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Transforming the Vocational Rehabilitation Services of Occupational Therapists in Gauteng Public Healthcare through Action Learning Action Research

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A thesis submitted to the Faculty of Health Sciences, University of the Witwatersrand, Johannesburg,
in fulfilment of the requirements of the degree of Doctor of Philosophy.

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Declaration

I Hester Maria van Biljon, Student Number 732054 declare that this thesis, **Transforming the Vocational Rehabilitation Services of Occupational Therapists in Gauteng Public Healthcare through Action Learning Action Research** is my own work.

It is being submitted for the Degree of Doctor of Philosophy at the University of the Witwatersrand, Johannesburg. It has not been submitted before, for any degree or examination, at any other University.

Hester Maria van Biljon

31st day of August 2016.

Parktown, Johannesburg

Dedication

To all occupational therapists in public healthcare, past, present and future. May your caring long continue to make a difference in the lives of those who need it most.

To Callie, Peter, James and Nurya. My hart se Punte.

To my mothers, Elfrida Veitch and Anna Lensing van Biljon, for being the finest examples of how to live caringly.

In memory of my father, James Blacklaw Veitch. (1928 to 2014)

Presentations arising from this study

Four congress presentations arose from this study:

At the **1st African Spinal Cord Injury Network (AFSCIN) congress**. Gabarone, Botswana. 4 November 2015.

Title: ***Vocational Rehabilitation. Working with a spinal cord injury in Africa***

Author and presenter: Hester van Biljon

At the **35th National Congress of the Occupational Therapy Association of South Africa**. Biennial National Congress "HARNESSING THE CHANGING WINDS" Johannesburg. 14 – 16 July 2016.

Title: ***Transforming Vocational Rehabilitation in Public Healthcare***

Authors: Hester van Biljon, Daleen Casteleijn, Sanetta H J du Toit

Presenter: Hester van Biljon

Title: ***A Report Writing Protocol for Vocational Rehabilitation services in Gauteng public healthcare***

Authors: July Masango, Daleen Casteleijn, Sanetta H.J. du Toit, Hester M van Biljon

Presenters: July Masango and Hester van Biljon

Title: ***Screening ability to drive in occupational therapy***

Authors: Hester van Biljon, Daleen Casteleijn, Sanetta du Toit, Simon Rabothata

Presenters: Hester van Biljon and Simon Radebe

Publications arising from this study

Four peer reviewed journal article and seven newsletter articles arose from this study:

One in **WORK. A Journal of Prevention, Assessment & Rehabilitation (Impact factor 0.715)**

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Three in **SAJOT. South African Journal of Occupational Therapy (Impact factor 0.2979)**

van Biljon HM, Casteleijn D, du Toit SHJ. *Developing a vocational rehabilitation report writing protocol - a collaborative action research process.* SAJOT, 2015; 45(2)

van Biljon HM, Casteleijn D, Du Toit SHJ, Rabothata S. *An Action Research Approach to Profile an Occupational Therapy Vocational Rehabilitation Service in Public Healthcare.* SAJOT, 2015; 45(3)

van Biljon HM, Casteleijn D, Du Toit SHJ, Soulsby L. *Opinions of Occupational Therapists on the Positioning of Vocational Rehabilitation Services in Gauteng Public Healthcare.* SAJOT, 2016; 1(1).

Seven in the **FOCUS. Occupational Therapy Association of South Africa newsletter**

van Biljon HM. *Ethics and Legal Implication for Vocational Rehabilitation Practice: a Basic Understanding.* FOCUS Official Newsletter of OTASA, 2013; 1: 14-6.

van Biljon HM. *The Work-Link ADL Screening Tool. An activities of daily living screening tool for vocational rehabilitation practice.* FOCUS Official Newsletter of OTASA, 2013; 3: 33-5.

van Biljon HM, Rabothata S. *"How do we go about starting a work unit?" Advice and guidelines from experts in vocational rehabilitation.* FOCUS Official Newsletter of OTASA, 2014; 1: 11-6.

van Biljon HM. *Using MODAPTS tasks in Public Healthcare's Clinical Settings.* FOCUS Official Newsletter of OTASA, 2014; 4: 9-15.

The above article gained international attention and was reprinted in the MODAPTS International newsletter as:

van Biljon HM. **MODAPTS&OTASA**. International Modapts Association IMA Newsletter, 2015; Fall 2015 (www.modapts.org): 9-16.

van Biljon HM, Parkinson C. **Reflections on a year of Action: The Vocational Rehabilitation Task Team (VRTT) Gauteng's critical reflection on their work in 2014**. FOCUS Official Newsletter of OTASA, 2015; 1: 11-3.

van Biljon HM, Moleofane B. **Reflections of Working in Gauteng's Public Healthcare**. FOCUS Official Newsletter of OTASA, 2015; 2: 12-5.

van Biljon, H. M. Akhals, Z. & Mdakane, S. **Reflecting on 2015: The Vocational Rehabilitation Task Team (VRTT) of Gauteng takes a good look at a busy year**. FOCUS Official Newsletter of OTASA, 2016; 1, 3-5.

Abstract

Vocational rehabilitation offered by occupational therapists in Gauteng's public healthcare is an essential service. Adult public healthcare users expressed being able to return to work or find work as an important need, however the efficiency and scope of vocational rehabilitation offered by occupational therapists in public healthcare was problematic. Introducing the research question: *Can an action learning, action research approach transform the vocational rehabilitation practises of occupational therapists in Gauteng public healthcare?*

The aim of the enquiry was to empower clinical occupational therapists, working in Gauteng public healthcare, to transform their vocational rehabilitation services using action learning action research (ALAR). The researcher, an outsider, integrated herself into a pre-existing insider group, the Vocational Rehabilitation Task Team (VRTT). They formed a collaborative research team and used ALAR as a transformation agent. Multiple action cycles and action learning opportunities took place in four phases. The initial phase was to observe the status quo of the vocational rehabilitation services. This was followed by a planning phase in which a framework of what vocational rehabilitation occupational therapists should be doing at different levels of service. The action phase involved transformative actions that addressed service needs as identified by the collaborative research team. The research concluded with a reflection phase where the four years of research tenure were reflected upon. This reflection took the form of a meta-reflection considering the service transformation that had taken place and the impact of ALAR.

When linked with mentoring, the multiple cycles of collaborative learning and action brought improvement of the quality and scope of occupational therapists vocational rehabilitation. The approach also resulted in the development of a Vocation Rehabilitation Practice Profile (VRPPT) tool and user documents for report writing, screening ability to drive, using MODAPTS in clinical practice, how to do a basic work assessment and supervise students. In addition four peer-reviewed journal articles appeared and the knowledge generated was presented at workshops and congresses. ALAR was instrumental in transforming clinician vocational rehabilitation practice while creating knowledge and enriching individuals who took part in the research.

Key words

Action learning, action research, occupational therapy, vocational rehabilitation, public healthcare, service transformation, mentoring.

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The user manuals developed in this research are available to interested readers. Readers who wish to obtain a full updated copy of a user manual are welcome to contact the researcher at vanbiljon@mjvn.co.za .

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Operational definitions, terms and abbreviations

Definitions, terms and abbreviations as used in the context of this research are presented in alphabetical order:

Action learning (AL) is a form of experiential learning. As opposed to passive learning which is associated with students passively absorbing knowledge imparted to them, active learning requires active engagement of students to acquire knowledge. There are different forms of experiential learning but action learning is defined by continuous questioning and reflection while engaging in real tasks. Zuber-Skerritt's (2009) definition of action learning was best seen during this enquiry. Working on real issues, in real conditions occupational therapists learnt from action and concrete experiences while transforming personal practice problems. They learnt from and with each other, questioning and reflecting in meetings and used trial and error approaches.

Action research (AR) is defined by Reason and Bradbury (2007) as the integration of research and action and theory and practice while creating practical knowledge and improving practice. In this enquiry AR was used as a systematic approach that enables clinical occupational therapists to find effective solutions to vocational rehabilitation problems they experienced in their practices (Stringer, 2014). It is a participatory, democratic worldview renowned for a cyclical iterative process of action and reflection on and in action (Zuber-Skerritt, 2009) that always makes its results public (Coghlan & Brydon-Miller, 2014).

Action learning action research (ALAR) Zuber-Skerritt (2007)(p423) indicates that "The very nature of action research is open-ended, collaborative, situation specific, methodologically eclectic, and thus not prescriptive in its use of methods and processes or final goals." Action learning (AL) is philosophically rooted in the theories of learning from experience, as practiced collaboratively with others through some form of action research (Marsick & O'Neil, 2010). Both AR and AL have the same philosophy and paradigm (Zuber-Skerritt, 2009). ALAR combines the benefits of experiential learning with the academic values of rigour and publication, found in action research (Zuber-Skerritt, 2009).

Basic work assessment refers to assessment of ability to work of injured or sick adults of working age (Beukes, 2011). It is often undertaken concurrently with acute rehabilitation to inform clinical occupational therapy's acute intervention and to cut down the time absent from work and loss of work conditioning and habits (Ross, 1982).

Community Service Occupational Therapists are collegially referred to as **com serves**. Compulsory community service in South Africa was implemented in 2003 for all graduates in the medical and allied health fields as a means to retain human resources as well as overcome the mal-distribution of personnel between the private and public sector, urban and rural areas. This compulsory requirement entails one year of practice in the public sector for all health professionals following their graduation (Maseko et al., 2014).

Critical Friends are objective experts in the field of vocational rehabilitation who could offer constructive advice. The selection criteria for the critical friend used in this enquiry were occupational therapists with experience of working in South Africa's public healthcare and who had more than five years of working in and/or teaching vocational rehabilitation.

Driver Screening refers to the process of screening a person with a disability, injury or illness, ability to drive a motor vehicle. This can be done by any occupational therapist and no additional skills or knowledge other than basic occupational therapy is necessary.

Introductory Vignette is also known as the positioning of the researcher. It is used in chapter one to give the reader insight into the back ground of the researcher and why she became involved in this research.

Labour market refers to work settings in the formal or informal sector where remunerative work is performed. This can be open labour market, protective or sheltered environments.

The **La Leche League principle of *do not offer and do not refuse*** was used by the researcher to wean her presence from the collaborative research group after four years. It refers to the La Leche organisation's simple technique of weaning a breastfed baby with the least possible physical and/or emotional trauma.

Two tiers of **management** are referred to in this enquiry by the collegial terms used for them amongst clinical occupational therapists. **Head office management** refers to national and regional level management and **departmental management** to managers of clinical occupational therapy, such as heads of departments and chief occupational therapists.

MODAPTS stands for M O D u l a r Arrangement of Predetermined Time Standards. Pre - determined Motion-Time- Standards comprise a list of motions by which work may be described. A time has been established for the completion of each motion. Thus the time a task should take may be established by identifying and listing all motions each time they occur in the task and totalling the times (Farrell, 1993).

Mentoring is a voluntary relationship formed between individuals, of whom one usually has more experience or knowledge, who share a desire for development of career goals and objectives (Fletcher & Mullen, 2012). In this research it took the form of informal small group sessions and ALAR principles were applied through mentoring sessions. The content of the mentoring was mostly clinical task related but with some mentees it developed beyond this to include professional and personal development aims (O' Neil & Marsick, 2009).

National Health Insurance (NHI) In South Africa the NHI derives its mandate from the National Development Plan and is a governmental initiative to reorganise the current health care system, both public and private. The goal is to realise the constitutional right to access health care services. It is a health financing system that is designed to pool funds to provide access to quality, affordable personal health services for all South Africans based on their health needs, irrespective of their socioeconomic status (Republic of South Africa, 2015).

Occupational therapy (OT) is a client-centred health profession concerned with promoting health and well-being through occupation. The primary goal of occupational therapy is to enable people to participate in the activities of everyday life. Occupational therapists achieve this outcome by working with people and communities to enhance their ability to engage in the occupations they want to, need to, or are expected to do, or by modifying the occupation or the environment to better support their occupational engagement (WFOT 2012).

PILIR stands for Policy and Procedure on Incapacity Leave and Ill-Health Retirement. Reports indicated that the abuse and poor management of sick leave has had serious financial implications for the State and a negative impact on service delivery due to the lack of capacity resulting from a high rate of absenteeism. The objectives of PILIR are to set up structures and processes which would ensure suitable interventions and management of incapacity leave in the workplace to accommodate temporary or permanently incapacitated employees and to provide for appropriate consequences on such incapacity where necessary. The implementation of PILIR is intended to address challenges and contribute to an improvement in the management of sick leave in the Public Service (Mgijima, 2010).

Public Healthcare In South Africa there are two healthcare sectors; public and private. Government funds all public healthcare services with tax money and private healthcare is funded by private citizens from a variety of sources such as medical aids, insurance funds or out-of-pocket. Government also funds private health care to an extent via medical aid subsidies provided in the

form of benefits to public service employees. Two thirds of public employees' contributions are paid for by government.

Public Private Partnerships (PPP) is a long-term contract between government, in this enquiry the department of health and a private entity where they jointly invest in the provision of public services. The concept was introduced by the national treasury of South Africa in 2007 (Manual, 2007).

The adage, "**See One, Do One, Teach One**" is often used to teach practical skills in healthcare and is a simple teaching concept based on the observation of a particular procedure, followed by the performing of that procedure followed by being able to teach another trainee how to conduct that procedure.

The **Socratic method of critical questioning** was used throughout this enquiry. It is a planned method of teaching where by asking the right question allows the truth to emerge while both the questioner and the questioned further their understanding of the discussion matter (Mason, 1960).

Stakeholders are people who have a vested interest in the research and its outcome. In this study stakeholders are occupational therapists working in Gauteng's public healthcare referred to as **insider stakeholders** and the PhD researcher, referred to as an **outsider stakeholder**.

Student Supervision refers to clinical occupational therapists being part of a process of professional support and learning in which undergraduate occupational therapists develop their clinical skills.

Structured and unstructured reflections refer to the two reflection methods used in this enquiry. **Unstructured reflections** were when reflection was encouraged by two questions, what should change and what should stay the same. The reflective process was then left to evolve of its own using only prompts to guide the reflection if necessary. **Structured reflections** were more ordered and directed by written and verbal questions involving for example Likert scales and contingency questions.

Transformation in this study refers specifically to occupational therapists vocational rehabilitation services. In line with the Batho Pele approach the first transformation consideration is the positive change of such services to benefit public healthcare users (Republic of South Africa, 1997). It also refers to positive change in services peripheral to clinical contact such as research, student supervision and to enrichment of clinicians as action learning comes about. The reason being that such transformation will eventually also impact on public healthcare users experiences.

Vocational Rehabilitation (VR) – Vocational rehabilitation is a multi-professional service provided to individuals of working age with health-related impairment, limitations or restriction within work functioning. Vocational rehabilitation's primary aim is to optimize work participation in spite of illness or activity limitations (Escorpizo et al., 2010).

Vocational rehabilitation services – This refers to therapeutic assessments, interventions and programs that occupational therapists offer. Which aim to enable adults of a working age to work. These can be prevention, assessment, remedial, restorative or compensatory (Buys, 2006).

The **Vocational Rehabilitation Task Team, Gauteng** (VRTT) is an interest group formed in 2011 and headed by Simon Rabothata, Assistant Director of Rehabilitation Gauteng. The group consists of occupational therapists from Gauteng public healthcare who are interested in and concerned with vocational rehabilitation.

Ubuntu is an ancient African philosophy that includes the virtues of compassion and humanity advocating a universal bond of shared community.

Chapter One: Orientation to the Study

“Ubuntu speaks particularly about the fact that you can’t exist as a human being in isolation. It speaks about our interconnectedness. We believe that a person is a person through another person, that my humanity is caught up, bound up, inextricably, with yours.” Archbishop Emeritus Desmond Tutu (Tutu, 2012)

1.1 An Introductory Vignette

In 1988, Apartheid was statutory in South Africa. Legalised racial segregation dictated there had to be separate facilities for black and white people and public services, such as healthcare, led by example in this racial segregation. In 1988, living in South Africa was stressful; limpet mines, hand grenades, land mines and car bombs exploded in private and public places. The banning of artists and archbishops, international sanctions, detention without trial and suppression of free speech was rampant. In 1988, Nelson Mandela was moved from Robben Island, where he had been imprisoned for 26 years, to a prison on the South African mainland, starting negotiating processes that would lead to a democratic South Africa in 1994 (Mandela, 1995).

In 1988, the researcher started working at Hillbrow hospital in the occupational therapy department’s work unit, doing vocational rehabilitation. Hillbrow hospital was a public healthcare hospital designated for black people and was situated in the centre of Johannesburg. The hospital’s infrastructure was derelict and therapists worked with limited resources. Vocational rehabilitation was challenging, as legislation to protect injured or ill workers was sparse and there was no incentive for employers to employ disabled workers (Strasheim & Buys, 1996). The general profile of healthcare users at Hillbrow hospital was manual labourers, with little or no technical or professional work skills and severe financial restrictions. Despite these challenges, the work unit, headed by the researcher and the occupational therapy department in Hillbrow Hospital, was proficient. The vocational rehabilitation services offered in this work unit received national and international recognition (Naik & van Biljon, 1991, Birkhead, 2009). The first VALPAR work sample system in South Africa was bought and used in this work unit (van Biljon, 1994); functional capacity evaluations and medico legal assessments were done (van Biljon, 1997); weekly group therapy sessions offered support and training in job seeking skills, work readiness, work hardening and home industry. Work-site visits were done and workers were assisted in returning to work, to access sheltered or protected workshops or develop their work skills at training centres and look for suitable alternative

work. The researcher was involved in starting and hosting interest groups and workshops on vocational rehabilitation, which were attended by occupational therapists and other professionals from a variety of vocational rehabilitation settings.

The researcher left public healthcare in 1995 to raise her family. Working part time, she started a private practice specialising in vocational rehabilitation (Buys & van Biljon, 1998, Buys & van Biljon, 2007) and medico legal work (van Biljon, 2013). In 2013, she returned to work units and vocational rehabilitation services in public healthcare through this research. Reflective journaling notes, in November 2013, showed the researcher's comments after visiting a work unit in a central Johannesburg public healthcare hospital:

"I feel like a time traveller. Here are all the old files and work samples we used (at Hillbrow Hospital) 20 years ago. Neatly packed away in cupboards and covered in dust. Have they not been used?"

1.2 Background and Rationale of the Study

In 1996, the Constitution of a new democratic South Africa was promulgated by President Nelson Mandela (Republic of South Africa, 1996). As the highest law of the land, the constitution is generally regarded as the defining transformation between the apartheid and post-apartheid era. The South African Constitution indicates that everyone who lives in South Africa has the right of access to health services and that the Government should apply all reasonable measures within its means to ensure this right is achieved. There are two healthcare providers in South Africa: public and private. Gauteng province, where this study is situated, is one of the country's nine provinces and home to 30% of South Africa's total population, with an age distribution indicating 73% of this population is of working age (Lehohla, 2012). This province is the hub of South Africa's commerce and industry and experiences the highest population influx of all provinces. People from across Southern Africa come to look for work in Gauteng and the prediction is for this influx to increase and with it, the demand on Gauteng's resources (Republic of South Africa, 2011b). One of these resources is healthcare.

The ideal, to provide healthcare to all citizens, is challenging in South Africa, as 68% of the population depends entirely on public healthcare. Adding those who are partially dependent on public healthcare, this figure rises to 84% (Ataguba & Akazili, 2010). In addition, 41% of all healthcare expenditure is attributed to the public healthcare sector and 59% to the private healthcare sector (McIntyre & Thiede, 2007). Most healthcare workers work in the private sector. In 2015, only 15% (N=242) of the 1 618 occupational therapists registered with the Health Professions

Council of South Africa who resided in Gauteng (Health Professions Council of South Africa, 2015), were working in public healthcare. Despite this, Gauteng is considered better off than the rest of the country regarding healthcare resource distribution (Ataguba & Akazili, 2010).

The quality of publicly funded healthcare is an ongoing global concern (Blendon et al., 2002), as the nature of such healthcare is fraught with problems ranging from global generic to culture specific (Halverson et al., 1998). In many countries, including South Africa, an ongoing public-private sector divergence discourse further complicates matters (Nichols et al., 2004). Despite 20 years of democracy in South Africa, the health system's effectiveness and efficiency remains a challenge whereby the poor, who are predominantly dependent on public healthcare, are largely marginalised (Republic of South Africa, 2015).

To address these challenges and in response to the World Health Organization's health funding policies (2013) the National Health Insurance, commonly referred to as the NHI (Republic of South Africa, 2011a), was launched. The NHI promotes equity, efficiency and effectiveness, ensuring everyone has access to quality health services, regardless of their socio-economic status or geographic location. This initiative is currently being phased-in and will entail major changes in service delivery structures and administrative and management systems (Republic of South Africa, 2011a). Another initiative that affects public healthcare services is the 'Batho Pele' (People First) principle to improve the quality, accessibility, efficiency and accountability of service delivery in the public sector (Republic of South Africa, 1997).

In his National Assembly address, on 14 August 2012, Dr Aaron Motsoaledi, South Africa's Minister of Health said, "The quality of healthcare in our public hospitals has been a thorn in the flesh of our country for quite some time." Within South Africa, public healthcare has a myriad of problems (Thom, 2012) and occupational therapy services are not exempt from this with services requiring specialised knowledge and experience, such as vocational rehabilitation, being mostly affected.

Vocational rehabilitation is a multi-professional service provided to working-age individuals with health-related impairments, limitations or restrictions within work functioning. Vocational rehabilitation's primary aim is to optimise work participation in spite of illness or functional limitations (Escorpizo et al., 2011). The unique focus of occupational therapy involves functional ability and purposeful activity which allows the profession an important place in vocational rehabilitation practice (Beukes, 2011). These services typically include injury prevention, vocational assessment, - guidance, - intervention and training, placement in the open labour market or an alternative work environment and follow up (Buys, 2015). An effective occupational therapy

vocational rehabilitation service assists the transition between injury/illness which resulted in hospitalisation and returning to the labour market. Through prevention programmes, assessment of ability to work, various intervention strategies, placement and follow-up, occupational therapists offer preparation for return to work programmes, job seeking and/or support groups, workplace visits, ensure accessibility and ergonomic compliance, implement the use of assistive devices and work station adaptations, act as counsellors and/or advisors regarding aspects of disability in the workplace to employers/employee's/trainers/unions. In the case of unemployment or inability to fit the requirements and demands of the open labour market, occupational therapists guide and assist clients to explore entrepreneurial, sheltered or protected work options (Buys, 2006). This in turn has social and fiscal significance to the individual, his/her family, their community and the national economy (Buys & van Biljon, 1998).

Occupational therapists in Gauteng's public healthcare have a history of offering outstanding vocational rehabilitation services (Buys & van Biljon, 2007). Working in Pretoria in the 1960s, Vona du Toit and Judith Farrell established occupational therapy's role in vocational rehabilitation, or work rehabilitation as it was then known (1991). In the 1970s and 1980s work units offered services which included advocating for the rights of their clients despite a lack of legislative protection for workers and apartheid policies (Naik & van Biljon, 1991). In the 1990s, South Africa underwent much needed transformation to become a democracy. To address gross inequalities of service and resource distribution, legislative and infrastructural changes had to be made in all service sectors, including vocational rehabilitation (Strasheim & Buys, 1996).

An unfortunate casualty during this transformation was the vocational rehabilitation services of occupational therapists in Gauteng's public healthcare. The infrastructure of the previous vocational rehabilitation services still existed, but the services were scarce and insufficient to meet the needs of the population it served.

One strength of a professional discipline is its ability to critically re-examine and re-form itself and address the need for change (Gibson, 2015). Ramukumba demonstrates this strength in his Vona du Toit memorial lecture (2015). In a post-apartheid South Africa, he had hoped that as part of the transformation process, the democratic Government would address poverty, but concluded that not much had changed for the historically disadvantaged. He appeals to occupational therapists to address the needs of their clients for economic occupation and calls this the foundation upon which all their other needs rest (Abasa et al., 2010).

In February 2011, the Assistant Director of Rehabilitation services in Gauteng started a Vocational Rehabilitation Task Team (VRTT) to resuscitate occupational therapy's vocational rehabilitation services in Gauteng. Meeting minutes provided evidence of investigation of vocational rehabilitation units with various attempts to align and designate services. Most notable were the development of a screening tool and the start of a vocational rehabilitation orientation workshop for all new occupational therapists in Gauteng public healthcare. Of importance to this research was that in meeting minutes of March 2011 it was noted the VRTT felt they should ask vocational rehabilitation experts to assist them.

In June 2013 an independent private occupational therapist (the researcher), with 20 years' experience in vocational rehabilitation, joined forces with the VRTT for her PhD research. The focus of her research supported the work of the VRTT in line with the National Government's National Health Insurance (NHI) plan. A collaborative research team was formed, consisting of the PhD student, an outsider and the VRTT, an interest group of insiders. The research team agreed to adopt action research and its epistemological framework for all aspects of their interaction and transformation work.

1.3 Problem Statement

The Vocational Rehabilitation Task Team (VRTT) and other healthcare professionals expressed a concern that vocational rehabilitation services in public healthcare were showing low patient statistics, not providing evidence they were addressing the needs of users and were not contributing to vocational rehabilitation forums. In addition, important aspects of holistic vocational rehabilitation services were missing, students were unable to do fieldwork in vocational rehabilitation settings in public healthcare and no research or publications were being generated.

The resources of the work units of 20 years ago were still available, but the services were offered partially or not at all. The Assistant Director for Rehabilitation in Gauteng, during an interview, indicated the work units used to have designated occupational therapists doing only vocational rehabilitation, however the number of patients seen and the services offered did not justify a designated post. Therapists employed in acute and pathology specific rehabilitation services were now required to do vocational rehabilitation in addition to acute rehabilitation. They reported only providing vocational rehabilitation if and when their work load afforded them time to do so. He noted that additional challenges to vocational rehabilitation service delivery were in-experienced staff and a high staff turnover. Occupational therapists with an interest in vocational rehabilitation

usually left once they had adequate experience and additional vocational rehabilitation qualifications to start their own or join existing private practices. In South Africa, private vocational rehabilitation practices were lucrative and often offered the opportunity of doing medico-legal work (van Biljon, 2013). Experienced occupational therapists who stayed in public healthcare were usually promoted to managerial positions, which reduced their time in clinical practice and patient contact.

Vocational rehabilitation is an important part of any adult healthcare user's occupational therapy. In a commercial and industrial province such as Gauteng, with a high prevalence of injury at work, crime and motor vehicle related injuries, the impact of HIV Aids and pressure to return to work as quickly and effectively as possible, it is an essential service. An effective vocational rehabilitation service, which assists the transition between injury and hospitalisation and return to the labour market, typically includes injury prevention, vocational assessment, guidance, intervention and training, placement in the open labour market or an alternative work environment and follow up (Buys & van Biljon, 1998). Occupational therapists support their clients to move from the hospital environment into the labour market. Doing workplace visits, ensuring accessibility, ergonomics, implement assistive devices, work station adaptations and counselling/advising employers regarding 'reasonable accommodation' in keeping with South Africa's labour laws, they enable clients to return to work. In the case of unemployment or inability to cope in the open labour market, assistance is given in exploring entrepreneurial, sheltered or protected work options.

In Gauteng, where more than half the population depends entirely on public healthcare, the need for vocational rehabilitation services, as offered by occupational therapists, are vital. The absence of or inadequacy of such services directly impact on the quality of life of individuals, the health of societies they return to and increases the burden on state resources such as grants and health support structures.

1.4 Research Question

From the background given above, the following question emerged: Why are occupational therapists, working in public healthcare, not offering efficient and effective vocational rehabilitation services?'

For several years the question was asked and discussed at all levels of occupational therapy society in South Africa, as the lack of these services were being felt on an inter-sectorial level. Although attempts were made to address the problem, the problem persisted. This incited the researcher to

become involved through a PhD study. Formalising efforts to address the practice problem of poor vocational rehabilitation services in public healthcare brought to light the research question: Can an action learning, action research approach transform the vocational rehabilitation practises of occupational therapists in Gauteng public healthcare?

1.5 Research Paradigm

Research is a form of disciplined enquiry leading to the generation of knowledge (Koshy et al., 2011). Guba and Lincoln (1985) support this, indicating that when conducting research of any kind, a consideration of philosophical stance or world view is important, as this affects all aspects of a disciplined enquiry. Referring to such philosophical stances or worldviews, Trochim notes that nobody really knows how best to perceive and understand the world and philosophers have been arguing about it for millennia (2006). The best a researcher can do is declare their chosen and identified world-view so that readers can evaluate the process, methods and outcomes, using relevant criteria from the researcher's particular perspective (Zuber-Skerritt, 2001).

This researcher declares the following four worldviews that influenced the research: the research framework, the physical context within which the research was conducted, the professional context within which the research was conducted, the collective and individual researchers' bio-, socio-, cultural and religious grounding. Within an unstructured and subjective enquiry such as this, it is important to note not only the common ground the various worldviews share, but also their differences. Ultimately both commonalities and differences influenced each other as well as the larger enquiry.

1.5.1 The Research Framework used: Action learning action research (ALAR)

All aspects of this research were permeated by the action research (AR) paradigm, which Zuber-Skerritt describes as plural way of knowing (2007). It falls in neither the positivist nor the interpretive paradigms as neither have sufficient epistemological structure to incorporate it (Bergold & Thomas, 2012) and it can be conducted from a qualitative, quantitative or combined approach (Koshy et al., 2011). As a member of the AR family, ALAR is located in the social sciences, as researchers deal with sentient human beings, groups of people and organisations, whose characteristics, ideas, strategies and behaviour are complex and not easy to predict, if at all (Zuber-Skerritt, 2001).

Reason and Bradbury's (2007) definition of action research best suits the context and milieu of this research. They state action research is a participatory, democratic worldview and is concerned with developing practical knowledge. Zuber-Skerritt's (2007) working definition of ALAR expands on this and describes what took place in this research. Participants participated in and learned from collaborative problem identification, planning, implementation of actions, data gathering, data analysis and knowledge dissemination. Zuber-Skerritt (2007)(p423) indicates that "The very nature of action research is open-ended, collaborative, situation specific, methodologically eclectic, and thus not prescriptive in its use of methods and processes or final goals." Action learning (AL) is philosophically rooted in the theories of learning from experience, as practiced collaboratively with others through some form of action research (Marsick & O'Neil, 2010). Both AR and AL have the same philosophy and paradigm (Zuber-Skerritt, 2009).

O'Brien (2001) feels that a paradigm of praxis is where the main affinities of action research lie. Praxis, a term used by Aristotle, is the art of acting upon the conditions one faces in order to change them; it deals with the disciplines and activities predominant in the ethical and political lives of people. Aristotle contrasted this with Theoria, where the concern is with knowing for its own sake (Kielhofner, 2006). A cornerstone of action research is that knowledge is derived from practice and practice informed by knowledge, in an ongoing process. Action researchers also reject the notion of researcher neutrality, understanding that the most active researcher is often one who has most at stake in resolving a problematic situation (O'Brien, 2001). Ebersöhn et al (2010) state that action research mirrors assumptions related to post-positivist, interpretative and constructivist epistemological paradigms. It honours the tradition of applied research, which is situated between knowledge creation, dissemination and practical application (Maree, 2007). Accordingly, process, choices and knowledge creation were perceived through the following paradigmatic lenses: Multiple realities exist, research and intervention can coexist, blurred boundaries exist between aspects of the research process, subjectivity is a strength and central to the research process, quality criteria exist to ensure rigour within a flexible research design.

1.5.2 The physical context within which the research was conducted: South African public healthcare

All efforts of transformation in public service delivery should be grounded in reform that will promote service proficiency, equity and efficiency. The South African Constitution (Republic of South Africa, 1996), the National Health Insurance plan (Republic of South Africa, 2011a) and the public healthcare Batho Pele principles (Republic of South Africa, 1997) all impact on this research. The

underlying philosophies of these three frames of principles are that all South Africans should have access to affordable quality healthcare services, regardless of their socio-economic status.

1.5.3 The professional context within which the research was conducted: Occupational therapy and vocational rehabilitation

The profession of occupational therapy is essentially practical and humanistic in nature (Kielhofner, 2006), with client-centred practice embedded in its values and beliefs (Sumsion, 2006), all of which are shared values with action research. Occupation based practice is the core of the profession's paradigm and the focus for service (Kielhofner, 2009), with the occupation of work being recognised as the most important occupation in an adult's life (Schultz-Krohn & Pendleton, 2013) as it provides a life role (Ross, 2007).

1.5.4 The collective research group: The Vocational Rehabilitation Task Team (VRTT) and the researcher (the PhD candidate)

All the above formed and directed the researchers' worldview, both individually and as a collective. There were however additional nuances that needed consideration and cognisance taken. South Africa is richly diverse in its cultural and religious make up, leading Archbishop Desmond Tutu to coin the term *Rainbow Nation* describing the new South Africa after the first fully democratic election in 1994 (2012). The Vocational Rehabilitation Task Team (VRTT) reflected this diversity as its members were from seven different cultural groups, four different religious beliefs and gender and age diversity. The VRTT took time to discuss and reflect on its chosen worldview and agreed the philosophy of *Ubuntu* best represented the group's worldview as occupational therapists working in public healthcare.

Discussing Ubuntu, Archbishop Desmond Tutu (2012) notes that a person with Ubuntu is open and available to others, has a humble spirit with curiosity and compassion and a desire to learn from others. In the spirit of Ubuntu, people do not feel threatened by other's achievements, but affirms and supports them, sharing freely from their own achievements. Embracing Ubuntu brings about a self-assurance that comes from knowing you belong to a greater whole. A collective empathy ensures that someone embracing the philosophy of Ubuntu will feel and own the humility, oppression, or other forms of degradations of others (Lief, 2015). Ubuntu's characteristics of compassion, consideration, co-operation and a sense of community is found throughout Africa and transcends cultural, gender and religious differences (Ndlovu, 2016). Both Zuber-Skerritt (2007) and

Whitehead (2009) refer to Ubuntu as representing values and qualities embodied in the living meaning and practice of action research.

1.6 Questions and Aims of the Study

This research aimed to empower clinical occupational therapists, working in Gauteng public healthcare, to transform their vocational rehabilitation services using action learning and action research (ALAR).

Using action research to transform practice requires a democratic context which allows participants to shape the research process (Bergold & Thomas, 2012) as their needs arise and new knowledge emerges. In this way, aims and objectives could only be formalised in retrospect. Reflections of this research showed an organic process that could be depicted in Lewins familiar phase of an action research cycle: observe, plan, act and reflect (Kemmis et al., 2014).

The research began when the researcher entered the research environment as an outsider and integrated into a pre-existing insider interest group. Four phases, each with its own question, aims and objectives ensued. A premeditated withdrawal from the research environment concluded the researcher's tenure with the insider group.

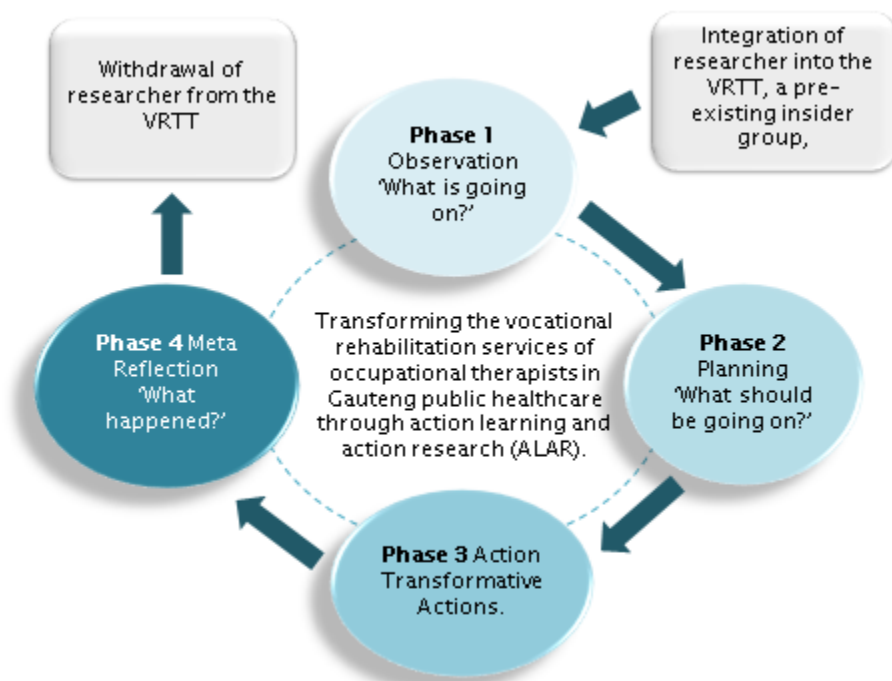


Figure 1.1: Diagrammatic presentation of the research process

1.6.1 Integration

The question 'Could we merge our efforts to transform occupational therapy's vocational rehabilitation services in Gauteng's public healthcare and use action learning and action research (ALAR) principles to do so?' framed the aim of the researcher, an outsider, to integrate herself and the action researcher paradigm into a pre-existing group of insiders. The aim was to form a collaborative research group with an ALAR approach to motivate and navigate transformation.

1.6.2 The Observation Phase

The observation phase prompted the research question: What is happening in Gauteng public healthcare regarding vocational rehabilitation? This outlined the aim to explore the status of occupational therapy's vocational rehabilitation services in Gauteng public healthcare using an ALAR approach.

1.6.3 The Planning Phase

The planning phase followed with the research question: What should be happening in Gauteng public healthcare regarding vocational rehabilitation? The aim was to have a framework within which occupational therapists' vocational rehabilitation services in Gauteng's public healthcare could be positioned.

1.6.4 The Action Phase

The aim of this phase was to set in motion transformational processes within the vocational rehabilitation practice of occupational therapists in Gauteng public healthcare. Multiple practice specific research questions were brought to the collaborative research team as they emerged from clinical practice. The aim was to address these vocational rehabilitation practice problems using ALAR to bring about transformation of clinical practice.

1.6.5 The Reflection Phase

The reflection phase was a meta reflection of the question: What was the transformation impact of action learning action research on the vocational rehabilitation services in Gauteng's public healthcare? The aim was to explore what the impact had been of having used ALAR to transform occupational therapy's vocational rehabilitation services.

1.6.6 Premeditated withdrawal from collaborative research group

An undertone to the previous phase was a withdrawal of the researcher from the VRTT group's activities as her research tenure neared its end. The aim was to withdraw from all activities and action cycles the VRTT were engaged in, in such a way that it did not affect the ALAR process or the transformational progress.

1.7 Significance and contribution of the research

This research project had practical and theoretical significance. The *practical significance* was the transformation of vocational rehabilitation services and the clinical skills and confidence of occupational therapists' in Gauteng's public healthcare. The *theoretical significance* was a typical outcome of action research, namely the generation (Ebersöhn et al., 2010) and dissemination of knowledge (Zuber-Skerritt, 2009).

The practical and theoretical significance was in keeping with the ethos of client-centred practice as the most important benefit was improved quality of care for public healthcare users. In Gauteng, there are three medical training institutions relying heavily on the services in public healthcare to educate their students. Functional work units would benefit all undergraduate and post-graduate students from these faculties. In two of the four academic hospitals involved in this study, clinical supervision of undergraduate occupational therapy students commenced during this research. In addition the value of mentoring was experienced and espoused by the VRTT. The cohesion and operation of the VRTT was improved. Awareness of vocational rehabilitation was increased on multiple levels within and outside of public healthcare during the time of this research (van Biljon & Parkinson, 2015, van Biljon et al., 2016).

Using ALAR as methodology, occupational therapists working in public healthcare in Gauteng became fellow researchers, learning from the experience and producing knowledge that was relevant to their practice situations and that they could relate to (Zuber-Skerritt, 2009). They were part of a team that collaboratively worked towards the solution of self-identified practical problems (Reason & Bradbury, 2007). Action research and an embedded action learning approach encouraged a natural process for addressing practice problems based on the opportunity to acquire knowledge and experience which continued after the researcher withdrew (Zuber-Skerritt, 2009). The research showed that professional and personal benefits were experienced in the improvement of participating therapists' clinical skills, their confidence and enjoyment of their work (van Biljon &

Parkinson, 2015). As the work environment within vocational rehabilitation practices in public healthcare became more stimulating and the excellence of their services were acknowledged by the occupational therapy fraternity, therapists chose to stay in their posts thus curbing high staff turnover. Three of the VRTT members enrolled for postgraduate studies in vocational rehabilitation during this research.

The collaborative and emancipatory research approach of ALAR had several beneficial outcomes. By creating an opportunity where the researcher explored practice problems alongside practitioners, and the research design focuses on translating research into practice, findings are generated and implemented to facilitate a culture for self-empowerment. This motivated policies and strategy development to get experienced occupational therapists back into the public healthcare in the form of mentors. It improved other specialised occupational therapy services in South Africa's public healthcare and could be used for service improvement in other professional health fields.

Research findings, publications and the development of policy documents were generated during this study. The knowledge generated in this study was disseminated through seven non-peer reviewed publications, four peer reviewed publications, three congress presentations and at seven workshops and interest group meetings.

The study was in line with the Government's NHI plan to bring about reform that will promote service proficiency, equity and efficiency and ensure all South Africans have access to affordable quality healthcare services regardless of their socio-economic status (Republic of South Africa, 2015). The study produced knowledge and understanding that was fed back to the league of occupational therapists who would continue the work after the researcher left. It also created awareness and dialogue within the larger national and international occupational therapy community. Evidence was found that private public partnerships were emerging within the occupational therapy vocational rehabilitation fraternity of Gauteng. Practical user documents, guidelines and principles that enriched the profession and the public healthcare users they served were generated. For this reason prominence was given to disseminate results in local and open access publications.

1.8 Layout of the Report

This thesis is a hybrid of the traditional thesis format and the thesis by publication format. The structure of the report is the traditional introductory contextualisation chapters, followed by chapters showing the process and results of the study and ending in concluding reflection chapters.

Throughout the thesis, publications and presentations that emerged will be placed within the body of the thesis as they relate to the reported context.

There is no designated literature section as continuous engagement with scientific and grey literature will be seen throughout the body of the thesis. In action research, literature is comprehensively and critically consulted as is relevant and as the study proceeds (Dick, 2013a), which will be seen in this study. As the study progressed literature was used to illuminate findings, deepen understanding, suggest direction for the next actions (Herr & Anderson, 2005) and as support for the dissemination of generated knowledge.

This action research enquiry was done with a collaboration of insider and outsider researchers, the Vocational Rehabilitation Task Team (VRTT). As the VRTT's membership changed continuously, multiple variations of this collaboration was experienced. The thesis will reflect this by being written in a variety of 'voices' e.g. first person, second person and the objective academic person.

Two chapters which follow, contextualise and map the research for the reader.

Chapter One: An orientation to the research gives an introduction to and the context of the research. The position of the researcher is given in the form of an introductory vignette. Background and rationale of the study is provided and problem statements and research questions are discussed.

The worldview and paradigm of this research is discussed in the introductory chapter, as the way the researcher perceived herself within her physical and professional context precedes the engagement in an action research enquiry. The researcher's world-view was the reason for embarking on the enquiry and influenced the research framework choice. As is typical in action research, this worldview was then continuously challenged and shaped. The researcher became part of a multi-dimensional collaborative research group. As the study developed reflections showed that individually and collectively, perspectives of the world, within which the research group were collectively immersed, changed as their understanding deepened.

Questions and aims of the research are given, the significance and contribution of the research is discussed and the layout of the report provided.

Chapter Two: The methodology chapter explains the approach taken. It sets out the research design and the setting and stakeholders. The research process is discussed and the trustworthiness of the research and ethical considerations considered.

The limitations of the study are not discussed in the introductory chapters but found in Chapter Seven, where the results are reflected on and discussed. In action research, the researcher is immersed in the study and the actions. Throughout the study critical reflection is done but objective hindsight of the enquiry, as a whole, occurs at the end of the research. In the closure phase of an action research enquiry, a larger retrospection of the whole study leads to objective insight and discussion of the scope and limitations of the study.

Chapters Three, Four, Five and Six present the major findings of this study in the typical action research phases of observe, plan, act and reflect. In each of these chapters, a discussion of the findings and how they were derived is included, relevant literature engaged with, action learning that took place is described and reflected on.

Chapter Three: The integration and entry of the outsider researchers into a pre-existing insider group is shown. The observation phase, where the question: “What is happening in Gauteng public healthcare regarding occupational therapy’s vocational rehabilitation services?” is described. Three enquiries are used to identify the current status of vocational rehabilitation in the observation phase: A Vocational Rehabilitation Practice Profile Tool (VRPPT) was designed for therapists to use to profile their own practices while experiencing action learning. The designing of the VRPPT is presented as a published journal article and a summary of the resulting practice profiles given. The results of semi-structured interviews with the Heads of Department and interested occupational therapists, to gauge their views of what their vocational rehabilitation services are, are given. Clinical occupational therapists were co-opted as researchers to use convergent interviewing to establish health care users opinions of the vocational rehabilitation services in their departments. These results are presented in the form of a journal article.

Chapter Four: This enquiry had multi-layered planning to address transformation and enable action learning. Clinical planning that addressed specific practice problems is described in association with the action it took place in and is seen throughout chapters three, four, five and six. This chapter specifically shows the planning of a framework within which occupational therapists could practice their vocational rehabilitation. It naturally follows the observational phase to address the question: “What vocational rehabilitation services should occupational therapists offer in Gauteng’s public healthcare?” A literature search and an opinion survey and the VRTT’s collaborative reflections on the results of these are shown.

Chapter Five: The action phase describes the transformative actions that took place and five action cycles that concluded during the research are described: report writing, driver screening, using a

time-method-study called MODAPTS, doing a basic work assessment in and supervising students. The actions are described and the user documents that resulted are available as appendices.

Chapter Six: The reflection phase of the research was to answer the question: “What transformation did ALAR bring about?” This meta reflection considers: annual reflection by the collaborative research team, in the form of published newsletter articles, results of the 2013 and 2016 VRPPT are compared and critically reflected on and the results of a vocational rehabilitation task team (VRTT) meeting, which was dedicated to collaborative reflectivity on the transformative effect that ALAR has had since 2013. The chapter concludes with a description of the withdrawal of the researcher from the VRTT.

Chapter Seven: The concluding chapter shows the researcher’s personal reflections of the study and recommendations. A conclusion of the research is given.

