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# Occupational therapy in adult social care

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## Introduction

The purpose of the briefing is to support occupational therapists (OTs) in adult social care to underpin their practice with an understanding of current relevant evidence, theory and models. It will also be useful for other practitioners across adult social care to develop their understanding of occupational therapy. The briefing cannot cover all aspects of occupational therapy practice in detail, and so aims to provide an overview with a focus on some specific areas.

Occupational therapists have been challenged to find 'new, creative and collaborative ways of working that may be outside normal statutory provision' and to 'actively engage with service users to co-produce, design, deliver and evaluate the support/services received' (SCIE & COT, 2010, p.1). This publication will help practitioners to do this by exploring:

- **Occupation-centred practice and occupational science.**
- **Concepts and language of occupational science.**
- **Models for practice.**
- **Key policy drivers for occupational therapy within adult social care.**

Traditional occupational therapy roles are often well known and practised within certain aspects of adult social care; in particular:

- Promoting health and wellbeing
- Prevention
- Housing adaptations and the provision of equipment
- Reablement.

**Reflection**

Through questions, prompts and exercises, this briefing will encourage and challenge readers to reflect on how the theory, evidence and models presented apply to their practice. This can be done individually or as a group activity, and considered as part of continuing professional development (CPD).

## Occupation-centred practice and occupational science

Underpinning occupational therapy practice is the belief that occupations – 'all the things we need, want or have to do' (Wilcock, 2006, p. 14) – and activity are fundamental to a person's health and wellbeing (Royal College of Occupational Therapists (RCOT), 2021, section 4.1.1). This is because they provide meaning, identity and structure to people's lives and reflect society's values and culture (Whiteford, 2004).

A person's ability to carry out their activities and roles in daily life is understood as their occupational performance. This ability to perform and participate, or engage, in occupations can affect and be affected by the individual's experiences or circumstances.

Occupational science is a research-focused discipline, started in the 1990s, that generates knowledge about human occupation to complement and enhance occupation-based occupational therapy practice (Rudman & Aldrich, 2017, p. 21). Occupational science and occupational therapy share values, including the centrality of occupation to human existence and the belief that occupational participation and engagement can influence health and wellbeing (Molineux, 2011).

Law et al. (2002, p. 34) provide the following broad definition:

> ***Occupation refers to groups of activities and tasks of everyday life, named, organised and given value and meaning by individuals and a culture. Occupation is everything people do to occupy themselves, including looking after themselves (self-care), enjoying life (leisure) and contributing to the social and economic fabric of their communities (productivity).***

Wilcock and Hocking (2015, p. 180) discuss restful and active occupations, and 'doing' and 'being':

> ***The different aspects of the doing to being continuum includes the need for satisfaction, meaning, fulfilment and purpose; having choice and energy; finding pleasure, balance, and opportunity; and being challenged, committed, free, creative, and able to cope.***

Christiansen and Townsend (2011, p. 176) highlight the social nature of doing occupations:

> ***Human communities consist of groups of people who do things together and individually. People participate collectively through shared interests and activities in work, sports, hobbies, volunteerism, home life and civic involvement.***

These definitions highlight the complexity and breadth of occupation. The challenge to adult social care, therefore, is to look beyond the occupational therapy services that are restricted to meeting only basic needs (Seymour et al., 2012; Boniface et al., 2012).

Occupation-centred practice includes working collaboratively with a person to support their engagement, performance and participation in their occupations. This involves being person-centred, collaboratively prioritising occupations, goal-setting, supporting interventions and measuring outcomes (COT, 2015a, p. 2). Kielhofner (2005, p. 231) discusses a disparity between the ideal of occupation-centred practice and the reality experienced by some people. This disparity is of particular importance when considering issues of diversity and equality.

Conversely, interventions which enable engagement in meaningful activities and occupational performance are seen as a factor in effective reablement (SCIE, 2020, p. 8). The majority of the current Occupational Therapy (OT) workforce is white, and black, Asian and minoritised ethnic people are underrepresented within the profession (**RCOT, 2020**).

There is a need to ensure interventions are sensitive to cultural, religious or other considerations that may not be in a practitioner's realm of direct personal experience or background. This emphasises the importance of working with people to identify what is meaningful to them in terms of occupation and using this to plan any therapy input.

