assessments required. They (3) also point out that community-working OTs must communicate more extensively to users and other professionals their choices and judgments in the provision of assistive devices. Another study (29) identified assistive technology to be one of the top research priorities among community-working occupational therapists in Norway. They particularly emphasized the need for research on assistive devices related to clients with cognitive problems or related to reablement interventions.

New solutions, professional change, new technology, and new methods are highlighted as crucial to meet society's health challenges in the future (30, 31). Policy changes rapidly, new healthcare initiatives are started, and the pressure on community health care services are increasing. That creates new opportunities for service improvements for occupational therapy practice. Our study showed that community-working OTs are aware of professional and policy trends and position themselves as innovators. An ongoing Norwegian survey (n=561) showed that 40% of the community-working occupational therapists take part in projects or development work (17). In the current study, we demonstrate that they innovate in an effort to influence policy for the profession and for the people they serve. Some communicate locally with service authorities and policy makers to make the service known and to show how the profession can contribute to solve health challenges. Innovation can be about simplifying processes and developing models and new forms of cooperation that optimize professional resources. The study shows trends in that direction, but also being “trapped” in what the participants called “traditional occupational therapy tasks”. We found that innovation initiatives are made in community services, such as making new priorities systematizing their work, offering group interventions, and working more with prevention and health promotion.

We have also provided examples of internal and external barriers toward working as innovators. The process of change in community-based OT has just started and there is a lot of work left. This and other studies (32, 33) point out that community-based OT supporting participation in everyday life for clients implies a wide range of interventions that may or may not include assistive devices.

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Declaration of interest

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