Chapter Two - The Method

“Action without reflection and understanding is blind, just as theory without action is meaningless.”

Reason and Bradbury (Reason & Bradbury, 2008)

2.1 Introduction to the Method

Dick calls Zuber-Skerritt the midwife of Action Learning Action Research (ALAR), as she has first-hand experience of the birth of ALAR (2009). Zuber-Skerritt describes ALAR as a method where participants think, plan, observe and reflect while working together, solving practical problems and creating new understanding. She calls it theory grounded in experience and collected data to produce a widely accepted and sustainable outcome (2009). Visiting South Africa, she generated an ALAR interest in the country that continues to date (Wood & Zuber-Skerritt, 2013). Action learning (AL) is increasingly being used for improving healthcare practices (Brook, 2010) and action research (AR) has been proven a successful methodology to use in public healthcare (Knowles et al., 2015) as well as in clinical occupational therapy (Cockburn & Trentham, 2002) contexts. Both AL and AR are reported to thrive in unpredictable and uncontrolled environments (Dick, 2013a), which are commonly found in the clinical practices of occupational therapists in South African public healthcare. The purpose of this research study was to transform vocational rehabilitation services in occupational therapy departments in Gauteng’s public healthcare using ALAR.

Chapter One contextualised the research. Chapter Two is dedicated to the research approach. The research design, setting and stakeholders and the research process are described, the trustworthiness is discussed and the chapter concludes with the ethical considerations that were taken.

2.2 Research Design

Lewin is generally considered to be the originator of a research approach that proved the effectiveness of democratic participation, reflective thinking, discussion and decision making by ordinary people, which in the 1930’s (Adelman, 1998) he called *action research*. Revans’ work in the 1940’s created the philosophy behind *action learning* (Welskop, 2013). In the 1990’s the combining of action research and action learning was officiated and the field of Action Learning Action Research (ALAR) came about (Zuber-Skerritt, 2009).

Since its original emergence, action research has become a hybrid of different approaches definitions and applications (Hart & Bond, 1995) creating considerable confusion. As an emergent genre within the family of action research, the defining of action learning has also not been without confusion as it often means different things to different people (Welskop, 2013). The combining of action learning with action research brings about comments and questions about the similarities between the two (Wood & Zuber-Skerritt, 2013). For this reason these concepts will be defined as they are implicit in this research.

In this enquiry, *Action Research* (AR) is seen as a systematic approach that enables people to find effective solutions to problems they confront in their everyday lives (Stringer, 2014). It is a cyclical iterative process of action and reflection on and in action (Zuber-Skerritt, 2009) that has the capacity for developing confidence in practical situations where there is uncertainty (McNiff, 2013). Action research integrates research and action and theory and practice while creating knowledge and improving practice (Reason & Bradbury, 2007) and always makes its results public (Coghlan & Brydon-Miller, 2014). Ebersohn et al (2010) distinguish four types of action research, technical, practical, participatory and emancipatory, and describe how the type of action research is determined by the contextual variables within which the research takes place. As this research took place in a variety of contexts, it was decided to describe the research design as AR.

In this enquiry, *Action Learning* (AL) is seen as a way of learning from and through actions and experience, then taking action as a result of this learning (Zuber-Skerritt, 2009). Action learning is about asking critical questions, learning from and with colleagues while working on matters of mutual concern, sharing experiences and critically reflecting on these. Marsick and O'Neil (2010) discuss four schools of action learning: scientific, experiential and critical reflective and tactical. Reflection on this research showed how learning took place as a natural outcome of the collaborative transformational process. In addition, the two common elements found in all the schools of AL (Marsick & O' Neil, 2010) were present in this inquiry, namely opportunity for discussion that included frequent use of practical and undefined problem solving. These reflections led to the decision to describe the learning that took place in the inquiry as AL.

Action Learning Action Research (ALAR) as an integrated concept of inquiry, using AL processes and AR principles, was adopted as the research design. ALAR combines the benefits of experiential learning with the academic values of rigour and publication, found in action research (Zuber-Skerritt, 2009).

Aiming to enable the transformation of occupational therapy vocational rehabilitation services in public healthcare, the researcher recognised ALAR as a positive approach to a complex problem. There was also evidence that South African occupational therapy researchers were using action research (du Toit & Wilkinson, 2010) and specifically in relation to vocational rehabilitation (van Niekerk et al., 2006). Lorenzo et al (2006) also advocate the importance of learning in the real life situation for South African occupational therapy students, which is a fundamental attribute of action learning. ALAR is an emancipatory way of changing a situation so that it empowered the people concerned to take responsibility for their own destiny through self-directed learning and leadership (Zuber-Skerritt, 2009).

Considering the definitions of ALAR draws attention to its collaborative participatory dimension (Pedler & Burgonye, 2008), its focus on practical problems for which practical solutions are sought (Ebersöhn et al., 2010) and the ability of participants to be active constructors and interpreters of experiences, to personalise knowledge and make it relevant to practices (Zuber-Skerritt, 2009). The following characteristics of ALAR were found in this enquiry:

- The aim of developing solutions to practical problems (Brockbank & McGill, 2004). In this study the practical problem was the inefficient vocational rehabilitation services of occupational therapists in public healthcare.
- The focus on change and its inherently transformative and developmental characteristic which created new knowledge as change happened (Brook, 2010). This study aimed to transform vocational rehabilitation practices and develop associated skills of occupational therapists in public healthcare.
- The cyclical process of strategic planning, implementing action plans, evaluating and observing the outcome and critical reflection on the results to make decisions for the next cycle. Repeating the cycles of planning, action, reflection and observation as often as necessary to address the problem (Pedler & Burgonye, 2008). In this study, the observe-plan-act-reflect cycles were found as phases in the larger research design, within the collaborative research team's transformational planning and as multiple cyclical processes when addressing specific practice problems.
- The participation of all role players and a democratic grounding allowing an equal partnership between the researcher, an outsider and insider participants. In this enquiry, the researcher became a member of a pre-existing insider group, the Vocational Rehabilitation Task Team, sharing the same transformational goals.

- It was an interactive form of knowledge development with constant interaction between theory and practice (Zuber-Skerritt, 2009). In this enquiry, the insider group identified the issues, concerns and problems that were instrumental in deciding how to address these and identified who was to take part in the actions to transform. All generated knowledge was disseminated and shared within the local context.

The primary focus in ALAR is that people learn best when they do it themselves (Pedler & Burgonye, 2008) and that decisions are best implemented by those who helped to make them (O' Brien, 2001). This focus echoes the basic principles of adult education, that adults learn by doing and solving problems they associate with their reality and that they need real time feedback (Moon, 2004). ALAR bridges the gap between learning and action, theory and practice and research and development (Zuber-Skerritt, 2009), with the definitive aim of transforming practice.

2.3 Setting and Stakeholders

Zuber-Skerritt described the attributes of people who are attracted to ALAR as being collaborative, open to criticism and self-critical, caring and appreciative, mindful of the needs of others and who have a concern for the wellbeing of their collective group (2009). In 2013, the researcher joined the VRTT to form a collaborative research team, with the shared aim of transforming occupational therapy's vocational rehabilitation services in public healthcare through action research.

Dick (2013b) uses the term 'stakeholders' in action research to describe an action research population. He describes stakeholders as persons who have a stake in a programme and who are affected by or able to affect practical change. Within a collective of stakeholders, there are numerous forms of positionalities (Herr & Anderson, 2005) that influence the research. Two positionalities will be referred to in this study, insiders and outsiders. Herr and Anderson (2005) view 'insiders' as practitioners who reflect on and learn from their practices to become better practitioners. Outsiders are not related to the practice problem but interact for academic or other interests, often bringing expert or organisation knowledge that insiders request (Herr & Anderson, 2005).

The insiders in this group were clinical occupational therapists working in Gauteng public healthcare with an interest in vocational rehabilitation. They formed an interest group, the Vocational Rehabilitation Task Team (VRTT). During the four years of this research, the Assistant Director of Rehabilitation Services in Gauteng acted as chair and convener of the VRTT. VRTT meetings were

held every two months and the venue was rotated between hospitals. The VRTT membership fluctuated as new members joined and others left. The group size varied between five and 16 members, with the only three constant members throughout this research being the Chairperson, a chief occupational therapist and the researcher.

Biographical and positional description of the VRTT group: the Chair was an African male with 23 years of occupational therapy experience, 15 of them in vocational rehabilitation. He had a natural non-confrontational affiliative leadership style and went out of his way to be accommodating, to soothe upsets and clear misunderstandings. By example, he placed emphasis on all conduct in the group being respectful and politically correct. The bio-graphics of the rest of the group showed an average of 5 years occupational therapy experience and 2 years vocational rehabilitation experience. The gender distribution was predominantly female, with a variety of cultural and religious backgrounds.

A continuum of outsider stakeholders was present during the research period. The primary outsider was the researcher and her two supervisors. At the start of the research, the researcher co-opted a dedicated group of 12 outsiders who volunteered to be critical friends. The concept of having critical friends who offer constructive advice is well documented in AR (Herr & Anderson, 2005) and ALAR (Zuber-Skerritt, 2009). The selection criteria for the critical friend group was occupational therapists with experience of working in South Africa's public healthcare and more than five years of working in and/or teaching vocational rehabilitation. On various occasions, outsider experts were invited to attend meetings and workshops as consultants for a specific problem. Towards the end of the study, outsiders approached the VRTT requesting access to generated knowledge and offering to be mentors and to help with future transformation actions.

The biographical and positionality of the researcher: a white female of Afrikaner descent, with 28 years of occupational therapy experience of which 22 years were in vocational rehabilitation and in which she is considered to be an expert in the South African field. As is common in action research, this researcher had multiple roles and this needs to be acknowledged and described for the reader to understand the impact it could have on the research (Herr & Anderson, 2005). Another reality of action research is that the positionality of the researcher and the impact of her role changed continuously through the four-year research period. At the beginning of the research, the researcher was a 'new' member entering a pre-existing group of insiders, by the end she was seen as an established VRTT member. The group dynamic changed as group members developed trust in her presence. She had developed a good track-record and reputation, which prompted non-member insiders requesting to become part of the VRTT group. In general, the researcher was viewed by

VRTT members as a visiting expert and her knowledge of vocational rehabilitation was therefore utilised within the group and by individuals. She also acted as a mentor to therapists who requested this and held numerous training sessions both formally and informally. She was approached for counselling with difficult cases and clinicians sent her reports to proofread and comment on. On several occasions clinicians, who found themselves not confident, requested her support/supervision with the functional capacity assessments of patients perceived to be challenging. Within the clinical practice settings, the researcher demonstrated specific treatment and assessment techniques on patients. She helped clinicians to negotiate student fieldwork placement and showed them how to supervise students' vocational rehabilitation clinical practice blocks. She demonstrated how to write reports, went on work visits with them and she demonstrated how to use, interpret and report the results of work samples. During the time spent in the clinical settings, she demonstrated how to deal with difficult and abusive clients when such occasions arose. When mistakes were made she started constructive critical reflections on how to handle and correct these. She illustrated the use of MODAPTS within the clinical vocational rehabilitation contexts to which she was invited.

Positive positionality considerations of the VRTT were that new members joining the group brought new insights, fresh perspectives and energy once they had been orientated to the group's working aims and ethos. The management position of the chairperson was considered a negative positionality that had to be taken into consideration and managed to ensure optimal ALAR benefits. The fact the researcher was a private practitioner and had no stake in public healthcare was a positive position. However, this benefit came to fruition only once the possibility of power positions were acknowledged and negated. The possible power positionalities she had were that she was older, had a higher academic qualification and more clinical experience compared to the other members. She also had access to and regular contact with management and academic occupational therapists who group members viewed as power figures.

Efforts were made by both the VRTT and the researcher to minimise possible negative positionality impacts on the collective aim. One effective effort was having the chairperson endorse the researcher's position within the group; treating her as an expert, supporting all research efforts and celebrating achievements, such as publications and international interest, were practical examples of this. Additionally, attempts to equalise member positionality and reduced power relations was to create a colloquial atmosphere during meetings. Values such as loyalty, respect and patience were discussed and insisted on. Action research principles such as transparency and democracy were upheld. The VRTT discussed and agreed to have the shared worldview of Ubuntu and upheld its

principles within the group. When discontent arose, it was discussed and managed immediately and in the spirit of Ubuntu. This approach requires awareness that it is more important to maintain a relationship than to prove a point.

Approaches the researcher used to achieve a natural and conducive position within the group were willingness to acknowledge when she made mistakes and free sharing of knowledge and information, patience in repeating basic levels of knowledge, ability to demystify difficult aspects of the practice and get the information across in a simple way that was understandable for all, with a non-judgemental attitude. Other approaches were commitment to the group by attending all meetings, paying attention to non-essential aspects, such as VRTT members' birthdays or weddings, professional conduct, such as being on time for appointments, and responding quickly to emails and telephone calls.

At the end of each year, the VRTT undertook a structured anonymous critical reflection, which included considerations of the positionalities of the group members and its activities. These reflections were published in the national occupational therapy newsletter and discussed as a meta-reflection in Chapters Six and synthesised as learning in Chapter Seven.

2.4 Research Process

Action learning action research (ALAR) takes time and should be allowed to dictate its own progress and process. All this is difficult when combining it with the requirements of academic deadlines. The researcher had to learn to trust the ALAR process, which meant allowing the research process to be organic and abiding by the emancipatory and democratic principles of ALAR, letting the VRTT nominate practice problems in the order of what they perceived to be most important, staying engaged and supportive whilst allowing individuals to make mistakes they could learn from and waiting for them to recognise an error and take the time they needed to acknowledge it. All of this meant that phases did not proceed in a neat chronological order.

2.4.1 The Process

The research process was planned to have observe, plan, act, and reflect phases in keeping with typical action research cycle phases. Within each phase, multiple ALAR cycles would take place. The plan was to start with an observational phase in which the occupational therapy's vocational rehabilitation services would be observed to establish its current status. This would be followed by a planning stage, in which a vision of occupational therapists vocational rehabilitation services could

be established in order to act as an indicator of what services should look like. Once this was established, transformative actions could be undertaken. At the end of the research tenure, there would be a reflection of the transformation achieved and the effect of ALAR.



True to the nature of ALAR, the expectation was not for these phases to follow in a linear chronological fashion. Allowance would be made for the collaborative research team to identify and influence the content and progress of the cycles. In addition, cycles would be allowed to influence each other. This resulted in phases and cycles within phases, on occasions running concurrently and influencing each other. Furthermore, the VRTT used the last meeting of each year to reflect on the years' transformative actions with the aim of planning for the new year.

Keeping all this in mind, the research process can best be described accordingly:

- It started with an integration phase, when the researcher, an outsider, entered a pre-existing insider group and they formed a collaborative research team.
- An observation phase was launched in which three ALAR cycles were started and concluded.
- A planning phase with a literature review and an opinion survey continues to date.
- The action phase began whilst the researcher was integrating herself into the group, and continues to date.
- The reflection phase was a meta-reflection of the researcher's tenure with the insider group. Consensual and gradual withdrawal of the researcher from the VRTT concluded the research tenure.

This is illustrated in the form of a time line and shown in Table 2.1 below.

Table 2.1 Research Timeline

	2013	2014	2015	2016
INTEGRATION PHASE	Integration into the VRTT and forming a collaborative research team. (Nov 2012 - Dec 2013) ❖ How to start a Work Unit.			
OBSERVATION PHASE	Observation : "What is happening?" (June 2013 to November 2014) ❖ Profile Tool (June 2013) ❖ 4 x Semi-structured Interviews (March 2014, April 2014, October 2014x2) ❖ Convergent Interviews (October 2014 - November 2014)			
PLANNING PHASE		Planning : "What should be happening?" (January 2014 to date) ❖ Literature Review (January and February 2014) ❖ Opinion Survey (August 2014 - March 2015)		
ACTION PHASE	Transformative Actions (August 2013 to date)			
	❖ Report Writing (August, 2013) ❖ Driver Screening (September 2013)	❖ MODAPTS (Workshops) ❖ How to do a Basic Work Assessment (June 2014) 11 Workshops were held in 2014	❖ Students (June 2015.) ❖ PILIR (November 2015) 281 hours of mentoring was done in 2015	
REFLECTION AND WITHDRAWAL PHASE				Reflection: "What happened?" Meta Reflection (Jan 2016 to Aug 2016) ❖ Profile Tool (June 2016) ❖ VRTT reflections 2014, 2015, 2016 Withdrawal from the VRTT

2.4.2 Data Collection

The researchers were in agreement with Koshy et al. (2011) that in action research it is important to collect the type of data that best serves the transformative purpose of the study. Although action research is popularly aligned with qualitative enquiry (Denzin & Lincoln, 2007) and its associated data collection tools, it is more correct to see it as an approach to change (Hart & Bond, 1995) that systematically draws on many ways of knowing, both qualitative and quantitative, in an iterative fashion (Reason & Bradbury, 2007). In this enquiry, data were collected as the context and framework of the particular ALAR phase and cycle required.

The data collected took the form of individual and group narratives, participant observations, field notes, reflective journaling and critical reflection, written and verbal feedback from stakeholders, meeting minutes, opinion surveys, semi-structured interviews, convergent interviews, the Vocational Rehabilitation Practice Profile Tool, biographical questionnaires, photographs and anonymous workshop feedback forms.

2.4.3 Data Analysis

In keeping with good research practice (Creswell, 2009) and in support of ALAR principles (Zuber-Skerritt, 2009), analysis of data were done manually and directly after the conclusion of an event or cycle. In action research this is especially important as data analysis guides further data gathering and decision making (Herr & Anderson, 2005). As is required in ALAR, the researcher and volunteering members of the VRTT conducted data analysis together (Marsick & O'Neil, 2010). An important consideration for the researchers was the suggestion made by Winter and Munn-Giddings (2005), that action research data should be analysed in such a way that it can be related, in an appropriate fashion, to the community from which it was gathered.

In action research different cycles and questions required different analysis approaches and in this research both quantitative and qualitative data analysis was used. Throughout the research inductive and deductive analysis and thematic and content analysis as described by Creswell (2009) were utilised..

Zuber-Skerritt's (2005) suggestion of data analysis was followed for routine reflections, field notes and personal journaling. At the end of each month raw data were summarised and categorised. For specific actions such as a mentoring occasion, practice orientation action cycles, workshops or interviews the data were analysed immediately after gathering. Throughout the research the

summarised and categorised data were further refined and used for presentation as a journal or newsletter article, feedback at a VRTT meeting or oral presentations on a variety of forums.

2.5 Trustworthiness of the Research

Throughout the study, efforts were made to build confidence in the research processes and results (Lincoln & Guba, 1985). The research aligned itself with Guba's trustworthiness criteria (1981) and credibility, dependability, transferability and confirmability were used to describe the various aspects of trustworthiness.

2.5.1 Credibility

Credibility addresses the question of whether the research established confidence in the truth of the results (Lincoln & Guba, 1985). This was addressed by ongoing and extensive consultation of scientific and grey literature to inform all planning and actions. Prolonged engagement was ensured as the researcher was actively involved and attended all meetings for four years as a member of the VRTT. The researcher and all members of the VRTT consistently practiced observation and reflection. Routine, regular and immediate analysis of data by the researcher and volunteer VRTT members occurred throughout the research. In the case of data analysis for scientific publications, a VRTT member was used as a second analyst to co-code and authenticate coded data. Routine member checking and participant validation occurred and involvement of critical friends where possible. Active and equal participation of all VRTT members was seen as a priority. Formal and structured reflections of the VRTT actions were held at the end of each year, summarised and used to inform further action and shared on a national level with all South African occupational therapists by publication in the National Occupational Therapy newsletter, FOCUS. Referential adequacy was gained through VRTT meeting minutes, field notes, reflective journaling, debriefing summaries, researcher and member transcription. Within the collaborative research group the experience and educational qualifications of individual members was utilised and on several occasions, experts were invited to the VRTT meetings to further enhance the quality of knowledge and participation in the group. A variety of both qualitative and quantitative data collection methods were used throughout the research. For several knowledge generating cycles, peer scrutiny was achieved through publication in internationally accredited peer reviewed journals and at the National Occupational Therapy Congress.

2.5.2 Dependability

If the research and its findings could be repeated, and were consistent, indicates the dependability of an enquiry (Elo et al., 2014). This was attended to with a dense description of the research design and methodology. Further dependability considerations were, the code-recode data analysis procedure and using VRTT volunteers to help analyse data. Triangulation, using a variety of qualitative and quantitative strategies and data sources, participant validation, as well as the use of critical friends also increased dependability. Submission to scientific peer reviewed journals and a National Congress ensured additional reflective appraisal of the research.

2.5.3 Transferability

The degree to which findings can be applied to other contexts or with other respondents is called transferability (Guba, 1981) and in action research, which focuses on unique and specific contexts, this needs to be considered with caution (Koshy et al., 2011). The aim of this research was to address practice problems in a specific context and not to generalise the findings; this does not necessarily mean the findings of one specific context cannot be applied to another. Note needs to be taken of the context within which the research was done and considered by future researchers who want to use the results.

Keeping this in mind, attempts were made to improve the transferability of the research by giving thick in-depth descriptions of population samples, methods and data collection techniques. In addition, dissemination through peer reviewed journal articles, professional newsletters, workshops and congress presentations allowed objective interpretation and comparison of findings, thus augmenting transferability.

2.5.4 Confirmability

Confirmability is the degree to which the results of the study are the product of the enquiry (Ebersöhn et al., 2010). This was affected by the application of ethical conduct in all aspects of the research and doing the research as a collaborative team. Literature was consulted as a prerequisite to actions. The research was guided through regular contact with and active involvement of the supervisors of the PhD study, who were from two different educational facilities (University of the Witwatersrand, South Africa and University of Sydney, Australia). The University of the Witwatersrand Ethics Board considered the research application and their guidelines were applied throughout. All VRTT members and others who came in contact with the research had independent access to the University's Ethics Board, with contact persons and details provided. The 'open to

scrutiny' policy of action research was applied throughout, participant validation, experts critical appraisal and peer review were built into all aspects of the research.

VRTT meetings, workshops and mentoring sessions were registered with the Health Professional Counsel of South Africa (HPCSA) as professional development sessions going through their formal application system for accreditation. All these activities passed the review process and received accreditation. Acknowledgement of the researchers pre-disposition was done throughout and dissemination of the outcome was planned in advance.

2.6 Ethical considerations

Action researchers face a complex dimension to ethical issues (Koshy et al., 2011). In this research, this complexity was fuelled by professional ethical and healthcare considerations. The research included professional therapist-therapist-, therapist-patient-, supervisor-student- and mentor-mentee liaisons. In this regard, the ethical consideration of Winter and Munn-Giddings (2005), that the duty of patient care and protection from harm overrides all other interests, respect for cultural diversity and for all individuals irrespective of their race, gender, age or pathology would be upheld and that individual dignity will be respected at all times were used as a gold standard throughout the research.

This research was reviewed and cleared by the University of the Witwatersrand's Human Research Ethics Committee (Medical) in August 2013 (see Appendix A. Ethic Clearance Certificate). Action research has unique, often sticky, ethical issues (Zeni, 1998) because it is done in 'real world' circumstances, does not allow a predetermined design and requires multiple layers of participation (O' Brien, 2001). To address this the researcher, assuming responsibility for all ethical aspects of this enquiry, applied the moral principles of respect and beneficence in all interpersonal relations and transparency, honesty and accountability in all practice. Once she was accepted by the group the researcher found her positionality to be helpful. As an older more experienced therapist who, as an outsider, had no vested interests in the context she had a certain value. Therapists used her as a sounding board for their frustrations and problems. Offering an objective perspective on occasion helped to restore working relationships and re-align professional commitments. On several occasions non-judgemental and sincere discussions generated the courage in clinicians to own up to deficient or incorrect practices. These core principles lay the foundation for credible and influential research (Rallis, 2015).

The research took place in Gauteng public healthcare facilities, during public healthcare therapists working hours. The required clearance and consent to use the information for this research was received for all meeting minutes, focus groups, semi-structured interviews, convergent interviews, questionnaires, surveys, profile tools, field notes, critical reflections and reflection reports and journaling, workshops, demonstrating practical vocational rehabilitation skills on therapists, students and healthcare users, group and one-on-one mentoring and students supervision.

The Socratic method of critical questioning was employed throughout this enquiry as it resonated well with ALAR principles. Developing his philosophy within an Athenian democracy, Socrates showed that by asking the right question you allow the truth to emerge while both the questioner and the questioned further their understanding of the discussion matter (Mason, 1960).

2.6.1 Informed consent and autonomy

Participant information sheets were produced to give a clear and easily understandable description of the purpose and nature of the research. In addition, notes about action research were included as most occupational therapists have little or no knowledge or experience thereof. Examples of these are attached as Appendix A.

Informed consent was signed by all VRTT members, workshop attendees, visiting experts and presenters, students and public healthcare users who were involved in the research. Additional and more specified information sheets and consent forms were used for audiotaping of semi-structured interviews, photos taken, clinical work done by the researcher, mentors and critical friends. Verbal consent was given and signed for by public healthcare users who agreed to convergent interviews with their occupational therapists. Additionally, regular reaffirmation of consent already given was done verbally and in the form of minute meetings with the VRTT.

All consent forms were kept chronologically sorted and in a safe private facility to which no participant other than the researcher had access. Autonomy of participants and facilities where the data were gathered was safeguarded. All participation was done and consent given on a voluntary basis, without coercion, and the possibility of any kind of fear of penalty or repercussions for refusal or withdrawal of participation was eased. All participants in this study were adults and compos mentis (of sound mind).

2.6.2 Authentic Collaborations

The quality of the collaborative research team, the alliance between the VRTT and the PhD researcher was considered important to the success of the research as a whole. The collaboration

had to benefit the community of insider participants, the actions had to hold contextual relevance for them and they had to feel ownership of all knowledge generated. It was believed to be important for the insider participants to feel they benefited, personally and professionally, from being part of a collaborative research team. To achieve this the researcher took time to teach them how to do action research, to involve them, on a voluntary basis, in the collection and analysing of data and the dissemination of generated knowledge.

Consideration of the fact that power relations could have a negative impact on action research outcomes (du Toit & Wilkinson, 2010) were made. Feedback and transparency were applied to address possible concerns regarding power relations within the collaboration. The researcher made a point of avoiding condescending, patronising or pedantic behaviour. Regular journaling and reflections helped her to identify, apologise for and/or correct any such approaches that occurred. Such sensitivity and confessions were seen to set a positive tone in the group. In cases where clinical occupational therapists worked with public healthcare users, the therapist-patient relationship could also have been seen as a power relationship and this was taken into consideration.

No remuneration was given or received other than the benefit of CPD points the occupational therapists received from the researcher for workshops, mentoring and meetings attended.

2.6.3 Dissemination of results

All writing and dissemination of results were in collaboration with volunteer vocational rehabilitation task team (VRTT) members. Results were made available to VRTT members first, usually during a verbal, PowerPoint or written presentation at meetings. Collaborative decisions were made as to what to do with the data and then captured in meeting minutes. The decisions for dissemination were in the form of articles written for peer reviewed journals or an occupational therapy newsletter, to be shared with this research's supervisors and presented at research days, workshops, congresses and in this thesis.

In the case of co-authors and publications in journals, written permission was given for use in this thesis (see Appendix B. Copyright Clearance from WORK, SAJOT and FOCUS).

2.6.4 Beneficence and doing no harm.

In action research, the principle of beneficence requires that research be undertaken in the interest of the people involved and affected (Kemmis et al., 2014), which in this research were occupational therapists in public healthcare and the public healthcare users they were seeing. This was addressed by using the VRTT as the basis for all decisions made and actions undertaken and making it team

practice to openly discuss negative experiences, possible frictions, disagreements, rumours and misunderstandings.

In action learning there are multiple elements of risk which need to be considered (Marsick & O'Neil, 2010). Action learning takes place in actual work situations where a social laboratory is created and the outcome can never be fully prepared for. In addition, the change that takes place happens on a personal level generating insight, awareness of personal values and beliefs that could be alarming. Some clinicians, especially those with limited clinical experience, could be distressed at having to take charge of their own learning and doing so within actual clinical practice settings where real time feedback occurs. This visibility is further enhanced when it happens within collaborative learning situations such as the VRTT. AL brings about improved awareness of organisational strengths and weakness. Within a large employer, such as public healthcare, this could cause organisational discomfort resulting in negative feedback. AL also involves taking the risk of making mistakes and the healthcare environment is notoriously unsupportive of mistakes. All these had to be considered as possible harmful elements. Creating awareness and insight with regular verbalisation and questioning addressed the issue.

The researcher took cognisance of the potential harm related to the relational bonding that takes place during mentoring and four years of collaborative effort. At the end of each year she asked for time on the agenda at the VRTT meetings to report back on the progress and future plans of the PhD research, keeping participants up-to-date with the academic development of the project. The year before termination, participants were told there were only 12 months left, the researcher's tasks had to be taken over and mentoring was on a needs only basis. The last year of the research applied the La Leche League principle of *do not offer and do not refuse* to wean her presence from the group.

2.6.5 Bias

The research was funded predominantly from the researcher's private funds, assisted by a University of the Witwatersrand, Faculty Research Committee Individual Research Grant in 2013. The collaborative research team aggregated funds from the registration fees paid by attendees to the annual vocational rehabilitation orientation workshop and this was used to reimburse the researcher for some of the costs she had incurred relating to the registration of continuing professional development (CPD) activities and the presentation of workshops. The researcher was also financially assisted by one of the supervisors who contributed towards the cost of writer-retreats they attended together when writing co-authored scientific journal articles and paying the

registration fee for the researcher to present at the national Occupational Therapy Association of South Africa (OTASA) congress.

2.7 Conclusion

Maguire (2005) warns PhD students that action research is never a neat academic exercise with correct answers, but messy work done in relationship with other people. In addition, it is time consuming and often develops a life of its own that is hard to reconcile with the expectations of an academic institution. In the same refrain, Marsick and O'Neil (2010) warn that action learning should not be entered into lightly as it is often a powerful and potentially frightening experience. After many years of involvement with ALAR, Zuber-Skerritt (2009) (p200) reached the conclusion that "evocative action is better than fear of failure; that taking risks and choosing high performance goals of significance over mediocrity or complacency is more rewarding and pleasurable than being too careful and hesitant".

With this insight the next four chapters will show how ALAR allowed an outsider access to a pre-existing insider group and was used to transform a service and the clinicians who offered it, by crossing the gap between theory and practice and how, in the process, it enriched the lives of all involved.

Chapter Three: Observation Phase

“For as long as people have been interested in studying the social and natural world around them, observation has served as the bedrock source of human knowledge.” Patricia and Peter Adler (Adler & Adler, 1994)

3.1 Introduction to the Observation Phase

This chapter describes the observation phase of the research, where the question is asked: “What is happening in Gauteng public healthcare regarding occupational therapy’s vocational rehabilitation services?” However, in action research, before observation or any other form of research can be done, a collaborative research team has to be formed. The quality of this collaboration will have a significant impact on the progress and outcome of the research (Dick, 2013b). The forming of this enquiry’s collaborative research team is discussed below. It illustrates how the researcher, who was an outsider, integrated herself into a pre-existing insider group, the Vocational Rehabilitation Task Team (VRTT) to form a collaborative research team. The remainder of the chapter is dedicated to the observation phase. Figure 3.1 presents the entire study, with the highlighted sections indicating the position of this chapter on integration and observation.

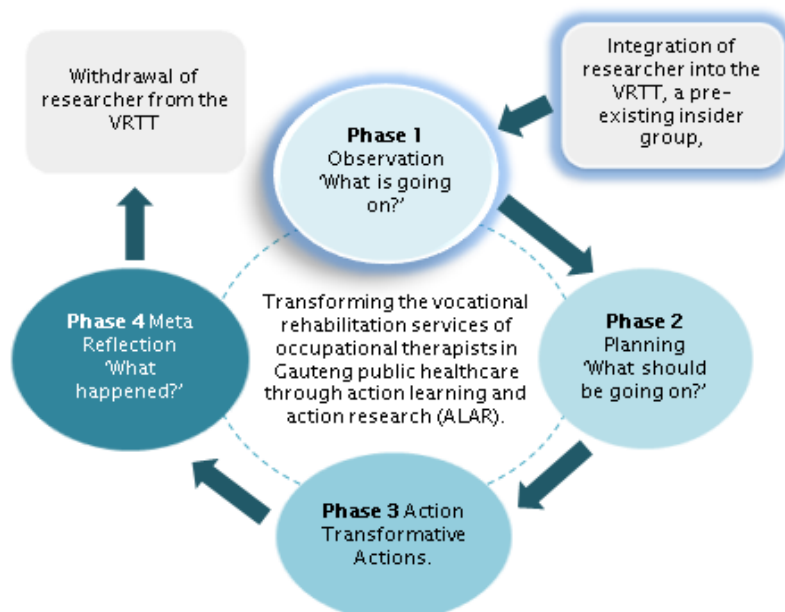


Figure 3.1 Diagrammatic presentation of the research process positioning integration and the observation phase.

3.2 Integration into the VRTT and forming a collaborative research team

Prior to the involvement of this research, there had been acknowledgment that the vocational rehabilitation services of occupational therapists in Gauteng's public healthcare were problematic and consequently, the vocational rehabilitation task team (VRTT) was formed. At the time the researcher joined this group, they had created a vocational rehabilitation-screening tool and offered an annual vocational rehabilitation orientation workshop. To this pre-existing task team, and their efforts to address vocational rehabilitation problems, this research offered the ideals of a collaborative team approach, action learning and the methodology of action research, should they accept the researcher as a team member.

Referring to the integration phase, Dick mentions that entry and contracting are crucial in an effective action research project (2013b). Zuber-Skerritt (2009) elaborates on this by saying the most problematic issue for an outsider researcher is to ensure that insiders take ownership of the research problem. If this is not achieved, she warns, insiders may only pay lip service to the research and not really be committed to taking action and achieving transformation. Taking heed of this advice, the researcher scrupulously attended to the process of integration into the VRTT and the formation of a collaborative research team.

The integration process was advantaged by the fact that in South Africa, the occupational therapy fraternity is a small one and most occupational therapists are known to each other. Another opportunistic situation was that at the time of this research, the head office management of Gauteng Rehabilitation Services were predominantly represented by occupational therapists and the Deputy Head of Gauteng's Rehabilitation was the chair of the VRTT. This advantaged the initiation of the research project as regional management and the researcher shared common views and ideals for the development of vocational rehabilitation services within the province. Gauteng's head office management remained supportive of the research throughout the research tenure and assisted with official clearance processes and the integration into the VRTT. Throughout the enquiry, an open-door policy between the researcher and Gauteng head office management was maintained, which proved to be of mutual benefit to both the researcher, head office management and the momentum of the research project.

Dick describes how action research is an emergent process that gradually develops as understanding grows (2013b) and the researcher anticipated the same would apply to the formation of a collaborative research team. Whilst waiting official clearance for the research, the researcher

attended the VRTT meetings as a guest of the VRTT's chair, which allowed her to act as an observer familiarising herself with members and proceedings. This also allowed VRTT members gradual and non-threatening exposure to the researcher, reducing possible intimidation that could be caused by the researcher's reputation as an expert in the field of vocational rehabilitation.

Two constraints were found to affect the integration of the researcher into the group and had to be overcome. One was the researcher's preconceived assumptions about public healthcare as much had changed since she worked in this environment 20 years ago and working in public healthcare was different to working in private practice. The other constraint was the researcher's positionality as a private practitioner and her good relations with head office management, as discussed above. It took some time for the VRTT members to overcome their unspoken concern that the researcher would judge and/or check up on them.

Some features that helped with acceptance and authentic integration of the researcher into the group warrant highlighting. One such feature was the bonding initiated by the researcher. She was candid about her initial assumptions of public healthcare and verbalised her changed insights. Her interest and positive acknowledgement of the VRTT's efforts in addressing their vocational rehabilitation practice problems prior to her joining them was also seen to be appreciated. The researcher purposefully applied her knowledge and experience of interpersonal social skills and Dick's suggested strategies for entry and contracting (2013b). Examples of these were an authentic self-presentation, having an unassuming presence in the group and unprejudiced acceptance of all group members. Another beneficial integration feature was the VRTT chairman's sanctioning of the researcher's presence and the research and the extent to which he went out of his way to support all research efforts. Of his own volition, he accompanied the researcher on visits to the four central hospitals, orientated her to the hospitals, occupational therapy departments, work units and work samples and introduced her to the heads of departments and therapists he knew were interested in vocational rehabilitation. However the most effective integration action was when the group started working together.

After the successful conclusion of the first action learning action research (ALAR) cycle, the collaborative research team of the researcher and the VRTT was consolidated. This first ALAR cycle was initiated during a visit to a central hospital where there were no vocational rehabilitation services. The head of department asked advice on how to start a work unit. The researcher started an action cycle with the VRTT, showing them how action research worked, allowing action learning to take place and publishing the generated knowledge in the Occupational Therapy Association of South Africa's newsletter, the FOCUS. When the article appeared members experienced real time

positive feedback from various sources. A task team, from the Office of the Deputy President of South Africa, became aware of the article and visited the VRTT to discuss vocational rehabilitation services. This article is still in use, often requested and sent to anyone who approaches the VRTT asking for advice on how to start a work unit.

Once VRTT members had experienced ALAR they became interested in using it to address their vocational rehabilitation practice problems.

3.3 Observation in action learning action research

Observation is commonly reported as one of the cyclical elements that characterises action research; it is also an important component of action learning action research (ALAR), as it informs the planning and reflection of learning and action. For the research aspect of this enquiry, scientific observation, which requires a transparent purpose with systematic planned observations aimed at understanding a specific phenomenon (Stein et al., 2013), had to be taken into consideration. The challenge came when trying to combine objective scientific observation with the collaborative characteristics of action learning action research (ALAR), especially when the collaboration is an insider-outsider collective.

Within action research projects two types of observation are commonly referred to, participant observation and non-participant observation (Koshy et al., 2011), and both types were used in this enquiry. Johnson's (2012) suggestion was also taken into consideration, that in an action research study, the systematic collection of two to four sources of information will keep the research focused while allowing for enough data to ensure the truth value of conclusions.

In order to transform their services, the status of occupational therapists vocational rehabilitation practice in Gauteng had to be reviewed. Observation of practice can be threatening and in the context of this enquiry, there was a history of judgemental accusations within the fraternity about the status of occupational therapy's vocational rehabilitation in Gauteng. ALAR would be a unique approach and the researcher persuaded the VRTT to launch an observational phase for this aim.

Three observational approaches were used in this phase: the Vocational Rehabilitation Practice Profile tool (VRPP tool), semi-structured interviews with occupational therapists managing and offering vocational rehabilitation services, and public healthcare users were engaged in convergent interviews. This provided multiple and varied sources of information allowing the observational phase to come to a trustworthy conclusion of what is happening in occupational therapists

vocational rehabilitation services in Gauteng public healthcare. In addition, the observation phase allowed multiple levels of action learning to take place and it strengthened the collaborative bond of the VRTT.

3.4 Overview of Tools and Processes used in the Observation Phase

Tools used to gather observation data in this phase were VRTT meeting minutes supported by the researcher's meeting summaries, individual and collaborative reflections, journaling and field notes, formal and informal interviews in the form of one-on-one interviews, semi-structured interviews, convergent interviews and a vocational rehabilitation practice profile tool (VRPPT).

Using ALAR principles, the Vocational Rehabilitation Practice Profile tool (VRPPT) was designed and developed to meet the need for a systematic, comprehensive observation tool, which clinicians could use to observe and reflect on the status of their vocational rehabilitation practices. To date the VRPPT continues to be in use within Gauteng public healthcare, in the form of a user manual with an introductory section, a structure, process and outcome section (Appendix D: The VRPP Tool user manual). The tool consists of open and closed ended questions, nominal and ordinal scales, personal opinion statements and reflective essaying. The development of the VRPPT was written up, peer-reviewed and published in the South African Journal of Occupational Therapy (van Biljon et al., 2015b) and the process and findings discussed below.

It was decided to use semi-structured interviews to gauge the opinion of clinical occupational therapists and their heads of department as this type of interviewing is particularly useful when exploring sensitive and personal issues (Greef, 2012), as are the observation of clinical occupational therapy services offered. Most occupational therapists, in clinical as well as academic settings, are familiar with this type of interviewing, due to its frequent use as a data collection tool in the profession, as it allows for rapport building and detailed in-depth understanding of variables of interest (Kielhofner, 2006). In addition, the interviews in this enquiry were to be held at four different hospital's occupational therapy departments. The flexibility offered by this type of interviewing was necessary to enable the researcher to adapt the interview situation to meet the uniqueness of each interview context. Discussed below is the process that was followed and resultant findings.

The VRTT identified the exploration of healthcare users views of occupational therapy's vocational rehabilitation services to be a potentially problematic source of information to attain and research

supported this opinion (Durieux et al., 2004). They decided to use a form of interviewing endorsed by action research experts - convergent interviewing (Dick, 2012). Using ALAR principles, convergent interviews were conducted with public healthcare users. The observational experience and results, described below, were disseminated in the form of a peer reviewed journal article to enrich the dissemination of the generated knowledge and broaden the AL experience.

3.5 Findings of the Observation Phase

Findings for each of the observation approaches are described and presented accordingly: The status of vocational rehabilitation services in Gauteng's four tertiary public healthcare hospitals, the views of occupational therapy clinicians, their Heads of Department (HoD) and healthcare users on the vocational rehabilitation services offered.

3.5.1 The status of vocational rehabilitation services in Gauteng's four tertiary public healthcare hospitals

The journal article inserted below reported on the development of the VRPPT (van Biljon et al., 2015b). The aim of the publication was to promote the ALAR process and address transferability and dissemination of the tool.

An Action Research Approach to Profile an Occupational Therapy Vocational Rehabilitation Service in Public Healthcare

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ABSTRACT

The need for occupational therapists to profile their vocational rehabilitation services, initiated an action research project, within a PhD study. The PhD study was aimed at transforming vocational rehabilitation services in occupational therapy departments in Gauteng public healthcare through action research. The aim of the project was to develop a tool that would allow occupational therapists doing vocational rehabilitation, to systematically and comprehensively profile their services. The profile tool could be used for practice reflection, research, to assist with planning, policy making and/or quality management. It will be used in the final phase of the PhD study to allow for critical reflection on vocational rehabilitation practice transformation in Gauteng public healthcare.

The profile tool was designed and developed during action research cycles in public healthcare vocational rehabilitation units. It was refined through further action research cycles with occupational therapists that offer vocational rehabilitation services in Gauteng's public healthcare. The service profiles generated from these cycles were presented for participant validation. The final profile tool was sent for critical appraisal to a panel of experts acting as 'critical friends'.

The processes of designing, developing, refining, validating and disseminating the tool are presented in this article as a contribution to the practice of vocational rehabilitation and to conclude the dissemination outcome of action research.

Key words: occupational therapy, vocational rehabilitation services, public healthcare, action research, profile tool

INTRODUCTION

Background

Vocational rehabilitation is a multi-professional service provided to individuals of working age with health-related impairments, limitations or restrictions within work functioning. The primary aim of such a service is to optimise work participation in spite of illness or activity limitations¹. In occupational therapy, concern with functional ability and purposeful activity are unique features² that allow the profession an important place in vocational rehabilitation practice³. An effective occupational therapy vocational rehabilitation service assists the transition between injury, illness, impairment, disability and return to optimal functional ability in a work sphere. It bridges the gap between health institutions, which are usually the point of entry for an injured or sick worker, and the labour market⁴.

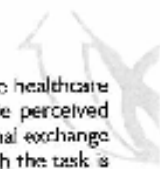
South Africa's Gauteng province has a high demand for vocational rehabilitation services. It is the hub of the country's commerce and industry. Home to 30% of South Africa's (SA) total population, its age distribution shows that 73% of this population is of working age⁵. In South Africa, 68% of the population depend entirely on public healthcare⁶. The effect of no or poor vocational rehabilita-

tion in public healthcare is obvious in a commerce and industry driven province such as Gauteng, with a high prevalence of injury at work, crime and motor vehicle related injury, the impact of Aids and pressure to return to work as quickly and effectively as possible.

In the National Health Amendment Bill debate on the 14 August 2012 Dr Aaron Motsoaledi, South Africa's Minister of Health said: "The deteriorating quality of healthcare in our public hospitals has been a thorn in the flesh of our country for quite some time"⁷. Occupational therapy services within public healthcare are included in this and services that require specialised knowledge and experience, like vocational rehabilitation are most affected. A Vocational Rehabilitation Task Team (VRTT) was convened, in 2010 in Gauteng with the aim of resuscitating the province's vocational rehabilitation services. The VRTT is a group of occupational therapists, working in Gauteng's public healthcare sector and concerned with occupational therapy vocational rehabilitation services in the province. In 2013 the first author, a PhD candidate from the University of the Witwatersrand, joined the group with the research aim of transforming occupational therapy vocational rehabilitation services in Gauteng through action research.

In keeping with the cyclical nature of action research (i.e. ob-





serve, plan, act and reflect) the first phase of the PhD. research was to observe and ask: 'What is going on in occupational therapy vocational rehabilitation services in Gauteng's public healthcare?' If occupational therapists were able to subjectively compile a comprehensive and accurate profile of their own vocational rehabilitation service, their insight and understanding could be a transformative agent for service development. A comprehensive service profile drawn up at the beginning of a research intervention could also be used to compare with a service profile at the end of the intervention. This could allow objective macro post-reflexivity to answer the question: 'What was the impact of action research on occupational therapy vocational rehabilitation services in Gauteng's public healthcare?'

Searching for a means to profile a vocational rehabilitation services in public healthcare left the researcher with insight into the importance as well as the problems of service measurement⁶. Selecting an appropriate method to facilitate a collaborative approach with occupational therapists working in the services was an important point of departure. Audits, quality surveillance or observation style inspections are easily interpreted as judgmental and could exaggerate power relations which prohibit the emancipatory effects of action research⁶. The first author wished to engage in a profile process that would not only support practice development but actively involve practitioners in the process. She opted for action research methodology as it provided the cooperative development of a non-threatening and non-invasive tool. A tool that therapists could potentially use to profile their vocational rehabilitation services at a certain point in time. Such a profile would allow them to critically reflect on their practice and identify areas that needed improvement and thus it holds the potential to transform a vocational rehabilitation service.