Newton (2012) highlights how personalisation, or person-centred working, enables the practitioner to understand the motivation and effort required by the individual to regain abilities and re-engage in the occupations they value. The ***Professional standards for occupational therapy practice, conduct and ethics*** (RCOT, 2021) section 3.4 (p. 10) states that practice is shaped by and focused on the occupational needs, aspirations, values and choices of those who access the service. This means that occupation-focused intervention is not organisationally or service-led, but person-centred and person-shaped. The following practice example demonstrates this.

**Practice example**

Mrs C was discharged from hospital paralysed from the waist down as a result of spinal cord compression. The occupational therapist's initial involvement was to consider equipment provision and long-term adaptation requirements. The assessment identified various issues but it became evident that it was paramount to Mrs C's wellbeing that she was able to leave her house to visit friends, family and the wider community.

The occupational therapist looked at making Mrs C's home more accessible for wheelchair use. They also identified that the lack of a wheelchair-accessible vehicle meant she was confined to her own home, making her feel extremely isolated. Before her paralysis, she and her husband had enjoyed the freedom and independence a car gave them to spend time together visiting people and places.

Mrs C completed a self-assessment questionnaire which highlighted the key areas of importance in her life and the goals she wished to achieve. The outcome of this led to her using part of her personal budget to hire a wheelchair-adapted vehicle once a week. This option was an alternative to traditional day care provision, which would not have met Mrs C's preference.

Working in multi-disciplinary contexts and across health and social care, occupational therapists can collaborate with social care practitioners, physiotherapists, and housing workers to enable support to be tailored to individual preferences in all care settings. The separate but inter-related roles focus on the person rather than on the delivery of a particular service.

Adapted from **www.scie.org.uk/personalisation/practice/occupational-therapists** (2010)

**Questions for reflection**

- How does occupation-based practice fit with strength-based working?
- What are the opportunities to share practice examples between occupational therapy and other practice areas within adult social care?

## Concepts and language of occupational science

Occupational science has developed a range of concepts that are important to reflect upon within an adult social care role.

### Occupational balance

Occupational balance is about having a harmonious mix of occupations (Polatajko et al., 2011), which is important for an individual's health and wellbeing (Stadnyk et al., 2011).

> ***People engage in multiple occupations that support different roles in life, and their choices are shaped by the demands of the occupations, the environment, and their personal skills and resources. The extent to which a pattern of occupation is perceived as harmonious, fulfilling and compatible with one's values is called occupational balance.***
> **(Backman, 2011, p. 231)**

Occupational balance is different for everyone, but imbalance may be common for those with caring responsibilities, and for disabled people. Identifying where this may be happening is part of the assessment conversation. Watford et al. (2019) explored an intervention for carers and found that, by increasing the participant's awareness of their own occupational balance, although challenging, it meant that they made time for re-engaging in valued and meaningful occupations.

### Occupational justice

An occupational justice perspective supports therapists to understand organisational, social and environmental factors that may limit people's engagement in valued occupations (Rudman & Aldrich, 2017).

> ***The concept of occupational justice juxtaposes moral, ethical and political ideas of justice on occupation. A focus on occupational justice means that we look at diverse occupational needs, strengths, and potential of individuals and groups, while at the same time considering issues of rights, fairness, empowerment and enablement of occupational opportunities.***
> **(Stadnyk et al., 2011, p. 331)**

In simple terms, occupational justice is about equal opportunities; everyone has the right to engage and participate in their meaningful and valued occupations. For example, if a resident of a care home cannot access communal activities because they do not have adequate specialist seating, is this occupational injustice?

The Black Lives Matter movement has shone a light on the many ways racism still pervades Western society. Racism, and all forms of discrimination, create occupational injustice on a broad as well as individual scale. OTs play a role in addressing these injustices through practice, communities and the systems in which they work. The World Federation of Occupational Therapists (WFOT) with the **full support of RCOT** has taken a clear position:

The WFOT Position Statement ***Occupational Therapy and Human Rights*** states that occupational therapists around the world are obligated to promote occupational rights as the actualisation of human rights and have a responsibility to advocate for change.

It argues that it is imperative that occupational therapists address the systemic discrimination, oppression and injustices that are pervasive in health and social services around the world and that action is required to address the social determinants of health that currently impede justice and equity. Such determinants include racism, poverty, economic restrictions, discrimination, displacement, disasters, conflict and historically oppressive systems.

**Occupational deprivation**

Occupational deprivation is a form of occupational injustice. It is the long-term prevention from engaging in meaningful occupations due to outside factors beyond an individual or group's control. This includes cultural or social attitudes and stereotyping, and environmental and economic barriers (Whiteford, 2011).

Environmental barriers impact upon peoples' meaningful occupations within the home and influence their access to, and around, the wider community (Hamilton, 2011, p. 275).

Practitioners can consider occupational deprivation in its broadest sense and challenge it when recognised. This occupational deprivation may be due to societal barriers regarding someone's mental health condition, physical disability or ageing (Whiteford, 2011) in addition to race, class, sexuality, gender and religion.

Evidence shows that **Black, Asian and minority ethnic groups are more likely to experience ill health** than white British people and face greater barriers to accessing appropriate care and support. These communities, therefore, are more likely to experience occupational deprivation because of the associated unmet needs arising from poor health. Occupational therapists can be mindful of these statistics when considering the ease of access to their services and when setting individual goals with people from minoritised groups.

Hand et al. (2017) highlight the link between social isolation and poor health and wellbeing in **older people**, suggesting occupational therapists are ideally placed to support engagement or re-engagement with social occupations, thus reducing occupational deprivation and ill-health.

Ward et al.'s (2007) study highlighted the importance of rapport-building to remove barriers to social and occupational participation for individuals with **spinal cord injury**. They discuss one individual's experience where the occupational therapist used a positive attitude and supported experiential learning to enable them to change their viewpoint from thinking they were unable to do something, to having the confidence to problem solve and participate in their meaningful occupations.

When working with **people experiencing multiple disadvantage**, allowing time, consistency and flexibility is of even more importance in establishing a successful therapeutic relationship. The **MEAM Approach** highlights this as being essential in achieving good outcomes with people who so often fall through the **gaps between services** because of the inflexibility of services in engaging them successfully.

## Occupational participation

Working in adult social care provides a unique opportunity to enable occupational participation at individual, group, community and societal levels (Rudman & Aldrich 2017, p. 17). Examples include:

- enabling an individual to cook safely and confidently
- enabling an individual to re-engage with their community
- collaborating with people to set up and run their own group
- educating communities and wider society about the importance and benefits of occupational participation.

### Questions for reflection

Consider some of the people you work with in the light of occupational deprivation or occupational injustice.

> What is stopping people you work with from fulfilling or accessing the occupations that are important to them?
> Are there any service or organisational barriers that prevent people from accessing the occupations that are important to them?
> How could you increase occupational opportunities for people experiencing social stigma, environmental challenges, or restricted opportunities to engage in their chosen occupations?
> Discuss with your colleagues possible new ways of working with people to enable them to reduce or overcome these challenges.

## Models for practice

An occupational therapy model provides an occupation-centred theoretical framework to guide practice (Kielhofner, 2002; Boniface, 2012). Using theory, in the form of a model for practice, can ensure that practice is holistic in nature by taking into account areas of self-care, productivity and leisure (Seymour et al., 2012, p. 183), together with context and meaning for the individual (Iwama, 2011).

This section explores how models can be implemented to support OT practice in adult social care.

The following practice example outlines some of the benefits of using a model as a framework for practice.

**Practice example**
**Gloucestershire - Canadian Model of Occupational Performance (CMOP) (Canadian Association of Occupational Therapists, 1997)**

Prior to implementing the use of a model, several occupational therapists in Gloucestershire were shadowed to observe how they worked. At their initial visit, most used the reason for the referral (which was generally adaptation or equipment-focused) as their reason for being there. Generic documentation was used and therapists did not overtly demonstrate occupationally-focused professional reasoning.

It was identified, using action research, that occupation and person-centred working needed reconsidering. Therapists chose to use the CMOP and developed their understanding of the theory underpinning it, to enhance their own practice and to inform stakeholders of occupational therapy's worth (Boniface et al., 2008).

Using this practice model enabled occupational therapists to focus upon occupation and enable people to engage in their valued occupations. It also provided a way of demonstrating the professional identity of occupational therapy to the wider team and the employing organisation.

(Waygood et al., 2012, p. 101).

In the practice example above, Waygood et al. (2012) discuss how the implementation of CMOP brought about a learning culture, and showed the benefits of highlighting service quality to stakeholders, clearly based on person-centred and occupation-centred practice. During the implementation, a range of education activities were used to embed theoretical understanding.

These included:

- regular workshops
- a manual given to all practitioners and other colleagues
- Model of Adaptation through Occupation (Reed & Sanderson, 1999)
- a supervision DVD using a range of scenarios to encourage debate and reflection
- a newsletter
- local conferences.