It was decided to develop the tool through action research cycles within and with the population it would be used for⁶. This tool would be designed and developed by gathering data from multiple sources and in different ways about all aspects of vocational rehabilitation by occupational therapists considered to be experts in the field. Practitioners were incorporated as fellow researchers in the refining and validation of the tool. This allowed them to experience ownership of the tool, the service profiles generated by the tool and by extension the actions that would follow to improve and transform their vocational rehabilitation practices¹¹.

The aim of this article is to describe the process and outcome of designing, developing, refining, validating and disseminating a tool that occupational therapists working in public healthcare can use to profile their vocational rehabilitation services.

LITERATURE REVIEW

The four sources from literature that principally influenced the development of this profile tool were Donabedian's work^{5,12-14} the Gauteng Department of Health's 'Allied Health Care Professionals Standards and Audit Tools'^{15,16} and research by Buys¹⁷ and Beukes³. Various other frameworks and bodies of knowledge measure healthcare outcomes^{3,12}, but the selected sources best embodied the purpose and context for which the profile tool was developed. Mant¹⁸, commenting on performance indicators in assessing quality of healthcare, states that the context and purpose in which indicators are used should be considered. He cautions that using only an outcome measure as performance indicator is a mis-demeanor. He feels that outcome measures only focus on the impact of therapy but do not consider lifestyle and socio-economic factors (as vocational rehabilitation services do).

Donabedian developed a model in the 1960's that provided a framework for examining healthcare services and evaluating quality of healthcare that is still widely recognised and referred to. The model has three categories: structure (the context in which healthcare is delivered), process (the sum of all actions that make up healthcare) and outcome (the effects of healthcare on patients and relevant communities)⁵. Donabedian developed his

model to be flexible enough for application in diverse healthcare settings and at various levels of service delivery¹². He perceived healthcare as consisting of technical tasks, interpersonal exchange and amenities of care (the circumstances under which the task is performed) and that the quality of healthcare in practice was the product of these factors. He felt that every form of interaction in a healthcare setting is "the measure of the humanity and dignity of us all"^{14,24}. This resonates well with action research methodology and the service occupational therapists render within the field of vocational rehabilitation.

Occupational therapists working in Gauteng's public healthcare identified a need to implement standards for the profession in public healthcare and developed an audit tool for this purpose¹⁶, of which a section was published in 2006. The Gauteng Department of Health's 'Allied Health Care Professionals Standards and Audit Tools (Hospital)' is for use in occupational therapy, physiotherapy, speech therapy and audiology and social work professions and acknowledges Donabedian's work. It comprises four audit tools; the environment, equipment and facilities audit tool; the client record keeping tool; the management audit tool; and the client satisfaction audit tool. The Head of Departments are meant to ensure that these audits are done at least once a year, summarised, compliance and non-compliance areas identified with a work plan attached and submitted to a profession specific quality assurance coordinator in head office. At present there is a 75% submission compliance rate. The results of the audits are used as a management tool to improve service delivery. To ensure compliance, the head office staff conduct random spot clinical audits¹⁵.

Several authors in South African literature provide valuable contributions to vocational rehabilitation services in terms of professional competences, quality and standards of service. Buys⁷ identified 16 professional competencies required by occupational therapists who deliver vocational rehabilitation services in South Africa. Beukes³, developed a standard statement and measurement criteria for an effective and efficient occupational therapy service, regarding the assessment of work abilities (vocational assessment). Robinson²⁵ notes that setting standards from within a profession is fundamentally positive, as standards will be relevant, achievable and realistic if set by those who understand the challenge and emphasis of the profession. She also notes that occupational therapists often work in relative isolation both in government and in private practice and that these practitioners may find it more difficult to implement quality measurement, improvement or management techniques.

'Batho Pele' (People First) is a South Africa initiative to improve the quality, accessibility, efficiency and accountability of service delivery in the public sector²⁶. The National Health Insurance (NHI) was launched to ensure that everyone living in South Africa gets access to quality healthcare, regardless of their socio-economic status²⁷. The research method and aim of this study are in line with these initiatives.

METHOD

Study design

Action research phenomenology forms the basis of this study and a multi-collaborative and interpretivist action research approach was used^{28,29}. Action research is practice based and done by people who want to find out more about their practice with the view of improving it³⁰. It places practitioners at the center of an enquiry³¹ allowing them to be fellow researchers and participants, learning from their experiences and producing knowledge that is relevant to their practice situations and to which they can relate³². Action research is an emancipatory intervention that brings about shared responsibility and open accountability³³. Reason and Bradbury²⁴ and Reason³⁴ offer three strategies of action research practice: first-person action research which is a personal inquiry approach, second-person action research which is an ability to inquire face-to-face with others into issues of mutual concern and third-person practice which aims to extend the research to a wider community of enquiry. They suggest



that the most compelling and enduring kind of action research will engage all three strategies, as this study does.

Critical reflection is an essential component of action research³⁶. It brings about the conscious questioning of practice³⁵, a collective analysis of action³⁷ and allows enquiry that leads to learning³². In so doing it contributes to personal and professional development and improvement³⁰. This critical reflection can be done individually or as a group with the distinguishing factor being to change practice³⁸. McNiff^{30,33} notes that "Action researchers are real-life people who wish to investigate their practices and offer explanations for what they are doing so they can show how they hold themselves publicly accountable".

Population

Dick¹¹ uses the term 'stakeholders' in action research to describe the population. He describes stakeholders as persons who have a stake in a programme and who are affected by or able to affect practical change.

In this research the first author, applying first-person action research, researched and designed a concept profile tool (see step 1).

There were two developing stakeholders: The first and fourth authors, using second-person action research, developed the profile tool through several action research cycles at four academic hospitals in Gauteng where vocational rehabilitation services are offered. They were also the field researchers and acted as catalysts, informed observers³² and data collectors throughout the research process (see step 2).

There were 127 refining-stakeholders involved as third-person researchers. They were occupational therapists working in Gauteng's public healthcare, who were interested in and/or offered vocational rehabilitation, were invited to host workshops called 'Profiling a Vocational Rehabilitation Service' within their practices. The first author presented three workshops as action research cycles and the tool was refined during each cycle. (see step 3).

There were two groups of validation stakeholders:

The refined profile tool and the service profiles that resulted from the developmental and refining cycles were presented to the vocational rehabilitation task team (VRTT) of Gauteng. They critically reflected on the tool and provided participant validation of the practice profiles (see step 4).

A group of 39 pre-selected vocational rehabilitation experts were identified by the authors for use as 'critical friends'. In action research the concept of 'critical friends' is used to indicate stakeholders who are invested in the field of knowledge and can offer objective and expert feedback³⁹. The criteria for inclusion into this group were occupational therapists with previous experience of working in South Africa's public healthcare and current experience of more than five years of working in and/or teaching vocational rehabilitation. The refined profile tool was sent to them for critical reflection (see step 4).

All participants were informed verbally and by a written pamphlet that they could keep, that this project was part of a larger PhD study. How this project fitted into the study was explained, how the generated knowledge will be used was discussed and consent forms were signed. The PhD research had university and hospital clearance.

Data gathering

Throughout the research, data were gathered in the form of field notes, reflective journaling, critical reflection,

written and verbal feedback from stakeholders and experts.

The process

There were five steps to the research: the designing, the development, the refining, the validation and the dissemination of the profile tool.

Step 1: (See Figure 1) The designing of the profile tool was done by the first author, engaging in first-person action research. A systematic search and study of literature relevant to objective observation of occupational therapy and vocational rehabilitation services was done. This included; audits, models, frameworks and instruments concerned with quality control, practice standards, service and outcome measurement tools and performance indicators. Four sources as discussed above were identified^{3,13,15,17} to be relevant to the context and methodology. Donabedian's framework¹³ was chosen to guide the systematic plotting of all elements of occupational therapy vocational rehabilitation services within the three categories of structure, process and outcome. The elements were compiled based on information from competencies identified by Buys¹⁷; suggestions by Beukes³; the Gauteng Department of Health's standards and audit tool¹⁵; and the first author's 20 years' experience in the field of vocational rehabilitation. Confirmation and expansion of these elements were supplemented through additional (verbal and electronic) discussions with Buys, Beukes, some of the authors of the Gauteng standards and audit tool and in consultation with colleagues of the first author who have experience in vocational rehabilitation. A concept profile tool with three parts, namely the structure, the process and an outcome was designed.

Continuous first-person action research cycles were used throughout the designing stage. The first author reflected on the need and circumstances for the use of a profile tool, all available information was gathered and considered; a draft tool was drawn up and critically reflected on through continuous action research cycles until the tool was to the satisfaction of the first author. Reflective journaling was done throughout this stage. In the final cycle of the design step journaling guided planning, of the next step of the tool development.

Step 2: The profile tool was developed during four action research cycles. The first and fourth author, using second-person action research, put the concept profile tool through an action

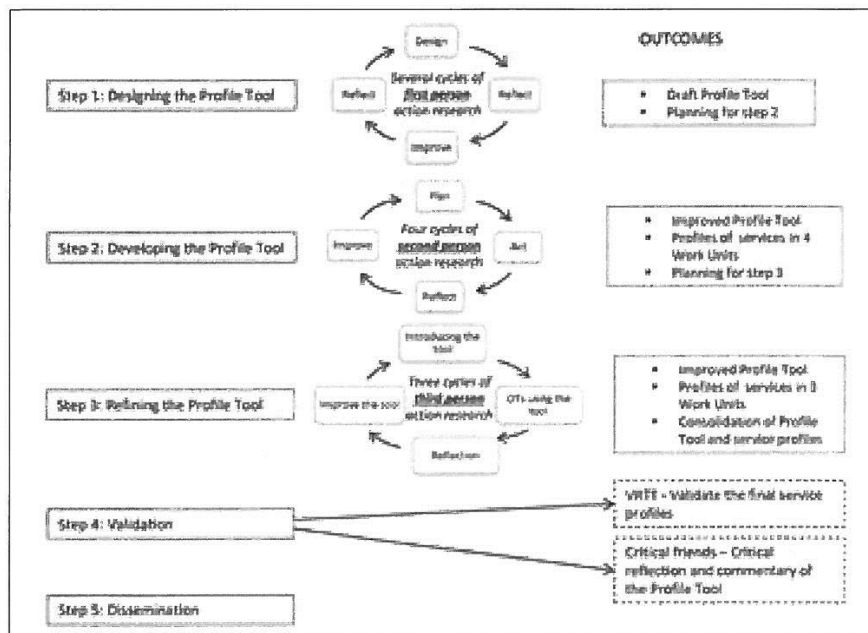


Figure 1: A graphical representation of the five research steps



research cycle at each of the four academic hospitals in Gauteng that offer vocational rehabilitation services.

The authors planned unannounced visits during working hours, to the four academic hospitals in Gauteng who had occupational therapy departments with work units. Working in the area where the vocational rehabilitation services were offered the tool was used separately by each author to profile the service. Field notes were kept. Reflective journaling done separately by each author was completed post profiling, while still on the premises. This was followed by a face-to-face critical reflection, discussing their findings and experiences with each other. Specific attention was paid to the design and content of the tool, improving and changing it for the next visit. The final step of the visit was to compile an agreed upon profile of the visited vocational rehabilitation service. In this way their collective experience, skills and knowledge contributed towards improving the tool and compiling a profile of the vocational rehabilitation service offered.

After each cycle the first author studied the field notes and reflective journals, made the necessary changes to the profile tool, sorted, saved and stored all data. Additional ideas or comments between the visits were shared electronically between the first and fourth authors and changes incorporated as necessary. Each new cycle thus started with an improved profile tool.

Step 3: To refine the profile tool a workshop introducing the profile tool with a practical session of applying and critically reflecting on it, was planned and presented by the first author. The workshop was for any clinical occupational therapists interested in vocational rehabilitation. The third-person research aims of the workshops were to incorporate the wider community of clinical occupational therapy practitioners in Gauteng's public healthcare as partners in the development of the tool and to expand and authenticate the vocational rehabilitation service profiles that emerged from the developmental step.

An invitation to host the workshop within their practices was extended to the four academic hospitals in Gauteng who had been used for the development of the profile tool. They were requested to invite all occupational therapists in their departments and surrounding hospitals and clinics that referred clients and made use of the specialised vocational rehabilitation equipment and services offered at the hosting hospital.

Each workshop was presented in the form of an action cycle. Firstly, the profile tool was introduced by providing the background and contextual information. Participants then used the profile tool, applying it specifically to their vocational rehabilitation services, while maintaining an open dialogue on an individual and/or group basis with the presenter. They then divided into small groups to critically reflect and discuss the design and use of the tool as well as the service profiles that were generated by the use of the tool. They were asked to consider how its use and results could impact on their vocational rehabilitation practices. Verbal feedback from each group was provided. The workshop concluded with anonymous individual critical reflection on the workshop and the tool forms.

The expected outcome of the workshop was to enable clinical occupational therapists to profile their vocational rehabilitation services which holds practical, theoretical and research value. Implementing a comprehensive and contextually relevant profile tool that effectively indicates what a vocational rehabilitation service looks like, and/or should look like, would be helpful to occupational therapists that are offering, or wish to offer, vocational rehabilitation services in public healthcare. The profile tool could also be used for research, to assist with planning and policy making and quality management of occupational therapy vocational rehabilitation services. The workshop was registered and accredited with the Health Professions Council of South Africa's (HPCSA) continuing professional development units.

After each workshop the first author analysed and sorted the contributions, feedback and information. The tool was revised and improved before presentation at the next workshops. Information

was added to expand the vocational rehabilitation service profiles of the hospitals that were developed during step two. These profiles were used in the next step.

Step 4: The validation of the profile tool was done in two sections.

The vocational rehabilitation service profiles that emerged from the development and refining steps of the research were presented to the VRTT for validation, by the first and fourth authors. The therapist(s) received the profile of the hospital she/he was working in and was given 30 minutes to study it and ask questions if necessary. The instruction was to provide comments and participant validation of the profile handed to them. This was collected in the form of written comments, reflective journaling, verbal interaction with the primary and/or secondary author and general discussion in the group.

To further validate and enrich the credibility of the profile tool it was sent for objective critical appraisal and expert opinion to a panel of pre-selected 'critical friends'. The selection criteria for these critical friends were that they should be South African occupational therapists that had experience of working in public healthcare and had more than five years of current experience in vocational rehabilitation. The experts were sent electronic formats of the tool and asked to consider it, use it and comment on it within two weeks.

All data from this step were considered, reflected on and selected changes were made to the tool.

Step 5: The final step of dissemination of the tool was undertaken. The VRTT decided that the profile tool would be taught at the annual vocational rehabilitation orientation workshop, an event attended by newly appointed occupational therapists to Gauteng's public healthcare. The first author made an electronic format of the tool available to share with any interested occupational therapists working in vocational rehabilitation. The fourth author introduced the tool to all occupational therapists working in Gauteng public healthcare through official public healthcare forums. The development process and tool content are intended for publication in the form of a scientific paper to a South African peer reviewed journal with national and international circulation.

Data analysis

The field notes, reflective journaling, written and verbal feedback from the workshops and from the experts were systematically analysed by the researcher through thematic and discourse analysis. In keeping with good research practice and in support of action research principles^{32,33}, thematic analysis of the raw data was manually analysed immediately after gathering. Data were summarised and categorised. These thematic summaries influenced the next action research phase.

'Authentic voices'³⁴ used in this article will be indicated as FN for field notes, RJ for reflective journaling, CR for critical reflection, WFS for written feedback from stakeholders, VFS for verbal feedback from stakeholders, WFE for written feedback from experts and VFE for verbal feedback from experts acting as critical friends.

RESULTS

In step one the tool was designed using first-person action research strategy. Through several action research cycles the first author continuously reflected on her actions and incorporated new information into the development of the concept profile tool.

"This tool must have a variety of data capturing methods like listing, interviews, sliding scales, photos. Like Donabedian says³⁵ - variety should give better validity." (RJ)

"I wish I had something like this when I was a young OT. I would have gotten the bigger picture instead of getting bogged down with the small stuff," and "it (the tool) must be easy to understand and use so the most inexperienced occupational therapist can use and benefit from it." (RJ)

During step one a technical action research process directed the initial design of the tool. The first author was instrumental in





designing the draft format of the tool and prepared it for the action research process engaged in during step two.

In step two the visits to vocational rehabilitation services at four academic hospitals and the use of the tool in these services brought development of the tool through using second-person action research strategies. Areas identified for changes related to the duplication of data gathered; ambiguous instructions; and time concerns. Therefore the tool had to be simplified, shortened and language and grammatical errors addressed. The time it took to administer the profile tool depended on the size and extent of the vocational rehabilitation service as well as familiarity with the tool. The times varied between two to five hours. The action research cycles of implementing the tool and reflecting on it provided a profile of each service. Simultaneously the profile tool emerged as a standardised instrument.

"What we have with this tool is the ideal vocational rehabilitation service. It will be nice to use as a measurement in future." (FN)

"We must not immobilise a service with paperwork. The core business of therapists is to see patients." (RJ)

It was decided to get clinical occupational therapists to use it and in so doing incorporate their feedback into the development of the tool and existing profiles. The planning of a workshop ensued; it was registered with the Health Professional Council of South Africa (HPCSA) as an approved continued professional development (CPD) activity and marketed to occupational therapists at the four academic hospitals.

The workshops offered in step three were to refine the tool and include additional aspects to the profile, using third-person action research strategy. Three of the four academic hospitals in Gauteng who had been used for the development of the profile tool accepted the invitation. The fourth hospital declined the invitation, stating that their occupational therapists were not interested in vocational rehabilitation.

Overall the feedback from therapists participating in the workshops was that they enjoyed an opportunity to use the tool and apply it to their own situations. They felt this offered them the opportunity to reflect and discuss specific aspects of the service and to plan and set goals. They also enjoyed discussing their practice with the researcher and their peers, valuing the impartial feedback. The primary contribution of the workshop was that it captured an authentic picture of the challenges and concerns clinical occupational therapists on grassroots level experienced. For example:

"You cannot use part two (process profiling) if you do not know vocational rehabilitation and understand the aspect of a vocational rehabilitation service and some of us were not trained sufficiently in vocational rehabilitation." (VFS)

In step four the validation of the tool was undertaken. The profiles of the vocational rehabilitation services that emerged in step two and three were consolidated into a single profile of each hospital's vocational rehabilitation service. At a VRTT meeting occupational therapists familiar with a relevant profile contributed to the validation of its authenticity. Discussion in the group and individual written feedback showed that all profiles were accepted to be true reflections of the services being offered. The group discussion and written feedback also reflected a dimension of greater transparency in the group.

"Now that we know what the problems are we can work together to fix them and need not worry about trying to keep up a front." (VFS)

Reflection on the profile tool itself showed that they felt the first part (structure profile) is long and tedious and the second part (process profile) was more enjoyable to complete. The outcome profile instigated an animated discussion. There were strong feelings expressed regarding the absence of student training, marketing of services, research and publication.

"It is impossible to get ethical clearance to do research if you are a clinician and there is nobody to help you or give advice if you find yourself

stuck. The only way you can do research as a clinician is if you enrol for a university post grad degree or course and why should we do that! It will not affect our promotion or our salary and nobody has time." (VFS)

"You put hours and hours of work into it (writing a journal article) and then it's not good enough. We don't really know what we are doing anyway. It is easier to write for the FOCUS (newsletter) but can that be considered publication?" (VFS)

"This is just about it. This shows exactly what our problem is; we have the motivation but not the know-how." (VFS)

Very few changes were suggested for the tool content and layout. It appeared as if the group lacked confidence and expressed that their opinions on the tool might not be "good enough". They suggested that it be sent to 'academics' to take a look at it. Suggestions of sending it to a panel of experts were unanimously supported.

The tool was sent to 39 critical friends for critical appraisal and expert opinion. Thirteen of them responded within the requested timeframe. Changes suggested were grammatical in nature and no shortfalls were identified. A critical friend in a private vocational rehabilitation practice noted: *"It makes you realise that in private practice we run assessment units and not a vocational rehabilitation service."* (WFE)

A critical friend in a public healthcare management position from another province indicated:

"We need this kind of tool to critically evaluate and improve our (vocational rehabilitation) services in public healthcare. Thank you to everyone in Gauteng for all the hard work and sharing it with us."

The fifth and final step of dissemination then followed. As a result interest and enquiries into the tool were received from the provinces of KwaZulu Natal, Free State and the Western Cape.

Summary of the content of the finalised profile tool

The Vocational Rehabilitation Profile Tool is written in easy to understand English so that therapists of all levels of experience could find it accessible and useful. It consists of four sections: an introduction, structure profiling, process profiling and outcome profiling. The time it takes to complete the tool will be influenced by the size of the work practice. It should take two to five hours to complete the tool for the first time. Thereafter an occupational therapist familiar with the tool and the work unit would take less than an hour to update and expand it.

The introductory section is four pages long. It includes a cover letter written in a personal tone suggesting why occupational therapists might consider using the profile tool to reflect on and enhance their vocational rehabilitation practices. They are asked to use the tool and send suggestions, ideas and questions to the author so that the tool can continue evolving and maintain relevance. Contact details for such feedback are provided. Background and general information on the research and reason for the development of the tool is given. A discussion on how to use the tool and suggestions on what to do with the information generated from the profile follows. It concludes with references, recommended reading and the last review date.

The structure profiling section (see Table 1) enquires about the context within which vocational rehabilitation services are offered. These include resources available, accessibility to the service, appearance of the area, tests tools and activities available, staff, managerial and maintenance support for the service.

The process profiling section (see Figure 2) enquires about the occupational therapy practice of vocational rehabilitation and the scope of the service occupational therapists offered. It works on the premise that in their vocational rehabilitation service, occupational therapists offer prevention of injury and awareness of good practice programmes; screening and assessment of functional ability; various forms of intervention; involvement in the placement of persons with injuries/disabilities into open, sheltered, protected and other alternatives in the labour market; and offer follow-up services. Investigation of these services is done in the form of sliding scales and comments.



Table I: A section from the Structure Profiling – An investigation of resources available to the vocational rehabilitation service

6. Resources to support the Vocational Rehabilitation Service	
Are the following resources available to the Vocational Rehabilitation Service?	Describe and discuss
Social work services (For referral of social intervention, grants etc.)	
Referral resources for skills development, (Training facilities etc.)	
Open labour market placement support (Placement or personnel agencies etc.)	
Alternative placement options and support. (Sheltered/protected workshops, self-employment.)	
Motor vehicle driving assessment and adaptations/customisation.	
Other	

Table II: A section from the Outcome Profiling – An investigation of student training in the vocational rehabilitation service

3. Student training	
Are there any undergraduates and/or post-graduate students being trained in the Vocational Rehabilitation Services? Yes/No	
If 'Yes':	Answers and Comments
From which institution? How many are undergraduates and how many are post-graduates?	
How many students does the service have in a year?	
How often does the service have students in a year?	
How long are they here at a time?	
Who supervises them?	
If 'No': Why not?	

3. Intervention

3.1 Are work visits being done as part of the vocational rehabilitation service?

0 ----- 10

None is being done Excellent and comprehensive service.

3.2 Are there work-hardening, work-readiness, conditioning and return to work programs offered?

0 ----- 10

None is being done Excellent and comprehensive services

3.3 Are there job-seeker programs and related support?

0 ----- 10

None is offered Excellent and comprehensive programs exists

3.4 Are there pre-vocational skills training programs and support offered?

0 ----- 10

No such programs exists Excellent and comprehensive programs exists

3.5 Are occupational therapists trained, mentored and supported in such programs?

0 ----- 10

No training/ mentoring support is provided Excellent comprehensive training/mentoring/ support exists

Discuss and describe your opinions:

Figure 2: A section from the Process Profiling – An investigation of the intervention aspect of the vocational rehabilitation service

The outcome profiling section (see Table 11) enquires about the effect of the services offered. Service outcomes that were identified to be indicators of a matured and comprehensive occupational therapy vocational rehabilitation service are: general awareness of

the services, user satisfaction, student training, research, publication, statistics and future plans of the service and auto-reputation. Auto-reputation being a form of self-evaluation described by Donabedian¹².

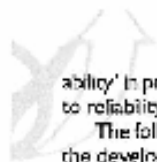
DISCUSSION

The notion of profiling is to record and analyse the current status of services in a non-judgmental, objective manner. Donabedian suggests that in studies of quality one needs to ask "What goes on here?" rather than "What is wrong?"^{13,72}. The profile tool offers public healthcare occupational therapy vocational rehabilitation practitioners a structured and systematic observation of their practice. It gives them information that they gather themselves to critically reflect on their practices to manage, plan and improve their vocational rehabilitation service, using a tool they were instrumental in developing. In addition the tool and resulting profiles will be used in further research aimed at improving vocational rehabilitation services in these practices. It will also be used to measure the effectiveness of the research intervention at the conclusion of the research.

In action research the researcher is considered an equal partner within a team, contributing knowledge and/or experience and acting as a catalyst in addressing practical problems³⁵. Action research is also essentially practitioner and practice-based research³⁵ and focuses on change and participation as an interactive form of knowledge development⁴³. The cyclical process of continuous and structured planning, action and reflection characterise action research^{35,43}. Incorporating these elements in the design, development and refining of the profile tool was brought about in a manner sensitive to context and perspectives of those directly involved²⁸. In addition the potential benefits of participant empowerment and accountability⁴⁴ were incorporated.

As with all tools the question of standardisation and validation arises²⁵. Literature showed that 'standardisation' is a term generically used by occupational therapists when discussing validity and reliability features of test and tools. Shenton⁴⁵ describes the use of all the above terms as 'positivist terminology' and propagates the use of Guba's constructs and terminology⁴⁶ for discussions of rigour in qualitative research (such as action research). Guba addresses criteria that ensure trustworthiness/ rigour similar to that pursued by positivists but compatible to qualitative research⁴⁶. This paper chooses to align itself with this and use the word 'trustworthiness' to indicate the generic use of standardisation, 'credibility' in preference to internal validity, 'transfer-





ability' in preference to external validity, 'dependability' in preference to reliability and 'conformability' in preference to objectivity²⁵.

The following criteria of trustworthiness were addressed during the development of the profile tool:

The *credibility of the tool* (i.e. Does the profile tool measure/show what it is intended to show?) was considered and addressed. Participant validation of the ensuing profiles was done. A variety of data collection methods and overlapping methods and data sources were used with the generating of the tool and designed in the administration of the tool itself. The intention was to obtain peer scrutiny through critical appraisal of experts and publication in a peer reviewed journal. The background, experience and qualifications of the authors qualify them as experienced practitioners in occupational therapy, vocational rehabilitation and tool development.

The *transferability and generalisability of the tool* (i.e. To what degree can the tool be applied to other situations?) is affected by the methodology used. The critique that the knowledge generated by action research is generalisable only within the context of the research population²⁶ is noted by the authors. The tool is restricted for use in vocational rehabilitation practices for occupational therapists. Within this practice context the authors believe that the tool is generic enough to hold potential for use in vocational rehabilitation services outside of the public healthcare setting in which it was developed. The dissemination of the findings of this research was done within the South African context as it could be of interest to occupational therapists who are interested in vocational rehabilitation or practice in similar contexts. The process of generating the profile tool could be useful at local or international level for those who wish to apply the ideas and findings within similar contexts or to replicate the study.

The *dependability of the tool* (i.e. Would similar results be found if it was used by different occupational therapists?) was attended to by using simplified instructions and offering workshops where therapists were introduced and instructed in tool use. The tool went through design, development and refinement phases and was practically implemented by a variety of therapists during several action research cycles. Participant validation of the resulting profiles showed no dispute of the resulting practice profile.

The *conformability of the tool* (i.e. What efforts towards objectivity and restriction of researcher bias are in place?) was attended to through purposeful transparency. Critical reflection is a key element that defines action research²⁷ and an openness to feedback from 'critical friends' enhances the conformability of the research²⁸. In this research it was applied throughout the action research cycles and enhanced with participant validation, constantly inviting peer review and experts' critical appraisal. The knowledge generated through action research has to be fed back to the participants²⁹ and made public as this constitutes its characteristics of being scrutinisable³⁰ which is encapsulated in the dissemination of the development of the tool.

The profile tool has not been in use outside of the developmental stage and the authors acknowledge that many of its trustworthiness characteristics will only come to light once it is being used extensively and in different contexts. Use in different contexts would stimulate further research and strategies aimed at testing the trustworthiness.

We do believe that although developed within a public healthcare context and for specific research purposes it has the potential for more extensive use. The authors would like to encourage colleagues to use the profile tool, test it, improve it and expand its usefulness by sharing their findings on public forums. The hope is that eventually the tool can be used in vocational rehabilitation services to help therapists do quality management and provide information for planning and policy making. Tool dissemination could also raise an awareness of the scope of vocational rehabilitation services that occupational therapists can offer as so many practices are doing only the assessment aspect of vocational rehabilitation³¹.

Donsbedien has contributed significantly to strategies for quality of healthcare but his work is not without criticism. Carayon et al³² and Coyle and Bartles³³ caution that using the sequential progression

from structure to process to outcome is too linear a framework and limits the understanding of how the three aspects influence each other. They propose that users acquire an understanding of how the three aspects of service influence and interact with each other and with such consideration use them in varying orders as circumstances dictate. They also criticise the model for failing to incorporate antecedent characteristics e.g. environmental factors, cultural, belief and attitudinal influences. All of which are important precursors to quality, especially in a South African situation.

CONCLUSION

The ultimate aim of healthcare work is to enhance the quality of provision for the users³⁴. Managing and addressing the quality of service in public healthcare is an international and ongoing concern³⁵. In South Africa there are accreditation committees, national care standards, audits and guidelines in place to address the quality of service in public healthcare^{35,36}. All of them were developed and function externally to the practice setting they hope to improve and are not service specific. The authors have the experience and are of the opinion that it is very difficult to address the standard of a service by 'remote control'. By sharing the process of development of a tool that profiles a vocational rehabilitation service using action research allowing scrutiny, peer review and inviting feedback, authenticity is demonstrated which are important aspects of rigour in action research^{36,37}.

Action research allowed the practitioners offering the service to be part of the process of developing a tool they can use to profile the services they offer. Being able to profile a vocational rehabilitation service holds practical, theoretical and research benefits. Having a comprehensive and contextually relevant tool that effectively indicates what a vocational rehabilitation service looks like, and/or should look like, will be helpful to occupational therapists that are offering, or wish to offer, vocational rehabilitation services in public healthcare as well as in private practices. This allows them to set goals and develop their practices in a systematic and mindful manner.

Donsbedien, citing various studies to support his opinion, states that people are good judges of the effectiveness of the organisations in which they work³⁸ and the services they render. Allowing occupational therapists to measure their own services within certain guided constructs brings about the action research benefits of identifying and owning the problem³² which in most cases leads to the motivation to look for solutions of practice problems.

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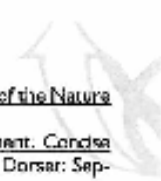
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The development of the VRPPT, in 2013, took place in Gauteng's four tertiary public healthcare hospitals and as part of the development process profiles were developed of the vocational rehabilitation services offered there. These profiles showed a structure ranking range with Hospital A being the best equipped, followed by Hospital C, then Hospital B, with Hospital D not having any form of vocational rehabilitation structure. The services offered could also be ranked, with only Hospital B offering comprehensive vocational rehabilitation, whilst Hospitals A, C and D offered only screening and occasional assessment services. The outcome profiles indicated therapists were not involved in research or publication based on their vocational rehabilitation practice, despite being linked to academic institutions, and that only Hospital B was involved, to a minimal extent, in student training.

3.5.2 The views of Gauteng's public healthcare clinicians and their Heads of Department on the vocational rehabilitation services they offered

The views of clinicians and heads of departments (HoD) of their vocational rehabilitation services are the only observational approach not available in journal article format. It is presented in a typical action research cycle process with results, discussion and conclusion included within the cycle stages. The first stage was the collaborative buy-in stage, followed by the planning of the process, the action stage shows the gathering and analysis of the results, the reflection stage is the discussion of the results and concludes this observational approach.

3.5.2.1 The collaborative buy-in

Using semi-structured interviews to gather the views of public healthcare clinicians and their HoDs was discussed with the Vocational Rehabilitation Task Team (VRTT), who sanctioned the concept. It was decided to conduct the interviews at the four tertiary public healthcare hospitals in Gauteng, as this was where the most vocational rehabilitation tests and equipment were and these were the main points of referral for all vocational rehabilitation services. These hospitals are henceforth indicated as Hospital A, B, C and D.

The researcher extended an invitation to the VRTT to become part of the data gathering and analysing for this observational approach. This was declined by all members as they felt uncomfortable interviewing their peers about clinical services. The researcher was requested to gather the data as an independent representative of the VRTT and she conceded. The researcher then contacted the heads of department, explained the reason, aim and outcome of the semi-structured interviews and made mutually acceptable appointments.

3.5.2.2 Planning of the semi-structured interviews

The researcher planned the content of the semi-structured interviews. The nature of the approach was to be inductive, allowing any form of information to emerge unrestricted and limiting researcher bias as far as possible (Stein et al., 2013). The interviews were planned using the question design strategy discussed by Dick (2013a); 'What' and 'why' questions were focused on. 'What' questions covered the situation, consequence and intended actions and from 'why' questions emerged the assumptions, and a combination of open-ended and probing questions were decided on. Two framing questions were formulated and multiple options of probing questions were prepared for possible use.

The interviews were audio recorded and the necessary ethical procedures planned. An email, sent to interviewees 48 hours before the interview, contained the following: a reminder of the semi-structured interview appointment, general information of the PhD study, a consent form addressing the research and the audio recording for participants to consider and sign, the aim of the interviews, what would be done with the interview content and who would have access to the interview results, the two framing questions were also given for them to consider and prepare their thoughts for the interview.

3.5.2.3 Actions and results of the semi-structured interviews

Cognisant of the fact she was an outsider investigating insider practice performance, the researcher made efforts to keep the interviews as non-threatening as possible. The interviews were purposefully held in the interviewee's places of work. The audio recorder was demonstrated to the participants, who were shown how to switch it off and given permission to do so at any stage during the interview should they feel it necessary. The recorder was then placed out of view, to prevent unnerving the interviewees, but within reach. With the exception of Hospital C, where the interviewee was felt to be evasive and apprehensive throughout the interview, all interviewees seemed at ease during the interviews and comfortable with the audio equipment.

Participants in the interviews ranged from three, at Hospitals B and D, to one at Hospital C. The HoD was a participant in all the interviews. At Hospital C, the four therapists who were reported to be involved with vocational rehabilitation services at this hospital had all taken leave, despite prior knowledge of the interview, which was only discovered when the researcher arrived for the interview. The time spent in the interviews ranged from 12 minutes at Hospital C to 60 minutes at Hospital A.

All interviews were conducted in English. The interview began with a confirmation of the aim of the interview and the first framing question. Conversation was allowed to flow freely with occasional

probing questions for depth or focus of content. Participant validation was used throughout in the form of a questioning statement, for example, "So you are saying ...". The interviews were concluded when repetition of previous ideas or statements began to occur, or the interviewees indicated they had nothing more to say.

All interviewees acknowledged their vocational rehabilitation services were inadequate. Predominantly they were all doing screening and assessments and only Hospital B offered a form of intervention. With the exception of Hospital D, they all reported having adequate equipment and other resources to do vocational rehabilitation. They all felt conducting research, supervising students and publishing was not a priority and several statements indicated problematic relations with academic institutions with which they were affiliated.

"We do only assessment and screening and then nothing else is possible. We do not have time or the knowhow for students and so on."

With the exception of Hospital B, they all asked for assistance to improve their vocational rehabilitation services.

The interview at Hospital A, who was the best equipped of all the hospitals, showed two concerning discussions, one of which was calculated avoidance of vocational rehabilitation work:

"We cannot let them know we do this work (vocational rehabilitation). We will be overrun."

Several statements were indicative of burnout:

"My hands are tied." "I am fighting a losing battle."

In all interviews, staffing for vocational rehabilitation was indicated as an ongoing problem. Finding clinical occupational therapists who were interested and willing to do vocational rehabilitation and had adequate skills and experience was one problem, keeping clinicians once they acquired the necessary vocational skills was another. At Hospital A, a staffing conundrum was voiced:

"I need more therapists to do voc (vocational rehabilitation) but I have to show the stats (statistics) to get posts and I cannot show this because we cannot do the work."

None of the hospitals had goals for their vocational rehabilitation services.

"We do not have goals (laughter) we do what we have to get through every day's work load."

In all the interviews, the interviewees asked the researcher for her opinion on various vocational rehabilitation related matters. The questions and discussions ranged from specific to their departments to more general questions about vocational rehabilitation.

“Who can do vocational rehabilitation? Is it not a very specialised practice and normal occupational therapist cannot do it? Like you need a diploma or something to be able to do it and then you have to go to court all the time?”

3.5.2.4 Reflection and discussion of the semi-structured interview results

Immediately after each semi-structured interview the researcher spent time reflecting on the experience. Reflections were journaled and used to improve the researcher’s skill as an interviewer and to enrich the discussion of the results. The audio recordings of the interviews were transcribed by the researcher and analysis done.

The researcher felt the different hospitals response and participation in the semi-structured interviews was in itself an indicator of the status of vocational rehabilitation at that hospital. With the exception of Hospitals A and B, no clinicians experienced in doing vocational rehabilitation were present at the interviews. The researcher felt the absence of such therapists in the interview at Hospital C could be indicative of avoidance or lack of interest, all of which would have negative impact on vocational rehabilitation services within a department. The short interview at Hospital C was due to lack of vocational rehabilitation knowledge and substance. The short interview at Hospital D was due to the absence of a work unit, vocational rehabilitation tools and equipment and the restrictions this placed on them.

With the exception of Hospital D, all the hospitals had adequate equipment and space to offer comprehensive vocational rehabilitation services. Staffing was the greatest problem as none had therapists designated to do only vocational rehabilitation. Only two hospitals had therapists who had vocational rehabilitation experience and both of these had to do managerial and clinical work in addition to vocational rehabilitation. They all had close links with academic institutions that were training occupational therapists, but there were collaboration problems.

The questions asked by the interviewees of the researcher indicated a general lack of knowledge and misinformation about vocational rehabilitation. There were also no standardised vocational rehabilitation goals or approaches to the service.

3.5.3 Public healthcare users’ observations of vocational rehabilitation

The collaborative research team now had profiles of the vocational rehabilitation services offered in Gauteng and interviews had been conducted with clinicians offering vocational rehabilitation. The most important observation of a healthcare service, that of the users of the service (Donabedian, 1992), was still needed.

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Convergent Interviews with Public Healthcare Users: Their Views on Occupational Therapy Vocational Rehabilitation Services in South Africa.

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Abstract

Background: Occupational therapy clinicians working in South Africa's public healthcare had unsubstantiated views on what users thought about their vocational rehabilitation services. Reliable information is important in client-centered practice and in the assessment of vocational rehabilitation service quality.

Objective: Clinical occupational therapists used the convergent interviewing technique to explore public healthcare users' views of vocational rehabilitation services in their practices.

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Method: An Action Learning Action Research (ALAR) approach was used. Occupational therapy clinicians, at three public healthcare hospitals used convergent interviewing to conduct interviews with users of their vocational rehabilitation services.

Results: The majority (96%) of healthcare users interviewed were not aware that occupational therapists offered vocational rehabilitation services. The convergent interview technique allowed continued unrestricted discussion of the topic and provided evidence that public healthcare users had significant concerns about their work. Critical reflection of the interview experience and technique indicated therapists were in favour of using the convergent interviewing technique with their clients as it was natural and efficient.

Conclusion: Establishing healthcare users' views of a service has multiple values, but as clinicians it is meaningless unless it is employed to pursue the welfare of those who provided the views. Convergent interviewing was a valuable technique for occupational therapy clinicians to incorporate users' views of their services into service development.

Keywords: public healthcare, quality assurance, occupational therapy, vocational rehabilitation, action learning and action research.

Introduction

In the South African public healthcare system specialized services like vocational rehabilitation are often an inherent component within the range of services offered by occupational therapists. Service delivery is complicated by high staff turnover and a yearly influx of newly graduated community service occupational therapists [1]; making the quality of vocational rehabilitation services offered a concern [2]. A collaborative research team in the Gauteng Province of South Africa had been addressing self-identified gaps in the knowledge, skills and utilization of equipment available for occupational therapists over the past 36 months as part of an action research and action learning (ALAR) project. The research team consisted of a PhD candidate, an outsider to public healthcare, who had joined a pre-existing insider group, and the Vocational Rehabilitation Task Team (VRTT) to transform vocational rehabilitation services in Gauteng, a South African province, public healthcare.

The evolving nature and cooperative processes of ALAR ensured that the VRTT included occupational therapy clinicians and clients (who are referred to as healthcare users in South Africa) within the public healthcare system. Engaging the voice of the client in action orientated research has ethical and practical significance [3]. In South Africa specifically, healthcare

clients engagement in their care is enshrined as a basic human right within the constitution [4]. Therefore, the needs and opinions of clients were a vital component for the transformation and improvement of the quality of vocational rehabilitation services. These sentiments are reflected by the work of Donabedian who noted that client's opinions of the healthcare services they receive is a necessary component of any quality assurance enterprise [5].

Globally vocational rehabilitation is usually a multi-disciplinary service provided in a distinct, equipped unit within which the occupational therapist is a well-established contributor [6]. In vocational rehabilitation the occupational therapists addresses the human occupation of work, using a knowledge of pathology, ability to analyze activity with an emphasis on occupational performance and purposeful activity [7]. The occupational therapy profession views the occupation of work as an integral part of the intervention process. [8]. Occupational therapy's vocational rehabilitation services can be offered within or outside healthcare facilities [9]. Within healthcare facilities occupational therapy assists with the transition from injury or illness to returning to optimal performance in occupations such as work [10].

In South Africa, healthcare is often the first port of call for injured or sick workers and early intervention is an important indicator for successful return to work [11]. Within a healthcare facility, occupational therapists are usually the team members that identify and promote the need to address, from the onset of intervention, the work associated aspects of care as part of the holistic management of their client's condition [12]. However, South African occupational therapy service delivery is hampered by personnel shortages; there are only 2.6 occupational therapists are employed per 100 000 people [13], and the public health system is renowned for being underfunded [14]. Moreover, South African public healthcare often serves a marginalized section of the population with multiple factors impacting on their ability to participate in paid employment [15].

Not only does South Africa have one of the highest unemployment rates in the world [16] but it also boasts 11 official languages. Providing vocational rehabilitation services to clients from a diverse range of cultural backgrounds is an additional challenge to underfunding, poor therapist-patient ratios and high staff turnover in public health care. A situation where demand surpasses the ability to address needs, inadvertently directs the focus to short-term care where high turnover is emphasized rather than quality of care. Research results have shown that the perceptions of healthcare providers and recipients often differ [17], especially when working across language, culture and education barriers, as occupational therapists in South Africa's

public healthcare often do. Collecting and reflecting authentic perceptions in an unbiased and trustworthy manner would be challenging [18] and fraught with practical and credibility problems [19] in such environments.

Public healthcare and occupational therapy services in South Africa have procedures in place to gain the opinions of users [20]. Members of the VRTT however questioned the reliability of the responses of healthcare users when using existing user opinion survey procedures. Within disenfranchised communities, where healthcare is a scarce commodity, healthcare users generally find it difficult to express dissatisfaction about healthcare services they receive [21, 22]. Such users often perceive themselves to be privileged to have access to healthcare and as the services they receive are subsidized, may feel they have no right to demand or dictate.

This attitude of healthcare users is illustrated by the following vignette from a South African public healthcare facility. During interviews in an outpatient clinic where healthcare users were sitting in queues waiting to be seen by healthcare clinicians, they were asked how they felt about the waiting periods; how they were treated by the clinic staff; and their opinion of general facilities available to them at the clinic. The interviewer, who was a young male, was reprimanded by an elderly female in the queue. She told him to stop making trouble by asking such questions, the doctors were busy people and they (the users) had nice chairs to sit in while waiting to be seen.

In a collective society, identity and meaning lie within the social collective rather than in personal agency [23]. Therapist need to respect this social ethos and actively seeking to contain and circumnavigate elements that promote historical power-relations to create a grass roots culture for enquiry [24]. Coyle [21] felt that engaging healthcare users calls for researchers to adopt strategies that are capable of exploring the complexity of opinions, as opinions are fluid, changeable and based on behavior, expectations and emotions. Dick [25], an advocate of ALAR, suggested that convergent interviewing is a technique designed for complex and uncertain situations, that would promote inclusion and empowerment of research participants. For the present enquiry both the interviewers and interviewees played an important role in developing an in-depth understanding of vocational rehabilitation within the South African health care context. Focusing on concrete experiences allows power sharing and learning from and with one another [26]. Convergent interviewing is especially applicable in healthcare as it requires attentiveness and empathic understanding from interviewers [27]. The VRTT also anticipated that the characteristics of the convergent interviewing technique could be beneficial

within the complexities associated with cross-cultural interviewing. The technique also reduces the therapist-patient power imbalance.

Distinctive features of convergent interviewing are that it empowers interviewees by encouraging them to do most of the talking and using their own words to dictate the direction of the interview [28]. Concluding the interview by asking interviewees to validate the summary, allows them ownership of the outcome [25]. This approach also resonates well with the 'Batho Pele'[29] (People First) initiative of South African public service. Donabedian captured the spirit of both by stating that "interpersonal exchange is the measure of the humanity and dignity of us all" [5] [page 248]. She envisioned *collaborative consent*, where the clinician and healthcare user actively engage, to be the most effective interaction mode for gathering users' opinions of services when addressing the quality of healthcare [5]. Ramukumba [15] supported this contention by urging South African occupational therapists to focus their approaches on meeting the most important needs of their patients which, in his experience, is to be able to work. He noted, "Undoubtedly, the inner world of the majority of the population in South Africa is clouded by poverty and poor socio-economic conditions and income generation is viewed as a priority. Despite their harsh realities, both urban and rural South African communities strive to improve their lives by seeking employment and participating in income generating projects" [30]p 397].

The aim of the present enquiry was to explore public healthcare users' views of the vocational rehabilitation services they received in occupational therapy. In keeping with the action-research methodology of the larger enquiry, clinical occupational therapists were co-opted as researchers to conduct the interviews. (Refer to Figure One. The Research Process.) Clinicians' critical reflections on their interview experiences and the interview technique itself were incorporated into the inquiry. This allowed action-learning, a natural outcome of systematic reflection on concrete actions [26], to occur.

Method

Study design

A multi-collaborative action research approach [27] underpins the ontological stance of the PhD research within which this inquiry is positioned. Good quality action-research empowers

clinicians by involvement in the processes of data collection, analysis, interpretation, and dissemination of results based on continuously stimulating self-reflections of their multi-level efforts [31]. This precipitates action learning while presenting opportunities for clinicians to embark on informed reflection of their practices and their relationship with their clients [32].

As a qualitative in-depth interview design, convergent interviewing is well suited to the early stages of an action research project especially when involving stakeholders, in this case occupational therapy clinicians, as co-researchers [33]. The technique is simple and easy to master for occupational therapists who use interviewing on a daily basis in their clinical practice [34, 35]. Convergent interviewing is regarded as a valid, reliable and rigorous process of data collection [36]. As an interview method it is time and cost effective [37], characterized by a structured process and an unstructured content [38]. Dick [25] describes it as emergent and data-driven with inbuilt sources of research rigor allowing a high level of confidence in the data and the interpretation of the findings [36, 39]. He described it as an interview procedure where data collection and analysis happen simultaneously. In a convergent interview the interviewer intervenes as little as possible, keeping the interviewee talking for as long as possible and using the content of the discourse to drive and guide the interview process. In the present study the time limitation of two weeks dictated the amount of interviews that could be completed. Data analysis and validation of the summarized conclusion is done, onsite, immediately after the interview. The researchers can then use the validated summaries to thematically analyze and draw conclusions [33].

Considerations of Trustworthiness

Lincoln and Guba's [40] criteria for the trustworthiness of an inquiry were considered throughout the various stages of this study. Confidence in the *credibility*, *transferability*, *dependability* and *confirmability* of the findings were found in the following strategies of this inquiry.

Dependability was enhanced by training insiders, i.e., clinical occupational therapists, to use the technique within their practice settings. The convergent interview technique prompted a reduction in interviewer bias as the interviewer used only the words and concepts provided by the interviewee for probing and focusing the discussion. Upon conclusion, interviewee validation of the summary was done onsite. Clinicians' critical written reflections of the interview experience as well as the content of the interview were captured immediately after each

interview. Peer-debriefing for clinicians were attended to in the larger group discussions concluding the data collection phase at the end of the two week intervention. At this time results were compared and findings checked between individual clinicians who participated in the large group discussion.

The inquiry was repeated in three similar settings and the results triangulated. An approach of purposeful transparency, the collaborative nature of the inquiry and submission to a peer reviewed journal article increased the trustworthiness.

Trustworthiness of data analysis was addressed as two of the authors, working independently of each other, transcribed the data and thematically analyzed it. They compared their interpretations and reached a consensus *Population and Sample*.

Dick [41] describes stakeholders as persons who have a stake in a project and who are affected by or are able to affect practical change. In the pursuit of transformation within a practice, local as well as expert knowledge is often harnessed for diverse insider-outsider [42] collaborations. Insider stakeholders were members of the organization where the research was conducted and outsider stakeholders joined the organization (and research collaboration) temporarily for the purposes of collaborative research [43].

For the larger action research enquiry aimed at transforming the vocational rehabilitation services of occupational therapists in Gauteng public healthcare, an insider-outsider research collaboration [44] was formed. This collaboration was between a pre-existing group, the vocational rehabilitation task team (VRTT) and a PhD candidate from the University of the Witwatersrand. The VRTT consisted of 14 occupational therapists, working in Gauteng's public healthcare sectors who were concerned with occupational therapy's vocational rehabilitation services in the province. Most of these therapists were clinicians who worked in public healthcare. The PhD candidate had been a member of the collaborative research group for a year at the time this enquiry was conducted. The VRTT decided to invite additional clinical occupational therapists onto the research team. These additional members were clinicians working in the four central hospitals in Gauteng public healthcare. They interviewed clients who visited their practices during the time of the inquiry. A total of 37 VRTT members and invited clinicians were willing to be trained to conduct convergent interviews and to take part in individual and group critical reflection.

The clients who were interviewed were the focal participants. Adults of working age who visit occupational therapy in public healthcare usually do so because they do not have the fiscal means to access private healthcare. They would be referred to occupational therapy for physical impairments or disabilities, disabling illness or psychiatric conditions that affect functional ability. These participants were conveniently sampled within the two weeks allocated to the interviews and provided informed consent.

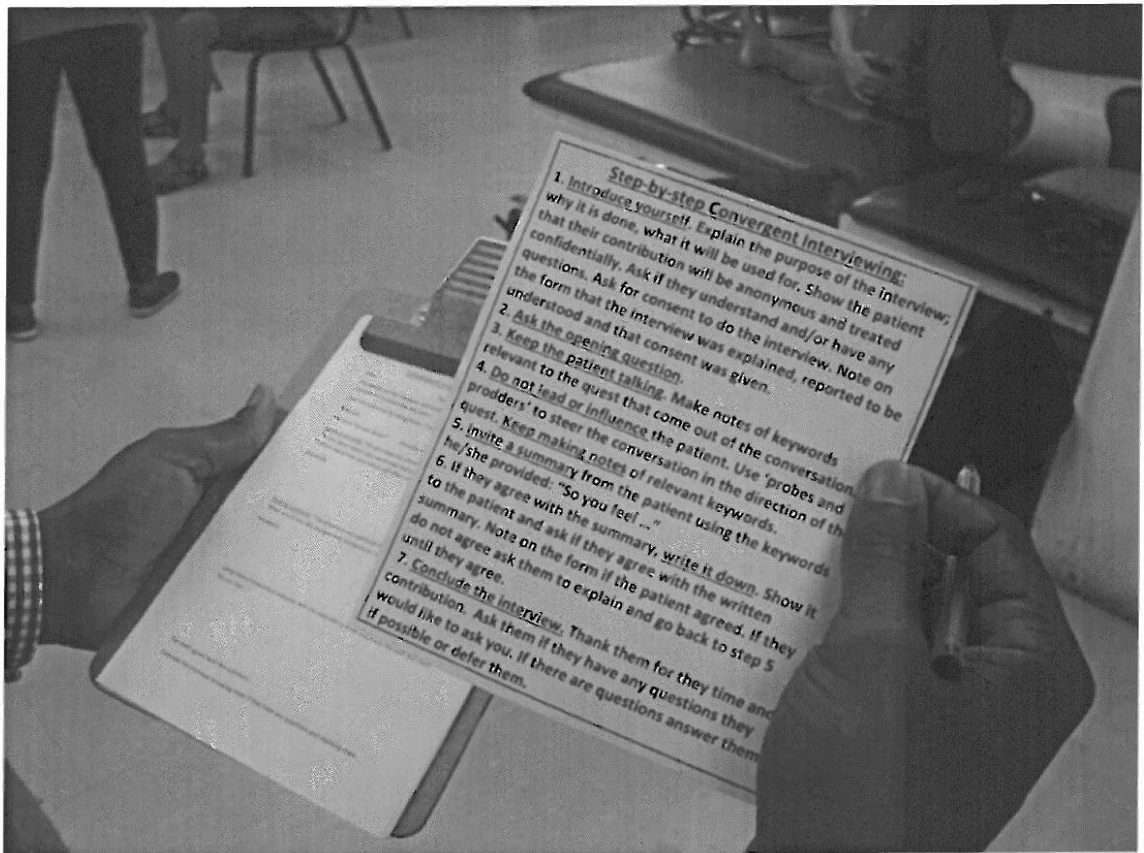
The PhD candidate, who will hereafter be referred to as the first author, and her two supervisors were 'outsider' stakeholders and everyone else involved in the research were 'insiders'. The first author acted as facilitator and mentor to healthcare clinicians during the inquiry.

Data Collection

A three-stage data-collection process was used: a collaborative planning stage, the interviews (as the data collecting and processing stage) and a dissemination stage. The dissemination stage was utilized for additional data analysis with the goal of publication. All the workshops and interviews were completed in the period October to November 2014. Five sets of data were gathered in this enquiry: (i) interviews with healthcare users; (ii) clinicians' critical reflections on the results of the individual interviews and (iii) of their interview experiences; (iv) large group discussion and debriefing; (v) and the first author's reflections.

Table 1: The process guiding data collection and analysis

Stage	Participants Involved	Process	Tools
The Collaborative Planning Stage	VRTT 1 st author	<ul style="list-style-type: none"> - Planning overall process - VRTT sanctioned support to promote the inquiry officially - An official explanation and an invitation to take part in the inquiry were sent to the four central hospitals in Gauteng Public Health. - Practical negotiation of mutually acceptable dates and booking of appropriate venues for the workshops. 	<p>Physical meetings</p> <p>Emails</p> <p>Telephonic follow-up.</p>
Data collection and Analysis Stage	<p>1st author,</p> <p>Clinical occupational therapists</p> <p>VRTT</p> <p>Public healthcare users</p>	<p><u>Instruction workshop</u> to teach clinical occupational therapists convergent interviewing:</p> <ul style="list-style-type: none"> - Explaining of the aim of the research, what would be expected of them, how their participation fitted into the larger research, what would be done with the data; - Signing consent forms; - Training in the convergent interviewing technique (including demonstrations and opportunities to practice) <p>Trained clinicians conducted as many <u>convergent interviews</u> as possible:</p> <ul style="list-style-type: none"> - Involvement of suitable healthcare users that accessed occupational therapy services during this period - Support from the first author who was available as mentor and could be contacted via email or telephonically throughout this time. <p><u>Closure workshop</u> focused on critical reflection and debriefing of the clinicians. The 1st author also followed the convergent interviewing style for this part of the process.</p> <p><u>Continuous professional development</u> (CPD): The workshops were registered as a CPD event and Clinicians received CPD points for taking part in the inquiry.</p>	<p>Written and verbal instructions to therapists of what to do in the two week cycle that included a framework for the convergent interviews:</p> <ul style="list-style-type: none"> - How to negotiate entry and introduce the interview - Potential standard opening questions: <i>Tell me about how your injury will affect your work</i> - Possible probing questions: <i>Tell me more about ...</i> <p>Reflection forms with questions to consider after each interview. For example: <i>Any thoughts or opinions on this interview?</i></p> <p>An interview kit: clip board and pen, a laminated step-by-step instruction sheet as a fieldwork reminder, interview forms to capture the content of the interviews and critical reflection forms to guide reflection of the experience.</p>
The Dissemination Stage	<p>Authors of this paper</p> <p>VRTT</p>	<ul style="list-style-type: none"> - VRTT members were invited to join the first author in analyzing and interpreting results after the closure workshop - one member, the fourth author, responded to the invitation. - The data were analyzed, processed and triangulated. - Findings were summarized and presented to the VRTT for member checking in keeping with the collaborative process. 	<p>Journal guidelines</p>



Artefact 1: Convergent interviewing fieldwork reminder.

Data analysis

At the end of an interview the clinical therapist summarized and validated the discussion with the client. S/he critically reflected on the experience and content of the interview and further validated the summary. Individual reflections of clinical occupational therapists were compared to the content of the large group debriefing discussions within the relevant hospital context. Finally the findings from the three hospitals were compared.

The first and fourth authors independently analyzed all interviews and critical reflections thematically and then reached consensus on the conclusion.

The consensus results were captured, shared at a VRTT meeting and used to inform the next action research cycle of the larger enquiry. Findings were also captured and presented for publication in a peer reviewed journal article.

Ethical considerations

The first author saw to it that research sites, clinicians' involved and healthcare users were kept anonymous and that all information was stored in sealed containers at a secure off site office space. With the exception of large group discussions, all critical reflections were anonymous.

All participation was informed and voluntary. The position of the inquiry within the larger PhD research was explained to participating clinicians, they signed consent forms and were debriefed after the two weeks of interviewing.

Participation was without remuneration, with the exception of continuing professional development points allotted to clinicians who took part in the study.

Results and Discussion

Three of the four hospitals accepted the invitation to take part in the study. Of the 37 clinical occupational therapists that started the research, 22 (59%) completed the full research process. The 22 therapists completed 46 interviews. However, only 27 interviews were considered valid as 19 had to be discarded. The reasons for discarding interviews were numerous and included: issues due to language barriers (in some cases an interpreter had been used, and in hindsight this proved to be problematic), interviews could not be completed in one uninterrupted sitting, or health conditions impacted the client's ability to provide coherent dialogue.

Table 2: Interview information

	Hospital A	Hospital B	Hospital C	Total
Therapists who indicated interest in participating in the research	10	13	14	37
Therapists who completed the full research process	7	2	13	22
Number of Convergent Interviews completed	17	13	16	46

Thematic analysis of the 27 interviews indicated that 96% (N=26/27) of healthcare users did not know occupational therapists could assist them with work related issues. One interviewee said that she knew occupational therapists offered vocational rehabilitation but felt that she had not received such intervention because she did not need it. Twenty-one interviewees (78%) asked for vocational rehabilitation assistance from occupational therapists, due to concerns about their

work. Four (15%) of the interviewed healthcare users indicated they thought social workers or doctors were supposed to help them with work related matters.

After establishing the healthcare users' opinion on vocational rehabilitation services, most of the interviews continued with a more general discussion of work related issues. Additionally, analysis of the guided individual reflections were consistent with the content of the large group discussions. No new information emerged from the large group discussions. In addition comparison of individual reflections with the large group discussion results from the three hospitals, revealed no important differences. Two themes emerged from a thematic analysis of the interview data:

1. Desperation and worry about returning to or finding work after the illness or injury
2. Despondency and resignation

These three themes are considered separately, supported by selective quotations and triangulated with the interviewers' reflections and literature.

1. *Desperation and worry about returning to or finding work after the illness or injury*

The vast majority of comments indicated that interviewees who were previously employed were very concerned about returning to work and contributing to the financial welfare of their families.

"I have to go back to work. If they tell me B you cannot work anymore my children will not eat."

Many seemed to/appeared to realize their positions could be jeopardized due to sustained impairments and that they would compete poorly with healthy applicants also desperate to join the workforce.

"If they (employers) see me walking like this they will chase me away and give my job to another man."

"Who is going to give me work with this arm? I am f#up. If you can help me, I... (patient starts crying)"

Clinicians' reflected the anguish voiced by interviewees and were concerned that patients were not aware of their rights as employees and too overwhelmed by their immediate situations to take action.

“Our patients’ live too close to the breadline. They will do anything to work. He will sacrifice his own health to ensure an income as an extended family depends on his salary.”

“This patient is very concrete. Focused on the here and now and not planning or thinking of the future. She has no understanding of her rights, at work or here in the hospital.”

Since 1996 the South African Constitution has enshrined the right of human dignity, equality and freedom [4]. This cornerstone of South African democracy initiated several laws that protect injured and or disabled workers [45]; that promote the equality and prevention of unfair discrimination against people with disabilities [46]; that promote the employment of people with disabilities [47] and that ensure safe and accessible working environments for injured or disabled workers [48].

2. Despondency and resignation

Overwhelming desperation was experienced by the majority of patients.

“I could not find work when I was strong. Now I am a cripple there is no hope for me.”

“What can I do? Nobody can help me.”

In some cases the desperation resulted into a quiet resignation that employment will never be an option, but hopefulness that a livelihood may still be generated through the country’s social welfare system.

“I just want the disability (a governmentally supplied disability grant).”

In South Africa the social grant have been the single most effective anti-poverty tool deployed since 1994 [49] and is often a sought after source of dependable income in poverty stricken households. Clinicians were concerned about how poverty and poor education contributed to healthcare users’ lack of insight and understanding about their own health, how to access appropriate support services and their attitude towards remunerative work.

“These patients have no idea of what we can offer.”

In addition to the insights gained from the interviews, clinical occupational therapists reflections on the use of convergent interviewing technique showed that all were in favor of its use in clinical practice, despite the fact that a few challenges were also identified.

Gains experienced using convergent interviewing

The practical and client-centered approach fostered by the convergent interviewing technique mirrored an occupational therapy ethos. Clinicians indicated that it fitted easily into their clinical routines and did not take much time out of actual clinical work. The natural character of the interview technique was appreciated. In the large group discussion a therapist said; *“It was like having a conversation with my patient.”*

The ease with which in-depth and focused information could be obtained from healthcare users in a relatively short time and with little effort on the clinicians' side was noted. Other reflections also indicated that incorporating this interview technique promoted therapeutic use of self in the patient-therapist relationship, something that easily gets lost when a high turn-over rate is expected of therapists.

“We tend to fall into a rut regarding our communication. We tell them (healthcare users) and talk to them. We seldom make the time to listen to them and this interview technique forces you to do so.”

“It was great to see how the patients start responding differently to you when you encouraged them to talk and you then actually listen to them.”

“It was fascinating to see my profession through the eyes of my patient.”

In general clinicians felt enriched by having acquired the skill to use convergent interviewing. Several even indicated they needed more practice with the technique and were planning to use it in future. Through these comments, action learning is evident, as self-development with action for change [50] was promoted through both concrete experience and critical reflection on this experience [26].

Challenges experienced using convergent interviewing

Therapists shared difficulties they had experienced with convergent interviewing and reflected on the perceived shortcomings of the technique. A significant problem was inability to do the interview with clients who had limited ability to communicate with the therapist. Language barriers in healthcare is a well-documented problem [51]. In some cases therapists tried to use interpreters to overcome the communication problem, but felt this did not work. It was noted that the interviews then became unnatural and that too much of the true meaning was lost in the two way translation process. Another problem was that the therapist-patient relationships

prevented honest expressions. A therapist noted, *“They want to please us because we are rehabilitating them so they say what they think will make us happy.”*

This enquiry set out to gather healthcare users' opinions of vocational rehabilitation services. The results of clinical occupational therapists using convergent interviewing techniques with healthcare users in their departments achieved and exceeded this goal. There was a clear indication of users' views on vocational rehabilitation services in occupational therapy departments. The interview technique also allowed clients to determine the direction of the interview sharing their needs and concerns about generating an income to support their families. This additional information should shape future therapeutic interaction and impact on occupational therapy's contribution to healthcare outcomes and management. Healthcare users were engaged in their care as they were allowed to express their needs and opinions.

The result of the inquiry showed that the majority of public healthcare users (96%) in occupational therapy departments had no knowledge of vocational rehabilitation services. There could be various reasons for this lack of insight: they were not being offered vocational rehabilitation; clinicians were not informing them that they could request the service; they were receiving vocational rehabilitation, but did not recognize it as such and perceived it to be part of primary therapeutic intervention.

Actions for the future

Further investigations to identify the reason for healthcare users' lack of knowledge about vocational rehabilitation services is called for. Although clinicians had suspected this, there was no empirical evidence to support it. In addition the ability of occupational therapists to provide such services in clinical public healthcare settings needs to be explored.

Limitations of this study

Interviewing skills are directly related to experience. Several of the therapists did only one interview and this could have had an impact on the quality of the content of their interviews. Dick suggests data saturation as the indicator of how many interviews should be done[25]. This study used the time limitation of two weeks and availability of healthcare users to dictate the amount of interviews done. It is suggested that data saturation should take precedence above time and other constraints in future.

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3.6 Discussion of the Observation Phase

Various barriers to the formation of an effective collaborative transformation and research team were overcome when Vocational Rehabilitation Task Team (VRTT) members became involved in ALAR cycles. Once a collaborative research team was formed, the question of what vocational rehabilitation services occupational therapists were currently offering in Gauteng's public healthcare was identified and approaches to attend to this problem defined.

The VRTT used three observation approaches to investigate the question. Complying with action learning action research (ALAR) principles, they developed a tool that would allow clinicians to observe, systematically, their own vocational rehabilitation practices and they explored the views of clinicians and healthcare users of these services. Within the observation processes, participants learnt tool development and systematic practice profiling skills; they acquired convergent interviewing skills, critical reflection and publication skills and were involved in the analysis, reflection and dissemination of the observational findings. This brought about the core values of ALAR, as described by Zuber-Skerritt (2015), collaboration, synergy, openness, trust, honesty, flexibility and mutual respect. The enrichment of action learning and the methodical action research approach brought a positive contribution to the observation phase, despite the potential of strain and harm associated with observation of personal professional practice.

The results from the three observation approaches showed occupational therapists in Gauteng were not meeting the work needs of public healthcare users. Awareness of the services was limited and in

the case of one hospital, the creating of awareness was seen as a threat. The skills and confidences of clinical occupational therapists to do vocational rehabilitation were seen as a problem, which was further complicated by a high staff turnover. Healthcare user statistics were low. Clinical supervision of students in vocational rehabilitation was only operational at one of the four academic hospitals. There was no involvement in research or publication and there was no scientific evidence that occupational therapists in public healthcare in Gauteng were involved in vocational rehabilitation. None of the hospitals had guidelines or goals for their vocational rehabilitation services.

All the hospitals indicated problems with their vocational rehabilitation services. One hospital felt they were doing the best they could, were satisfied with their vocational rehabilitation efforts and did not need transformational assistance. The other hospitals all indicated they required assistance to address their vocational rehabilitation. With the exception of one hospital, they all had adequate equipment and resources to offer comprehensive vocational rehabilitation services, however only screening and assessment of ability to work were being done at all the hospitals. One hospital did a form of intervention, but nothing was undertaken at the others. There was no prevention, placement or follow up services offered.

In addition to information of vocational rehabilitation practices, the observation also brought to light several unforeseen problems in Gauteng's public healthcare. One problem was the widespread confusion and contradictory opinions about what vocational rehabilitation entails, what the role of clinicians in public healthcare is within the field and how it fits into the different levels of service delivery offered in Gauteng's public healthcare. There was no framework or guidelines for the implementation of vocational rehabilitation services, at all available levels of care in Gauteng, which informed clinical staff.

It was obvious the levels of vocational rehabilitation skills, knowledge and confidence differed significantly between clinicians and was directly related to the academic institutions in which they were trained. In addition, where it applies to vocational rehabilitation, there were breaches in communication and cooperation between clinicians in public healthcare, clinicians in private healthcare and academic occupational therapists. All these could be contributing to the problematic status of vocational rehabilitation services in Gauteng and need further investigation and consideration.

In the light of such evidence it was vital for the researcher and the VRTT to uphold the Ubuntu spirit by not igniting a judgemental and blaming atmosphere. Hiding or ignoring the evidence or explain it away was also a form of avoidance that had no restorative prospective. The research group found

the collaborative strength of ALAR beneficial. Choosing to stand together as a collaborative unit in the face of negative evidence encouraged even the most inexperienced and diffident clinician that the problems were not insurmountable and that transformation was possible.

3.7 Conclusion to the Observation Phase

This chapter described the observation phase of the enquiry as well as the important aspect of integration of the researcher into the research setting. The outcome of this observation phase explored the views of the most important participants of a healthcare service, that of the users and the providers of the services. Combining this with a systematic profile of the service, offers a comprehensive observation of the status of the vocational rehabilitation services that occupational therapists offer in Gauteng's public healthcare.

The observation phase provided evidence to inform and direct future transformational efforts. It was realised that planning of such transformation had to take place on a clinical level, but there was also a need for a framework and guidelines, which would inform occupational therapists what vocational rehabilitation they needed to offer at the various levels of service delivery in Gauteng. The action learning elements in the observational approaches enriched participants, leaving them motivated to address future problems using the ALAR methodology.

This chapter discussed the integration of the researcher, an outsider, into a pre-existing insider group and how a collaborative research group was formed, which observed the vocational rehabilitation services offered in Gauteng. Chapter Four describes the logical successor to the observation phase, planning. However the reader must note that while integration and observation, as discussed in this chapter, were taking place, the collaborative research group called for ALAR cycles addressing clinical practice problems to start. These actions were part of the action phase of the research that was planned to happen after the observation and planning phases. In keeping with the ALAR ethos, this enthusiasm to take action was not curbed. The result was what is often described in action research literature as messiness (Townsend, 2013) when alluding to the processes of action research. The action phase ran concurrently with the observation and planning phases of this enquiry, as is shown in the timeline presented as Table 2.1 in Chapter Two. In this thesis account of the research, is the planned order of observation (discussed in this chapter), planning (discussed in Chapter Four) and action (discussed in Chapter Five) so as not to confuse the reader.

Chapter Four: Planning Phase

“A shared vision is like a beacon on a hill. It can be very useful for all to keep moving in the same appropriate direction.” Bob Dick (Dick, 2013a)

4.1 Introduction to the Planning Phase

This chapter describes the planning phase where the question is asked: “What should be happening in Gauteng’s public healthcare regarding occupational therapy’s vocational rehabilitation services?” The preceding observational phase brought to light that there was no framework or guidelines of what vocational rehabilitation services occupational therapists should be offering at the different levels of service delivery in public healthcare. The decision was made by the enquiry’s collaborative research group, the Vocational Rehabilitation Task Team (VRTT), to address this problem. The creation of such a framework brought into motion the planning phase of the research. Figure 4.1 presents the entire study, with the highlighted sections indicating the position of this chapter on planning.

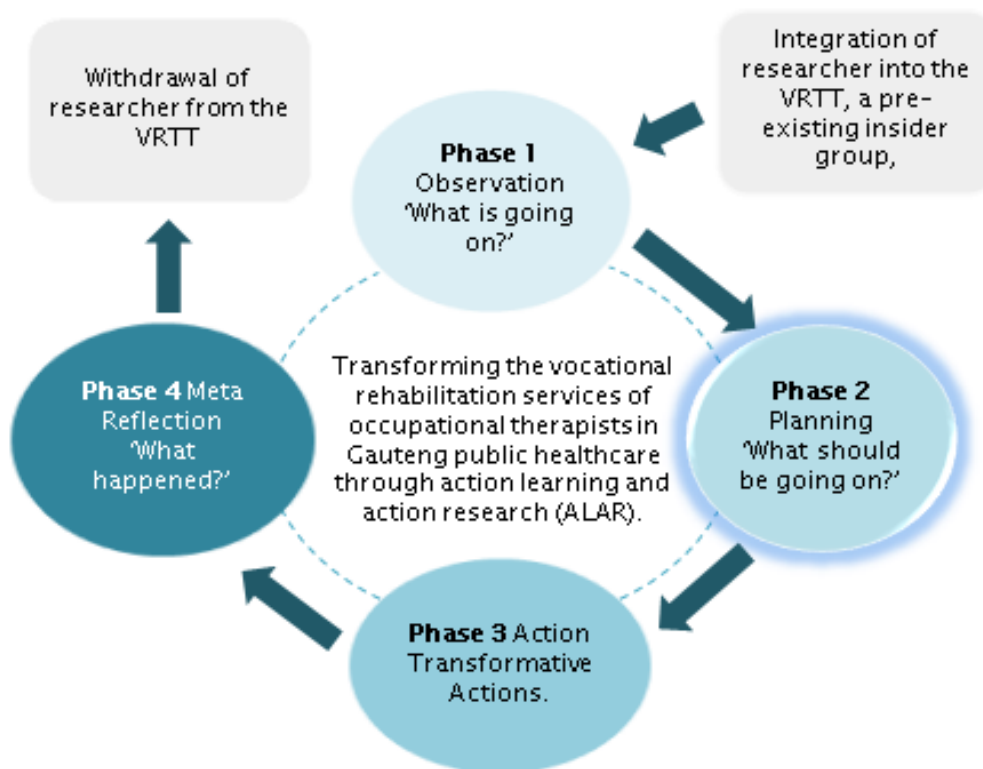


Figure 4.1: Diagrammatic presentation of the research process positioning the planning phase

To plan a framework, within which the vocational rehabilitation services that were being transformed could be positioned, two approaches were taken - a literature review and an opinion survey. The literature review was done to assist with the planning of the framework, informing the VRTT what vocational rehabilitation occupational therapists were doing and where, globally. The second approach was an opinion survey, asking clinical, academic and expert occupational therapists what vocational rehabilitation services they felt occupational therapy clinicians should be offering at the various levels of Gauteng's public healthcare.

This planning of a framework, within which transformational action could be positioned, was however not the only type of planning that occurred in this enquiry. Donabedian (2003) indicates the concept of quality healthcare needs to be monitored and measured against a standard. Having a practice standard, adjustment can be made and quality can be assured. It is important for occupational therapists to have a standard for their vocational rehabilitation practices so they can meet the needs and expectations of public healthcare users, the multi-professional healthcare team, governments and other stakeholders. This implied multi-layered planning at managerial level, which was what the creating of a framework and guidelines implied but also at clinical levels.

The planning of a framework that would position the practice of vocational rehabilitation within Gauteng's public healthcare is shown in this planning phase, but clinical planning was seen throughout the enquiry. Clinical planning took place within specific action cycles that addressed identified practice problems and is seen predominantly in the action phase that follows this planning phase. Having a framework that would inform occupational therapists what vocational rehabilitation they should be offering at the different levels of service was felt to be important for the sustainability of transformational actions, as it affected the distribution and co-ordination of services and resources as well as the referral of healthcare users.

Additional planning in this research was to ensure the incorporation of action learning and action research (ALAR) principles. In action learning (AL), participation in action and concrete experience is necessary for learning to take place (Zuber-Skerritt, 2009), which required planning of future actions, and action research (AR) required that planning had to be done collectively (Koshy et al., 2011).

4.2 Overview of Tools and Process used in the Planning Phase

The tools and processes used in this phase, for the planning of a framework were meeting minutes supported by the researcher's meeting summaries, individual and collaborative reflections,

journaling and field notes and formal and informal interviews in the form of one-on-one interviews. The two planning approaches aimed at creating a framework were a literature review and an opinion survey with collective reflections of the approaches.

Trained in evidence based practice, it was a natural first choice for the VRTT to decide to turn to available literature for the answer to the planning phase question. They commissioned the researcher and the chair of the VRTT to consult the literature and inform them of available policy and scientific evidence which could help with the planning of a strategy for vocational rehabilitation at the various public healthcare levels in Gauteng.

A literature review team was formed, which consisted of the two supervisors of this enquiry, the chair of the VRTT and the researcher, and they planned the search. A week long writers retreat, at the University of the Witwatersrand, was identified and used to do the literature review. The team reflected on the results and the researcher made the written account into a dissemination summary. Enriched and motivated by this action learning experience, the researcher felt the need to acquire more knowledge and experience on literature searching and attended a Joanna Briggs (2013) training course. As an assignment of the course, she repeated the search. The results of the first and second review were compared, shortened and summarised into a format that could be verbally presented to members at the next VRTT meeting.

The second planning approach was an opinion survey. The democratic foundation of an opinion survey suited the ALAR ethos and the VRTT decided to ask concerned occupational therapists their opinion of where to position vocational rehabilitation services. This opinion would help to inform the planning of a framework within which vocational rehabilitation could be practiced. To enhance learning opportunities for the collaborative research team the opinion survey's process and results were disseminated in the format of a peer reviewed journal publication. The article was published in the South African Journal of Occupational Therapy (SAJOT) and is presented below as 4.3.3.

4.3 Findings of the Planning Phase

Findings of the two planning approaches, the literature review and the opinion survey are given below. After each planning approach, the collaborative reflections of the results are shown as these guided and qualified the actions taken.

4.3.1 Reviewing the literature

The summarised literature review and its results, as presented to the VRTT members, are presented below.

Positioning Occupational Therapy's Vocational Rehabilitation Services in Gauteng's Public Healthcare: A Literature Review.

1. Background for the Literature Review

Since 1994 a constitutional, legal and policy framework that guarantees the right of access to health care to all persons in South Africa, had come into being, but difficulties lay in its implementation (Republic of South Africa, 2011). Twenty years later public healthcare in Gauteng still reflect inequality of resource distribution, staff strain and inadequate service (Dube, 2005) and the same applies to occupational therapy's vocational rehabilitation services. Schoeman (2009) notes that a lack of scientific evidence and the absence of a culture of evidence-based policy-making in the disability sector was the precursor for policy neglect and inadequate service delivery outcomes. An action research team, aiming to address the vocational rehabilitation practice problems that occupational therapists had in Gauteng's public healthcare, decided to launch a literature review to look for scientific evidence to inform them during the planning stage of their transformation. The objective of this literature review was to look for evidence that will inform and advise on:

- The effective synthesis of operational structures and distribution of vocational rehabilitation resources within Gauteng's public healthcare (The structure within which the service is rendered).
- The vocational rehabilitation services occupational therapists should be rendering at the different levels of service delivery in Gauteng's public healthcare (The process and practice of the service).
- The results that could be expected from an effective vocational rehabilitation service in Gauteng's public healthcare at the different levels of service delivery (The outcome of the service offered).

Vocational rehabilitation is a multi-professional service provided to individuals of working age with health-related impairments, limitations or restriction within work functioning. Vocational rehabilitations' primary aim is to optimise work participation in spite of illness or activity limitations (Escorpizo, 2011). The occupational therapy profession has a significant role to play within the multi-disciplinary team (Buys, 2015, Buys, 2006).

2. Process of the Literature Review

The following review process was followed: a review question, aims and objectives were formulated, data were collected, evaluated and analysed. The results were reflected on and discussed by the collaborative research team.

2.1 The review question, aims and objectives of the literature review

The question: What is occupational therapy's role regarding vocational rehabilitation at all levels of service delivery in Gauteng's public healthcare?

The aim: To review relevant policy documents and literature to create a framework that would position the services of vocational rehabilitation as rendered by occupational therapists in public healthcare.

The objectives: To describe the vocational rehabilitation services that an occupational therapist must be able to render within specific levels of public healthcare in a practical and accessible format.

To promote informed transformation, intervention, resource distribution, staff placement, training and client referral

2.2 Data collection for the literature review

Data were evaluated for collection. Inclusion and exclusion criteria were agreed upon and a search strategy was planned. Collected data were screened and selected. Two levels of the collected data were identified; South African policy documents were one and were called first level data; scientific literature was called second level data and was divided into local and international literature.

2.2.1 First level data - South African policy documents

The following search strategy was embarked on and the evidence gathered is illustrated. Thirty sources of level one data were collected.

Governmental and related associations libraries and websites were searched for protocols, strategies, policies, laws, reports, guidelines, strategic frameworks relevant to the review question. Thirteen documents were found. (Vocational Rehabilitation Task Team, 2013, Office on the Status of Disabled Persons, 2008, Republic of South Africa, 2009, Republic of South Africa, 2012, Republic of South Africa, 2013b, Republic of South Africa, 2003, Republic of South Africa, 1998, Republic of South Africa, 1995, Republic of South Africa, 1993, Government, 2000, Government, 2010, DPSA, 2010b, DPSA, 2010a, Republic of South Africa, 1996, Republic of South Africa, 2013a)

The Assistant Director of Therapeutic and Medical Support Services in Gauteng Health Department sent an official request to designated persons (N=23) in the nine provinces of South Africa, requesting any policy documents regarding occupational therapy's vocational rehabilitation services. A due date for response was given and email reminders were sent out two days before the due date. Four of the 23 responded. Three had relevant documentation and one reported there was no such documentation/policy available.

The Occupational Therapy Association of South Africa (OTASA) was approached with a similar request. Response indicated that OTASA is in the process of developing position statements on various occupational therapy services. A draft document existed and sent to the team accordingly. The only other policy document was on the role of the occupational therapists in protective workshops from February 1988, which was also sent (Unknown, 1988, Unknown, 2012).

A chance meeting with a team heading a directive from the Deputy President of South Africa to set up vocational rehabilitation centres for injured miners in four provinces brought to light a report which contained relevant information and which was also included (Abrahams, 2013).

2.2.2 Second level data - scientific literature

The following search strategy was embarked upon and the gathered evidence is illustrated. One hundred and eighty two sources of level two data were collected.

The following keywords were used randomly and with different Boolean operators: occupational therap\$, vocational rehabilitation, work rehabilitation, public healthcare. The

following search engines and databases were used: Medline, CINAHL, Africa Wide, OTseeker, EBSCO, Google Scholar. Hand searching of the references in journal articles found was also done.

The date restriction was the period 1994 to December 2013, as we were looking for data that coincided with South Africa's democracy and new legislative era.

Reasons for exclusion of well-known articles: The date restriction ruled out articles still being used extensively in support and validation of the occupational therapists role in vocational rehabilitation and for training of postgraduate vocational rehab courses OT's (Veloza, 1993, van Biljon, 1994, Farrell, 1993, Rybski, 1992, Matheson et al., 1985, Bell, 1986, Mitchell et al., 1989, Stockdell & Crawford, 1992, Naik & van Biljon, 1991). These are, however, 20 years old and South African occupational therapists have not produced new and updated evidence in support of their role and work in vocational rehabilitation to replace them.

2.3 Data analysis for the literature review

Data analysis and results: The selected literature was read, relevant data extracted, sorted into themes and synthesised. The articles, policies and documents that were chosen for data analysis, synthesis and extraction had been read three times, to select them, critically appraise them, extract data and check the outcome of the review's conclusion against them.

1st Level South African policy documentation: All 30 documents gathered were read. Three of them replicated information from the same source (Coetzee et al., 2008) and 17 made no mention of occupational therapy or vocational rehabilitation, but generically addressed the legal and constitutional rights of persons with disabilities. These were all excluded. Of the nine remaining documents, only three met the inclusion criteria (Coetzee et al., 2008, Rabothata, 2011, State, Undated) and were included. Seven other documents were included (DPSA, 2010a, DPSA, 2010b, Government, 2010, Office on the Status of Disabled Persons, 2008, Republic of South Africa, 2012, Government, 2000, Republic of South Africa, 2013a) and even though they did not mention occupational therapy, their content has an impact in the manner in which we plan, design, finance, implement and monitor services or programmes in public healthcare.

2nd level scientific literature documentation: All 182 documents were scan read. Twenty five duplicates were removed; 157 abstracts were screened, 18 excluded, mostly because they were not specific to occupational therapy; 126 full texts were collected and read; 59 were excluded as they were not directly related to service but addressed students or therapists

needs; 67 documents were felt to address the review question and were kept for re-reading and data extraction.

3. Results and discussion of the literature review

1st level SA policy documentation: Of the three documents that met the inclusion criteria, the most noteworthy was the Western Cape's provincial strategy for work assessment (Coetzee et al., 2008). It held information directly relevant to the review question and its content was supported by an international presentation (Coetzee, 2008) and a journal article (Coetzee, 2011). The Gauteng document (Rabothata, 2011) addresses the status of occupational therapy's vocational rehabilitation services in Gauteng and proposes a plan to address the shortfalls. The Free State (State, Undated) document describes the protocol of a public healthcare work unit. All documents address occupational therapy vocational rehabilitation services and skills. Only two place them within the various levels of healthcare (and in the case of the Western Cape document also in the Department of Education, Labour and Social Development) and skills. The Western Cape document offers a breakdown of work unit activities and requirements, staffing requirements, space requirements, equipment and consumables and the population serviced.

The seven other documents also included broadly facilitate the rights and equality of persons with disabilities in keeping with our constitution and all mention work or employment matters; none mentioned occupational therapy. The National Development Plan Vision of 2030 resonates well with occupational therapy efforts in vocational rehabilitation: "Due to various barriers, many people with disabilities are not able to develop to their full potential. They are often viewed as being unproductive and a burden, but this need not be the case. For most adults, work is a fundamental component of life, which confers status and economic security and opens up social networks. The most notable barriers to people with disabilities accessing work are: physical barriers, information barriers, communication barriers and attitudinal barriers"(page 10) (Republic of South Africa, 2013a).

It must be noted that the National Rehabilitation Policy (Government, 2000) and other prominent documents (Coetzee et al., 2008), propagate that only vocational screening services should be done in the Department of Health and that all other services and aspects of vocational rehabilitation should be conducted within the Department of Labour.

2nd level scientific literature documentation: This literature was divided into international and local research.

Local scientific literature represented 13% (N=9) of the body of literature. Most of the literature was pathology specific in relation to vocational rehabilitation e.g. return to work programs for stroke survivors. Several articles addressed the assessment of ability to work. There was also an indication that occupational therapists were involved in ergonomics, supported employment, return to work programmes and occupational health and safety issues. Two articles were related to more global vocational rehabilitation aspects, such as professional competencies of occupational therapists in vocational rehabilitation (Buys, 2006) and inter-sectorial collaboration model for occupational therapy's vocational rehabilitation services (Coetzee, 2011).

Internationally, vocational rehabilitation is well represented and there is global support of the occupational therapists role in vocational rehabilitation, most notably in assessment of ability to work or functional capacity evaluation, case management, work environment intervention, work readiness programmes and placement or return to work support. There is also repeated indication that occupational therapists work in multi-professional teams and that vocational rehabilitation services are mostly rendered in rehabilitation or end stage care centres. Terminology discrepancy and different healthcare policies and legislation made comparison of services difficult. In addition, professionals had different scopes of practice in different countries. For example, in the USA physiotherapists perform the vocational assessments that occupational therapists do in SA (Escorpizo et al., 2011). An interesting commonality throughout the world seems to be the challenge of keeping policy and service synchronised.

4. Conclusion of the literature review

South Africa's constitution enshrines the rights of all persons living here to access the intervention they need to live healthy prosperous lives. In Gauteng, there are policy documents, strategic plans, position papers, practice profiles and models available in public healthcare to guide general rehabilitation. It was concerning to see how many of them do not mention or recognise the role of occupational therapy.

Policy documentation that addressed vocational rehabilitation indicated that only screening should be done at the Department of Health and all other aspects at the Department of Labour (Government, 2000). A local scientific article (Coetzee, 2011) agreed with this and suggested an inter-sectorial collaboration model for such services, but reportedly this was met with significant resistance due to the cost involved in relocation and redistribution of existing services. International literature showed that vocational rehabilitation services are

mostly rendered in rehabilitation centres and end stage care centres within or beyond healthcare systems.

No scientific vocational rehabilitation literature, which originated from occupational therapy practices in Gauteng's public healthcare, was found. This scarcity of contextual literature implicated the difficulty of developing guidelines and framework for clinical practice in Gauteng. It affected the aim of this literature review, to inform the process of service application of occupational therapist's vocational rehabilitation services.

The final stage of a good literature review is transferring the evidence and knowledge gained in such a way that implementation of the revealed information is ensured (Pearson et al., 2005). In this review, the aim was to inform the VRTT to develop a framework that positions occupational therapy's vocational rehabilitation (work as an occupational performance area) at all levels of service delivery in Gauteng's public healthcare to promote informed transformation intervention, resource distribution, staff placement, training and client referral. To achieve this, all role-players need to know what they should be doing when and where, especially if there is a high turnover of therapists and those working in these facilities are inexperienced. Having a framework written in accessible language would help minimise the problems public healthcare currently experiences. It is also essential to co-ordinate and sustain the transformation of vocational rehabilitation services.

4.3.2 Collaborative reflection on the results of the literature review

The results of the literature reviews were summarised and presented to the VRTT. They reflected on and discussed the results and the implication they had for their framework phase. The result of this collaborative reflection is summarised and given below.

The VRTT noted that the literature review showed evidence that occupational therapists have a role to play in vocational rehabilitation. Literature indicates that the occupational therapist is an important partner in a multi-disciplinary team addressing the occupational work needs of adults whose ability to work is affected due to injury, illness, impairment or disability. The VRTT disagreed with the policy document (Government, 2000) indicating such efforts should take place in the Department of Labour. The feeling was that in public healthcare, the Department of Health was the first point of call for most labourers who are injured or sick and that this should be the catchment area where occupational therapists can start their vocational rehabilitation intervention.

There was agreement that acute healthcare settings were not the ideal place to do vocational rehabilitation and that specialised rehabilitation centres would be better suited. Unfortunately most of the vocational rehabilitation resources are currently situated in hospitals that provide acute healthcare. The VRTT discussed a concern which is expressed at occupational therapy forums, that at present there are significant problems with Gauteng's rehabilitation centres in public healthcare. They agreed the current situation, concerning rehabilitation centres, would not allow for the conducting of vocational rehabilitation.

It was felt that the scientific literature, both local and internationally, did not provide relevant evidence for the group to create a framework that would answer the question of this planning phase. A second planning approach was suggested and initiated - an opinion survey to gauge occupational therapists opinion on the question.

4.3.3 Opinions of Occupational Therapists

The VRTT decided they should ask the opinion of expert, academic and clinical occupational therapists what vocational rehabilitation services they felt clinical occupational therapists should be offering at the various service levels of public healthcare in Gauteng. Using ALAR principles, the collaborative research team planned and launched the opinion survey. The decision was made to write up the survey results as a journal article to share the knowledge generated with the larger occupational therapy community and to enhance the action learning experience.



Opinions of occupational therapists on the positioning of vocational rehabilitation services in Gauteng Public Healthcare

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ABSTRACT

Introduction: A collaborative effort to transform occupational therapist's vocational rehabilitation services in Gauteng's public healthcare was hampered by the fact that role players were unclear as to what the scope of the service should be within the various sectors and staffing levels of public healthcare. This article reports on the opinions of occupational therapists on the positioning of vocational rehabilitation services in the Gauteng Province.

Method: A collaborative action research team launched a non-experimental descriptive inquiry within the planning phase of a larger transformative project. Data were generated through an opinion survey to capture the perspectives of occupational therapists on the potential positioning of vocational rehabilitation services in the province. The opinions of three groups of occupational therapists were collected, i.e. clinicians working in Gauteng public healthcare, experienced vocational rehabilitation practitioners from all fields of service delivery who acted as critical friends and occupational therapy academia.

Results: The purposive sample was composed of 307 potential respondents. A low response rate of 31% was achieved. There was a lack of consensus as to which vocational rehabilitation services occupational therapists should render in public health care. The results reflected the need to address the scope and position of vocational rehabilitation services in public health care.

Conclusion: Positioning of vocational rehabilitation services in public health care remains a point of contention. However, the process of asking occupational therapists their opinion created awareness and directed continuous efforts to address the issues within the field of practice.

Key words: occupational therapy, vocational rehabilitation services, public healthcare action research, opinion survey

INTRODUCTION

In vocational rehabilitation occupational therapists focus on the human occupation of work, using their knowledge of pathology, ability to analyse activity and concern with occupational performance and purposeful activity¹. The profession views the occupation of work as an integral part of their treatment process and a planned outcome of rehabilitation²⁻⁴. Occupational therapy's vocational rehabilitation services can be offered in and outside of healthcare facilities. Within healthcare facilities they assist with the transition from injury or illness, to return to optimal performance in work. Healthcare is often the first port of call for injured or sick workers and early intervention is an important indicator for successful return to work⁵. Within a healthcare facility, occupational therapists are frequently the team members that identify and promote the need to address the work of a patient as part of the holistic management of his/her pathology⁶.