This supported shared values, communication and understanding across the occupational therapy service (Boniface et al., 2008; Waygood et al., 2012).

Rigid use of theory, applying it unthinkingly to practice, for example, the use of ill-designed 'checklists', may actually restrict occupationally-centred practice (Fish & Boniface, 2012, p. 11), so the importance of education and debate to embed theoretical understanding cannot be underestimated.

To illustrate this, using the Gloucestershire practice example, a participant of one of the steering groups stated they did not feel that using the CMOP helped with occupational or client-centred focus. It was identified that their perception was influenced by reading superficially completed 'CMOP documentation' as a simple checklist – therefore not fully understanding the theory underpinning the model, nor demonstrating critical thinking or professional reasoning. Professional judgement was being lost (Fish & Boniface, 2012).

**Implementation of a model will be more effective where therapists actively engage and understand the concepts of theory and how it applies to practice** and, importantly, how they articulate their professional reasoning about people's occupational challenges both verbally and in writing (Sumsion & Law, 2006; Melton et al., 2009; Seymour et al., 2012).

# Key policy drivers for occupational therapy within adult social care

## Mental capacity

The ***Mental Capacity Act 2005*** (MCA) requires adult social care practitioners to begin with an assumption that the person they are working with has capacity to make their own health and care decisions. The MCA makes clear that practitioners must 'permit and encourage the person to participate' or improve their ability to participate as fully as possible in any act or decision affecting them.

It also outlines the need to provide people with the **right information and support**, tailored to their **needs** and **circumstances**, throughout care and support planning processes. It is, therefore, imperative that practitioners work with people in a relational way that fosters positive and trusting relationships in order to support and enable people to:

- work together with them
- make choices that promote their independence
- consider a range of options available that fit with their wishes, feelings, values and beliefs.

The MCA also states that people are entitled to make decisions that others may deem unwise. Practitioners therefore need to take a relational approach that enables them to determine when an 'unwise decision' is a conscious and considered decision and where it may have been made by someone who lacks capacity.

When a person is found to lack capacity to make their own decision, practitioners must take a **best interest** approach and ensure that any decisions made consider the person's past and present **wishes, feelings, values and beliefs** and any other **relevant factors** the person them self would have likely considered. Any decisions or actions affecting the person must be the **least restrictive option in relation to the person's rights and freedoms**.

Practice around mental capacity assessments are explored in more detail in Research in Practice's Practice Tool ***Mental Capacity Act 2005 decision-making – care support and treatment***.

### Questions for reflection

- How do you work with people to make their own decisions about their care and support?
- How do you ensure people receive the right information and support tailored to their needs and circumstances?
- In what circumstances might you question a person's capacity to make their own decisions about their care and support?

If a person is found to lack capacity to make a specific decision, what steps do you take to ensure:

- the person's wishes, feelings, values and beliefs are central to any decisions made on their behalf?
- you involve relevant people in the best interest decision-making process?
- the least restrictive option, in relation to the person's rights and freedoms, is taken?

### Positive approaches to risk

Enabling choice and a personalised approach is a central principle of occupational therapy practice (RCOT, 2021, section 3.4). **Personalisation** promotes the rights of the individual to be an active and participating stakeholder, involved in the planning and management of their own care and support. It is a core principle of the ***Care Act 2014***.

The RCOT leaflet ***Making personalised care a reality: The role of occupational therapy*** (RCOT, 2019c) contains a diagram which captures the change in emphasis required in order to embed personalised care in practice.

**Making personalised care a reality**

1. **Focus** on people's strengths, balancing choice and risk.
2. **Maintain** people's occupations (daily activities).
3. **Connect** people to their community, family and friends.

Occupational therapists deliver personalised care by:

**Leading**
Training and mentoring colleagues to work in partnership with people

**Advising**
Signposting, guidance and linking with support services

**Enabling**
One to one work with people who have complex physical and/or mental health needs

To re-empower people to manage their health and wellbeing occupational therapists should be deployed across the health and care system to:

> **Intervene** early within primary care
> **Embed** personalised care through training and supervising others
> **Develop** wider partnerships to further innovation
> **Expand** therapy-led services

| From | To |
| --- | --- |
| Need | People’s strengths and assets |
| Risk management | Balancing choice and risk |
| Delivering to and for | Supporting people to maintain occupations (daily activities) and connect or re-engage people with their communities, family and friends. |

(RCOT, 2019c, p. 1)

It is possible that an individual’s choice may conflict with professional recommendations (RCOT, 2021, section 3.5.3.5).

Part of an occupational therapist’s role is to support people in balancing risk and addressing barriers, while respecting the choices they make about the way they wish to live their life. **Positive risk-taking** is intrinsic for occupational therapists when working with people, in order to embed their choices and achieve their goals (RCOT, 2018).

Occupational therapists can use the process of risk assessment and enablement to expand an individual’s ‘occupational participation’ in a safe way, to ‘avoid a focus on what cannot be done in favour of what can be done with greater certainty, accountability and transparency’ (Gallagher, 2013). Supporting and enabling risk management and risk-taking to maximise independence and choice is seen as a factor for effective **reablement** (SCIE, 2020, p. 8).

All practitioners have a duty of care and, in some circumstances, particular **safeguarding** duties under the ***Care Act 2014***. These need to be balanced with the right of the person to their own views, wishes, feelings and beliefs in deciding any action to be taken. A practitioner can work with an individual to establish what being safe means to them and how it can be achieved, moving towards the outcomes that the person wants (COT, 2016c, p. 11).

Making Safeguarding Personal (MSP) is an approach developed by the Local Government Association (LGA) and the Association of Directors of Adult Social Care (ADASS). It emphasises that safeguarding adults should be person-centred and outcomes-focused. **An MSP toolkit** (LGA, 2020) is available online to guide practitioners through the effective application of safeguarding.

A national **MSP Outcomes Framework** (LGA, 2018) can be also used by occupational therapists in social care to review their practice in any safeguarding circumstances with which they are involved.

Further resources around risk and enablement can be found on the **Research in Practice website**.

**Questions for reflection**

> When assessing individual risk with the people you work with, how do you build in opportunities for positive risk-taking? How has it enabled greater independence for those people?

> How does your organisation incorporate the recommendations from Make Safeguarding Personal within its processes?

**Strength-based approaches**

RCOT (2019c) identifies the use of people's strengths and assets as a key part of making personalisation a reality. The ***Care Act 2014*** requires local authorities to consider the person's own strengths and capabilities, and what support might be available from their wider community networks (Department of Health and Social Care, 2021, s.6.85 and s.6.101).

This approach encourages collaboration. The practitioner works with the individual to promote as much choice and control as possible and encourage them to propose options and solutions to enable them to have the life they want (DHSC, 2019, p. 42).

The Glasgow Centre for Population Health (2012) states that an assets and strengths-based approach supports sustained positive health and social change, at a community and individual level, when the intervention focuses on facilitating and empowering, rather than delivering.

Further information and the underlying evidence regarding strengths-based approaches in social care is available in ***Embedding strength-based practice*** (2019). The Department of Health & Social Care (2019) ***Strengths-based approach: practice framework and practice handbook*** is also a useful resource for practice.

The following practice example demonstrates how a strengths-based approach benefits the individual and the service.

**Practice example**
**Housing LIN**

Housing LIN has published a case study titled *A strengths based approach to delivering the Disabled Facilities Grant – Thurrock Council* (Beard, 2019). When considering the strengths of the person, where possible the council made the people themselves the grant 'agent', achieving a truly strengths-based approach.

The council encouraged and supported the individual to 'self serve' and progress the initial application. If successful, the individual could engage with contractors/suppliers of choice and obtain quotations to progress the application. As well as providing best value, this method provides the person with an approved amount necessary to satisfy the identified need and the occupational therapy specification.

The individual is enabled to see the works through to completion, minimising council input and reducing costs. The case study concludes that people can do more for themselves – supporting a strengths-based approach provides significant benefits for them and the service.

(Adapted from Beard, G., 2019)

**Questions for reflection**

- How do you take a strengths-based approach with the people you work with?
- Consider your organisation's processes for receiving Disabled Facilities Grants or other support. How can you make them more strengths-based?

**Working in collaboration**

Throughout this resource, collaboration with the individual has been highlighted as a fundamental principle for social care occupational therapists. Collaborative working is written into the ***Professional standards for occupational therapy practice, conduct and ethics*** (RCOT, 2021, section 5.7).

The ***Care Act 2014 statutory guidance*** states that local authorities must 'carry out their care and support responsibilities with the aim of joining up the services provided or other actions taken with those provided by the NHS and other health-related services (for example, housing or leisure services)' (Department of Health, 2016, section 15.3). Housing departments and services are specified in the statutory guidance, ensuring they are an integrated part of care and support services, including prevention. In practice, this means working with colleagues in other services to provide a comprehensive combined service.