Occupational therapy vocational rehabilitation practices tra-

ditionally offer a variety of services that can be found at various levels of healthcare⁷. Literature notes that vocational rehabilitation services offered by occupational therapists are not demarcated and grouped⁸ and that the categorising of healthcare facilities is a challenging exercise⁹. This double conundrum could be contributing to the difficulties of organising and managing the vocational rehabilitation services that occupational therapists offer in public healthcare facilities in Gauteng. In South Africa, 68% of the population depends entirely on public healthcare¹⁰ and injured or sick workers who fall within this group, can only access occupational therapy services through the various public healthcare facilities. With the restructuring of public healthcare to meet the constitutional ideals of a democratic South Africa, occupational therapy's vocational rehabilitation services in public healthcare became an unfortunate casualty. In Gauteng, these services appeared to have fallen into disarray.

In 2011 the Assistant Director of Therapeutic and Medical Sup-



port Services in Gauteng Health Department assembled a vocational rehabilitation task team (VRTT) to address vocational rehabilitation service problems in the province. In 2013 a PhD student, the first author, joined the VRTT as a member, with a research study titled: Transforming the vocational rehabilitation services of occupational therapy in Gauteng's public healthcare through action research. She had worked in and managed a public healthcare work unit in the 1980's and 1990's and retained a concern for and an awareness of the potential of vocational rehabilitation services in public healthcare.

The PhD study consisted of four phases. The first phase was observational in nature. The vocational rehabilitation practices offered by occupational therapists in Gauteng public health care, were observed. The second was a planning phase. The third phase was the implementation of multiple action research cycles to address specifically identified practice problems. The final phase was a meta-reflection on all previous phases, actions and practice transformation.

This article reports on part of phase two of the PhD study i.e. the need for a collaborative action plan that indicates what vocational rehabilitation services occupational therapists are and should be offering at the various healthcare facilities in Gauteng. The results would allow systematic and quantifiable actions such as addressing service delivery problems; managing resource distribution; organising personnel training; mentoring and support; as well as synchronising and coordinating service delivery to transform the service.

Multiple discussions about what vocational rehabilitation services occupational therapists should be offering at the various public healthcare facilities were held within the VRTT. The VRTT tasked the researcher to expand the discussion to public healthcare managers on hospital, regional and national level. The outcome of these discussions showed that previous attempts to address the question were not evidence based and had not filtered through to frontline clinical practice. During an interview with the Deputy Director: Disabilities in South Africa, it was agreed that there was no official demarcation of the vocational rehabilitation services that occupational therapist should be offering in public healthcare. He suggested that the occupational therapists that are, and should be, offering the services be asked for their opinion on the matter.

This democratic management approach of involving practitioners in the decision making process of their practice, is a fundamental characteristic of action research¹¹. It allows for the development of empowerment and ownership features in practitioners and is beneficial in the transformation of professional practice¹². Developing an opinion survey and circulating it to all occupational therapists working in Gauteng's public healthcare was discussed in the VRTT. There was unanimous support for the idea and members volunteered to be involved at all stages of the inquiry; designing the opinion survey, distribution and gathering the survey responses, analysing data, critical reflection on the process as a whole and the dissemination of the results in the form of a peer reviewed journal paper. To validate and strengthen the opinion of clinical occupational therapists, the VRTT felt that academic occupational therapists at the three universities in Gauteng and occupational therapists experienced in the field of vocational rehabilitation should also be asked for their opinions. The latter group of occupational therapists had already been co-opted as *critical friends* for the PhD study.

For the purpose of the opinion survey, vocational rehabilitation services and healthcare facilities were each categorised into six groups.

Types of vocational rehabilitation services offered by occupational therapists

In her research Buys⁸ identified professional competencies occupational therapists need for delivering vocational rehabilitation services. She groups the competencies into aspects associated with types of services namely Prevention, Assessment, Intervention and Placement. These groupings were used in this research with two

additional service groupings, Screening and Follow-up, that were practiced within the Gauteng public healthcare's practices.

Prevention is an educative service for the prevention of injury at work and to create an awareness of good work practice, averting the development and/or exacerbation of pathology¹³. Such services could include back programmes and spinal care education¹⁴, ergonomics¹⁵, stress management¹⁶, energy conservation⁸ and the teaching of precautionary measures related to joint care and spinal hygiene^{17,18}.

Screening of general or specific work related skills is a short prescriptive process used to filter and effectively refer patients to more specialised therapists or facilities¹⁹ and supports efficient service delivery. Examples of screening services currently in use in Gauteng's public healthcare would be screening of ability to work²⁰ or ability to drive.

Assessment services involve the assessment of the ability of a person who has an injury or illness's, to be able to work and is a popular reason for referral to occupational therapy^{20,21}. Such services would include work-place assessment²², functional capacity evaluations²³, medico legal assessments²⁴, pre-placement screening²⁵ and disability determination²⁶.

Intervention services are programmes aimed at correcting or compensating for ability to work deficits^{20,27}. There are a variety of intervention programmes that can be offered to correct work deficits or improve work performance. This is important in successful and sustainable placement into the open labour market, sheltered or protected work environments. Examples of such services could be job modification⁸, case management²⁸, pain management²⁹, work hardening²⁰, work preparation or readiness^{30,31} work visits⁸, work guidance⁸, work-place accommodation²⁵, work adaptation⁸, job seekers groups³², self-employment initiatives⁸, support groups³³ and other return to work efforts⁸.

Placement services are the returning of patients to their own, alternative or new work in the open labour market; or to sheltered - or protected workshops^{20,34}. Work site visits would be essential with for example services such as job analysis³⁵, accessibility and ergonomic audits³⁶. Additional placement services would be vocational guidance and counselling³⁷, outpatient support groups³⁷, job acquainting⁸, adaptation and accommodation efforts and the redesigning of architectural barriers³⁸.

Follow up is done of patients who used the services offered²⁰. This could be with employers, referral sources, family members and the patients themselves. It could be done telephonically, electronically or during physical work visits²⁶. The follow up of users of the vocational rehabilitation services demonstrates the occupational therapist's commitment to a case and conclude a comprehensive service. This service is fundamental to a sustainable and successful outcome.

Screening, follow-up and some of the intervention services can be offered by newly qualified occupational therapists, with no special skills or knowledge, but who have been orientated to the relevant protocols. No tools, equipment or venues other than what is available in a generic and basic occupational therapy department are required. Such services could be offered as regular programmes or as the need arises. The therapists could occasionally be expected to do work site and resource visits.

Prevention, assessment, placement and some of the intervention services need to be offered by occupational therapists with experience of a wide variety of pathologies²⁴, good clinical reasoning skills and specialised knowledge and skills of work assessment and the labour market⁸. The use of standardised assessment tools and activities within a designated work area, work site visits and resource visits would be necessary.

Public healthcare facilities in South Africa

The South African National Health Act³⁹ specifies district, regional, central and specialised hospitals, with clinics for primary healthcare as categories of public hospitals. In this study these categories were used to group healthcare facilities.



Clinics are facilities from which a range of primary healthcare services are provided to out-patients or ambulatory patients. The personnel who man these centres are focused on primary healthcare and are considered generalist in their professions. Clinics are normally open only 8 hours a day⁴⁰.

Specialised hospitals have a maximum of 600 beds and provide specialised health services like psychiatric and rehabilitation services. Patients are seen on an in- or out-patient basis and the personnel specialises in the context of the hospitals service. Personnel is specialised in rehabilitative and related practices³⁹.

District hospitals are 50 to 600 bed hospitals that serve a defined population within a health district and support primary health care. Such a facility provides 24 hour care services that include in-patient, out-patient and emergency health services. They could offer training for healthcare service providers. Their specialist services are limited and generally located at regional and central hospitals³⁹.

Regional hospitals are 200 to 800 bed hospitals and serve a defined regional population, limited to provincial boundaries and receive referrals from district hospitals. They provide 24 hour care that includes in-patient, out-patient and emergency health services. They could provide training for healthcare service providers. They offer limited specialist services³⁹.

Central hospitals, also known as *tertiary hospitals* are 400 to 1200 bed hospitals that provide a 24-hour care and a national referral service. They provide highly specialised units that require unique, highly skilled personnel. They must provide training for health care providers, conduct research and must be attached to a Health Science School or Faculty³⁹.

An opinion survey was designed using the categories of vocational rehabilitation services and healthcare facilities as discussed above. Using this survey three groups of occupational therapists were asked their opinion on where to position these services in healthcare facilities.

METHOD

Study design

A multi-collaborative action research approach⁴¹ is the underlying phenomenology of the PhD project within which this inquiry is positioned. Although action research is popularly aligned with qualitative inquiry⁴² it is more correct to see it as a democratic and empowering approach to change⁴² that systematically draws on many ways of knowing, both qualitative and quantitative, in an iterative fashion⁴³. The purpose of action research is to bring about change in a specific context⁴⁴. Depending on the context and framework of the practice enquiry, action researchers use methods which best suit their purpose. The context of the practice problem associated with the uniqueness of the situation dictates the research tools and methods used⁴¹. Within healthcare is not uncommon to utilise quantitative data to complement qualitative data in action research projects^{42,41}.

Action research places practitioners at the centre of an enquiry⁴⁵ allowing them to be fellow researchers, planners and policy makers. Dick⁴⁶ notes that plans provide the means by which the future can be influenced from the present and that if the planning is done collaboratively the journey of bringing about change is so much more efficient. A collaborative research team launched this non-experimental descriptive inquiry within the planning phase of a larger transformative action research project. The team needed a cost effective study design that could systematically and objectively collect the opinions of a selected population of occupational therapists'. An opinion survey study design was selected.

Population and Sample

Dick⁴⁷ uses the term *stakeholders* in action research to describe a population. He describes stakeholders as persons who have a stake in a project and who are affected by or are able to affect practical

change. In the pursuit of transformation within a practice, local as well as expert knowledge is often harnessed. This could bring about a variety of insider-outsider⁴⁸ collaborations. Insider stakeholders are regular members of the organisation where the research is being conducted and outsider stakeholders join the organisation or research collaboration temporarily for the purpose of a research project⁴⁹. In this research there are two groups of insider stakeholders and two groups of outsider stakeholders. All of them were used as consensus populations.

The one insider stakeholder group was the *research collaboration*; the VRTT and a PhD student. The VRTT group consists of 14 occupational therapists, working in Gauteng's public healthcare sectors who are concerned with occupational therapy's vocational rehabilitation services in the province. The other three groups were the occupational therapists whose opinions were being surveyed. The first included the main insider stakeholder group, namely all *occupational therapy clinicians* working in Gauteng's public healthcare - a potential group of 242 stakeholders. The second, a pre-determined population sample, were a group of outsider stakeholders. They were 26 occupational therapists working as *academics* at the three universities situated within Gauteng; the University of the Witwatersrand, the University of Pretoria and the Sefako Makgatho Health Sciences University. The aim was to collect opinions from all occupational therapy academics at the three training institutions in Gauteng. The third pre-determined population sample was also outsider stakeholders. A group of 39 pre-selected vocational rehabilitation experts identified by the first author for use as *critical friends* in her PhD. In action research the concept of critical friends is used to indicate stakeholders who are invested in the field of knowledge and can offer objective and expert feedback⁵⁰. The criteria for inclusion into this group the participants had to be occupational therapists with previous experience of working in South Africa's public healthcare system and current experience of more than five years working in vocational rehabilitation.

Data Collection Tool: The Opinion Survey

The opinions of all the stakeholders were gathered in the form of a two page survey that was completed anonymously. The first author designed a draft survey. The VRTT and the first author's PhD support group critically reflected on it and gave feedback for improvement. Suggestions were incorporated, the survey was finalised, language edited and made available in electronic and hard copy format.

The first page of the opinion survey stated the research question. In a collegial letter format the reader was given the reason and background for the survey, the position of the survey within the larger study and what the responses would be used for. The ethical clearance number and the ethics committee contact details were supplied. Instructions were given on how to indicate opinions supported by an example. The return date for the survey was highlighted. All opinion surveys were to be returned to the first author. Four options for returning completed surveys were personal hand-back, facsimile, electronic or postal.

The second page of the opinion survey was headed by three demographic questions; place of work, number of years of experience in occupational therapy and in vocational rehabilitation. The six vocational rehabilitation services were placed in a column on the left side of the page with a brief definition and examples of the service. On the right side of the same page six options of the five public healthcare facilities and the option of *none of the above* was placed in a column with a brief description as well as examples of well-known facilities in Gauteng that qualify under the category. The respondent's opinion was indicated by drawing a line linking a vocational rehabilitation service with a healthcare facility where they felt it should be offered, giving a linear response. An open section for comments was provided at the end of the survey, providing opportunity for additional narrative responses (see *Table 1* on page 48).



Table 1: Opinions of Occupational Therapists on the positioning of Vocational Rehabilitation Services in Gauteng's Public Healthcare Institutions

Where do you work? _____		
How many years of practice do you have? In Occupational Therapy: _____ years. In Vocational Rehabilitation: _____ years.		
From your experience, and/or opinion match the Vocational Rehabilitation Services that should be offered at the various categories/ institutions of public healthcare in Gauteng?		
Vocational rehabilitation services		Public Hospitals/Healthcare Institutions
Prevention: Programs for prevention of injury and awareness of good work practice e.g. joint care, spinal hygiene, ergonomics, and energy-saving practices.		Clinics: e.g. Alexandra, Birchleigh, Sonto Tobela, Zamani, Chiawelo, Crosby, Crown gardens, Diepkloof, Nokupila, Eldorado Park, Bophelong, Jeppe, Lenasia, Malvern, Mofolo South, Senoane, Polla Park, Itireleng, Westbury.
Screening: Using the Vocational Rehabilitation Screening Tool with the Modapts Work Samples guide.		Specialized Hospitals: e.g. Sterkfontein, Tara H Moross Center, Tshwane, Weskoppies, Cullinan Rehab Center, Sizwe Tropical Disease
Assessment Assessing ability to work e.g. FCE's, Pilir, Progress		District Hospitals: e.g. Mamelodi, Pretoria West, South Rand, Heidelberg, Germiston, Carletonville
Intervention: Work hardening, readiness, preparation, visits, guidance, accommodation, adaptation, job seekers groups, self-employment initiatives, support groups.		Regional Hospitals: Kalafong, Coronation, Edenvale, Helen Joseph, Tambo Meoriak, Far East Rand, Natalspruit, Pholosong, Tembisa, Leratong, Yusuf Dadoo, Sebokeng, Kopanong.
Placement: Return to work (open labour market/sheltered/protected), Training and reskilling, support groups, guidance, counselling.		Central/Tertiary Hospitals: e.g. GaRankuwa (DGMAH), Pretoria (SBAH), Soweto (CHBAH), Johannesburg (CMJAH)
Follow-up: With clients/employers/referral sources in the form of telephonic, electronic, home and/or work visits.		None of the above: This service should not be offered by occupational therapists and/or should not be offered in public healthcare and/or should not be offered in the Department of Health.
Do you have any additional questions or comments? NOTE: If you have already filled in an opinion sheet. Please do not do so again.		

Data Collection

The survey was distributed electronically and as hard copies by hand. Distribution and follow up was done by all members of the VRTT and the authors.

To maximise the response rate multiple distribution means were used. Emails were sent with a read receipt delivery option, the survey enclosed, a message explaining the inquiry and requesting assistance with distribution. This was sent to all members of the VRTT, the heads of occupational therapy departments in Gauteng public healthcare, the heads of department of the occupational therapy departments at the three universities in Gauteng and the individual emails of the vocational rehabilitation experts. VRTT members were given paper copies of the survey and asked to distribute them to the target population through all and any other opportunity that they could identify. Such forums were departmental meetings, interest groups, support groups, study groups, informal occupational therapy gatherings such as lunch breaks, continuing education and training workshops and regional and national occupational therapy forum meetings. Paper copies were also placed in the official personalised pigeon holes of all academic occupational therapists.

Additional follow-up was done by the VRTT members and the authors through telephonic and face to face awareness canvassing and promotion of the survey. Gauteng Health Head Office and management officially sanctioned the survey and contributed to follow up efforts through official channels.

The initial distribution was done from August 2014 to Novem-

ber 2014. A disappointing response saw a repeat of the distribution effort from January 2015 to March 2015.

Data analysis

After the final due date responses were analysed and summarised. Frequencies for each possible combination (36 combinations in total) in the linear responses were counted and presented in percentages. Consensus was determined if a certain percentage of votes for a specific combination fell within a prescribed range. These ranges were arbitrary decisions made by the authors. Percentages above 80% were viewed as strong consensus, between 70 and 79% as good consensus and between 60 and 69% as average consensus. Anything below 60% was viewed as inconclusive. Literature to support the authors' decision on the ranges of levels of consensus was scarce. Only one study by Hsu and Sandford⁵¹ briefly stated that consensus above 80% in opinion surveys by means of Delphi methods was good. These authors also mentioned that decisions on levels of consensus are situation-dependent and most of the time arbitrary.

The narrative responses were thematically categorised.

Results were shared at a VRTT meeting and kept for use in the planning phase of the larger research project.

FINDINGS AND DISCUSSION

Of the potential 307 occupational therapist identified, 96 responded, constituting a 31% response rate. This response rate is made up



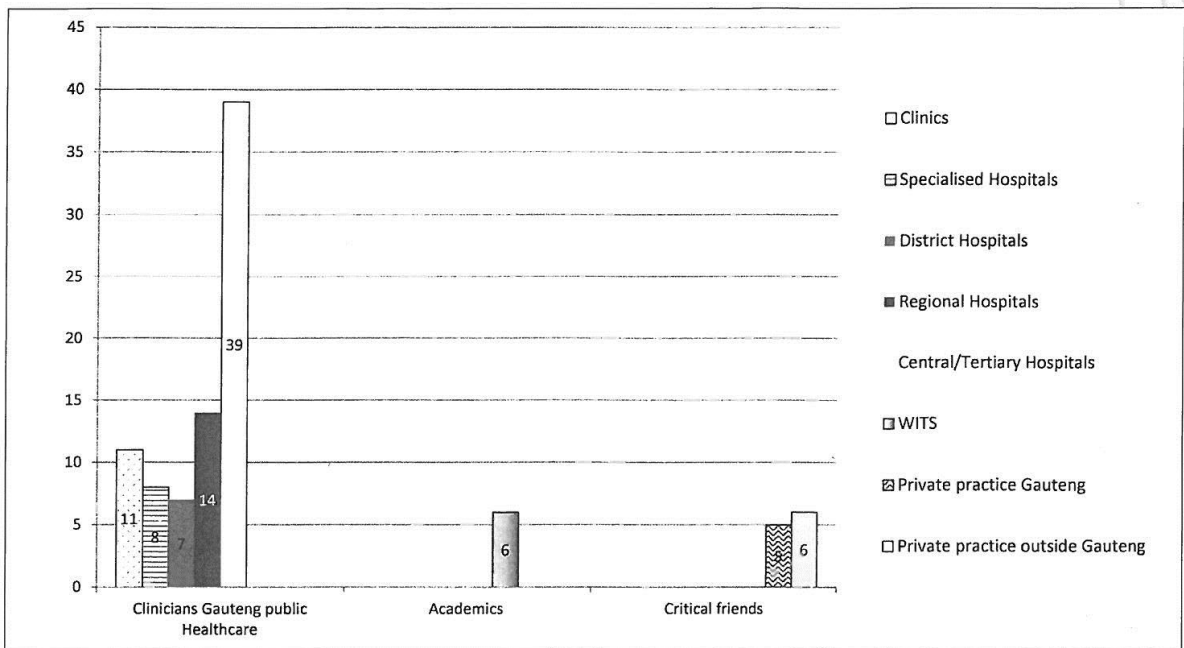


Figure 1: Service sector of respondents

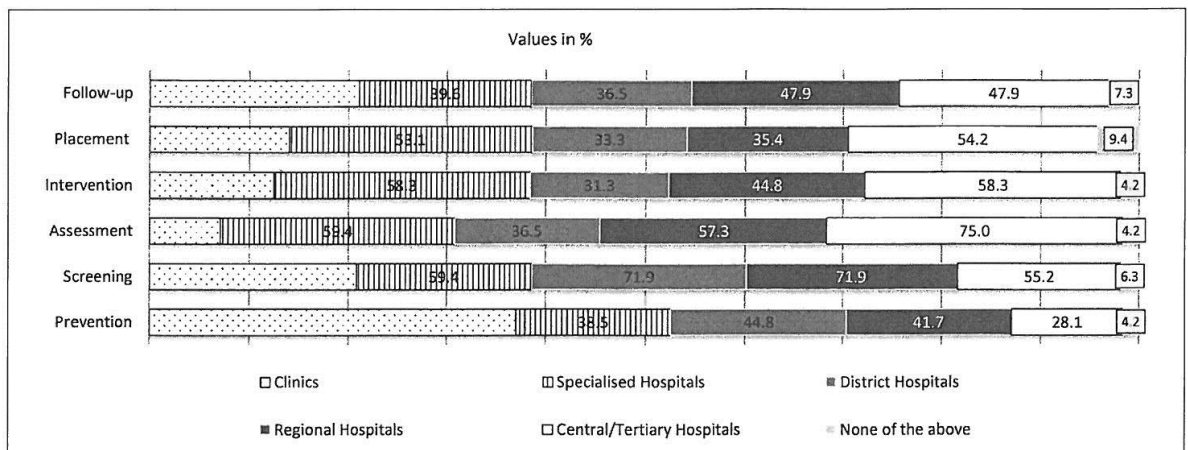


Figure 2: Opinions of clinicians, academics and critical friends of the positioning of vocational rehabilitation services in Gauteng Public Healthcare services

of 33% (n=79) occupational therapy clinicians working in public healthcare Gauteng, 28% (n=11) critical friends and 23% (n=6) academics. Academic responses were received from only one training institution.

The service sectors of respondents is presented in Figure 1: Service sector of respondents.

The linear responses were analysed for each group individually and for all respondents as a whole. The combined opinion of the three groups was rated from most preferred opinion to the least preferred opinion and displayed in Figure 2.

Response rate and demographic information: There is no agreed standard for an acceptable minimum response rate with mailed surveys, but a range from 30% to 80% is generally found⁵². This inquiry's response rate of 31% is at the bottom of the indicated general range. This nonresponse bias could be due to various reasons. Either occupational therapists do not have an opinion on the matter and did not make the effort to respond, or a lack of

knowledge about the field of vocational rehabilitation and/or public healthcare could have prevented participation.

These assumptions are supported by the demographic results. In the case of the clinician and academic populations an average of two years' experience in vocational rehabilitation was found. The critical friends who were experts in vocational rehabilitation with an average of 10 years' experience in the field, had no current experience of working in Gauteng's public healthcare as they were mostly in private practice or worked outside Gauteng. They thus lacked knowledge of the various facilities and services offered in Gauteng's public healthcare.

Demographic information also revealed that the clinical occupational therapists with the most experience in vocational rehabilitation were working at clinics and those with the least experience were working in the central hospitals. At the time of the survey, work units with standardised and commercial vocational rehabilitation tests and equipment were located in central hospitals. Patients



who needed more specialised vocational rehabilitation services were referred to these work units. The clinics offered only screening and supportive vocational rehabilitation services.

Linear responses: The three groups of survey respondents were clinicians working in Gauteng's public healthcare, academics, and critical friends. The group with the most respondents was *clinicians working in public healthcare*. Of these respondents 49% (n= 39) were community service occupational therapists who have less than one year of experience in occupational therapy. Their responses showed that with the exception of prevention services done at clinics, assessment should be done at central hospitals and screening at all other facilities. Of interest was a lack of consensus on what vocational rehabilitation services specialised hospitals should be offering. By a significant margin the least chosen response was that no vocational rehabilitation services should be offered in public healthcare. This leads to the deduction that most clinicians are of the opinion that some form of vocational rehabilitation should happen at the various public healthcare facilities.

Additional consideration of clinicians' opinions showed that they felt clinics should be doing prevention, screening and follow up. District and regional hospitals should be doing prevention, screening and follow up. Central hospitals should be doing screening, assessment, intervention, placement and follow-up.

The *academic* opinion was from only one of the three universities and showed the lowest internal consensus, with no clear agreement of what services should be offered where. They were however unanimous in that none of them chose the option of "none of the above", indicating that they were of the opinion that all forms of vocational rehabilitation services should be done in public healthcare.

The other outsider group, *critical friends*, supported the opinion that vocational rehabilitation services should be done in public health care with one respondent being of the opinion that prevention and placement services should not be done in public healthcare. They felt that screening should happen at all facilities but most prominently at district and regional hospitals. In their opinion, assessment should be done at specialised hospitals and central hospitals. Interventions should be done at all facilities with the exception of district hospitals. Placement and follow up should happen at all facilities except at clinics.

The three groups agreed with each other on one point: Eighty-nine (93%) indicated that preventative vocational rehabilitation services should be offered at clinics. Reflection on this strongly perceived opinion raises concern. Arguing from the premises that 1) the aim of occupational therapy services should be to meet the needs of the clients that visit the facility where they work^{53,54}, 2) the patient profile that visit public healthcare clinics is usually the elderly, the unemployed and mothers with babies or disabled children^{55,56} 3) the nature of vocational rehabilitation prevention services are aimed at the prevention of injury at work and to create an awareness of good work practice, which implies that clients should be employed workers^{20,57}. The conclusion must be drawn that the most strongly perceived opinion in this survey has been influenced by respondents' knowledge of the common clinical practice of prevention as part of primary healthcare at clinics. Respondents appeared unaware that prevention at clinic level would be an unsuitable option for vocational rehabilitation services within that setting.

A high level of consensus was that screening services should happen at clinics (70%), district (72%) and regional hospitals (72%) and that assessments should be done at central hospitals (75%). These opinions were reflective of the current state of affairs in Gauteng public health care facilities. There was no evidence of consensus about where intervention, placement and follow-up services should be offered. It is noteworthy that respondents reached consensus on only five of the 36 (5/36) combinations of services and facilities and poor consensus (ranging between four and 59%) for the rest of the combinations (31/36).

Narrative responses: The option for narrative responses at the

end of the survey was taken by 23% (n=72) of the respondents. The narrative responses showed three emergent themes of which the first two were contradictory. The contradictory themes, despite being in direct contrast with each other regarding practical implementation, deserve consideration as both schools of thought hold valid points.

The first theme indicated that all vocational rehabilitation services should be offered at all levels of healthcare and that all occupational therapists should be involved in offering such services. The suggestion was made that training of therapists, more equipment and more space should be considered by public healthcare management to ensure this. This opinion supports the constitutional right of equal access to health. It shows insight and consideration for the reality of public healthcare users when patients struggle to afford the out-of-pocket expenses associated with referral between healthcare facilities and other resources. It also addresses the sporadic problems of communication and service breakdown that occurs within the current referral system.

The second theme was that vocational rehabilitation is a specialised service that needs a multi-professional approach, dedicated posts, and implemented at a centralised location which is preferably not linked to healthcare. One strongly worded narrative indicated that vocational rehabilitation services cannot be categorised or separated. The opinion was that there should be a central work unit with a specialised multidisciplinary team attending to all aspects of vocational rehabilitation. Clinical experience in vocational rehabilitation services supports this opinion. Every patient that is seen has unique circumstances due to multiple variations of pathology and specific work requirements. This is further complicated by varying levels of prognosis, stages of recovery and availability of socio-economic resources. The result is that vocational rehabilitation services are often interlinked in clinical practice. Prevention services could for example be part of an intervention programme focused on returning to work.

The third theme identified current problems experienced with vocational rehabilitation services. These were mostly related to referral systems, problems with service efficiency and communication breakdown between healthcare facilities.

Both the linear and the narrative responses reflect the conflicting ideals and realities associated with vocational rehabilitation in public health. In order to provide affordable and accessible services to the majority of the South African population and to meet the rights of citizens, integrated service delivery models should be considered. However, due to the complexity of cases, as identified specifically by the second and third narrative themes, only highly trained and specialised staff with access to equipment and resources and to support multiple site visits, could deliver relevant outcomes. These contradictory expectations are evident within the linear responses.

Several factors had an impact on the trustworthiness of this inquiry. Respondents' varied levels of experience, competence and knowledge of vocational rehabilitation and the nature of public healthcare facilities could have negatively affected the credibility of the results. Practical challenges prevented the authors from presenting instructive workshops as an alternative to provide more detailed definitions of the various categories and using other data collection techniques like focus groups was not pursued.

Due to the unique focus of the inquiry into positioning of vocational rehabilitation services and its specific relevance for the Gauteng Public Health Care system, no research evidence could be accessed to support or contradict findings.

The trustworthiness of this inquiry was considered throughout by the authors. With deference to internal validity, the design and content of the opinion survey was standardised and critically reflected on by independent but concerned parties. All participants received the same survey form and reasonable attempts to avoid multiplications of a single respondent's opinion were done. Analysis of the results was done separately by the authors and then



compared for final analysis. Purposeful transparency at all stages of the research was maintained by researchers and authors. Insider stakeholders were used as fellow researchers and were involved in all aspects of the research from the design of the opinion survey to the writing up of the results into a peer reviewed journal article. Objectivity was attended to by launching the inquiry, which is part of a PhD study, as an insider project through the VRTT. The survey population was made up of both insider and outsiders. Comparing the insider opinion results with two groups of outsider opinions through triangulation further enhanced the objectivity element. The aim of this survey was to use the emerging knowledge, occupational therapists opinion of where their vocational rehabilitation services should be offered, for future collaborative planning and policy making to improve the service. This brings about an important action research principle i.e. applying emerging knowledge within the population it was generated from.

LIMITATIONS OF THE STUDY

Subjective opinion, that which was gathered in this inquiry, is influenced by a vast variety of internal and external factors. This survey did not attempt to control any of these factors. The low response rate could also have affected the reliability of the results. These limitations can only be effectively attended to by a much larger scale of inquiry over a longer timeframe. Recognising this shortfall and planning for this deficit with the use of the data is important.

CONCLUSION

The results of this survey showed a general lack of consensus amongst occupational therapists about what vocational rehabilitation services should be offered at the different levels of public healthcare. With singular exceptions the generic opinion was that occupational therapy's vocational rehabilitation services should be offered in public healthcare. No other opinions from this survey give guidance or insight to support planning and policy making.

Therefore, this research cannot be used in isolation to inform planning and decision making regarding the positioning of vocational rehabilitation services in Gauteng public healthcare. It could be used in combination with other sources of information as part of an informed decision making process. A systematic review of international literature on where occupational therapists are delivering vocational rehabilitation services is suggested.

The benefit of this study does not lie in the content of the opinion survey. It lies in the nature of the inquiry, namely that frontline occupational therapists were asked for their opinion on matters which will affect their service delivery in future. This approach constructs a collaborative relationship for future efforts to identify and address problems with vocational rehabilitation services in Gauteng public healthcare. It raised a general awareness of vocational rehabilitation, informed practitioners of a broader perspective of service problems and allowed them to be included in planning and decision making efforts to address these. Continuous transparency, keeping all practitioners involved and informed, will maintain this sentiment and collective energy for future transformational efforts.

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4.3.4 Collaborative reflection on the results of the opinion survey

Reflections on the result of the opinion survey left the VRTT feeling discouraged about being able to develop a framework that would guide and position transformational efforts. There was no clarity on what vocational rehabilitation services clinical occupational therapists should be offering throughout Gauteng. In addition, the practical problems of unequal resource distribution and the lack of skilled therapists who could do vocational rehabilitation complicated the planning. There was a general attitude of, *“We cannot do anything about this so let’s just get on with doing the things that we can do something about.”*

The VRTT decided to cease planning efforts towards forming a framework and guidelines that would inform occupational therapists what vocational rehabilitation they should offer at the various levels of service in Gauteng’s public healthcare. They decided to focus on addressing the vocational rehabilitation practice problems they identified in their clinical work. Such ALAR cycles were already in progress as part of the action phase, which will be discussed in Chapter Five. The action phase was running concurrent to this planning phase and proving to effectively address clinical vocational rehabilitation problems. While the results of planning approaches, taken in this phase, to create a framework within which these clinical vocational rehabilitation services should be done, were discouraging.

4.4 Discussion of the Planning Phase

The collective attitude of the VRTT was to abandon attempts at addressing the question of what vocational rehabilitation services occupational therapists should be offering in Gauteng’s public healthcare. While respecting and understanding this sentiment, the researcher had concerns regarding the long-term effects of not having a framework or guidelines for the vocational rehabilitation services of occupational therapists in Gauteng. She felt it was important for the sustainability of transformational actions and continuously brought up the matter as a point of discussion within VRTT meetings and with individual members or smaller groups of VRTT members. It was found that younger inexperienced VRTT members were reluctant to offer suggestions or take part in group discussions on framework, which inevitably ended up being between the chair of the VRTT, the deputy director of rehabilitation in Gauteng, one or two senior occupational therapists and the researcher. This negatively affected the ALAR nature of the process. It could be that the VRTT, which consisted of predominantly clinical occupational therapists with limited managerial experience, might not be the correct forum to address this type of planning.

It was difficult for the researcher to leave this important aspect of transformation unfinished and the temptation to revert to tactics that would violate the ALAR ethos was great. She had to caution herself to trust the research method and allow the VRTT to take sufficient time to gain authentic insight and understanding. Some progress was seen in this regard, albeit not at the rate the researcher would have liked. During the June 2016 meeting a decision was made by the VRTT that occupational therapists vocational rehabilitation in Gauteng's should be offered at all levels of service. They felt the work needs of the healthcare users should be met at the point of service, also the referral of healthcare users to specialised work units for vocational rehabilitation should be minimised as it caused out of pocket expenses and resulted in non-compliance or loss of referred individuals. They agreed there had to be some specialised work units in the province where specialised vocational rehabilitation clinicians, equipment and services, such as driver assessments, could be offered. The discussion however concluded with a listing of restrictions and problems that such planning would bring about.

At the end of the research tenure with the VRTT there was still no framework or guidelines in place. Occupational therapists in Gauteng public healthcare still do not know what vocational rehabilitation services they should be offering at the different levels of service in the province. This could have been a contributory factor for the current state of vocational rehabilitation services and could hold future problematic implications for the service. Future research and planning is needed to attend to this. The researcher was of the opinion that discussions concerning an executive plan for vocational rehabilitation services in Gauteng were becoming more informed and insight into the importance of such a plan was growing. This indicated VRTT members had experienced personal learning about the problem.

4.5 Conclusion to the Planning Phase

In ALAR, planning needs to be done with care, so the democratic grounding of actions and learning do not get lost in attempts to achieve a pre-conceived objective. This was seen in this phase. Two types of planning were identified in this enquiry, clinical planning and planning to create a framework and guidelines. The membership profile of the VRTT made clinical planning an easy exercise. As a result, transformational change of the vocational rehabilitation occupational therapists was seen on a clinical level, however planning to create a framework was problematic and remains so to date. It is the opinion of the researcher that without a framework and clear guidelines

of what vocational rehabilitation occupational therapy should offer at the various levels of Gauteng's public healthcare, sustainable transformation cannot be claimed.

Although it is important to have such a framework plan, it is more important to have a plan that is owned by the insiders group and not interjected by an outsider expert. Dick supports this by saying that change occurs most effectively when those who are to carry it out are involved and committed (2013a). Kemmis and McTaggart (2007) concurred saying that the success of action research is not whether steps have been followed dutifully or planned outcomes have been achieved, but rather whether participants have a strong feeling of authentic ownership and understanding of the transformation process.

Leaving this phase un-concluded, the researcher realises that despite not having reached the desired outcome of the phase, progress had been made and action learning had taken place on many levels during this phase. In addition, the transformation of clinical vocational rehabilitation was taking place as specific practice problems were being addressed by the VRTT in individual action cycles. This reflects some of the mind-set and reality of many occupational therapists working in public healthcare: they focus on getting the job at hand done. They work with what they have, where they are, as best they can.

The next chapter shows these clinical transformative actions as the action phase. The action phase illustrates the ALAR cycles that had taken place and concluded during the researcher's tenure with the VRTT.

Chapter Five: Action Phase

“Action researchers recognize that theory informs practice and practice can generate theory.”

Coghlan and Brydon-Miller (Coghlan & Brydon-Miller, 2014)

5.1 Introduction to the Action Phase

This chapter shows the action phase of the research and describes action learning action research cycles that took place during the research tenure. Ideally, the action phase comes after the observational and planning phases. However before these phases had shown any conclusive evidence, multiple action cycles were operational, addressing the practice problems clinicians working in Gauteng’s public healthcare experienced. Throughout the research, one action cycle would still be in progress when the next practice problem was identified by the Vocational Rehabilitation task Team (VRTT), and planning was started to address it. The VRTT members valued being part of clinical practice orientated action cycles. They grasped the action learning action research (ALAR) methodology and ethos while planning, acting, learning and reflecting on vocational rehabilitation practice problems they experienced and to which they could relate. Figure 5.1 presents the entire study with the highlighted sections indicating the position of this chapter on action.

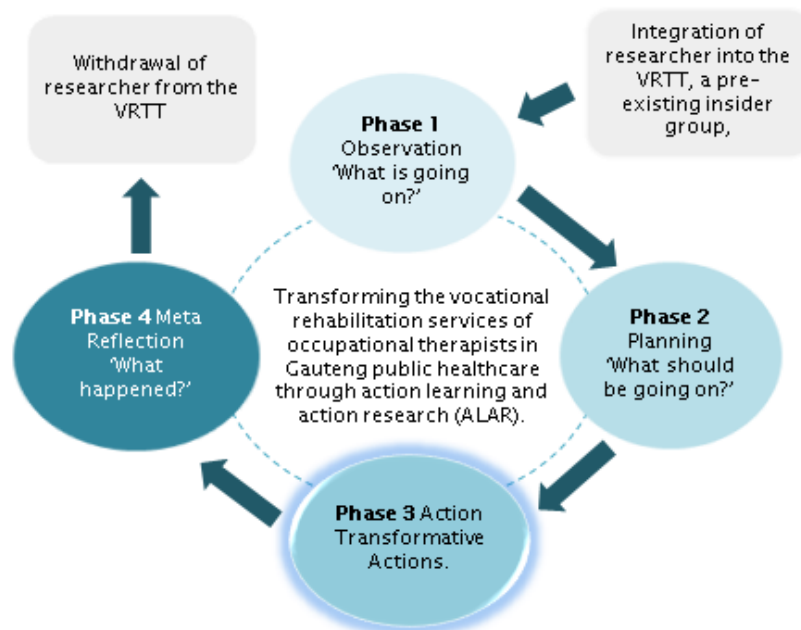


Figure 5.1: Diagrammatic presentation of the research process positioning the action phase

Action cycles that were concluded during the researcher's tenure with the VRTT are presented in this chapter, in chronological order of when they started. Some cycles took longer to conclude than others and often overlapped. This phase clearly shows how action and critical reflection brought about learning and improved further actions. It also provided evidence of new knowledge that was created and disseminated and the positive reaction this generated.

Five practice problems were identified by the Vocational Rehabilitation Task Team (VRTT). The ALAR cycle was implemented to address each problem. These problems included poor report writing and a lack of report template standardisation in the vocational rehabilitation practices. This was followed by the question of what practitioners should do about addressing the question of ability to drive with their clients. The VRTT felt the skill and practice of MODAPTS was underutilised in their vocational rehabilitation practices. The need for a user manual on how to do a basic work assessment was identified. The clinical supervision of undergraduate students was started and the question of how to do this addressed.

5.2 Overview of Tools and Processes used in the Action Phase

Each ALAR cycle used tools and processes unique to the practice problem it was addressing and these are discussed within the context of the cycle reported below. In addition to problem specific tools, generic tools, such as VRTT meeting minutes supported by the researchers meeting summaries, individual and collaborative reflections, individual, group and telephonic interviews, guided reflection questionnaires, journaling and field notes were used.

The researcher guided the VRTT members to reflect on their action at the end of each year. This critical reflection of action is discussed in Chapter Six as part of the reflection phase. These reflection results were used to make decisions regarding the transformational actions in which the VRTT was engaged. In 2014, the decision was made to use workshops as the tool to bring about learning and transformation of services. Critical reflection proved this ineffective and the transformational tactic was changed to mentoring in 2015.

5.3 Findings of the Action Phase

5.3.1 Report Writing

The first ALAR cycles, addressing the practice problem of vocational rehabilitation report writing, formed part of the successful integration of the outsider researcher into the insider VRTT group. In addition, VRTT members experienced the benefits of action learning while doing research that directly benefitted their clinical practices. The cycles concluded with a user manual titled *Report Writing Protocol* and report templates, which would be reviewed annually to improve their content. It was decided to write a journal article about the process, but no VRTT members were willing to be part of this first peer reviewed journal article. They cited previous bad experiences, lack of ability to write academic literature and being too busy, as excuses for not being co-authors. The researcher and her supervisors wrote the article.

Developing a vocational rehabilitation report writing protocol - a collaborative action research process

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ABSTRACT

A vocational rehabilitation interest group of occupational therapists in the public healthcare sector of Gauteng, South Africa, identified the writing of reports as a practice problem. Supported by a PhD candidate, they developed a report writing protocol with report templates, using action research as methodology.

Collaborative steps, as part of an action research inquiry were taken to compile a concept report writing protocol and report templates. The concept protocol and templates were implemented in public healthcare vocational rehabilitation services. Critical reflection and feedback on the trial applications took place to refine the protocol. The protocol consisted of a cover letter, background information, legal and ethical considerations for reports, a step by step report writing guide including handy tips, report writing templates, and a guiding checklist. It concluded with a request for feedback from users, an undertaking for annual revision and suggested readings and skills training. Selected experts reviewed and critically appraised the final version. Dissemination of the final report writing protocol and templates was done through public healthcare forums and the annual vocational rehabilitation orientation workshop for occupational therapists entering public healthcare.

Key words: occupational therapy report writing, vocational rehabilitation, public healthcare, action research

INTRODUCTION

Professional report writing is a generic skill and its proficiency easily assumed. In vocational rehabilitation, report writing is an essential skill for occupational therapists as it directly implicates the outcome of the intervention¹. Once the skill is mastered, the process of acquiring the experience and confidence for report writing is rarely systematically captured and skilled occupational therapy clinicians in public healthcare find it difficult to pass their skills onto less experienced and less confident colleagues.

In South Africa occupational therapy services in public healthcare are complicated by high staff turnover and a yearly influx of newly graduated community service occupational therapists who are often expected to render services and tasks they lack confidence and experience in. The general consensus from the Gauteng Vocational Rehabilitation Task Team (VRTT), an interest group of occupational therapists concerned with vocational rehabilitation services in public healthcare, was that experienced occupational therapists are usually in management positions and overloaded with managerial tasks, mentoring of new and inexperienced therapists, supervising students and carrying clinical patient care responsibilities. Members of the VRTT were also of the opinion that vocational rehabilitation report writing is an arduous task with potential conflict and repercussions as the report can be used by employees and employers for disputes and legal actions. As a result it appears that

in some hospitals newly appointed and inexperienced occupational therapists refuse to write vocational rehabilitation reports, leaving it to their more experienced colleagues and therefore perpetuating the challenges and complications mentioned above.

The VRTT identified report writing as a priority practice problem to be addressed as a section of their bi-monthly meetings. The aim of this study was to develop an easily understandable, user friendly vocational rehabilitation report writing protocol with standardised report templates for the type of reports most commonly written in public healthcare. The reports identified to be most commonly written in Gauteng's public healthcare and for which templates were needed were: Functional capacity evaluation (FCE) reports; Policy and Procedure on Incapacity Leave and Ill-health Retirement for public service employee's (PILIR) reports; Disability Grant (DG) reports; Vocational Rehabilitation Screening Tool reports and medico-legal reports. The function of the report writing protocol would therefore be to: set a standard for vocational rehabilitation report writing; to standardise the format of a report; provide practical guidelines for inexperienced occupational therapists for writing vocational rehabilitation reports and thereby to enable therapists to spend less clinical time writing reports.

This article forms part of a PhD study, the purpose of which is to transform vocational rehabilitational services in Gauteng's public health care through action research. The article aims to describe



the process and outcome of developing a report writing protocol and relevant templates using action research cycles to address a practitioner identified practice problem.

LITERATURE REVIEW

Scientific and grey literature were searched for articles with the key words; professional report writing, adult occupational therapy, protocol, vocational rehabilitation and public healthcare. The selected literature revealed that professional report writing skills, therapists' confidence and legal/ethical considerations were found to be recurring themes.

In vocational rehabilitation, the report forms the basis of decision making². Preparing a useful and effectively written report is an important part of a therapist's work as it communicates future intervention or the results of intervention^{3,4}. Buys identified knowledge, skills and values required by occupational therapists to deliver vocational rehabilitation services in South Africa. Among the important skills that Buys identified were report writing and competency in English as a business language. Beukes⁶ formulated a standard statement and measurement criteria for effective vocational assessment. She indicated that a report is compiled at the end of the assessment period and gives eight measurement criteria for report writing, for instance, recommendations regarding employability, a plan how to implement the recommendations made, and reports the assessment results to the referring agency. Her standard statement concludes that the report should focus on a worker profile of the client, and indicate problem areas and assets regarding the client's work abilities. De Clive-Lowe⁷ indicated that the ability to communicate the skills and techniques offered by the occupational therapist, are essential in a report, both for professional survival and for the long-term benefit of clients and emphasises that practice and training are needed to prepare well written reports.

The importance of accurate and skilled reporting of functional capacity evaluations are highlighted in several articles which also uses the ethical element of report writing^{1,3,8-14}. Escorpizo *et al*¹⁵ indicated that a successful vocational rehabilitation programme relies on the interrelationship between several elements and they note that effective communication between the employer and the healthcare practitioner is one such element. Reporting a client's work abilities accurately is essential in the rehabilitation process^{1,10,16}. Buys and van Biljon¹ noted that reporting the results of an occupational therapy functional capacity evaluation is often frustrating and time consuming, but without this vital step, the outcomes of the evaluation might not become a reality for the client. A framework for improving occupational therapists' opinions on work capacity¹⁷ indicated 17 guiding strategies and principles. Two of them are about report writing and advocate the practice of adopting a consistent occupational therapy assessment and reporting template and to shorten reports by reducing detail.

All newly qualified occupational therapists have to face the daunting transition from student to professional practitioner and the work environment and support they receive during this time have a significant impact on their confidence¹⁸. Developing and fostering professional confidence should be nurtured and valued to the same extent as professional competence, as the former underpins the latter, and both are linked to professional identity^{19,20}. The teaching of structured writing, like report-writing, is important as a means of teaching therapists and students how to express and present information effectively, but also to facilitate scientific thinking^{21,22}.

In South Africa there is legislation that impacts on the occupational therapist writing a vocational rehabilitation report. All occupational therapists should have a sound knowledge and understanding of the content and implication of such legislation and comply with these in practice.

The Constitution of the Republic of South Africa²³; the Bill of Rights (Chapter 2) affirms the democratic values of human dignity, equality and freedom. This holds implications for the content, the

storage and the distribution of reports. The Promotion of Access to Information Act²⁴ gives effect to the constitutional right of access to any information held by the State or any other person that is required for the exercise or protection of any rights and to provide for matters connected therewith. Informed consent, transparency and objective professionalism should permeate every aspect of the report and report writing practice.

Although report writing is not specifically mentioned in the following acts, reports can be seen as a form of communication with the client and this is addressed and outlined in the following legislation: The National Health Act²⁵ provides a framework for a structured uniform health system within the Republic of South Africa, taking into account the obligations imposed by the Constitution and other laws in the national, provincial and local governments with regard to health services matters. The Health Professions Amendment Act²⁶ led to the establishment of the Health Professions Council of South Africa (HPCSA) and the latter provides control over the training, registration and practices of health care professions and matters incidental thereto. The HPCSA has ethical rules of conduct²⁷ that outlines the regulation of practice, including that of report writing, for all professionals registered with the HPCSA, including occupational therapy practitioners.

Occupational therapists need to be informed about legislation that has implications for injured and disabled workers that would affect the outcome of their vocational rehabilitation intervention. Their knowledge of this legislation should be reflected in the recommendations and suggestions made in the report for example; The Labour Relations Act²⁸ which aims to promote economic development, social justice, labour peace and democracy in the workplace. The Employment Equity Act²⁹ is concerned with promoting equal opportunity and fair treatment in employment through the elimination of unfair discrimination and implementing affirmative action measures to redress the disadvantages in employment experienced by designated groups. The Employment Equity Act ensures equitable representation of designated groups in all occupational categories and levels in the workforce. The Occupational Health and Safety Act³⁰ provides for the health and safety of persons at work, in connection with plants and machinery and protection against hazards to health and safety arising out of activities at work.

Van der Reyden³¹ summarised the impact of legislation on occupational therapy practice in general and this understanding sets the tone for all report writing. She notes that acceptance of the client as an important partner in the healthcare process and acknowledgement of the individuals' ability to not only participate in, but make valid decisions about their lives, health, vocation/work and care is now central to every intervention. Such a mind-set diminishes the medical paternalism that formed the cornerstone of healthcare in the past. This mind-set should be reflected in the manner in which reports are written.

In the face of such challenges every effort should be made to mentor and support inexperienced occupational therapists to develop the relevant skills and confidence when writing vocational rehabilitation reports. Developing an easy-to-understand and user-friendly protocol with supportive templates and making sure that all therapists entering public healthcare are acquainted with it was directed at meeting the above challenge.

METHOD

Study design

The epistemology of action research permeated this study. Action research facilitated a process for protocol and report format development while simultaneously transforming practice. This process relied on a collaborative effort between the practitioners and the researcher adhering to an action research approach of working towards practical outcomes while contributing towards human emancipation and transformation³². It allows practitioners to be fellow researchers and participants, learning from experiences and



producing knowledge that is relevant to their practice situations and to which they can relate³³.

Population

In this study the researcher (first author) as an outsider was invited to collaborate with a group of insiders as they shared the common goal of developing a report writing protocol and templates for the vocational rehabilitation services in Gauteng public healthcare. These insiders are described by Dick³⁴ as *stakeholders* - persons involved who have a stake in a programme and who are affected by or able to effect practical change. In this research the VRTT of Gauteng constitutes the stakeholders. The VRTT is a group of occupational therapists with an interest in vocational rehabilitation, working at four large academic hospitals in Gauteng's public healthcare sector in which vocational rehabilitation services are offered. The group was formed in 2011, by the Assistant Deputy Director of Gauteng Health, to resuscitate and support occupational therapy's vocational rehabilitation services in Gauteng public healthcare.

The structure for participation that guided the action research process was created when the researcher (first author) was allowed entry into the VRTT as an honorary member. Her PhD, titled '*Transforming Vocational Rehabilitation in Occupational Therapy Departments in Gauteng public healthcare through Action Research*' corroborated the VRTT vision.

A selected group of experts in vocational rehabilitation was incorporated as 'critical friends'^{35,36} for their critical reflection, opinion and comment of the final protocol and templates for report writing. The selection criteria for inclusion into this group were occupational therapists with previous or current experience of working in South Africa's public healthcare and current experience of more than 5 years of working in and/or teaching vocational rehabilitation. Twelve such stakeholders were identified and 7 responded within the requested time frame.

All participants were informed verbally and by a written pamphlet that they could keep, that this project was part of a larger PhD study. How this project fitted into the study and how the

generated knowledge would be used was discussed and consent forms were signed.

Data collection

After the VRTT members identified the practice problem of vocational rehabilitation report writing the researcher suggested addressing the problem through action research cycles³⁵. Care was taken to process all decision making through the VRTT to avoid power relationships that could jeopardise the emancipatory nature of action research³⁷. Data were captured in the form of the VRTT meeting minutes. The researcher trained the participants in reflective journaling. They applied this technique and reflected after each meeting. The researcher kept her own reflective journal. While participants were using the report writing templates, they communicated through an e-mail group to clarify and discuss practice issues. Participants were encouraged to keep field notes to capture their experience and these were shared during the VRTT meetings as verbal feedback and/or written notes.

The report writing protocol and relevant templates were researched in the cyclical action research process of *reflect-plan-act*³². Nine steps ensued. *Figure 1* is a graphical representation of these nine steps, encapsulating the natural progression of the *reflect-plan-act* process that evolved during the research process.

In *step one* (*Figure 1*) the researcher enabled informed reflection on report writing for vocational rehabilitation services as she presented the results of a literature review in the form of a workshop to the VRTT. This workshop focused on report writing for vocational rehabilitation in public healthcare.

A variety of report writing templates were studied and discussed and five service specific templates were compiled for FCE, PILIR, DG, vocational rehabilitation screening tool and medico-legal reports. A draft report writing protocol with templates was **planned** and drawn up in *step two*. The decision was made to test these in the respective vocational rehabilitation practices, keep field notes and report back at the next VRTT meeting. This step focussed on the attainment of action-orientated outcomes and supported the validity of the research process³⁸.

This draft protocol and templates were put into **action** and used for two months in vocational rehabilitation practices at public healthcare hospitals as *step three*. The VRTT members and their colleagues who offered vocational rehabilitation services participated in this action phase. Process validity was promoted due to the active generation of new knowledge by all stakeholders during this step³⁸.

The VRTT members brought their findings and experiences back to the group in the form of verbal feedback and field notes. Analysis and critical **reflection** of the experiences and feedback was considered and discussed in *step four*. Therefore, the promotion of democratic validity was an inherent part of the process³⁸.

Step five's planning took cognisance of the feedback, field notes, reflections and refinement of the report protocol and templates. This was done by the researcher and presented for verification and approval by all participants at the following VRTT meeting.

The **action** to validate and enrich the credibility of the report writing protocol and templates was in *step six*. The report writing protocol was sent for objective and critical appraisal to pre-selected vocational rehabilitation experts who responded in electronic format with their opinions and comments.

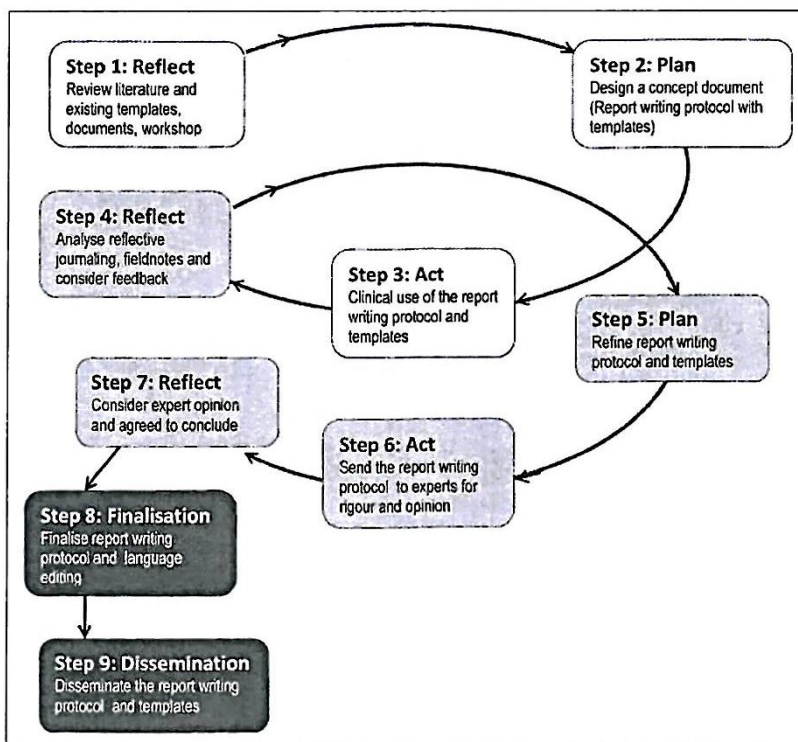


Figure 1: Action research process of developing a report writing protocol



Their opinions were considered, **reflected** on and incorporated in **step seven**.

In **step eight** the report writing protocol tool and templates were **finalised**. These were sent for language editing and compiled into an easy to use, bound hard copy document and in electronic format.

The **dissemination** of the finalised protocol and templates comprised **step nine**. The electronic format of the report writing protocol and templates were shared with all occupational therapists doing vocational rehabilitation in Gauteng public healthcare through official public healthcare forums. It was included as a training session in the annual vocational rehabilitation orientation workshop for occupational therapists entering the public healthcare for the first time. They were given a paper copy with the option to request electronic copies from one of the members of the VRTT (the secretary). The process of developing the report writing protocol will be more widely disseminated through this article in the South African Journal of Occupational Therapy.

Data Analysis

The field notes, reflective journaling and meeting minutes were systematically analysed by the researcher through thematic and discourse analysis. In keeping with good practice, thematic analysis and in support of action research principles^{35,39} the raw data were manually checked and analysed immediately after gathering, throughout the process. Data were summarised and categorised. These summaries drove and dictated the next action research phase. For the results and discussion thereof in this article, data used in the phases are indicated as M for meeting minutes, F for field notes and R for reflective journaling.

The results and discussion are integrated to ensure a thick description and to provide literature and investigators (both stakeholder and researcher) the triangulation of findings.

FINDINGS AND DISCUSSION

1. Action cycle

The focus of the embedded action cycle was to address a lack of professional standards in vocational rehabilitation reports within public health care. The involvement of VRTT members ensured that novice and expert practitioners contributed to a report writing protocol that would be accessible to all occupational therapy practitioners. Attention was given to:

- **Language proficiency:** The finalised report writing protocol for vocational rehabilitation services in public healthcare is written in easy to understand English. A language editor was an unplanned but valuable addition. This person added practical suggestions and generic principles on report writing e.g. 'use polite language' and 'think before you type it out'.
- **Design:** It consisted of a cover letter, background and general information, legal and ethical considerations, a report writing process, templates, report writing tips, a checklist, conclusion and references (with recommended reading and skills training). The cover letter was personalised with an informal tone to introduce the tool. The authors, contact details and the date of the document were included. Legal and ethical considerations specifically referred to challenges experienced in public health. Practical guidelines included how many pages the different types of reports generally were and an estimated time an experienced therapist would take to write such a report.
- **Methodical instructions:** The report writing process was described systematically in 12 practical step-by-step instructions. A check list that therapists should check before and after writing a report was included. *Table 1* presents the checklist.
- **Conformity:** To ensure a degree of uniformity report templates were drawn up for FCE reports, PILIR reports, DG reports, vocational rehabilitation screening tool reports and medico-legal reports.

Using scientific literature is a well-known and respected practice when developing a protocol^{40,41}. There are, however, several reasons why this practice was not sufficient evidence to draw up a protocol for occupational therapists' report writing of vocational rehabilitation services in the context of public healthcare in South Africa.

The first reason is that there are limited literature, guidelines and/or written instructions available on occupational therapy report writing for vocational rehabilitation in South Africa. What there was, are mostly used within universities and drawn up for the purpose of teaching undergraduate occupational therapy students.

Secondly, the practical nature of report writing lends itself to be investigated through methodologies such as action research. This methodology allowed for the active participation and involvement of practitioners in addressing their own practice problems and developing appropriate solutions. This was affirmed in this study when concerned occupational therapists developed a vocational

Table 1: Checklist for report writing from the Report Writing Protocol

Before you start to write a report
Do you know why you are writing this report?
Do you know who is going to read this report?
Do you have the client's consent to write and distribute this report?
Did you do a thorough assessment and do you have enough information to write the report and justify your conclusion?
Are all the tests marked and interpreted correctly?
Do you have a clear idea/opinion of the conclusion?
Do you have all the information for relevant referral sources and suggested accommodations, assistive devices, interventions?
Did you read and do you understand the ethical and legal issues relevant to writing this report?
Do your conclusion and suggestions hold the clients best interests at heart?
After you have written a report
Will the report be handled and stored with confidentiality and the patient/client's right to privacy in mind at all times?
Has the language and contents been checked?
Has a colleague read and commented on the report?
Has the report been shared and distributed to all the relevant role players?
Do you have proof that they received the report?
Did you make a note of what you learned from this report?



rehabilitation report writing protocol, using action research to complement a literature review.

A third reason was that public healthcare is a unique working milieu with opportunities and challenges that are not formally documented and best known to practitioners working within the context. This was constantly taken into consideration with the development of the report writing protocol.

2. Research cycle

The focus of the embedded research cycle was to generate new knowledge relating to setting professional standards for report writing protocols when working in collaboration with practitioners. The generation of new knowledge was a collaborative effort between vocational rehabilitation practitioners as insiders within the Gauteng public health service and the researcher as an outsider. The action research process promoted different modes of participation and resulted in involvement of relationships and associated actions of the parties involved.

Evolvement of the insider perspective: The initial co-option of the VRTT members meant they were chosen as mere representatives of the interest group but through their collaboration as stakeholders they could have felt that they had real power.

The VRTT had three meetings in which the need for standardisation of vocational rehabilitation report templates and the report writing process was noted. Meeting minutes (M1, 2, 3) showed discussions related to problems of report writing i.e. the need to write better reports, therapists feeling they should spend less time writing and reading reports as it kept them away from client contact and concerns about the quality of vocational rehabilitation reports going out from public healthcare services.

After six months these identified problems had not been addressed and the researcher offered to present a workshop on current report writing literature, legislation and ethical issues relevant to report writing. Although requested to collaborate by bringing existing documentation, none of the participants brought templates or prepared for the meeting and a concept protocol could not be drawn up. However, a discussion on the different types of reports that were being written and the practice of report writing ensued. This discussion ensured that the stakeholders felt consulted and provided input. They realised the scope of their role as stakeholders.

Evolvement of outsider perspective: The researcher as an outsider and well-established private practitioner in the field of vocational rehabilitation was initially challenged by the potential power relations between her and the rest of the VRTT members. Her defined roles as catalyst and informed observer³³ were initially undermined due to that fact that she was also acting as data collector and offered to act as mentor throughout the process. The latter could both be interpreted by VRTT members as authoritative roles. However, active involvement in the action research process allowed the researcher as an outsider to facilitate collaboration with insider members that was more reciprocal in nature³⁸.

The researcher shared and exposed her expertise during the workshop covering current report writing literature, legislation and ethical issues relevant to report writing. She promoted a situation for co-learning and facilitated an agreement between all parties to

work on a joint aim: drawing up templates and a protocol that would enable therapists to spend less time writing reports, set a vocational rehabilitation report standard and give practical guidelines for new/inexperienced occupational therapists to use. Her willingness to support collective action ensured that the practice problem was addressed. Electronic copies of report templates and suggestions for the protocol were emailed to her so that she could initiate a concept protocol and template for each of the types of report discussed. Five of the seven therapists complied with the provision of information (M6). Cooperative engagement was documented at a follow-up meeting when a VRTT member expressed:

"I am glad we can share this (a report writing protocol and templates) with therapists in secondary and primary healthcare facilities as they will also benefit from it." (R3)

At the same time reflective journaling by VRTT members showed a positive disposition towards the process. The feeling was that it was a worthwhile exercise for the group to engage in, especially as it would hold benefit for new and inexperienced therapists.

Reciprocal collaboration: Stakeholders were encouraged by the achievement of the action-orientated outcomes and collaborated in discussing and brain storming options for the draft protocol. Representatives from each hospital were given a file with the draft protocol and electronic report templates were e-mailed. All members agreed to trial the protocol and associated templates. The researcher maintained her facilitative role and sent out two emails and one text message as a reminder to the members of the VRTT to use the templates and protocol and prepare for the feedback. These messages were accompanied by an offer to assist if there were difficulties.

Co-learning continued during the feedback session after the initial report writing protocol tool was implemented (see Table II). The suggestions and feedback by VRTT members were analysed and incorporated in refining and improving the report writing protocol as well as the templates and represented for verification at the following VRTT Meeting (M7). Progress towards the agreed aim empowered VRTT members to the extent that one observed:

"It feels as if we are moving forward despite our current challenges (practising in public health care)" (R5).

The extent of true ownership is most evident in how the VRTT agreed to disseminate the final protocol and templates. Reflective journaling after this discussion showed that:

"The plan to publish what we have achieved as a team excites me. I feel it is important to share our knowledge and skill with our peers and those therapists with little or no experience in vocational rehabilitation" (R6).

To ensure ownership and as respect to the generation of new knowledge the end of the document stated that the protocol is the intellectual property of the VRTT, Gauteng Health and should be acknowledged as such.

During the development of an audit tool for allied healthcare professionals in Gauteng's public healthcare, Foote et al⁴² noted that quality improvement is a dynamic process and needs to be incorporated on a broader basis with service improvement within

Table II: Collaborative efforts from insiders to pilot the initial report writing protocol tool

Hospital A	No feedback could be given as no patients had been seen and thus no reports written.
Hospital B	Comprehensive written and verbal feedback was given. The written feedback was typed out and handed over to the author. Changes to the protocol were suggested. Suggestions to simplify the process and timesaving tips were provided. Field notes showed the following <i>"It is taking us longer to write the reports probably because the templates were unfamiliar. Hope it gets better."</i> (F1)
Hospital C	Verbal feedback (considered as field notes for the purposes of this article) was given. <i>"The templates help a lot. It is a good thing."</i> (F2)
Hospital D	No feedback could be given as a staff turnover had taken place and the therapist who had attended the prior meetings was not working there anymore. During hand over the instructions to use the report writing protocol and templates and prepare for feedback had been lost.



the Department of Health. They advocate that service improvement should be in line with the South African governments 'Batho Pele' (People First) initiative for quality and accountability in the public healthcare sector⁴². Robinson and Botha⁴³, in an article on quality management in occupational therapy recommend that increased standardisation for documentation, and its auditing, should be promoted and advocated. The development of a report writing protocol and templates echoes these sentiments and hoped to encourage similar activities to improve occupational therapy's services to their clients in public healthcare.

The occupational therapists rendering the vocational rehabilitation services actively participated in generating the knowledge and practical solutions sought to address their report writing problem. In the process they also experienced ownership of the outcome^{34,35,37}.

The effectiveness of a protocol lies in the hands of the clinicians for whom it was written. The accessibility of a protocol lies in the hands of the authors who drew it up. A number of suggestions for protocols to have a sustaining impact flowed from this research and are given below.

Practice problems are often addressed by policy makers isolated from the realities of everyday clinical practice. The authors of a protocol and clinicians to whom it applies need to work together to ensure that the content of protocols are relevant to the contexts they apply to. Action research is suggested as a methodology to drive the development of protocols as it ensures its authenticity³⁹. The data captured to form the content of the protocol will then be relevant and meaningful to health practitioners who will be using it. Action research frames the solution to a problem within the context it is to be used in⁴⁴.

3. Anticipated future action cycles

Awareness and understanding of this newly developed protocol would be essential. It could be introduced and taught to all occupational therapy practitioners entering a vocational rehabilitation service during orientation periods. Regular in-house workshops need to be done to refresh the commitment and memory of experienced therapist who might have become trail-weary.

Clinical managers could find it a long term benefit to sporadically monitor the practical application of protocol content and when necessary mentor the implementation and application.

Where occupational therapists lack confidence and experience it needs to be addressed within the practice and by the institutions where they are employed. Holland *et al*¹⁹, describe professional confidence as a dynamic, maturing personal belief held by a professional or student. This includes an understanding of and a belief in the role, scope of practice, and significance of the profession. It is based on their capacity to competently fulfil these expectations, fostered through a process of affirming experiences. Having protocols is one way to enable this²⁰. Mentoring could also be considered to facilitate the transformation.

Finally a protocol needs to be regularly revised to ensure continuous evolution to keep up with ever-changing healthcare environments as well as client and practitioner needs. This can only be done if there is feedback from the practitioners using it.

CONCLUSIONS

The action research design applied in this study suggested that a combination of scientific information and practical experience resulted in a trustworthy report writing protocol for the solution of an occupational therapy practice problem. This reciprocal collaboration is one of the inherent characteristics of action research. The VRTT and the researcher endeavoured to continue to use action research in future vocational rehabilitation practice transformation in Gauteng's public healthcare.

The authors would like to caution that a relevant and well researched report writing protocol does not in itself guarantee good practice. It should be accompanied and supported with mentoring, effective management, regular training and updating of practitioners' skills. Once these are entrenched in practice, occupational

therapists can say with conviction that their client's best interests are being placed first: Batho Pele.

The Report Writing Protocol has information on the latest legal and ethical consideration related to writing a report, a step by step writing guideline, report templates, ergonomic considerations for a computer workstation, some 'golden rules and tips' from experienced report writers and checklists to use before and after writing a report. An updated protocol is available to any interested person from Naazneen Ebrahim who is the designated Report Protocol VRTT member. Her contact detail is nazneen.ebrahim@gmail.com

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The researcher made a point to share her writing experiences, the frustrations of writing and re-writing, the distress of receiving peer review feedback, the joy of acceptance for publication. When the article appeared it was celebrated by the VRTT as a collective achievement.

The user document *Report Writing Protocol* was, and still is, presented annually to all new occupational therapists at the Vocational Rehabilitation Orientation Workshop and used in student supervision. By word of mouth and after the journal article appeared interest in the outcome of this action cycle expanded beyond Gauteng public healthcare. Requests for presentations and copies of the *Report Writing Protocol* were received from private healthcare practices, the regional occupational therapy association and from other provinces' occupational therapy practices and associations in public and private healthcare. The interest in the protocol expanded beyond the field of vocational rehabilitation as occupational therapists in paediatric and general rehabilitation practices requested it. In July 2016, the researcher and a VRTT member presented it at the South African Occupational Therapy Association's National Congress. This presentation elicited attention from interest groups, private practitioners and occupational therapy management and practices in other provinces. It was shared and electronically forwarded to all who asked.

The *Report Writing Protocol* 2015 user manual is Appendix E.

5.3.2 Driver Screening

The conundrum of occupational therapy's role when assessing and addressing the ability of people with disabilities to drive a motor vehicle is not a new problem, nor is it unique to public healthcare. The medical team is often faced with this question and few of them feel confident, or adequately equipped, to answer it (Sims et al., 2012). As driving often impacts on work and employment, the question was being deferred to occupational therapists. Clinical occupational therapists approached the VRTT asking what they should do with healthcare users who are referred with the request for them to comment on their ability to drive. The first cycle to address this practice problem was started in September 2013 and continued into 2015, when a user manual called *Screening Ability to Drive in Occupational Therapy* concluded the conceptual cycles. This user manual is Appendix F, which will be reviewed and improved annually by the VRTT.

The user document was distributed throughout Gauteng public healthcare to all occupational therapy practices at all levels of care. It was, and will be, presented annually to all new occupational therapists at the Vocational Rehabilitation Orientation Workshop and is used in student supervision. The researcher and the chair of the VRTT also presented it at the July 2016 South African

Occupational Therapy Association's National Congress, which resulted in considerable interest from interest groups, private practitioners and occupational therapy management and practices in other provinces. It was shared and electronically forwarded to all who asked.

5.3.3 MODAPTS

In 2014, clinical application of occupational therapists MODAPTS knowledge was identified by the VRTT as a practice problem. Asked why they were not using MODAPTS in their clinical practices, clinicians reported lack of knowledge and confidence as the main reasons. The VRTT recognised the value of MODAPTS in vocational rehabilitation as a low-cost and effective support to an existing screening tool. It was decided to present MODAPTS workshops within clinical settings and develop a MODAPTS user manual for clinicians to use.

Collectively the VRTT organised and hosted the MODAPTS workshop, but the researcher was the only presenter. The other members declined offers to co-present reporting lack of knowledge and confidence as the reason. The content of the workshop presentation was published in the National Occupational Therapy newsletter, FOCUS. The article is available as Appendix G.

The FOCUS article received international interest and the researcher was contacted by the International MODAPTS Association enquiring about the use of and interest in occupational therapy. The article was re-published in the International MODAPTS newsletter of Fall 2015.

The MODAPTS user document was distributed throughout Gauteng public healthcare to all occupational therapy practices, at all levels of care. It was, and will be, presented annually to all new occupational therapists at the Vocational Rehabilitation Orientation Workshop and is used in student supervision. Action learning took place throughout these cycles. This was demonstrated by members of the VRTT creating a shared cloud address through which they could easily access and share new MODAPTS activities. MODAPTS is now in use in various clinical settings and VRTT members were planning and presenting MODAPTS workshops without the researcher. The MODAPTS user manual is available as Appendix H.

5.3.4 Doing a Basic Work Assessment

Being able to assess the ability to work of a person with a disability is commonly viewed as the most important aspect of vocational rehabilitation (Beukes, 2011) and competency therein is seen as a basic ability for occupational therapists doing vocational rehabilitation (Buys, 2015). During the Observation phase, in 2013, the researcher recognised this as a vocational rehabilitation practice problem amongst most occupational therapists, but there was reluctance amongst clinicians to

report this. It could be they did not recognise it as being a problem, or were insecure in sharing their inability to do what is considered a basic vocational rehabilitation competency.

As the ALAR and Ubuntu principles of collectiveness and transparency matured in the group, the VRTT recognised and disclosed the problem. In June 2014, the VRTT identified this as a practice problem to be addressed. How to address it remained a point of discussion in the group until the decision was made to change their transformative interventions from doing workshops to mentoring in 2015. The researcher offered her services as a mentor, using ALAR within clinical practice settings to transform this problem. Three of the four tertiary hospitals that had work units invited her.

The researcher designed a guide and step-by-step process on how to do a basic work assessment. This was implemented within the clinical practices where she mentored and put through several ALAR cycles at the three work units.

The guide and process was made into posters and placed against a wall of the work unit. Using the guide, while observed by the clinical therapists, the researcher demonstrated how to do a basic work assessment with a patient booked for an assessment. After the patient left, the researcher and the clinicians interpreted the results, reached a conclusion and using the report writing guidelines, wrote a report of the assessment done and reflected on the use of the guide and process. This practical demonstration of doing a basic work assessment while clinicians observed, was repeated several times. Therapists often booked 'difficult cases' for the mentoring sessions they had with the researcher. Action learning took place, as they were gradually included in certain aspects of the assessment process. The process was repeated and their practical participation increased until they felt confident to do a basic work assessment on their own. The action research cycles were seen as the guide and the process was used, reflected on, improved and used again until all participants were satisfied that the guide was implementable, understandable and effective within their practices.

Thereafter, case discussion became a frequent feature in the VRTT meetings and at mentoring sessions. Clinical therapists would bring problematic work assessment cases and ask for guidance and advice and in the process, facilitate an action learning process for the whole group. In addition, clinical therapists would email basic work assessment reports to the researcher for her to proofread and give advice.

The user document, *How to do a Basic Work Assessment*, is still in use by VRTT members and is Appendix I. It is presented at the annual Vocational Rehabilitation Orientation workshop, freely shared with any interested occupational therapists and used in student supervision.

5.3.5 Supervising Students

The findings of a study by de Witt (2015), that clinicians were reluctant to supervise students, was confirmed in this research. Clinical occupational therapists were negative about student supervision in their vocational rehabilitation services. In addition, academic personnel's perceptions of clinicians doing vocational rehabilitation supervision were found to be at best neutral and at worst hostile. The researcher had had the personal experience, and which literature confirmed (Herbert & Caldwell, 2015), that clinicians improved their own skills when supervising undergraduate students. Additionally, clinicians who had had positive experiences of working with post-graduate students were enthusiastic to continue and develop their own qualifications.

The observation phase of this study showed under-graduate students were exposed to vocational rehabilitation services at only one of the hospitals. In the first two years of this research, multiple discussions were held by the collective research team and with individual clinical therapists. Meetings to bring about the practical implementation of students doing vocational rehabilitation in public healthcare were held with the heads of occupational therapy departments in both the clinical and academic fields.

Summary of informal discussions with clinical occupational therapists and their heads of departments:

- They were working in academic hospitals with the mandate to educate students written into their job descriptions but felt that this could be done "Only if our clinical load allowed it."
- They agreed the concept of transferring knowledge to the next generation was important for the continuation of vocational rehabilitation.
- They acknowledged that the current practice of training students in the private healthcare sector was because there were no opportunities for academic institutions to place their students into clinical practice in public healthcare work units. They agreed this practice could be contributory to the reason why new graduates went into private vocational rehabilitation practices rather than coming to public healthcare to do vocational rehabilitation.
- They told stories of how they had had no experience, as students, in vocational rehabilitation practice and acknowledged the irony that they were perpetuating the problem by not seeing students.
- Clinical occupational therapists often complained of the quality of graduate students and that they had to teach them skills they felt they should have acquired as undergraduates at academic institutions. A comment from a VRTT meeting minutes was *"We cannot really*

complain about the quality of com serves' (newly graduated occupational therapist doing compulsory community service year) vocational rehabilitation if we are not doing our part in training them."

- Therapists expressed insecurity in doing student supervision saying; *"They ask us questions we cannot answer."*
- One Head of Department stated he *'would not allow student supervision in the work unit'*. The reasons were it took too much time out of a clinical therapist's day to supervise students, students disrupted the general management of departments clinical therapists were in-experienced and not adequately skilled in supervising students and academic personnel who accompanied students were often condescending and critical of clinical environments.

Summary of informal discussions with academic personnel:

- They told how they would book students for supervision and clinical therapists would put in leave and be absent when they were supposed to do this. This experience was confirmed during this research when the clinician who was supposed to be mentored while supervising students, had put in leave for that time and was absent for the initial stages of student supervision. The researchers had to stand in and supervise the students while not being able to mentor anyone. Academics complained that this kind of behaviour was not uncommon and hugely problematic as student programmes were full and could not be rescheduled.
- They believed it was not their place to 'train' graduated clinical occupational therapists who lacked skills to do clinical work, if they were not part of their post graduate programs.
- They felt efforts to implement student supervision that was part of a research project, such as this, was not sustainable and that any effort to implement vocational rehabilitation student supervision would disseminate when the researcher left.

After extensive deliberation within the VRTT, one member agreed to supervise students if she was mentored by the researcher. The researcher convinced one of the academic institutions to place students there. Three students were supervised for their vocational rehabilitation elective, in June 2015. This was a positive experience for both clinicians and students. Feedback given at the VRTT turned previously negative discussions around students into a more positive discourse. During this period, one other academic institution agreed to use the work unit for post-graduate work if such an opportunity presented itself. No practical implementation of this had taken place at the time of this writing. In 2016, two other VRTT members agreed to supervise students. One such arrangement was stopped by the head of department who felt the VRTT member and their work unit was not ready

for students and refused permission for the placement of students. In 2016, ten students were clinically supervised for vocational rehabilitation electives at two different work units by VRTT members.

Mentoring was done in such a way that ALAR principles could take place. Various aspects of vocational rehabilitation practice were demonstrated by the researcher with the clinicians and the students observing. This was critically reflected upon afterwards and the researcher ensured participation of both students and clinicians in such reflections. The various tasks of student supervision were shared between the mentor and the clinical therapists and regular reflection thereof done afterwards.

The 'see one, do one, teach one' maxim is widely used in clinical medical skills training. The strategy provides a mix of analytic thinking, skills practice, professional judgment and clinical reasoning and has been proven useful for the educating of professionals in settings where theory and skills coincide (Coughlin, 2009). Purposeful application of this was done during the mentoring with positive feedback from clinicians. Reflective notes from a VRTT member who was involved in this showed the insight: *"I learn so much more about a work sample if I have to teach students to do it"*.

The researcher compiled her mentoring on the subject into a user document in which clinicians are given guidelines on how to supervise students. The step by step guidelines show clinicians how to introduce the students to the elective, supervise them and how to give feedback, handle and manage difficult questions or situations and how to give closure feedback at the end of the elective. The user document is currently in use by VRTT members who supervise students and they share it with any interested occupational therapists. The user document *Supervising Undergraduate Students in Vocational Rehabilitation* is Appendix J.

5.4 Discussion of the Action Phase

The conclusion of Chapter Four and the content of this action phase demonstrates how pragmatism, a fundamental value for occupational therapists (Ikiugu & Schultz, 2006), is part of the profession's coping strategy within public healthcare. It also provided evidence that being busy with worthy actions can be a distraction that renders actions fruitless, if not combined with systematic and mindful reflection. Reflection showed the VRTT that while action learning took place during planned and practical workshops within clinical settings, it did not transform the services. Changing the transformational tactic from workshops to mentoring brought about the required transformation of

clinical practice. In this action phase, clinicians throughout Gauteng's public healthcare acquired clinical vocational rehabilitation skills and if the knowledge generated and captured in user manuals and journal articles remains linked with mentoring, this action learning benefit will continue for future generations of occupational therapists.

The action learning that took place was not only restricted to clinicians, the researcher herself learnt a lot during this phase. The first practice problem the VRTT identified was to address the practice of vocational rehabilitation report writing. When this was suggested, the researcher wrote in her reflective journal, "This is so wrong ... there is barely a vocational rehabilitation service and now they are worrying about the quality of their reports!" This reflection took place at the beginning of the research and the researcher still entertained ideas of a methodical systematic research progress. Allowing insider participants to dictate the research needs and cycles was threatening her notions of logic and order. Discussing this with her PhD support-group mentor, the researcher was told to "*trust the methodology*" and allow the ALAR ethos to materialise. Hindsight proved this to be a most valuable counsel, the benefit of which prevailed throughout the remainder of the research.

The VRTT's decision to freely share the knowledge created by the ALAR cycles through journal article, newsletter articles, user documents and presentations at meetings and congresses brought about real-time positive feedback and generated awareness of its transformation actions. Combining this altruistic sharing with transparency and requests for feedback was seen to be instrumental to the fact that no adverse reactions were received, both of which strengthened the confidence of the group.

Initially the researcher facilitated and organised the ALAR cycles, managing the data and concluding the dissemination aspects of it. With time, her role in the cycles diminished and in November 2015, she wrote in her reflective journal: "*This is so exhilarating! They (the VRTT) are action researchers in their own right. They really don't need me anymore. That makes me so happy and so sad.*" On concluding her tenure with the VRTT, two ALAR cycles were being managed by VRTT members independent of the researcher. The one was addressing the question of occupational therapists involvement in policy and procedures on incapacity leave and ill health (PILIR) within public services and the other aimed at how to expand and develop mentoring practices in vocational rehabilitation.

There is some concern about the VRTT's motivation to disseminate the results of their ALAR cycles, as writing is not a favoured action of clinical occupational therapists (van Biljon et al., 2015a). Future research efforts are needed to address this predisposition. The current members of the VRTT have all experienced and been part of ALAR cycles and are motivated to continue using ALAR principles to

update exciting protocols, address new practice problems and address future transformation of services. A concern is the question of the sustainability of such efforts in a group that has shown a high membership turnover. A question that will need future addressing is - Will current VRTT members transfer their ALAR knowledge and experience to new members?

5.5. Conclusion to the Action Phase

The transformation of clinicians' vocational rehabilitation practices and the benefits of ALAR were most obvious during this phase. The writing of vocational rehabilitation reports, how to be involved in the decision making process of driving with a disability or illness, using MODAPTS in clinical practice, how to do a basic work assessment and how to supervise undergraduate students were cycles that generated knowledge and allowed learning to take place. The knowledge is still in use both inside and outside of Gauteng's public healthcare. The learning was practice specific as VRTT members acquired skills and confidence in vocational rehabilitation, but their participation in ALAR processes ensured they developed skills and confidence in the method as well. At the end of the research tenure, VRTT members were running their own action cycles and had started new ones without any input from the researcher. They had been part of an effective and enriching transformational experience. Using ALAR, they had been instrumental in addressing vocational rehabilitation practice problems and had received national and international confirmation of the significance of their actions.

Concluding the research tenure with the VRTT there only remains the reflection phase. The role that reflection itself has had on the research process is shown and consideration of the transformation that took place and the effect of ALAR are seen in the following chapter.

Chapter Six: Reflection Phase

“Reflection is the glue that binds the components of action and research together.” Elizabeth and Valsa Koshy (Koshy et al., 2011)

6.1 Introduction to the Reflection Phase

The reflection phase, discussed in this chapter, was collaborative engagement in a meta-reflection of the transformation, reflections thereof, that took place in the four year research tenure and the impact the action learning action research (ALAR) approach had had. Reflection is an essential part of the action research cycles and both structured and unstructured reflection, as illustrated in the previous phases, occurred throughout the research tenure. Drawing on multiple reflection sources, two types of reflection activities were undertaken in this phase, a comparative reflection of the Vocational Rehabilitation Practice Profile Tool’s (VRPPT) 2013 and 2016 results and the Vocational Rehabilitation Task Teams (VRTT) collaborative reflection. Personal reflections by the researcher are discussed in Chapter Seven. Figure 6.1 presents the entire study with the highlighted sections indicating the position of this chapter on reflection, and the withdrawal of the researcher from the research environment.

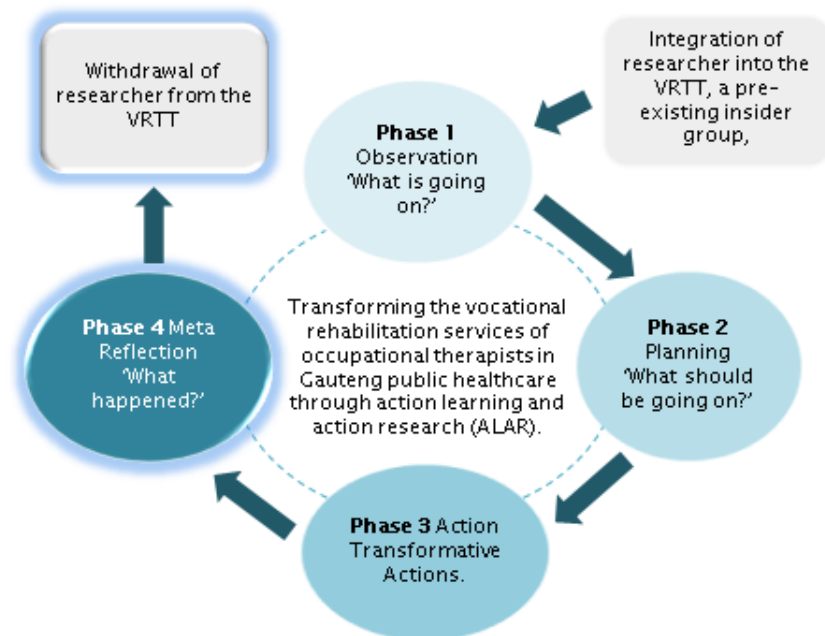


Figure 6.1: Diagrammatic presentation of the research process positioning the reflection phase and withdrawal actions

Meta-reflection is seen as an extension of reflective practice (Watson, 2005). It is a reflection on reflections to obtain an in-depth understanding about a matter (Georgiev & Nagai, 2011). Meta-reflection is a concept often used in action research (Riel & Lepori, 2014) and is usually done by a group of people with the aim to develop from descriptive to analytical levels of reflection (Thorpe & Garside, 2015). Zuber-Skerrit (2009) referring to meta-reflection, accounts how reflecting on her reflections had been a source of profound learning for her. This final phase of the research tenure was to critically reflect on the research aim using a variety of sources, including summaries of previous reflections.

Reflection is a cornerstone of action research (McNiff, 2013) and was fostered as an ongoing practice throughout the research to achieve optimal action learning benefits (Zuber-Skerritt, 2001). Riel and Lepori (2014) found the reflective process of action research brings about change and transformation within the individual as well as the collective group. This enquiry supports this. Reflection was seen to bring about practice specific vocational rehabilitation transformation. Confirming reports in literature that reflection is a valuable tool for healthcare professionals to transform theory into practice (Jasper, 2013) and develop clinical reasoning skills (Rigby et al., 2012). It was also seen to bring about personal transformation and enrichment (Sellars, 2012). VRTT members presented at congresses, published journal articles and enrolled for post-graduate training in vocational rehabilitation. This meta-reflection shows how ongoing reflection during four years of ALAR became a professional practice lifestyle that led to learning that changed behaviour (Dick, 1997).

In the case of an academic action research enquiry such as this, there has to be a conclusion to the association. Concluding an ALAR collaboration is potentially traumatic and requires ethical consideration. The systematic withdrawal of the researcher from the VRTT is described in this chapter. The practice of meta-reflection offers a logical preamble to the termination of collaboration and the researcher's withdrawal from the research environment took place in the same time-frame as the reflection phase.

6.2 Tools and processes

Numerous models of reflective practice have emerged since the 1970s and Gibbs' (1988) reflective cycle was seen to be the most often cited during online searching. Learning by doing, the title of Gibbs' work (1988), helps professionals to make sense of and learn from their experiences. This approach resonates well with ALAR and is reported in South African healthcare journals (Gibbs et al.,

2005). The simplicity of the Gibbs reflection cycle inspired the researcher to *keep it simple* in this enquiry. This decision was supported by the variety of situations within which reflection took place in this enquiry and so as not to alienate the insider group of clinical occupational therapists.

Tarrant's (2013) work on professional development through reflective practice led the researcher to choose two basic questions to initiate reflection sessions: *What needs to stay the same?* and *What needs to change?* Once the questions were asked, unstructured reflection was allowed to take place with only occasional guiding questions to redirect the reflections when necessary. The VRTT easily assimilated this reflection approach. Other than initiating, occasionally guiding and recording reflections the researcher imposed no control on the reflection processes, allowing participants to express themselves freely. Unstructured reflection took place in the form of personal, group, written and verbal reflections, meeting minutes that captured specific subject reflections, event specific journaling and field notes.

It was only at the end of each year that the researcher led the VRTT through a structured reflection of the past year's actions. In this enquiry, a calendar year was seen as an action research cycle. Reflection at the end of a year informed the planning at the beginning of the next year, transformative actions took place throughout the year and reflection of the year's actions at the end of the year concluded the annual action cycle. Ten days before the last meeting of 2014 and 2015 the VRTT members were sent a reflection guide to prepare their thoughts for the collaborative reflection in the meeting. The guide consisted of biographical questions that indicated how long the reflecting person had been a member of the VRTT, how much experience they had in vocational rehabilitation and in which actions they had taken part. Likert scales with opportunity for comment were used to reflect on the VRTT meetings and the specific activities of the VRTT in that year. Open ended and contingency questions guided reflections of goal achievement, VRTT membership experience and ALAR experience. In the meeting VRTT members used the guide to note their personal reflections on the guide's content but also on discussions that took place as the group reflected collectively on the same questions. Members volunteered to take part in the analysis of the reflections and the results were published in the official South African Occupational Therapy Association (OTASA) newsletter. This is discussed in 6.3.2.

The Vocational Rehabilitation Practice Profile Tool (VRPPT), described in chapter three, generated information that could be used for reflection. The VRPPT was used in 2013 as an observational tool and again in 2016 to enable pre and post intervention reflection. This is discussed in 6.3.1.

6.3 Findings

6.3.1 The Vocational Rehabilitation Practice Profile Tool: Pre- and post-intervention reflection

Reason and Bradbury, authorities in action research warn against using pre and post intervention techniques (2007) in action research studies as placing too much significance on such evidence could lessen the value of other collaborative and participatory enquiries benefits. The use of pre-and post-testing within action research enquiries have however been proven to be useful especially in learning environments (Nugent, 2011).

In this enquiry the pre- and post-intervention technique was used to inform collaborative reflection and to enrich the learning experiences. Collaborative development of a tool, the Vocational Rehabilitation Practice Profile Tool (VRPPT) which would allow clinical occupational therapists to systematically profile their services was discussed in Chapter 3 of this thesis. In the process of developing the VRPPT, profiles of the 2013 vocational rehabilitation services in Gauteng's four tertiary hospitals were established. In March 2016 the VRPPT was again used by clinical occupational therapists in the four tertiary hospitals to profile their current services. The 2013 and 2016 profiles were summarised and presented in Table 6.1.