The RCOT evidence-based report ***Living, not Existing: Putting prevention at the heart of care for older people in England*** (RCOT, 2017) seeks to encourage collaboration and integration between health and social care, with occupational therapists as part of integrated teams, working in partnership with GPs (RCOT, 2017, p. 8). This facilitates early intervention with older people at an earlier stage, to prevent or delay a decline in independence and the need for more costly intensive support following a crisis.

The report also proposes that occupational therapists are able to provide advice and training to develop other people's skills and knowledge. This applies not only to the individual and their family or carers, but also to other services in the community – promoting self-management and an enabling approach to care (RCOT, 2017, p. 10).

It goes on to recommend that partnership agreements are formally developed across local housing, health and social care sectors, to ensure all older people have access to occupational therapy, irrespective of their circumstances.

Research in Practice has developed a number of briefings to support partnerships across adult social care. These include:

> **Successful relationships - working together across housing and social care: Practice Tool**

> **NHS Continuing Healthcare – Practice Guidance**

> ***Ordinary residence – Practice Guidance***

**Questions for reflection**

> How much do you communicate and work with your adult social care colleagues and other services when you are considering a person's occupational needs and choices?

> What opportunities might you or your service have for building collaborative practice with other services in your area, such as hospitals, GPs or housing?

**Practice example**
**Occupational therapy within an Adult Social Care Provider Quality Team**

A senior occupational therapist has been based within the Provider Quality Team since 2016. The work has included compiling and delivering training to care home providers, with topics including bed rails, seating and plus-sized handling.
The occupational therapist developed a training package for delivery on-site within care homes to maximise attendance. These sessions have been informed by trends of concerns that the 'Organisational Safeguarding Team' receive and an analysis of moving and handling audits.

The work extended to supporting individual care homes to improve their standards and reduce the risk of safeguarding concerns arising and to improve the way adult social care occupational therapists work with and support care providers. This highlights the positive impact of a collaborative approach to achieve better outcomes.

For example, during an occupational therapy visit, a care home manager requested a seating review for a person living in the home. The person was being cared for in bed and required hoisting for transfers. The occupational therapist requested a hoist and slings to move the person out of bed and onto a chair to review their seating ability. It was quickly identified that several of the slings provided would fail *Lifting Operations and Lifting Equipment Regulations 1998* (LOLER) regulations and were not safe to use. The occupational therapist checked the other slings that were in use in the home. Several failed LOLER inspections and the manager was advised and observed to remove these slings from circulation immediately, thus preventing possible injury. New slings were ordered and placed in circulation by the home.

When another concern was raised, the occupational therapist returned and observed six people being hoisted with toileting slings. Most were not appropriate slings for this purpose and were additionally being fitted incorrectly. The occupational therapist provided further guidance, education and review to ensure support workers were using the appropriate equipment for people's transfer needs, thus reducing the likelihood of injury when being transferred.

## Conclusion

The use of occupational therapy theory and evidence has developed over time (Thomas & Penman, 2019). It is increasingly important for occupational therapists to have current evidence-based knowledge, pertinent to their work setting, upon which they may establish and explain the work they do. Professional reasoning should be underpinned with theoretical knowledge, sound values and practice skills (Fish & Boniface, 2012).

The RCOT ***Professional standards for occupational therapy practice, conduct and ethics*** (2021, 5.6.2) states:

> ***You are able to articulate the purpose of occupational therapy and the reason for any intervention being undertaken, so enabling fully informed consent and promoting understanding of the profession.***

Turner and Knight (2015), in discussing professional identity, make the point that practitioners need to understand and articulate their unique identity using contemporary occupation-centred theory and evidence. Boniface et al. (2013, p. 545) stress how important it is that occupational therapists recognise the significance of their role in supporting people's occupational engagement, and its link with wellbeing.

This resource supports occupational therapists in adult social care to be more confident in both these aspects of their practice. Other practitioners will also have a greater understanding of the value of occupational therapy across adult social care.

The COVID-19 pandemic has had a dramatic impact on health and social care services, including the field of occupational therapy. It has further exacerbated pre-existing inequalities of health and health outcomes. Whilst this context is challenging, it provides the opportunity to rebuild, reshape and refocus occupational therapy and wider adult social care practice. This briefing aims to support practitioners in this endeavour.

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