Table 6.1 The VRPPT 2013 and 2015 summaries

		Vocational Rehabilitation Practice Profile Tool			
		Structure	Process	Outcome	Intervention
Hospital A	2013	<p>A designated room, furniture and extensive tests, tools and activities most of which were packed away in a storeroom.</p> <p>One occupational therapist with managerial autonomy did vocational rehabilitation.</p> <p>Community and environmental structures, resources, support staff, management and maintenance resources were shared with the general occupational therapy department.</p>	<p>Screening and assessment was done.</p> <p>No prevention of injury and awareness of good work practice, intervention, placement or follow-up.</p>	<p>Five healthcare users received vocational rehabilitation monthly.</p> <p>Limited internal and external awareness.</p> <p>No user satisfaction information.</p> <p>There was no student supervision, research, publication or future plans.</p> <p>Auto-reputation was 2/10</p>	<p>VRTT member</p> <p>3</p>
	2016	<p>The same room and furniture were available but this was better structured and more operational.</p> <p>Most tests and equipment were out of the storeroom and in use. Additional MODAPTS tasks and posters were available.</p> <p>One occupational therapist with no managerial autonomy did vocational rehabilitation.</p> <p>Community and environmental structures, resources, support staff, management and maintenance resources are shared with the general occupational therapy department.</p>	<p>Screening and assessment, occasional intervention, placement and follow-up were offered.</p> <p>No prevention of injury and awareness of good work practice.</p>	<p>Fifteen healthcare users received vocational rehabilitation monthly.</p> <p>Internal and external awareness of the vocational rehabilitation services.</p> <p>No user satisfaction information and no student supervision.</p> <p>There was evidence of research and publications.</p> <p>Goals set and feedback given of goal achievement at the VRTT meetings.</p> <p>Auto-reputation was 6/10</p>	<p>workshops in 2014</p> <p>29 hours of mentoring in 2015</p>

Hospital B	2013	<p>A designated room, furniture available and adequate testing, tools and activities.</p> <p>One occupational therapist with managerial autonomy did vocational rehabilitation.</p> <p>Resources to support vocational rehabilitation services were available.</p> <p>Community and environmental structures, support staff and maintenance of the vocational rehabilitation service were shared with the general occupational therapy department.</p>	<p>Screening, assessment and intervention with occasional placement and follow-up were available.</p> <p>No prevention of injury and awareness of good work practice programmes.</p>	<p>Twenty-two healthcare users receive vocational rehabilitation monthly.</p> <p>Good internal and external awareness of vocational rehabilitation services.</p> <p>No user satisfaction information.</p> <p>Occasional student supervision.</p> <p>No research, publication or future plans.</p> <p>Auto-reputation was 8/10.</p>	<p>VRTT member</p> <p>2 workshops in 2014</p>
	2016	<p>The same room, furniture, tests and equipment were available.</p> <p>One occupational therapist did vocational rehabilitation. There had been a change of staff with 4 months in which vocational rehabilitation ceased.</p> <p>Community and environmental structures, resources, support staff and maintenance of the vocational rehabilitation service were shared with the general occupational therapy department.</p>	<p>Screening, assessment and limited intervention was offered.</p> <p>No prevention programmes, placement or follow up.</p>	<p>Four healthcare users a month receive vocational rehabilitation.</p> <p>The same level of internal and external awareness of the vocational rehabilitation services.</p> <p>No user satisfaction information.</p> <p>No student supervision, research, publication or future plans.</p> <p>Auto-reputation 6/10.</p>	<p>No mentoring</p>
Hospital C	2013	<p>A designated room and furniture. Extensive tests, tools and equipment, most of which was unused and in storage.</p> <p>Four occupational therapists did vocational rehabilitation.</p> <p>Community and environmental structures, resources, and support staff, management and maintenance resources were shared with the general occupational therapy department.</p>	<p>Screening and assessment was done.</p> <p>No prevention of injury and awareness of good work practice, intervention, placement or follow-up</p>	<p>Five healthcare users a month receive vocational rehabilitation.</p> <p>Limited internal awareness.</p> <p>No user satisfaction information.</p> <p>No student training, research or publications, future plans or goals.</p> <p>Auto-reputation was 4/10.</p>	<p>VRTT member</p> <p>4 workshops in 2014</p>

Hospital D	2016	<p>The same room, furniture, tests and equipment are available. All were functional and in regular use. Additional MODAPTS tasks were available and damaged work samples had been operationalised.</p> <p>Two occupational therapists with greater management autonomy did vocational rehabilitation. Resources had been sourced and were available.</p> <p>Support staff and maintenance was still being shared with the general occupational therapy department.</p>	<p>Screening and assessment, intervention, placement, follow-up, prevention of injury and awareness of good work practice programs are being done.</p>	<p>Thirty healthcare users receive vocational rehabilitation a month.</p> <p>Good internal and external awareness</p> <p>User satisfaction showed positive responses.</p> <p>Evidence of student training, research and publications.</p> <p>There are annual goals set with feedback of achievement given at the last VRTT meeting of each year.</p> <p>Auto-reputation was 10/10.</p>	<p>225 hours of mentoring in 2015</p>
	2013	<p>No room or furniture was designated for vocational rehabilitation.</p> <p>The vocational rehabilitation that was done shared community and environmental structures, resources, building structures and furniture, tests, tools and activities, staff, management and maintenance with the general occupational therapy department.</p>	<p>Screening and assessment is done.</p> <p>No prevention of injury and awareness of good work practice, intervention, placement or follow-up being done.</p>	<p>Six healthcare users were seen in the last 12 months.</p> <p>No awareness of vocational rehabilitation services.</p> <p>No user satisfaction information, student training, research or publication.</p> <p>The question was asked: How do we go about starting a work unit?</p> <p>Auto-reputation was 1/10.</p>	<p>VRTT member</p> <p>4</p>
	2016	<p>A work unit with designated room and furniture, tests, tools and activities and two occupational therapists for the vocational rehabilitation services.</p> <p>Community and environmental structures, resources, support staff, management and maintenance is still shared with the general occupational therapy department.</p>	<p>Screening and assessment, intervention, placement and follow-up is being done.</p> <p>Prevention of injury and awareness of good work practice programs are planned but not in practice.</p>	<p>Thirty-six healthcare users receive vocational rehabilitation a month.</p> <p>Internal and external awareness of the vocational rehabilitation services.</p> <p>User satisfaction was done</p> <p>There is evidence of student supervision, research and publications.</p> <p>Goals with regular feedback of achievement at the VRTT meetings.</p> <p>Auto-reputation was 8/10.</p>	<p>workshops in 2014</p> <p>27 hours of mentoring in 2015</p>

The VRPPT profiles were presented to the VRTT for validation and collaborative discussion. After the 2016 profiling, everyone except Hospital B felt positive about the improvement of their vocational rehabilitation services. The summary of the 2013 and 2016 VRPPT results, as presented in Table 6.1 was also used to inform the VRTT's collective meta-reflection in May 2016, as discussed in 6.3.2.3. It brought about the following discussion.

What needs to change?

In Hospital A and C there had been negative interference from the management of the occupational therapy department. VRTT members from these hospitals were occasionally refused permission to attend VRTT meetings or workshops. At one hospital, departmental management refused permission for students to come and do clinical electives in the work unit. In another case a mentored occupational therapist was told not to start a job seeker support group as they felt this would create too much interest and result in too much work. In both hospitals, departmental managers warned mentored clinicians not to see potentially difficult cases despite the mentor offering to be present and to assist with the cases. This had a negative effect on the transformation of some services and restricted the action learning potential of therapist working there.

Hospital B was the only hospital where the vocational rehabilitation services had not shown an improvement. The most significant reason for this was felt to be the fact that the occupational therapist that had been crucial to the vocational rehabilitation services had left and her post had not been filled for four months. This hospital had also shown less involvement in the ALAR processes and had not requested mentoring.

What needs to stay the same?

With the exception of Hospital B, all other hospitals vocational rehabilitation practices improved; the outcome profiles of these three hospitals confirmed this. Awareness of and the scope and quality of their services had improved. Two of the hospitals (Hospital C and D) were supervising students and Hospital A was willing to do so but was denied permission by their Head of Department. They were all seeing more clients, mentoring other occupational therapists, taking part in research and publications and presenting at workshops and congresses.

A work unit had been established in Hospital D, where one had not existed before. In Hospital A and C, where there had been work units, the use of available structure (tests, equipment, building, furniture and staff) had improved without any extra cost or expense. In Hospital C, less therapists were offering an improved vocational rehabilitation service.

The VRTT discussed matters they felt contributed positively towards transformation. Membership of the VRTT were felt to be important. This kept hospitals up-to-date with the transformational actions and decisions made and the VRTT also operated as a support group. The VRTT meetings, usually held in the work unit, rotated between facilities offering vocational rehabilitation, to ensure equal access and participation for the occupational therapists. The researcher mentored at Hospital A, C and D and there appears to be a positive link between the hours spent mentoring at a hospitals and the level of improvement that took place.

6.3.2 Collective Reflections of the Vocational Rehabilitation Task Team's Annual Actions

Action research cycles of plan-act-reflect described the annual transformative actions of the VRTT. Planning at the beginning of the year the VRTT engaged in transformational actions during the year and reflected on these at the end of the year. In 2014 and 2015, the researcher engaged the VRTT in structured reflection of their actions in the past year. The VRTT members received a reflection guide 10 days before and time was set aside in the last meeting of the year for individual and collaborative reflection. Members were encouraged to anonymously write their ideas and feelings, while the group discussion continued. This was to address the possibility of inexperienced and/or more introverted members not expressing their opinions. Summaries of the collective meeting reflections are shown as conclusions in 6.3.2.1 and 6.3.2.2.

The researcher and volunteering members of the VRTT analysed and summarised the annual reflections. These reflections were then written up as a newsletter article for the FOCUS, the Occupational Therapy Association of South Africa's newsletter. This was done to allow action learning in the dissemination of ALAR results, on a less daunting level than peer review publication and to create a national awareness of the VRTT's actions. The articles are presented as 6.3.2.1 and 6.3.2.2 below. In addition, summaries of the annual reflections were sent to all VRTT members for them to further reflect upon and prepare for the first meeting in the new year. At this meeting, the transformational goals and plans for the year would be decided on.

In May 2016 the researcher used the results of the Vocational Rehabilitation Practice Profile Tool's pre- and post-intervention reflections, discussed in 6.3.1, and the collective annual structured reflections of 2014 and 2015, for a meta-reflection. Considering these reflections, and using an unstructured reflection format, the VRTT reflected on four years of ALAR and transformation. The researcher's summary of this meta-reflection is given under 6.3.2.3.

6.3.2.1 Reflections on a year of Action: The Vocational Rehabilitation Task Team Gauteng's critical reflection on their work in 2014

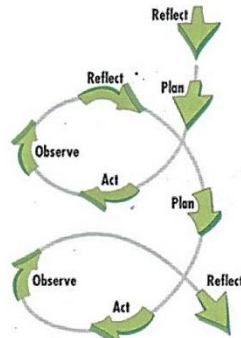
Reflections on a year of Action: The Vocational Rehabilitation Task Team Gauteng's critical reflection on their work in 2014

submitted by Hester van Biljon and Claudette Parkinson

"Many people remain trapped at one window in their lives by complacency, habit and lack of insight. They look out every day at the same scene in the same way. Real growth is experienced when you draw back from that one window, turn and walk around the inner tower of the soul and see all the different windows that await your gaze. Through these different windows, you can see new vistas of possibility and creativity."¹

The exercise of reflecting on your practice is fundamental to professionals. As occupational therapists we were taught to practise mindfully and to question and continuously improve what we do. This mind-set is the basis of accountable and ethical occupational therapy. Johns² notes that reflection encourages a practitioner to pay attention to themselves within their professional context. It allows them to become active creators of and take responsibility for their practices.

Reflection is also an essential step within the cyclical action research process³.



The Vocational Rehabilitation Task Team (VRTT), Gauteng uses action research to address their goal of improving vocational rehabilitation services in Gauteng. Action Research (AR) is a collaborative form of research aimed at improving practice and implementing changes⁴. It is essentially practitioner and practice-based research that is commonly done in partnership with someone with skills and knowledge of the research method⁵. In AR we identify a problem, examine it, formulate plans of action, make changes, monitor changes, review and amend the plans of action. This process helps us to consciously engage in and commit to our practices.⁶

Substantial learning takes place with action research³. Within health-care, AR has been proven to bridge the gap between theory and practice, service and science and improve evidence-based practice⁵.

Action research has five characteristics⁵:

- ❖ It is practical (developing solutions to practical problems)
- ❖ It is focused on change (transformation and development)
- ❖ It follows a cyclical process (see diagram below)
- ❖ It involves participation or collaboration (a partnership between researcher and participants)
- ❖ It is an interactive form of knowledge development (theory and practice meet to develop and test knowledge)

The VRTT set aside time in their last 2014 meeting to critically reflect on the activities they had been involved in in the past year. A summary is given to share the experience and encourage other groups of occupational therapists to do the same.

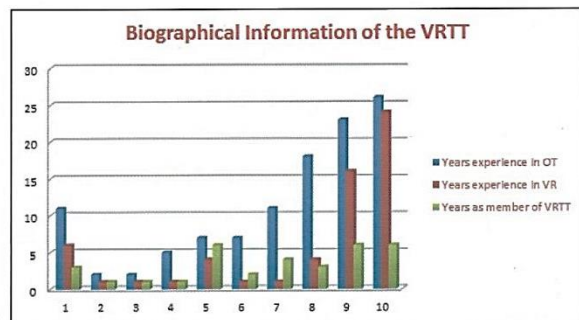
The aim of the VRTT, Gauteng is to improve the vocational rehabilitation practices in our own occupational therapy departments as well as in the wider public healthcare setting of Gauteng. We choose to approach the practice problems we identify using the internationally recognised research method discussed above, namely Action Research. By using this system-

atic enquiry we improve ourselves professionally, increase the authority of our efforts, generate knowledge that we can confidently share with our colleagues and demonstrate the degree of determination to improve the services we offer and the accountability we have towards our clients.

The VRTT was established in late 2010, after the release of a mandate to improve vocational rehabilitation services in Gauteng Public Health. In early 2011 a screening tool was developed, which was presented during an orientation workshop later that year. Two more orientation workshops were held in 2012. By late 2012 a PhD student from the University of the Witwatersrand contacted the VRTT, as she was doing her PhD and her goals were very similar to that of the VRTT. With the support of the PhD researcher the VRTT started using Action Research as a systematic way to approach the problems they identified. With this systematic and collaborative approach the work of the VRTT expanded significantly; The orientation workshops continued to be an annual event, the screening tool is still widely used, report writing and driver screening protocols has been developed, a Vocational Rehabilitation Profile Tool was developed, workshops were held on MODAPTS, Convergent Interviewing techniques and the use of the VR Profile Tool and a Mentoring SOP drawn up and attended to.

With that basic background of the VRTT, let us return to 2015. The VRTT currently consists of the following members: Simon Rabothata (Assistant Deputy Director of Gauteng Health and chairperson of VRTT), Lynn Soulsby (CHBAH), Naazneen Ebrahim (CHBAH), Claudette Parkinson (DGMAH), Madidimalo Mogale (TRC), Marlene Robus (TRC), Siphosethu Mdakane (CMJAH), Tumelo Galane (Tara), Zakkhiya Akhalwaya (Johannesburg Clinics), Hester van Biljon (private vocational rehabilitation practice and researcher). The VRTT is quite diverse, with different levels of experience as OTs and also in vocational rehabilitation itself (see graph below). Despite this, or perhaps because of this, the team is very motivated and passionate about vocational rehabilitation, its implementation in our province and the benefits it holds for our valued patients.

During the last meeting of 2014 there were nine VRTT members present. Throughout the year, the amount of members who attended each meeting varied between seven and nine. The following graph indicates the years of both OT and VR experience within the VRTT, as well as how long each member has been part of the VRTT.



Based on the graph above, the VRTT has an average of eleven years' Occupational Therapy experience and an average of six years' experience in voc rehab.

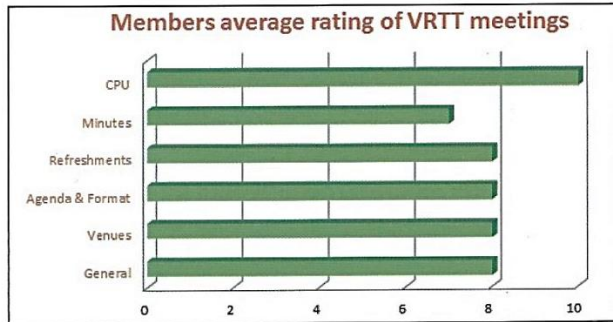
The VRTT meetings take place once every two months. The meeting venues are rotated between the hospitals involved and usually last ap-

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Reflections on a year of action continued from page 11

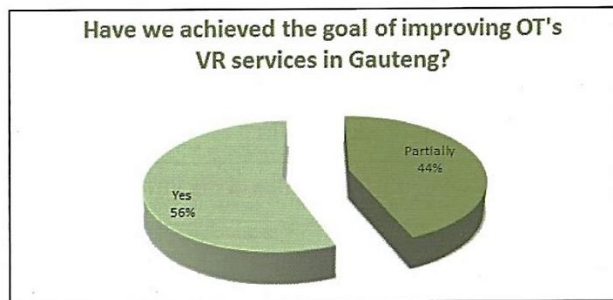
proximately four hours. The venues being rotated facilitates the process of improving services, as the team then experience the different settings first hand and have a better understanding of possible difficulties the facility experiences. This insight allows for easier and more appropriate problem solving within the team.

A general meeting protocol is followed, with an agenda sent out before the meeting and minutes being taken (this is fortunately also on a rotation basis). The team signs in and out on a register, which allows us to apply for CPUs for the meetings attended during the year. The following graph indicates the VRTT's rating of meetings held in 2014.



Some additional comments that were made when completing this part of the reflection includes that the meetings in general are very positive and allow for 'learning new things' and 'sharing information'. The aspect with the lowest score, the minutes, was described as 'being late', 'too many mistakes' and the question was asked: 'does anyone even read them?', although the new format used by the VRTT did 'improve the quality of the minutes'. Some members felt that the meetings could be even more structured, since the discussion does go off the agenda at times, although the refreshments were always enjoyed during these long moments of circumstantiality. CPU points awarded for hard work and dedication during the year was described as 'awesome!'.

The question was asked, "Have we achieved the goal of improving OT's VR services in Gauteng?". The following chart indicates the answers/opinions given by the members.



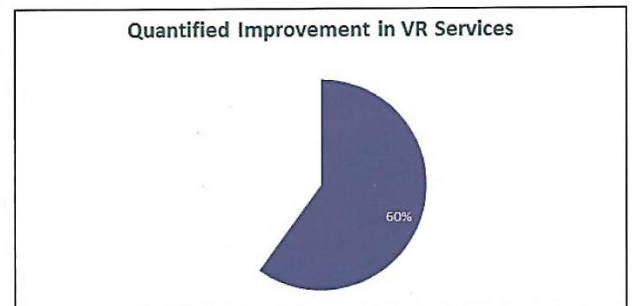
The following table indicates the positive and negative comments made when answering this question:

On the positive side	On the negative side
Awareness of VR was increased	There was not enough implementation of plans made during the year
More patients were being seen	More work needs to be done in various aspects
Ot and VR was better established in the hospital team	Not enough is being done at some institutions, especially clinic level
Lots of learning opportunities were created	
VR in Gauteng is going in the right direction	

The critical reflection also included reflection of each member on their membership in the VRTT during 2014. Not surprisingly, all members felt that their membership in the VRTT was positive and answered 'YES!' to membership/participation being a valuable experience. Although it was stated that some members, especially when new to the team, felt a bit 'lost' at times, nobody felt marginalized or misled at any stage. It was a common feeling that each member's perspectives were listened to and honoured and that nobody felt intimidated by the researcher or chairperson at any stage. Everybody felt that the team had authentic relationships with one another, that we work as a team towards a common goal and all were happy to continue being a part of the VRTT in 2015.

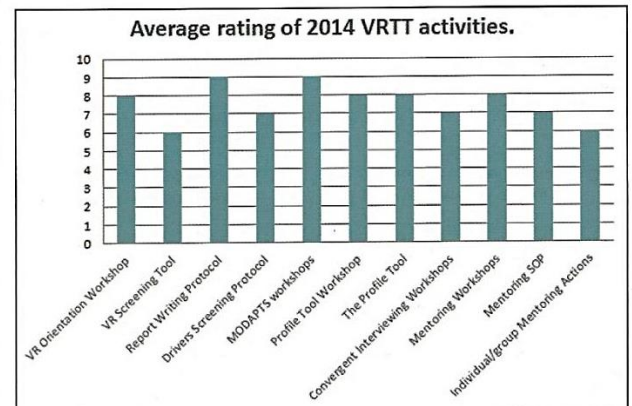
The team next reflected on the VRTT activities for 2014. All members felt that the activities were relevant and applicable. The workshops were most valued and a comment was made that the team put the province on the map by publishing what was achieved during 2014, such as the Modapts Assessments and Report Writing Protocol. Everybody agreed that new knowledge was generated, although some voices urged for greater implementation of protocols and newly learnt skills.

The following graph indicates the quantified opinion of improvement of VR services in Gauteng.



While the quantified improvement is excellent, the most prominent qualified opinion of improvement of VR services was the increased awareness of VR services in our hospitals, while the greatest concern was found to be the 'limited implementation of protocols and services'.

The following graph indicates the average individual rating of the VRTT activities for 2014.



The team was asked to reflect on and provide suggestions on how we can improve our efforts in 2015. The table below indicates responses, from most often indicated to least often indicated.

Some additional comments included:

"I enjoy being part of this team and the growth I have seen in my professional sphere is beyond words."

"It is really great to be a member of this group."

.... continued on page 13

Reflections on a year of action continued from page 12

- More mentoring
- Actual physical assistance in terms of voc rehab in each setting
- Set goals as a team
- Add an indicator on the PMDS system to monitor implementation
- As lots of people still have no idea what services OT provides in VR, more workshops or talks on VR should be implemented.
- Continuation of current services.

"Looking forward to setting goals in the coming year and working on achieving them."

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Reflection on the transformation that had taken place during 2014's actions informed the VRTT's planning for the next year. There was a general feeling of careful optimism about the transformation that had taken place, indicating an opinion that there had been a 56 to 60% transformation of the vocational rehabilitation services in Gauteng's public healthcare.

What needs to stay the same?

The 2014 actions of the VRTT were bringing about improvement in Gauteng's vocational rehabilitation services and it was felt the actions undertaken should continue. The MODAPTS and report writing cycles were identified to be the most effective and the areas in which members felt they had learnt the most. VRTT meetings were also identified as good learning opportunities. Members valued the continuing education units (CEU) they received and perceived them to be compensation for hard work and knowledge creation. The dissemination of knowledge created during the action cycles were seen to bring about increased awareness within public healthcare, on a regional, national and international level. This interest in the work of the VRTT increased the motivation of team members to continue and improve their transformational actions.

What needs to change?

It was felt there was still a lot of work to be done. The VRTT realised that workshops held in 2014 were popular and had benefit, but they were not bringing about practice transformation. Clinicians attended the workshops but did not implement the knowledge gained in their practices. This insight led the team to consider mentoring as an additional action for the next year's transformational activity.

The concept of clinical mentoring in South Africa's public healthcare had been proven to be successful for the nursing profession (Green et al., 2014) and was familiar to clinical occupational

therapists (Domina & Nelson, 2015). There was agreement in the VRTT that mentoring could work, but few members felt confident to be mentors due to lack of experience with and knowledge of mentoring, a situation supported by literature (Falzarano & Zipp, 2012). An expert in mentoring was to be invited to advise and educate the VRTT on how to do mentoring within occupational therapy clinical settings. In the interim, it was decided that the researcher would be available to mentor VRTT members who worked in the tertiary care hospitals. They were to initiate the mentoring by inviting her to their clinical practices and setting up the mentoring opportunities as it suited both parties. VRTT members who worked at Hospital A, C and D did so.

Evidence that action learning was improving the professional practice of VRTT was that they were starting to expect greater proficiency from the meetings and each other's conduct in the meetings. They felt the quality of the VRTT meeting minutes and the focus of the meetings themselves should improve.

6.3.2.2 Reflecting on 2015: The Vocational Rehabilitation Task Team (VRTT) Gauteng takes a good look at a busy year

Reflecting on 2015: The Vocational Rehabilitation Task Team (VRTT) of Gauteng takes a good look at a busy year

submitted by Hester van Biljon, Zakkiya Akhals and Siphosethu Mdakane

Our aim in the Vocational Rehabilitation Task Team (VRTT) in Gauteng is to improve the vocational rehabilitation practices in our own occupational therapy departments and in the wider public healthcare setting of Gauteng. We choose to approach the practice problems that we identify using a research method called Action Research. By using this systematic approach to problem solving we improve ourselves professionally, increase the authority of our efforts, generate knowledge that we can confidently share with our colleagues and demonstrate the degree of our determination to improve the services we offer and the accountability we have towards our clients. It is our custom to take time out of the last meeting of each year to critically reflect individually and anonymously on what actions we took and the outcomes thereof. This helps us to adjust and focus our efforts for the New Year. It also gives us reasons to identify our achievements and celebrate them; BECAUSE 'life is not just a problem to be solved', we must also remember to enjoy the journey. We share a summary of the VRTT's reflection to encourage and enrich our profession.

Action Research (AR) is a collaborative form of research aimed at improving practice and implementing changes⁽¹⁾. It is essentially practitioner and practice-based research that is commonly done in partnership with someone with skills and knowledge of the research method⁽²⁾. In AR we identify a problem, examine it, formulate plans of action, make changes,

monitor changes, review and amend the plans of action. This process helps us to consciously engage in and commit to our practices⁽³⁾. Substantial learning takes place with action research⁽⁴⁾. Within healthcare, AR has been proven to bridge the gap between theory and practice, service and science and improve evidence-based practice⁽²⁾.

Action research has five characteristics⁽²⁾:

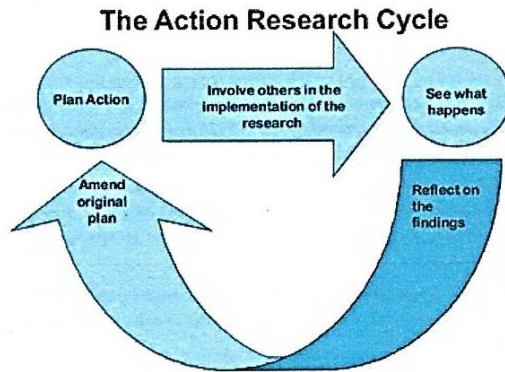
1. It is practical (developing solutions to practical problems)
2. It is focused on change (transformation and development)
3. It follows a cyclical process (see diagram below)
4. It involves participation or collaboration (a partnership between researcher and participants)
5. It is an interactive form of knowledge development (theory and practice meet to develop and test knowledge)

In 2015 there were twelve VRTT members who were representatives from: Head Office, Chris Hani Baragwanath Hospital, Dr George Mukhari Academic Hospital, Steve Biko Academic Hospital, Tara Moros

.... continued on page 4

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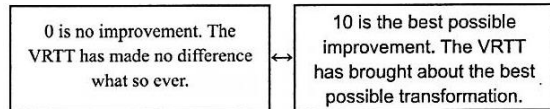
Reflecting on 2015: The Vocational Rehabilitation Task Team (VRTT) of Gauteng takes a good look at a busy year continued from page 3



Hospital, Charlotte Maxeke Johannesburg Academic Hospital, Central Wits Clinics, Ekurhuleni District, Tshwane Rehabilitation Hospital, and a University of the Witwatersrand PhD student. Biographical data of the members showed that they had an average of 7 years of experience in occupational therapy and 4 years in vocational rehabilitation. Their VRTT membership varied between 6 years and less than 1 year.

Members were asked: **Do you think that the VRTT has achieved the goal of transforming OTs in Gauteng public healthcare's vocational rehabilitation services in 2015?**

Quantifying their opinion on a sliding scale showed an average of 8/10.



Qualifying their opinions showed the following statements:

"I think the VRTT is working very hard but it is a work in progress and a lot still needs to be done."

"Awareness, confidence and an interest in vocational rehabilitation has improved."

"Vocational rehabilitation has been simplified and many OTs feel for the first time that they can actually do vocational rehabilitation."

"The work units have experienced an increased patient load and more referrals."

"The support structures that are now in place are very good. There is always someone to help."

Answering the question: **Have you found being a member of the VRTT a meaningful experience?** All members said 'Yes' and some contributing comments were:

"I feel so much more informed and my perceptions of vocational rehabilitation have changed for the better."

"I love the discussion we have. It challenges me professionally and personally. Especially when we disagree with each other"

"I find it transforming and enriching. My uncertainties are being addressed and I have developed confidence in applying my voc rehab knowledge."

"It is a most meaningful part of my working in public healthcare."

"I have been personally inspired by group members and the projects we undertake."

"On a personal and professional level the team has motivated and inspired me to be a better OT and to improve my knowledge and skills in vocational rehabilitation."

spired me to be a better OT and to improve my knowledge and skills in vocational rehabilitation."

All the VRTT members indicated that they, at no stage, felt misled or marginalised and that they never felt intimidated in any way. They all indicated that there were authentic relations between group members. They were asked to **Consider the researchers presence in the group.** The following comments were made:

"Our goals are the same."

"She has brought new ideas such as getting CPD for the meetings, publishing articles, developing the protocols, the training workshops and the ethical consideration to what we do."

"She is like an expert but one of us. We can ask her if we are unsure about things and she does not mind."

"She is funny and makes us laugh."

"She is a great mentor and always available. I can always contact her by email or telephone if I feel unsure and she is always happy to help. She does not mind."

"The researcher's passion and love for our profession and vocational rehabilitation is contagious. It increased all our motivation to participate and do our work better."

The VRTT members were asked: **Do you feel your perspectives have been honoured and listened to, do you feel you have a voice, and do you feel an authentic member of the VRTT?** All members said 'Yes' and some comments were:

"All opinions are heard and everyone and anyone has the opportunity to disagree or provide other points of view. The VRTT function as a team and is not manipulated in any way."

"The work that I do is noted and my views are valued. I feel appreciated."

"I have experienced a feeling of belonging in the group"

"We are all equal here in this group no matter who you are."

They felt that the team's membership represented the Gauteng public healthcare's multi-dimensional make up. There were suggestions to broaden the scope of the task team to include and have more contact with academic occupational therapists and private practice occupational therapists. All members felt happy to continue **being a VRTT member in the new year** and some reasons given were:

"I want to see us make our goals become a reality and I believe my input is important to ensure the success of our goals."

"There is a growing need and awareness of vocational rehabilitation. The VRTT helps us to link and to network."

.... continued on page 5

Reflecting on 2015: The Vocational Rehabilitation Task Team (VRTT) Gauteng's takes a good look at a busy year continued from page 4



"I learn so much and I enjoy teaching others what I have learnt. I enjoy advocating vocational rehabilitation and the work we do in my institution and ensuring the implementation thereof."

"I need and love the support I get from the VRTT."

"It feels good to be a part of this process. We are a dedicated team that gets things done."

Reflecting on *the actions that the VRTT had been involved in in 2015*, members indicated that they felt all activities to be relevant and applicable to the clinical practice of occupational therapists in public healthcare and that they all felt a sense of ownership of the actions. The actions were listed and members asked to indicate their opinions of the activity on a sliding scale between 0 (the most negative point/the worst possible) and 10 (the most positive point/the best possible).

The 'Vocational Rehabilitation Orientation Workshop', the 'Vocational Rehabilitation Screening Tool', the SAJOT and FOCUS articles that were published and the 'Basic Assessment of Ability to Work' protocol averaged a 9/10.

The 'Report Writing' protocol, 'MODAPTS' booklet, 'Vocational Rehabilitation Practice Tool (VRPT)' and 'Drivers Screening' protocol all got an 8/10 but several cautionary statements were made asking that we should investigate if occupational therapists are actually using the protocols in their practices. Also achieving an 8/10 was the awareness of VRTT actions and outcomes, the goal setting and planning of the VRTT, the general support between the work units and the mentoring that members received. In 2015, therapists at Charlotte Maxeke Johannesburg Academic Hospital had received 225 hours of direct face-to-face mentoring mentoring, at Dr George Mukhari Academic Hospital they had received 27 hours and at Steve Biko Academic Hospital they had received 29 hours of individual mentoring from the researcher.

A 7/10 was averaged for the mentoring that members had to offer to others in the survey that was done of occupational therapists' opinion of what vocational rehabilitation services should be done and where in public health care they should be done, for the PILIR protocol. Members indicated that they felt not enough mentoring was being offered by VRTT members and that they should not be passively waiting for therapists to ask them for mentoring but should be more active in offering their mentoring and checking if therapists need help with vocational rehabilitation. They felt that the survey was a disappointment in that it offered no solution to the problem the team had; deciding what vocational rehabilitation services should be offered where in public healthcare. The PILIR was considered to still be 'a work in progress'.

The VRTT's relationship with the Universities and the vocational rehabilitation services offered to students was a 6/10 with comments indicating that members felt a lot of work still needed to be done. Clinicians' relationship with academic occupational therapists is seen to be a 'problem' that needs addressing from both sides.

The worst rated activity was the progress and implementation of vocational rehabilitation interventions such as job seekers groups, work hardening and work conditioning programmes. The comment: *'This has not really started yet'* summed up the general feeling towards these actions.

VRTT members were asked to give; **Suggestions and ideas on how VRTT can improve or expand efforts in 2016 and what actions members would like the VRTT to be involved in.** Some of the comments were:

"I think all the previous activities should be continued while each unit must make it a priority to communicate with the clinics in their areas to ensure increased referral and provision of skills groups such as job seekers groups."

"We know the researcher is leaving us so we have to make the Action Research our own and continue with it in order to solve our problems we encounter."

"I would like to be more involved in the writing of articles."

"We need to break walls and build bridges with private and academic occupational therapists. It is no more this 'us and them' perception."

The reflections concluded with **general comments:**

"Thank you for all the hard work that everyone puts into the tasks that the VRTT is involved in! The one-on-one mentoring that the researchers gave me is definitely a highlight for me this year as it provided me with more confidence in handling different cases."

"I would like to see that the VRTT activities and our way of doing things expand to other provinces in South Africa. They can learn a lot from us."



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Reflection on the transformation that had taken place during 2015's actions showed an improvement of opinion, from 60%, in 2014 to 80%. The general feeling was that transformation had improved even more than in 2014 and that this was on a service as well as an individual level. The benefits of increased awareness and improved service delivery continued. Involvement of VRTT members in the research aspects of the study had stimulated an interest amongst members to become more involved in publications and post graduate studies. The VRTT's discussions of what they felt should stay the same and what should change, showed an improved ability to analyse experiences as they explored the researcher's mentoring at three of the four tertiary hospitals.

What should stay the same?

The workshops were still popular but the combining of mentoring with ALAR was seen as a singularly effective way to improve vocational rehabilitation services. At the end of 2014 only one senior clinician reported being involved in mentoring inexperienced colleagues. Other therapists avoided the responsibility or referred questions to this clinician or the researcher. As the year progressed it was found that those VRTT members who were being mentored by the researcher were now starting to mentor others, they reported that having been mentored enabled them be mentors, although they still reported a lack of confidence in their own mentoring skills.

Mentoring by the researcher had often been discussed in previous VRTT meetings and several of the VRTT members had first hand experienced of this mentoring. Using this as back-ground information the researcher and the VRTT reflected on the mentoring that had taken place. The following elements were highlighted as having been positive components.

The mentoring approach the researcher had used was based on the principles of action learning and action research (ALAR), creating a reciprocal and collaborative learning relationship (O' Neil & Marsick, 2009). Effort was made to reduce the power relations between the researcher, an expert in the field, and the occupational therapists who were being mentored, as such relationships are known to reduce the benefits of ALAR (du Toit & Wilkinson, 2010). Slowing down the vocational rehabilitation processes and using Socratic questioning were found to help with this.

The mentoring was registered as a continued professional development (CPD) activity. An attendance register was kept, creating evidence of the time, place and type of mentoring. The mentoring took place in clinical settings and work units. The mentored activities involved demonstration of vocational rehabilitation skills and techniques, while working with public healthcare users, using the tests and equipment available in the setting. In this way, work units were set up to be functional and ergonomic compliant. Stored tests and equipment were used again, work

assessments were done and reports written, work conditioning and work visits were done, students were supervised, journal and newsletter articles were written, MODAPTS tasks were developed and driver screenings done. As the relationships matured the mentoring sessions became popular and eventually, were restricted only by the researcher's cost and time restraints. The initial mentoring was conducted on a one-on-one basis between the researcher and a VRTT member, but eventually mentoring was done in groups. Mentor sessions were attended by occupational therapists who were not VRTT members but were interested in vocational rehabilitation or inquisitive about a mentoring experience. Mentoring sessions were attended by two or three clinicians but never more than five.

The physical presence of the mentor in the work units allowed clinicians' practical experience with real time support and guidance. The mentoring was extended to email and WhatsApp support, where the researcher's answered questions, gave advice, proof read reports and encouraged the clinicians. Towards the end of the year, a WhatsApp group was formed amongst all VRTT members. It was found that collective support took over the researcher's role as the group supported each other and more action learning continued.

An unforeseen benefit of the mentoring was that, of their own volition, the three therapists who were mentored in 2015 enrolled for the post-graduate vocational rehabilitation diploma at the University of Pretoria in 2016. This enriched the individual and the collective mentoring as they brought their newly acquired vocational rehabilitation knowledge to the VRTT.

What should change?

Vocational rehabilitation at primary healthcare level was seen as a priority problem to attend to in 2016. Mentoring had to be extended but it was realised that mentors needed to be clinicians experienced in vocational rehabilitation. Finding and keeping experienced vocational rehabilitation clinicians in public healthcare was a problem and the possibility of using therapists from private practice was discussed. This would mean forming public private partnerships (PPP). This concept of liaisons between public and private bodies is familiar in South Africa as several successful examples of PPP in healthcare exist (Manual, 2007). There was a concern as to how to go about doing this as there were barriers between occupational therapists working in public healthcare and private practice vocational rehabilitation which needed to be overcome.

Communication and liaisons with academic institutions were also noted as not being ideal and needing future attention. Intervention programmes such as job seekers groups and work conditioning needed attention. PILIR, work visits, referral processes, driving assessments and

placement of disabled workers were mentioned as vocational rehabilitation matters that needed future attention.

6.3.2.3 Meta-reflections on four years of transformation and ALAR

In May 2016 collective meta-reflection of the impact of the research took place in a VRTT meeting. Only two of the 11 VRTT members had been in the group when the researcher started in 2013. The average VRTT membership and experience in vocational rehabilitation was two years and members had an average of seven years' experience in occupational therapy.

Considering the usual reflection questions of *What should stay the same?* and *What should change?* illustrated how the groups' insight had matured. The VRTT felt they would change nothing that had taken place in the last four years. Even negative events such as the vocational rehabilitation services closing down at Hospital B were seen to have had positive outcomes. It showed the VRTT that vocational rehabilitation services should not be developed around a single therapist because if she leaves the whole service closes down. This event alerted the VRTT to the fact that hand-over procedures were problematic and that valuable information was being lost in this way.

Asked if they felt transformation of the vocational rehabilitation services in Gauteng public healthcare had taken place, all members felt positive about this despite there still being a lot of work to be done. They indicated an increased awareness, within occupational therapy and in the multi-disciplinary team, to be the most prominent transformation. The second prominent transformation was the increased levels of confidence and skill clinicians had acquired for delivering vocational rehabilitation. Some comments on the transformation were:

"We are now becoming established as the people who can do vocational rehabilitation."

"We have helped ourselves and now we can help others to do vocational rehabilitation."

Discussion around personal enrichment and empowerment experienced during the research showed mentoring to have been the most positive experience. Receiving mentoring from an expert vocational rehabilitation clinician was reported to have been a positive experience. Attending the VRTT meetings was mentioned as enriching; having the meeting as a case discussion, problem solving forum and ethos of the group were indicated as the reasons for this.

"This group values my opinions and empowers me to pursue a vocational rehabilitation practice that I feel proud of."

Considerations of the action research methodology showed an appreciation for skills acquired peripheral to vocational rehabilitation practice skills. They felt enriched after learning to analyse

data, publish journal articles, present at congresses and workshops and develop user manuals. It was felt the speed of vocational rehabilitation practice transformation had increased since the VRTT adopted an ALAR intervention. With the exception of two members, the rest of the team felt confident they would be able to continue transformation, using ALAR, when the researcher left at the end of the year.

“Hester (the researcher) was the most goal-directed (member of the group) but we now have the skills (to do ALAR) because we have done it so many times and have seen it works well for us.”

6.4 Withdrawal from the collaborative research team

Withdrawal from a collaborative research team is as important as the entry. Where successful entry into a group and building good relations impacts on the content of ALAR (Dick, 2013b), withdrawal from the group indicates the quality of the ethical research construct. The socio-emotional bonds that form with collaborative work, especially if mentoring is involved, need to be handled with care. In this research, the bonding with the VRTT was felt to lie on an individual as well as a collective level. The relationships the researcher formed varied in depth and nature. The cultural, religious, gender and personality differences in the VRTT further affected the approaches the researcher had to consider when withdrawing from the collaboration. It was decided to do so applying the principles of forewarning and mutual consent.

At the end of each year the researcher asked for time on the agenda at the VRTT meetings to report on the progress and future plans of her PhD, keeping participants up-to-date with the academic development of the project. In 2015, the year before her tenure with the group expired, VRTT members were told there were only 12 months left and planning for the withdrawal of the researcher was discussed. In 2016, the researcher’s tasks were taken over by other VRTT members and mentoring was on a needs only basis. Without disclosing it, the researcher applied the La Leche League principle of *do not offer and do not refuse* to wean her presence from the VRTT. This proved very effective. She continued to mentor and participate as a VRTT member but backed off by not offering her assistance. An example of this was that for one of the workshops a presenter was required. The researcher had to strongly control her impulse to offer to do the presentation. The positive outcome was that one of the other group member’s did the presentation which provided a learning opportunity for that member. In 2016, the VRTT members were organising and presenting workshops independently with the researcher asked to make only a cameo appearance.

The withdrawal from the VRTT group proved easier than separation from individual clinicians. This, however, affected the researcher more than it did the individual clinicians as they continued with their busy public healthcare practices while she returned to the isolation of private practice. ALAR had allowed the researcher authentic and in-depth access to an otherwise inaccessible insider group and she experienced symptoms similar to those found in *empty nest syndrome* (Mount & Moas, 2015). Beneficial to addressing this was the presenting of her personal reflections of her research tenure at the National Occupational Therapy Association of South Africa congress (van Biljon, 2016) as this brought a personal sense of closure to the research.

6.5 Discussion

Johns (2007) notes that reflective practice is fundamental to professional practice and in which occupational therapists in South Africa are trained in and familiar with (du Toit & Wilkinson, 2010). It is also an important skill to acquire in ALAR (Zuber-Skerritt, 2009) as it enables learning. Where action, as described in the previous chapter, came naturally to the Vocational Rehabilitation Task Team (VRTT), reflection did not. At the start of the research tenure members of the team indicated they reflected subconsciously and that it was part of their clinical reasoning. They felt conscious reflection was time consuming and potentially a threatening exercise that had no value unless used for research purposes. They agreed that because their reflections were not done systematically and consciously, no evidence could be shown that they practiced reflectively. In addition they had a difficult time identifying the personal and professional benefits of reflective practice. With regular structured and unstructured reflections, the VRTT members gradually acquired the practice of reflection on both a collective and a personal level. These reflections informed subsequent action cycles and enriched the learning experience.

The annual reflections were instrumental in guiding the transformational actions and showed that the practical workshop approach was not as effective as mentoring in bringing about service transformation. Meta-reflection brought the insight that action learning could not take place effectively within large groups and impersonal settings such as workshops. Workshops with groups of 30 to 40 attendants did not produce adequate exposure and confrontation, which allowed critical self-reflection and insight and could not change behaviour. Mentoring in groups of no more than three clinicians, or on a one-on-one basis did so. In addition, the mentoring was done within the real work situation, with real time feedback. Within such context the researcher could take on a variety

of roles to enhance the action learning as the situation required, such as a role model, demonstrator, confidant, problem solver, debriefing agent and critical friend.

As a member of the VRTT taking part in this meta-reflection, the researcher gained insight into the fact that the scope of her research had been too wide. Attempting to transform a profession's practice within a province at all levels of service in public healthcare had been too extensive a subject matter for a single enquiry. While the results of the meta reflection phase illustrated there had been service transformation, that action learning took place and new knowledge was developed, these happened at multiple levels. However no single spiral can portray the benefits of AR or the extent of AL that took place. Future researchers in this context are cautioned to choose a more defined aspect of the service.

6.6 Conclusion

The VRTT had been attending to problems associated with vocational rehabilitation in Gauteng's public healthcare prior to the researcher joining them in 2013. Meta-reflection showed that the use of ALAR had increased the tempo of transformation. An important aspect of ALAR reflection not to only guided change, but enriched the lives of those who participated. Having been exposed to structured and unstructured, collective and individual reflection throughout the research, VRTT members experienced and observed the benefits of reflective practice. They were less reluctant to take part in reflection and the content and quality of their reflections became more professional.

The meta-reflection in this chapter was collaborative in nature and the chapter shows the conclusion of the researcher's tenure with this research team. In the next chapter, the researcher's personal reflections and insights are presented.

Chapter Seven: Personal reflections recommendations and conclusions

“...the heart of the matter is a matter of the heart ...” Ortrun Zuber-Skerritt (Zuber-Skerritt, 2007)

7.1 Introduction

This chapter presents the researcher’s personal reflections from her journaling, field notes, e-mail correspondence and critical reflections. Issues described in this chapter range from challenges in healthcare delivery, the role of action learning action research (ALAR) in addressing these challenges and the personal learning that took place during the past four years. Limitations of the research are discussed. The researcher’s recommendations for further research and intervention are given. Personal insights are shown indented and in inverted commas. A conclusion is researched

7.2 On management

Pillay (2008) makes the statement that in South Africa, the lack of management capacity was the key stumbling block to the transformation and re-conceptualisation of the public sector into a more effective, efficient and responsive system of health delivery. Public media furthers this perception. In this enquiry, the two management levels, head office management and departmental management, will be referred to as they are informally referred to amongst clinicians. Head office management refers to regional and national level management, Departmental management refers to managers of clinical occupational therapy, such as heads of departments and chief occupational therapists.

For this enquiry, the support and encouragement from head office management was exceptional, without it this research would not have been as successful. It is seen as one of the primary elements that allowed effective formation of the collaborative research team. Their continued support kept the researcher enthused and achieved buy-in from potentially problematic personnel. Unfortunately isolated incidences of interference by managers on departmental level, negatively impacted the progress of transformation and action learning. Management does have an effect on the quality of a service and this could be negative or positive. However, management should not be relied on as the only practice transformation agents, but should rather be seen and utilized as co-workers of a transformational team.

“During my research I was often asked, ‘Is management part of the problem?’ There was no easy answer to the question. By association management is guilty, if a service is not offered optimally. It is also important to understand that managers in public healthcare are piloting the service equivalent of a large freight ship. In South Africa’s current leadership environment, managers are often entangled in political tangos. Especially at higher levels of management, power struggles and a constant uncertainty regarding the security of their positions was sensed. Surely this has to have a negative effect.”

The results of the planning phase, described in chapter four, recommend that attention should be given by management to formulate a framework within which occupational therapy’s vocational rehabilitation services can be positioned. This will guide the distribution of resources, inform clinicians and ensure the sustainability of good vocational rehabilitation practice.

7.3 On the transformation of vocational rehabilitation

The vocational rehabilitation crisis in Gauteng’s public healthcare is not an isolated one. The fact that occupational therapists in private practice are doing assessments and writing reports that have no therapeutic impact on the lives of the people they see, is an ethical crisis. The fact that our academic institutions are producing graduates with significantly different levels of vocational rehabilitation knowledge, skills and confidence is causing a clinical crisis.

Different reactions to these crises were observed during this enquiry. The reminiscing about the good old days and the work units of bygone era’s reaction was usually combined with blaming and claiming innocence remarks. The blame game has only losers and a nasty tendency to ricochet. This type of reaction also contributes nothing towards addressing the problem. It would be best to acknowledge the past and the present and do something about the future. Another reaction to the crisis was to smother it in administrative chaos or managerial smoke-screen-and-mirror tactics. This reaction will not deodorise the reality that 84% of our population do not have access to the therapeutic values of vocational rehabilitation because we, as occupational therapists, are not offering it at public healthcare facilities.

“There is no future in isolating ourselves in private practice or academic conclaves or trying to ignore the crisis until it goes away. Our profession is too small and too vulnerable for us to divide or isolate any efforts of transforming vocational rehabilitation.”

7.4 On mentoring

“I have come to realise that you cannot fix clinical occupational therapy practice by remote control. Practice and personal transformation was seen in this research, by getting involved at the coalface of clinical practice within an action learning action research paradigm. Mentoring clinicians within their everyday practice realities in such a way that action learning is allowed to take place. That’s what worked.”

Mentoring has many forms and in this research, it was purposefully combined with ALAR principles and ethos. Initially a more formalised mentoring approach was attempted with a contract, preset dates and times, but this did not work as it made the clinicians apprehensive. Learning from this, the researcher decided to loosen the mentoring process and structure, allowing clinicians to set the time, place and content of their mentoring sessions. They had to consider their own and the researcher’s programs, make the appointments and be responsible for all arrangements, such as booking patients, work visits. The researcher was available for telephonic, email or WhatsApp contact at any time. Using the VRTT as a critical friend forum for the mentoring was found to be useful in addressing problems and sharing successes. It also offered them the opportunity to learn to critically reflect and give educating feedback.

Additional factors that affected the mentoring were the personalities of the clinicians and the researcher. This interpersonal connection affected the quality and speed of transformation and learning that took place during mentoring. Occupational therapists are generally easy people to get along with, but one mentor-mentee relationship did not work. This gave the researcher a good learning experience in mentoring.

“I have to make peace with this. We do not like each other. Mentoring is not going to work here, we are wasting each other’s time. How I wish there was someone else, another experienced voc OT (vocational rehabilitation occupational therapists) that I could ask to take over. Someone she can relate to and trust. Someone she can drop all this defensive baggage we have to deal with and allow the action learning to come about.”

A problem experienced with mentoring was the lack of funding. The researcher had to take time out of her private practice to mentor. The cost of the 281 hours she mentored in 2015 amounted to R 182, 650.00 if calculated using the hourly tariff of R 650.00 she charged in private practice and this did not include the cost of transportation to and from the hospitals. The furthest hospital was a 214 kilometer round journey which took about three hours of travelling time a day mentoring at this

facility. In addition, the time and cost spent responding to e-mail and WhatsApp questions or requests, proofreading reports and preparing for mentoring sessions is not recorded or calculated.

Mentoring using ALAR principles in real time clinical situations required considerable skill. The researcher often found she had to demonstrate a vocational rehabilitation technique with a healthcare user who needed the intervention, while several mentored clinicians observed and practiced aspects of the technique. This required the researcher to simultaneously engage multiple levels of skills. The needs and the rights of the healthcare user always had to come first throughout such engagements and this often required engaging with the user. The vocational rehabilitation technique had to be demonstrated correctly and at a pace that learning could take place. What was taking place had to be verbalised, analysed and critically reflected on with the clinicians, in such a way that the healthcare user was not negatively affected. Clinicians had to be allowed to practically apply their skills and the researcher had to facilitate this as a learning experience for the clinician while ensuring the healthcare user remained a priority. This kind of mentoring cannot be expected of clinicians inexperienced in vocational rehabilitation.

On presenting the results of the research and sharing the above insight with the head office management, the question was asked: *“Where are we going to find mentors who have the skills and experience to do this and how are we going to pay them?”* These are both legitimate questions that need future investigation. The possibility of public private partnerships could be explored.

7.5 On working in public healthcare

“I will never tell them this as I fear it would discourage them, but we cannot begin to address the many problems or exploit the amazing potential of vocational rehabilitation in public healthcare, if the staff problems are not sorted out.”

Vocational rehabilitation in public healthcare has a high staff turnover. Occupational therapists usually stay a year or two and then leave to go into private practice, resulting in experienced clinical occupational therapists being scarce in public healthcare. Experienced staff usually had to combine administrative and management duties with their clinical practice. Without experienced staff it is difficult to offer or maintain the quality of specialised services such as vocational rehabilitation. Complicating the high staff turnover problem was the fact that there was no, or poor, hand-over. When a clinician left, the post remained unfilled for months, the service was suspended and no handover could be done resulting in the loss of clinical and procedural experience and knowledge.

“One of the most basic premises of a civilisation is to pass on its heritage. We learn from prior generations and this is how we improve our current situation. Without a thorough and well documented hand over no service can be sustained and no progress can be made in the work units. “

The researcher heard and observed multiple frustrations and problems related to working in public healthcare. Experienced staff expressed feelings of being inundated and over committed resulting in despondency and burn-out. This had a negative effect on inexperienced staff who observed experienced staff as role models. In some institutions inexperienced staff had limited or no support or mentoring in clinical work. Clinicians reported feeling they could not cope and expressed a working ethos of *‘keep your head down and do what you can’*. Some clinicians in work units expressed the concern that they could not market their services as they would be inundated with work. Another problem mentioned when offering vocational rehabilitation services, was the inability to communicate effectively with their patients due to language barriers. Patients did not understand or know what occupational therapists could offer them and did not ask for or insist on necessary services. Similarly, referring medical personnel did not know or understand what occupational therapist’s roles were within the team and their referrals were often incorrect or untimely.

The management, distribution and acquirement of resources were frustrating, laborious and associated with long waits. The same applied to the management and maintenance of infrastructure and equipment. For example, clinicians spent a lot of time asking for lights to be fixed, broken furniture to be replaced or fixed, or rooms to be painted, requests were often ignored or took months to be attended to. In some departments it was frustrating and time consuming to do basic administrative tasks such as make photocopies, print a document, or send a facsimile as internet and telephonic communication were not always reliable. All of this resulted in occupational therapists becoming disillusioned and disenchanted with their working conditions.

Clinical staff in public healthcare also contributed to their own isolation. Many clinical occupational therapists in public healthcare were not affiliated with the Occupational Therapy Association of South Africa. Asked why not, they gave reasons such as, *‘There is nothing in it for me’*. They therefore had little or no way of keeping up to date with developments in the profession, they did not receive notification of workshops and training opportunities and did not receive the official association newsletter or the South African Occupational Therapy Journal. Few therapists continued their studies or expanded their skills beyond what is necessary for continued professional development requirements. Discussion on this tendency brought to light statements such as, *‘There are no promotional or salary benefits to furthering my qualifications’*. Doing research or publishing is

difficult for clinical occupational therapists in general and so to in public healthcare. Clinicians reported a lack of confidence and experience in research and publishing. They said it was *'too difficult'* and that getting ethical clearance without affiliation to a training institution was *'impossible.'* Clinicians also reported largely negative experiences of doing research in conjunction with an academic occupational therapist, *'They just milk us for information and then take all the credit for the research or journal article'*. They felt scientific literature and the evidence available to be largely inappropriate to the context of their practices but did not take steps to address this problem.

Studies on job satisfaction amongst occupational therapists in public healthcare in the Freestate (Swanepoel, 2010) and KwaZulu Natal (Sewpersadh et al., 2016) both showed low levels of job satisfaction that would affect the retention of staff. Sewpersadh et al (2016) identified poor pay and the lack of promotional opportunities as the main reason for dissatisfaction and Swanepoel (2010) the influence of contextual factors and frustrations. Sources of job satisfaction for occupational therapists working in public healthcare were identified by Swanepoel (2010). They were, in order of prevalence: working with people, making a difference and experiencing success with clients, the relationships colleagues had with each other and inherent characteristics of the profession such as autonomy, creativity, diversity and to a lesser degree advantages of working in public healthcare such as fringe benefits and job/income security were also mentioned.

Despite all the frustrations of working in public healthcare, the researcher found private practitioners who had worked in public healthcare yearned for what some described as the best time of their lives, referring to the time they worked in public healthcare. *"I worked in public and private sector and nothing compares to the wonder and fulfillment I felt as a clinical occupational therapist working in public healthcare. I felt I was making a difference in the lives of people who really needed it."* Asked why they had left public healthcare, the most common answer was, lack of flexibility regarding working hours in public healthcare. They gave reasons such as wanting to work one or two days in a week and not working during school holidays. There are two options of employment in public healthcare, to work full day or half day. In a profession of predominantly females, this became problematic when life stages that involved the raising of children, were entered.

Discussions with private practice clinicians highlighted several aspects of working in public healthcare that they envied. In South Africa, occupational therapy's vocational rehabilitation practices in public healthcare are usually well established and equipped, whereas clinicians going into private practice have the stresses to fund the cost of setting up practices. For example, there

were two work units in Gauteng public healthcare that had commercial and standardised work samples and tests that no private practice in South Africa could afford or maintain. In public healthcare, the patient population that needs occupational therapy is readily available and if taking into consideration that 82% of the South African population moves through public healthcare it stands to reason there is a vast number of potential patients available to treat. In private practices you have to constantly look for work and hope your referring sources don't divert their referrals, merge with another company or change their referring policies.

“If public healthcare work units were fully functional and private-public-partnerships were operational, experienced vocational rehabilitation clinicians from private practice would move back into public healthcare, especially now that the competition in private practice is so high and the National Health Insurance (NHI) policy brings further uncertainty.”

7.6 On action learning and action research (ALAR)

“When I started this research I had delusions of grandeur. I really thought I knew how to fix the problem, but action research does not tolerate delusion. It is too grounded in reality. ALAR allowed me to become part of an amazing group of colleagues. As individuals from diverse backgrounds we formed a team with a unifying approach addressing a goal we all felt passionate about, vocational rehabilitation. I have been enriched by this research beyond what I could have planned or imagined when setting out to get a PhD.”

When starting to immerse herself in the body of knowledge around action research, the researcher was struck by the irony that a practical down-to-earth no-nonsense research approach such as action research, could be surrounded by such widespread chaos when it came to literature that define and typify it. Starting the enquiry, the researcher chose to avoid choosing a specific branch or type of action research. She felt she could only speculate on what the future of the enquiry would look like and wanted to avoid having a preconceived theoretical framework that could affect her perceptions. In planning the enquiry she chose the term action research (AR) and focused on the basic elements of AR. As the enquiry progressed it became obvious that action learning (AL) was central to the transformation taking place. The researcher had to acknowledge that the ALAR paradigm best described the research process of which she was a part.

Operationalising the principles of ALAR enriched the enquiry for all participants. The researcher is convinced that the ALAR approach was instrumental in stimulating the motivation of VRTT members

to expanding their personal learning through post-graduate studies. It was also central to the most effective transformation action that was undertaken, mentoring using ALAR principles.

Towards the end of the research tenure, the researcher was challenged by a statement that warrants consideration and future attention. Sharing the success of the enquiry in transforming vocational rehabilitation services in public healthcare through ALAR, the question asked was: *“That is all very well but is it sustainable?”* Only time can provide the answer to this question, but it does bring to fore the importance of ensuring the continued use of ALAR and mentoring. Several actions were taken to address this and ensure sustainability and additional suggestions are made for future enquiries and interventions.

“If you can, create a vocational rehabilitation service that is grounded in the Ubuntu philosophy. A service bigger/greater than the individuals who are in it. That has a firm foundation. That cannot be tampered with by management or people who do not understand or know the service. THEN you have safeguarded the service from transient interferences. Focus on offering services that are in demand and have a reputation of excellence and that are not linked to individual clinicians but rather to a collective body of clinicians. A collective body such as the VRTT, that supports, addresses problems and attend to quality deficits. AND if all of this can be permeated with the principles and ethos of action learning and action research, then there could be a sustainable vocational rehabilitation practice in Gauteng’s public healthcare.”

Nearing the conclusion of her research tenure the researcher tried to replace her mentoring role and ensure that action learning continued. Head office management was supportive of the idea and alerted the researcher to an existing concept called public private partnerships (PPP). She approached vocational rehabilitation experts in private practice to take over from her, asking them if they would be willing to work as mentors in public healthcare.

Many of them expressed interest and offered to become involved in a work unit close to them and all said they would do so at no cost, on a volunteering basis in their free time. Those who were not willing to become involved said they were interested and supportive of the idea but expressed work, family and financial pressures as reasons why they could not engage. There were however problems affecting this public-private-partnership (PPP) implementation. Getting the necessary clearance from public healthcare to allow private practitioners into public facilities took a long time. Private practitioners had no knowledge and skill in ALAR principles and expressed their concern about ‘getting it right.’ Public healthcare clinicians were apprehensive of forming new mentoring liaisons with strangers. At the time of writing this thesis only one such PPP had come about.

An important element to sustain and ensure future transformation is to facilitate the internalisation of approaches that worked. The current VRTT feel confident in their knowledge and experience of ALAR. Individual VRTT members were convinced of the value of the ALAR approach and that it held future benefit as an operational basis for building trust in private-public insider-outsider relations that could come about in the future. The concern is that will this still be the case if the current membership changes. It is recommended that regular training in and use of ALAR techniques becomes part of the VRTT processes.

7.7 On the collaborative research team

There is some concern about the continuation and sustainability of the collaborative research team's current efficiency should key members such as the chair of the VRTT or other senior therapists leave. The ever-changing membership of the VRTT had positive and negative impacts on the research, both of which were managed effectively within the team. The VRTT membership expanded in count and contribution during this research tenure as awareness and interest in vocational rehabilitation grew. The researcher often felt herself exceeding the ALAR aim to integrate herself in the collaborative research team.

"I am too at home in this group. I love being part of them. I have become submerged rather than immersed. I wonder if this affects my efficiency as a researcher. I can hear the positivists nodding their heads at that question. Maybe it doesn't matter so much in action research. What I do know is that it's going to hurt to leave them."

Individual members of the VRTT repeatedly expressed how ALAR and being members of the VRTT had enriched their lives. They felt the group offered them a support forum from which they could take new ideas back to their practice and also where they could bring problems they felt unable to attend to. They also expanded their professional skills by being part of research processes, being co-authors in peer review publications, presenting at workshops and being co-presenters at National congresses. However it was also noted that the group became passive participants instead of active contributors if actions became too academic. This happened every time the researcher tried to use research methods or enforce trustworthiness compliance that exceeded their levels of knowledge, interest and skill too much. It alienated the clinicians and restricted ALAR benefits, which illustrated the value of action research as it was easy and practical enough for the most inexperienced occupational therapists to understand and take part in. The researcher learnt some valuable lessons in this regard.

“In occupational therapy models and theoretical frame works should be seen as servants of clinical practice. As clinicians we are so in awe of anyone who can talk academees and banter around highfaluting ideas and concepts. We really should stop this. The heart of our profession lies in occupational therapists making a difference in the lives of broken people.”

It is recommended that future researchers take note of these findings and additional investigation of the transferability of such results is recommended.

7.8 On other factors and approaches that influenced the enquiry

It would be misleading to leave the reader thinking that only ALAR and mentoring were instrumental in the successful transformation of vocational rehabilitation services in Gauteng’s public healthcare during this research tenure. There were multiple other factors that contributed to the successful service transformation seen, some planned, others unplanned and some the researcher might still not be aware of. Some approaches the researcher used fell outside the ALAR realm and are mentioned here.

“If I do nothing I won’t get into trouble” was a disturbing mind-set the researcher found amongst some clinicians. They would go to great lengths to hide the fact that they lacked skill and/or experience. Left un-confronted, this type of conduct could go on for a long time, paralysing service delivery and denying healthcare users interventions that could change their lives. Clinicians had to be reminded that in South Africa the law views an act of omission as seriously as doing something wrong and that *“I did not know “* is not seen as a valid excuse by our courts.

“Doing nothing when you should be doing something can get you into just as much trouble as doing something wrong. AND Finding out how to do something you should be doing but do not know how to do is your responsibility.”

The researcher felt that in many cases the bedrock cause of *“do nothing then I cannot get into trouble”* mind-set was insecurity and a lack of confidence. She found that introducing the see-one do-one-teach-one approach worked well in such cases. She would demonstrate a vocational rehabilitation skill, observe them doing the same skill and then ask them to teach it to a colleague or students.

“A little push is necessary to get some clinicians to claim the confidence they need. I tell them that when it comes to confidence in clinical settings you fake-it-till-you-make-it for the sake of the

patients and the students. Nobody wants to be treated by or to learn from a shaking bundle of nerves. And how do you get confidence in clinical skills? They all know the answer – by doing it.”

The *Socratic method of critical questioning* was employed throughout this enquiry. It resonated well with ALAR principles (Zuber-Skerritt, 2002). Developing his philosophy within an Athenian democracy, Socrates showed that by asking the right question you allow the truth to emerge while both the questioner and the questioned furthers their understanding of the discussion matter (Mason, 1960). This proved to be an effective method throughout the enquiry and worked well with the research population of qualified occupational therapists. They enjoyed personal problem-solving and reportedly increased their confidence and personal growth. In addition it curbed the researcher’s interfering nature.

“I often felt like just telling them what to do. Doing traditional teaching is a faster and easier way to transfer skills and knowledge than action learning. But action learning is a more gratifying and mutually enriching way of doing so and maybe the lessons stick better this way.”

Working in South Africa, Zuber-Skerritt (2009) learnt of the traditional African concept of *Ubuntu* and notes its similarity to the values of ALAR. Adopting the Ubuntu ethos within the collaborative research group was a good idea as all the members were Africans and had knowledge and understanding of the Ubuntu values. This made it easy to align and sustain the group’s fundamental work ethic. Regular collaborative reflection often brought up discussion of these values with affirmation or correction of actions and decisions to comply with the Ubuntu way of doing something. It was felt that this eased the collaborative process and enriched personal participation.

“I had such a distressing discussion with an experienced occupational therapist. She advised me against ‘the Ubuntu thing’ saying that it was a philosophy designed for societal living and not suitable for professional working environments. She used the example of our philanthropic dissemination of knowledge created in this research. The motives for her opinion were considerations of intellectual property rights, plagiarism of my ideas and that I would lose acknowledgement of the effort and time of my contribution within the VRTT. I had to dig deep to still the angst this discussion brought me.”

Some positive transformational factors the researcher did not plan or foresee warrant mentioning. The personal and professional qualities of individuals involved in this enquiry had an impact on the amount of work that could be done and the quality of work. Throughout the previous chapters mention is made of them. The effect their altruistic contributions and dedication have had warrant a call for future research to investigate the influence that personal traits and working ethos have on

ALAR studies. Of great value to the VRTT, was the interest and support from a revered academic expert in vocational rehabilitation. She visited the meetings, took part in some of their activities and joined the VRTT's WhatsApp group, where she still contributes advice and ideas. Her sanctioning was confirmation to the group that they were doing the right thing, which motivated them further.

A limitation of this study was the lack of ability to form a frame work within which vocational rehabilitation services could be positioned as discussed in chapter four. The literature review was restricted by the lack of contextual scientific evidence and it could have been more beneficial if approached as a scoping review. In addition, instead of using a survey tool to gauge occupational therapist opinion on this matter more beneficial knowledge might have emerged from focus groups.

7.9 On critical friends, supervisors and support structures

The nature of ALAR required skills beyond what this researcher possessed. Realising this, she tried to acquire the relevant skills by attending workshops and online courses on ALAR related topics. In addition she read books, journal articles, internet blogs and theses and she made contact with practitioners who had experience in action research. All this helped but as action learning preaches, nothing on paper can prepare adequately for the reality of practice. Had it not been for the guidance and support of critical friends, supervisors and the University of the Witwatersrand PhD support group that this researcher was allocated to, the enquiry would not have concluded. Their contributions are shown through the research, but of great value to the researcher was she never felt she was alone, there was always someone to ask for help, bounce ideas off, unpack problems and blow off steam.

“This type of research cannot be done without a variety of support structures. There are too many facets to it. Where one support structure cannot understand or envision a problem another one moves in to fill the gap.”

It is recommended that future action researchers surround themselves with a variety of support structures. Within the University of the Witwatersrand there is extensive post-graduate support available and action research students should use these or create their own multi-level support structures.

7.10 Summary of key principles of learning.

The researcher experienced a tremendous amount of learning during this study. One thing she now knows is that action researchers are brave souls who err on the side of risk. They face giants and stand in the gaps in the wall to make the world a better place and they need all the help they can get. This section is a summary of the lessons she learnt with the hope that it will be of some benefit to other action researchers.

Three generic principles of learning emerged that encapsulated all the previously discussed reflections. The researcher learnt that to be an effective action researcher she had to acquire, implement and maintain; the skill to form positive relationships and function effectively in a group, the discipline to scientifically order and record data, a laissez faire approach.

Relationships were principal elements in the successes and the failures of this research. The principles of action research and Ubuntu formed the foundation of the Interpersonal relational skills that drove action learning and action research cycles. Action researchers need to know this and acquire the skills if this does not come naturally. In addition, as in any relationship, it needed to be continuously worked at. Positive relational aspects such as trust, authenticity, loyalty, respect had to be reinforced and negative ones such as polarization, exclusion, falsity, secretiveness, competitiveness had to be corrected.

Routine reflection and journaling was the most effective instrument that consolidated and contextualized the researcher's learning. Over and above the scientific purposes it has it helped the researcher to make sense of what was often a deluge of information. It consolidated and framed experiences and offered the consolation of some form of order within the chaotic realm of action research. The researcher was principally responsible for the rigour and quality of the research and had to do this without losing the essence of the other two principles of learning.

Patience and composure were attributes the researcher had to constantly reinstate in her approach to the research. It was imperative to allow the progress of transformation to dictate its own pace. Forcing an issue destroyed the collaborative and democratic nature of the group. Towards the end of the research tenure, as the VRTT became more confident in the ALAR paradigm they on occasion reminded the researcher to *just let it go, it will sort itself out* when she was attempting to press a matter for closure before she left the research team. The VRTT had become a truly collaborative research team that upheld the principles of ALAR.

7.11 Conclusion

There is still a lot of work to be done to achieve successfully and sustainable vocational rehabilitation services in Gauteng's public healthcare. This enquiry showed that mentoring combined with ALAR successfully transformed vocational rehabilitation services in Gauteng. The sustainability of the transformed service is a concern. Having a clear idea of what vocational rehabilitation services should be offered where with a framework within which all resources can be equally distributed with the least amount of patient referral is an important strategy that still needs to be implemented. Acknowledging that the need for transformational actions will never stop and so too the need for action learning and action research cycles is another way of addressing this concern. This research suggests that ALAR should be seen as a professional lifestyle imbedded in the clinical practice of occupational therapy's vocational rehabilitation and the researcher ventures to extend this suggestion to the greater occupational therapy fraternity including undergraduate training.

This research recognises that it offers a small contribution to a large and multi-faceted problem. Within public healthcare the transformation of occupational therapy's vocational rehabilitation services will continue through the VRTT and there is ample subject matter and opportunity for further research. Occupational therapy's vocational rehabilitation problems exceed the boundaries of a single healthcare sector and cannot be addressed through isolated efforts such as this enquiry. A collaborative approach across sectors is necessary and imperative in the light of future changes to national healthcare.

All and any efforts of transformation should be grounded in the principles of our constitution. They should be aimed at bringing about reform that will promote the service proficiency, equity and efficiently to all who live in or visit South Africa, transcending cultural and economic barriers. There is a long road ahead for occupational therapy vocational rehabilitation services, but if our hearts are aligned we can at least be sure we are all traveling on the same road and in the same direction.

The researcher grew up on a mission station in Zambia and shares the following vignette as an allegory to the vocational rehabilitation services of occupational therapy in South Africa.

As children we could roam freely through the bush surrounding the mission station, playing from one homestead to the other. The adults used to warn us: 'Mu yenda payekha. Mu dzafa.' (If you walk alone you die.) They referred to rogue hyenas or leopards that could pick off a lone wandering child. But as a noisy boisterous group we were safe.

The same warning applies to occupational therapists in South Africa today. If therapists continue to isolate themselves in public, private or academic conclaves the profession will lose its role and reputation within the field of vocational rehabilitation. This enquiry brought to light the need to break down the segregation currently seen amongst occupational therapists practicing vocational rehabilitation. We have to start working together to improve the services we offer and consolidate the role of occupational therapy within the field. There is a collective responsibility for the transformation of our profession's vocational rehabilitation services so we can meet the-need-to-work of those who need it most in this southern part of Africa.

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M130649

R14/49 Ms Hester van Biljon

HUMAN RESEARCH ETHICS COMMITTEE (MEDICAL)

CLEARANCE CERTIFICATE NO. M130649

NAME: Ms Hester van Biljon
(Principal Investigator)

DEPARTMENT: Occupational Therapy
School of Therapeutic Sciences


PROJECT TITLE: Transforming Vocational Rehabilitation in
Occupational Therapy Departments in Gauteng
Public Health Care through Action Research
and Mentoring

DATE CONSIDERED: 28/05/2013

DECISION: Approved unconditionally

CONDITIONS:

SUPERVISOR: Dr Daleen Castalijn

APPROVED BY: 

Professor PE Cleaton-Jones, Chairperson, HREC (Medical)

DATE OF APPROVAL: 02/08/2013

This clearance certificate is valid for 5 years from date of approval. Extension may be applied for.

DECLARATION OF INVESTIGATORS

To be completed in duplicate and **ONE COPY** returned to the Secretary in Room 10004, 10th floor, Senate House, University.

I/we fully understand the conditions under which I am/we are authorized to carry out the above-mentioned research and I/we undertake to ensure compliance with these conditions. Should any departure be contemplated, from the research protocol as approved, I/we undertake to resubmit the application to the Committee. **I agree to submit a yearly progress report.**

Principal Investigator Signature

M130649Date

PLEASE QUOTE THE PROTOCOL NUMBER IN ALL ENQUIRIES

Information Sheet for the research inquiry titled:

**Transforming the Vocational Rehabilitation Services of Occupational Therapists
in Gauteng Public Healthcare through Action Learning Action Research**

I'd like to invite you to take part in this Action Learning Action Research (ALAR) inquiry. The reason for this research is to improve the vocational rehabilitation services of occupational therapists in Gauteng's public healthcare. Working is an important aspect of adults' lives and the vocational rehabilitation services occupational therapists offer in Gauteng's public healthcare is not functioning optimally. The research question arose: Can ALAR transform the vocational rehabilitation services occupational therapists offer in Gauteng's public healthcare?

Action research is a collaborative and practice based research method and action learning a form of experimental learning where learning takes place in real time practice and groups. The Vocational Rehabilitation Task Team (VRTT) and the researcher will form a collaborative research team using ALAR to identify and address vocational rehabilitation practice problems. A four year research tenure is foreseen, during which time multiple action research cycles will be run and action learning will take place.

There are no risks involved in the study. There is no remuneration but you can expect the benefits of professional and personal growth and development. Participation is voluntary and refusal to participate or discontinuation of participation will involve no penalty or loss of benefit to which you would otherwise be entitled.

Please note that every effort will be made to keep personal information confidential through coding and the use of pseudo-names. However: Absolute confidentiality cannot be guaranteed as dissemination of results may lead to individual/cohort identification.

Contact Details of Researcher: Hester van Biljon, Occupational Therapist, Tel 0117263658 or vanbiljon@mjvn.co.za

Contact Details of Research Ethics Committee administrator and chair for the reporting of complaints or problems: Anisa Keshav, Wits Research Office, 0117171234 or anisa.keshav@wits.ac.za

Informed Consent Form - General

Contact Details of Researcher: Hester van Biljon, Occupational Therapist, Tel 0117263658 or vanbiljon@mjvn.co.za

Contact Details of Research Ethics Committee administrator and chair for the reporting of complaints or problems:
Anisa Keshav, Wits Research Office, 0117171234 or anisa.keshav@wits.ac.za

I hereby confirm that I have been informed by the researcher, Hester van Biljon, about the nature, conduct benefits and risks of the study entitled: Transforming the Vocational Rehabilitation Services of Occupational Therapists in Gauteng Public Healthcare through Action Learning Action Research.

I have also received, read and understood the information in the participant information sheet regarding this study. I am aware that the data from the study will be processed into a thesis and could be disseminated in other forms.

I am aware that due to the nature of action research and action learning no claim to confidentiality can be made. I hereby give consent that my contribution to and participation in all aspects of the study can be used by the researcher for research related purposes. I am aware that the information that I provide may be used in future studies.

I may, at any stage, without prejudice, withdraw my consent and participation in the study. I have had sufficient opportunity to ask questions and (of my own free will) declare myself prepare to participate in the study.

I understand that although the study foresees no danger of such occurrence, I cannot hold the University of the Witwatersrand and the researcher responsible for any damages, injuries or discomforts incurred and undertake to treat all fellow participants with respect and consideration.

Participant:

Printed name Signature Place Date and Time

I, Hester van Biljon, herewith confirm that the above participant has been fully informed about the nature, conduct and risk of the above study.

The Researcher:

Printed name Signature Place Date and Time

Informed Consent as Critical Friend/ Expert

Contact Details of Researcher: Hester van Biljon, Occupational Therapist, Tel 0117263658 or vanbiljon@mjvn.co.za

Contact Details of Research Ethics Committee administrator and chair for the reporting of complaints or problems: Anisa Keshav, Wits Research Office, 0117171234 or anisa.keshav@wits.ac.za

I hereby confirm that I have been informed by the researcher, Hester van Biljon, about the nature, conduct benefits and risks of the study entitled: **Transforming the Vocational Rehabilitation Services of Occupational Therapists in Gauteng Public Healthcare through Action Learning Action Research**

I have also received, read and understood the information in the information sheet regarding this study and I understand the reason for and extent of my participation as an expert or critical friend to this study. I am aware that the data from the study will be processed into a thesis and could be disseminated in other forms.

I hereby give consent that my contribution to and participation in all aspects of the study can be used by the researcher for research related purposes.

I hereby give consent that my name may be used as acknowledgement of my contribution in all forms of publication.

I am aware that the information that I provide and any form of contribution may be used in future studies. I may, at any stage, without prejudice, withdraw my consent. I have had sufficient opportunity to ask questions.

Participant:

Printed name	Signature	Place	Date and Time
--------------	-----------	-------	---------------

I, Hester van Biljon herewith confirm that the above participant has been fully informed about the nature, conduct and risk of the above study.

The Researcher:

Printed name	Signature	Place	Date and Time
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Informed Consent Form - Mentoring

Contact Details of Researcher: Hester van Biljon, Occupational Therapist, Tel 0117263658 or vanbiljon@mjvn.co.za
Contact Details of Research Ethics Committee administrator and chair for the reporting of complaints or problems:
Anisa Keshav, Wits Research Office, 0117171234 or anisa.keshav@wits.ac.za

I hereby confirm that I have been informed by the researcher, Hester van Biljon, about the nature, conduct benefits and risks of the study entitled: **Transforming the Vocational Rehabilitation Services of Occupational Therapists in Gauteng Public Healthcare through Action Learning Action Research**

I have also received, read and understood the information in the participant information sheet regarding this study. I am aware that the data from the study will be processed into a thesis and could be disseminated in other forms.

I am aware that the researcher, Hester van Biljon (PhD candidate), will act as mentor applying action learning and action research principles. I hereby give consent to be mentored by her and that my contribution to and participation in all aspects of the study can be used by the researcher for research related purposes. I am aware that the information that I provide may be used in future studies.

I may, at any stage, without prejudice, withdraw my consent and participation in the study. I have sufficient opportunity to ask questions and (of my own free will) declare myself prepare to participate in the study.

I understand that although the study foresees no danger of such occurrence, I cannot hold the University of the Witwatersrand and the researcher responsible for any damages, injuries or discomforts incurred and undertake to treat all fellow participants with respect and consideration.

Participant:

Printed name Signature Place Date and Time

I, Hester van Biljon herewith confirm that the above participant has been fully informed about the nature, conduct and risk of the above study.

The Researcher:

Printed name Signature Place Date and Time

Informed Consent for Audiotaping and Photographs

Contact Details of Researcher: Hester van Biljon, Occupational Therapist, Tel 0117263658 or vanbiljon@mjvn.co.za

Contact Details of Research Ethics Committee administrator and chair for the reporting of complaints or problems:
Anisa Keshav, Wits Research Office, 0117171234 or anisa.keshav@wits.ac.za

I hereby confirm that I have been informed by the researcher, Hester van Biljon, about the nature, conduct benefits and risks of the study entitled: **Transforming the Vocational Rehabilitation Services of Occupational Therapists in Gauteng Public Healthcare through Action Learning Action Research**

I have received, read and understood the information in the participant information sheet regarding this study and I understand that audiotapes and photographs will be taken when and where relevant. I am aware that the data from the study will be for a thesis and could be disseminated in other forms. **I hereby give consent that my contribution to and participation in all aspects of the study can be audiotaped, photographed and used by the researcher for research related purposes.**

I am aware that the information that I provide as well as the audiotapes and photographs may be used in future studies. I may, at any stage, without prejudice, withdraw my consent. I have sufficient opportunity to ask questions.

Participant:

Printed name Signature Place Date and Time

I, Hester van Biljon herewith confirm that the above participant has been fully informed about the nature, conduct and risk of the above study.

The Researcher:

Printed name Signature Place Date and Time



To whom it may concern,

On behalf of OTASA I, Sylvia Birkhead, editor of the Focus newsletter which is produced for members of the Occupational Therapy Association of South Africa (OTASA), give copyright permission/clearance to Hester van Biljon, to include articles submitted by her and published in the Focus during the time of her research, in her PhD thesis titled: “Transforming Vocational Rehabilitation in Occupational Therapy Departments in Gauteng public healthcare through Action Learning and Action Research.”

These articles record information generated in her research and are proof that she has shared and disseminated information to make it available to peers and other interested or knowledgeable persons who could comment on and “test” it. The articles are as follows:

1. van Biljon HM. Ethics and Legal Implication for Vocational Rehabilitation Practice: a Basic Understanding. FOCUS Official Newsletter of OTASA, 2013; 1: 14-6.
2. van Biljon HM. The Work-Link ADL Screening Tool. An activities of daily living screening tool for vocational rehabilitation practice. FOCUS Official Newsletter of OTASA, 2013; 3: 33-5.
3. van Biljon HM, Rabothata S. "How do we go about starting a work unit?" Advice and guidelines from experts in vocational rehabilitation. FOCUS Official Newsletter of OTASA, 2014; 1: 11-6.
4. van Biljon HM. Using MODAPTS tasks in Public Healthcare's Clinical Settings. FOCUS Official Newsletter of OTASA, 2014; 3: 9-15.
5. van Biljon HM, Parkinson C. Reflections on a year of Action: The Vocational Rehabilitation Task Team (VRTT) Gauteng's critical reflection on their work in 2014. FOCUS Official Newsletter of OTASA, 2015; 1: 11-3.
6. van Biljon HM, Moleofane B. Reflections of Working in Gauteng's Public Healthcare. FOCUS Official Newsletter of OTASA, 2015; 2: 12-5.
7. van Biljon HM. Positioning occupational therapy's vocational rehabilitation intervention within the management of Spinal Cord Injuries (SCI). FOCUS Official Newsletter of OTASA, 2015;3:14-5.
8. van Biljon HM, Burger E. The First AFSCIN (African Spinal Cord Injury Network) Congress in Gaborone, Botswana – 2nd to 4th November 2015: “Working in Africa with a Spinal Cord Injury.” FOCUS Official Newsletter of OTASA, 2015;3:38
9. van Biljon HM, Akhals Z, Mdakane S. Reflecting on 2015: The Vocational Rehabilitation Task Team (VRTT) of Gauteng takes a good look at a busy year. FOCUS Official Newsletter of OTASA, 2016; 1: 3-5.

Regards

Sylvia Birkhead, Editor of Focus, OTASA's official Newsletter



South African Journal of Occupational Therapy

To: Hester van Biljon

From: Dr Marjorie Concha

Editor

South African Journal of Occupational therapy

Date: 18/7/16

Re: Copy right articles published in SAJOT

Permission is hereby given for Hester van Biljon to include the following articles as published in SAJOT:

1. van Biljon HM, Casteleijn D, Du Toit SHJ, Soulsby L. Opinions of Occupational Therapists on the Positioning of Vocational Rehabilitation Services in Gauteng Public Healthcare. *SAJOT*, 2016; 1(1).
2. van Biljon HM, Casteleijn D, Du Toit SHJ, Rabothata S. An Action Research Approach to Profile an Occupational Therapy Vocational Rehabilitation Service in Public Healthcare. *SAJOT*, 2015; 45(3): 40 - 47.
3. van Biljon HM, Casteleijn D, du Toit SHJ. Developing a vocational rehabilitation report writing protocol - a collaborative action research process. *SAJOT*, 2015; 45(2): 15-21.

M Concha

A handwritten signature in black ink, appearing to read 'M Concha', is written below the printed name.

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by Hester Van Biljon

NOTE: The PhD Thesis TRANSFORMING THE VOCATIONAL REHABILITATION SERVICES OF OCCUPATIONAL THERAPISTS IN GAUTENG PUBLIC HEALTHCARE THROUGH ACTION LEARNING ACTION RESEARCH by Hester van Biljon student number 732054, contains four peer reviewed journals written by the researcher. For this reason the thesis was submitted to Turnitin under the title *TurnitinChapters 1 to 7 unformatted.docx* with the journal articles removed. The certificate is enclosed.


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9	Ramukumba, Tshinetise Alfred. "Economic	

Vocational Rehabilitation Practice Profile Tool

Introduction to using it in Gauteng public healthcare

"It is the ethical dimensions of individuals that are essential to a health system's success. Ultimately, the secret of quality is love. You have to love your patient, you have to love your profession, you have to love your God. If you have love, you can then work backward to monitor and improve the system." - Avedis Donabedian

Dear Colleague,

We have committed ourselves to helping you improve the Vocational Rehabilitation Services offered in Gauteng's public healthcare. We acknowledge that occupational therapists in public healthcare have unique external and internal challenges. We want you to know that you are not alone in facing these challenges. We have every confidence in your ability to offer an efficient, effective and comprehensive Vocational Rehabilitation Service.

To help you with this, we would like to share with you a tool that you can use to profile your VRS. It was developed by us within public healthcare practices to ensure that it is relevant to your practice context. Using this profile tool allows you to take an objective look at what your service offers as well as what it could/should look like. You can also use the tool to help you with planning, goal setting, policy making, quality management and research.

You can help us by using the profile tool and writing down any suggestions, ideas, questions you have, then sending these to us at vanbiljon@mjvn.co.za. This way we can make sure that the profile tool continuously evolves, remains relevant, easy to use and helps occupational therapists in public healthcare to offer the kind of VRS that we can all be proud of.

Regards Vocational Rehabilitation Task Team (VRTT), Gauteng
(Next review will be done December 2016)



GAUTENG PROVINCE
HEALTH
REPUBLIC OF SOUTH AFRICA

Report Writing Protocol for Vocational Rehabilitation Services in Gauteng Public Healthcare

“This is how you do it: you sit down at the keyboard and you put one word after another until it’s done. It’s that easy, and that hard.” – Neil Gaiman

Dear Colleague,

We hope that you see this protocol as a guide to help you write vocational rehabilitation reports. We have undertaken to familiarize all new occupational therapists with it and to review it once a year. It is our resolve to manage the standard and address the difficulties of writing reports for vocational rehabilitation services in public healthcare. We want to emphasize that this protocol is not a guarantee that great reports will be written or no errors will be made. That responsibility remains yours. This protocol is our acknowledgement that occupational therapists in public healthcare have unique external and internal challenges when it comes to writing vocational rehabilitation reports. We want you to know that you are not alone in facing these challenges and that we have confidence in your ability to improve and/or acquire the skills to write good vocational rehabilitation reports and spend the least possible time doing so.

To help us with helping you: use the protocol and the templates, and send us any suggestions, ideas, questions and/or difficulties you have to naazneen.ebrahim@gmail.com. Together we can make sure that this protocol continuously evolves and remains a relevant, easy to use document that helps occupational therapists be proficient and productive vocational rehabilitation report writers.

Regards

Vocational Rehabilitation Task Team (VRTT), Gauteng

December 2015 (Next date of Review: December 2016)



GAUTENG PROVINCE
HEALTH
REPUBLIC OF SOUTH AFRICA

OCCUPATIONAL THERAPY PROTOCOL FOR SCREENING ABILITY TO DRIVE

"The one thing that unites all human beings, regardless of age, gender, religion, economic status, or ethnic background, is that, deep down inside, we all believe that we are above-average drivers." — [Dave Barry](#)

Dear Colleagues

We hope you see this protocol as a guide to help you screen your patients' ability to drive a motor vehicle. We realize the importance and necessity of driving and that occupational therapists are often asked to be involved in the decision-making process regarding ability to drive. At the same time, we realise that there are currently no guidelines to help occupational therapists in Gauteng public healthcare to understand the extent to which they can become involved in such decision-making or how to go about doing this.

With this protocol we hope to offer some practical guidelines for you to:

1. Understand your position within the process of establishing a patient's ability to drive.
2. Provide you with an easy to follow process of how to screen for and indicate your patient's ability to drive a motor vehicle.

This protocol can be used by any qualified registered occupational therapist, in any adult occupational therapy practice and at any level of public healthcare in Gauteng.

To assist us with helping you, please use the protocol and share any suggestions, ideas, questions and/or difficulties you have with us at marlene.robus@gmail.com.

We undertake to review this protocol every year, making sure it continuously evolves and remains a relevant, easy to use document that helps therapists to be proficient in the screening of their patients' ability to drive.

Regards

Vocational Rehabilitation Task Team (VRTT), Gauteng

December 2015 (Next review date is December 2016)



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GAUTENG PROVINCE
HEALTH
REPUBLIC OF SOUTH AFRICA

MODAPTS user manual for Occupational Therapy Practice

"How many seconds does it take to win second? As many as it takes to win first—if you don't use them properly." — Jarod Kintz, [A Zebra is the Pingo of the Animal Kingdom](#)

Dear Colleague,

We hope that you see this as a guide to help you use MODAPTS as part of the vocational rehabilitation screening tool and in your general occupational therapy practices. MODAPTS is an affordable, effective, easy to use tool that you can use to develop a predetermined time standard for activities relevant to your practice and patient population.

We acknowledge that occupational therapists in public healthcare have unique external and internal challenges; varying levels of MODAPTS competence being one of them. For that reason we have tried to give you some basic MODAPTS background, a few MODAPTS tasks and simple step by step instruction on how to develop your own MODAPTS activities.

We want you to know that you are not alone and that we will help you address any challenges. We have confidence in your ability to improve and/or acquire the skills necessary to implement MODAPTS into your practice. It however remains your responsibility to do so and access the assistance we offer.

To help us with helping you: use the booklet, the MODAPTS tasks enclosed and develop your own. Share your experiences with us and send any MODAPTS tasks you developed, suggestions, ideas, questions and/or difficulties you have to parkinsonclaudette@gmail.com.

Together we can make sure that MODAPTS becomes a part of our practices and helps us be proficient and productive occupational therapists.

Regards

Vocational Rehabilitation Task Team (VRTT), Gauteng
(Next date of Review: December 2016)



Doing a Basic Assessment of Ability to Work in Gauteng Public Healthcare

“Ya gots to work with what you gots to work with.”- Stevie Wonder

Dear Colleague,

We hope that you see this as a guide to help you assess the ability to work of the patients you see where you practice. We acknowledge that occupational therapists in public healthcare have unique external and internal challenges, when it comes to assessing ability to work. We want you to know that you are not alone in facing these challenges. We also have confidence in your ability to improve and/or acquire the skills to do good work assessments where you are and with the resources available to you.

We want to emphasize that these guidelines are not a guarantee that great work assessments will be done. That responsibility remains yours. It is our resolve to manage the standard and address the difficulties occupational therapists in public healthcare experience when asked to do a work assessment. We have undertaken to familiarize all new occupational therapists with these guidelines and to review it once a year.

To help us with helping you send us any suggestions, ideas, questions and/or difficulties you have to naazneen.ebrahim@gmail.com. That way we can make sure that these guidelines continuously evolve and remain relevant and easy to use. Together we can ensure that occupational therapists consolidate their reputation of being proficient assessor of ability to work.

Regards

Vocational Rehabilitation Task Team (VRTT), Gauteng

3 December 2015 (Next date of Review: December 2016)



Supervising Undergraduate Occupational Therapy Students in Vocational Rehabilitation

A user manual for Gauteng's Public Healthcare

"Tell me and I forget, teach me and I may remember, involve me and I learn." — Benjamin Franklin

Dear Colleague,

We hope you see this as a guide to help you clinically supervise occupational therapy students in vocational rehabilitation in Gauteng's public healthcare. Your contribution in preparing future occupational therapists is important. Remember, today's student is tomorrow's colleague.

We acknowledge that occupational therapists in public healthcare have unique external and internal challenges when it comes to the supervision of students. We also know that as clinicians, it is a challenge to supervise students in addition to your usual clinical and administrative duties. This is further complicated by the fact that the three academic institutions in Gauteng have different requirements for student supervision and their students come with different levels of skill and knowledge in vocational rehabilitation. For that reason we have tried to provide some basic guidelines and share our knowledge and experience with you.

We want you to know that you are not alone and that we will help you address any challenges. We have confidence in your ability to improve and/or acquire the skills necessary to clinically supervise under-graduate students in your practice. It however remains your responsibility to do so and access the assistance we offer.

To help us help you, use this manual and develop your own skills and experience. Send and share your experiences, ideas and suggestions with us to buhlemolefana@gmail.com so we can continue to improve our collective contributions towards the future of our profession.

Regards

Vocational Rehabilitation Task Team (VRTT), Gauteng

(Next date of Review: December 2016)