Title: The Experiences of Social Care Community Occupational Therapists in Wales of Addressing Obesity in the Adult Population.

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RR researched literature and conceived the study. RR gained ethical approval and carried out the research, supervised by AS. RR wrote the first draft of the manuscript. All authors reviewed and edited the manuscript and approved the final version of the manuscript.

During the development, progress, and reporting of the submitted research, Patient and Public Involvement in the research was not included at any stage of the research'

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ABSTRACT

The prevalence of obesity, and the associated costs to health and social care services has attracted the attention of policy makers recently. This increase in obesity has had a direct impact on the practice of occupational therapy in social care. This exploratory study aimed to evaluate community occupational therapists experiences in South Wales, to identify enablers and barriers faced by occupational therapists in social care. Semi-structured interviews were carried out with eight occupational therapists working in social services departments across local authorities in South Wales in the UK. Interviews were analysed thematically using the Braun and Clarke framework (2006). Four key themes were identified from the semi-structured interviews with the occupational therapists: 1) feelings of Competence and Duty; 2) the changing nature of practice in social care settings; 3) managing complex relationships with clients, management and other healthcare professionals and 4) accessing physical resources in the community. The occupational therapists described their practice experiences relating to the prevention, management and treatment for adults with obesity seen in a community setting. Taking into account the information gained from the interviews, several recommendations have been made to enable occupational therapists to promote independence and quality of life as well as ensuring best practice when working with adults with obesity.

Introduction:

The prevalence of obesity, and the associated costs to health and social care services has attracted the attention of policy makers recently. This increase in obesity has had a direct impact on the practice of occupational therapy in social care.

Obesity is defined by having an "abnormal or excessive fat accumulation that poses a risk to health" (World Health Organisation, (WHO) 2018a). Since 1975, the rate of obesity has tripled worldwide with figures in 2016 showing that 39% of adults (1.9 billion) were overweight in 2016, with 13% (650 million) of those being obese (WHO, 2018a). This increase in obesity has been described as a global epidemic (WHO, 2018a) and has a negative impact on the health and wellbeing of individuals and societies worldwide. In the UK, obesity rates doubled between 1993 and 2011 recent statistical information for England shows that over a quarter of adults are obese (NHS Digital, 2018). In Wales, 24% of adults are classed as obese and 59% of adults in Wales are overweight or obese (Public Health Wales, 2016). Despite the number of adults who are morbidly obese representing a small proportion of the adult population,their use of health and social care services are prevalent. Obesity is indicated in acute and chronic co-morbidities including type 2 diabetes, stroke and cardiovascular disease (Brewster and Nowrouzi, 2014). Consequently, intervention is required at a clinical, social and population level due to the negative impact of obesity on health care provision and the wider economy (Brewster and Nowrouzi, 2014).

Obesity is considered within the paradigm of chronic illness or disease by occupational therapists and can impact negatively on functional abilities, causing difficulties with engaging and participating in meaningful activities of daily living (Brewster and Nowrouzi, 2014). Opportunities to participate in education, work or preferred leisure time can be limited by the experience of being overweight or obese and this can have a devastating impact on quality of life (AOTA, 2013). Professional bodies of occupational therapy advocate that occupational therapists have the potential to make a positive impact in the treatment, management and prevention of obesity.

Despite the increasing discussion around obesity and occupational therapy, there is limited evidence relating to how the social services occupational therapy workforce approaches obesity when working in the community.

The aim of this study was to explore and understand the experiences of occupational therapists working with adults who are obese in social services settings in Wales, specifically to explore the enablers and barriers to providing a holistic intervention approach.

Literature Review

A systematic search strategy was undertaken using relevant databases including CINAH and OVID. Relevant occupational therapy and obesity-based journals and grey literature were identified using combinations of the key terms "occupational therapy", "obesity" and "overweight". The literature was critically appraised using the Mixed Methods Appraisal Tool (Hong, Fàbregues and Bartlett et al., 2018)

Definitions and Diagnosis of Obesity

Obesity is defined by having an "abnormal or excessive fat accumulation that poses a risk to health" (WHO, 2018b). Derived from the Greek word, 'barros', meaning large or heavy, the term bariatric is used to refer to the medical domain of addressing the causes, treatment and prevention of obesity (AOTA, 2010). The standard way of measuring if an adult is overweight or obese is by using the Body Mass Index (BMI) score. A high BMI score can often be attributed to a high level of body fat although it is a screening tool rather than a diagnostic tool (CDC, 2016). A BMI of between 18.5 and 25 is classed as within the normal range, between 25 and 30 as overweight and any score of 30 falls within the obese range (CDC, 2016). Obesity is considered within the paradigm of chronic illness or disease by occupational therapists and should therefore be treated as a health condition (Brewster and Nowrouzi 2014). The multi-faceted etiology of obesity means that the impact is often felt from a medical, social and functional perspective (Brewster and Nowrouzi 2014) and this is consistent with many other physical and mental conditions that are classified as a disability (Puhl and Brownell 2001). Due to its complexities, it is suggested that a multi-disciplinary approach is required at an individual and population level to effectively tackle the management and prevention of obesity (Brewster and Nowrouzi 2014).

Causes of obesity

The Foresight Report (UK Government, 2007) suggested how the UK Government should respond to the prolific rise in obesity across the nation. It was identified that there was an oversimplification of both the causes and treatment of obesity attributed causes to a complex interplay of multiple factors, including a person's biological make-up, behavioural tendencies

and a set of wider environmental influences (Laddu, Dow, Hingle, Thomson & Going, 2011). The fundamental cause of a rise in obesity in the UK is due to individuals consuming more energy through calorific intake and expending less energy through activity (Laddu et al., 2011). These issues are not unique to the United Kingdom. In 2011, "The Obesity in Canada" (The Canadian Population Health Initiative) report was published, identifying very similar causes of its population's prolific rise in obesity and announcing its own strategy to tackle the issue. Similarly, the USA has a range of state, local and community programmes aimed at tackling the multi-faceted issues that cause obesity (CDC, 2022).

In relation to the international impact of populations with obesity, position papers have been published by occupational therapy professional bodies in the USA (AOTA, 2013) and Canada (Canadian Association of Occupational Therapy (CAOT), 2015) exploring the scope of occupational therapy in the treatment, management and prevention of obesity. The Royal College of Occupational Therapists published a response to a UK based obesity project by the Academy of Medical Royal Colleges (2013) detailing their perspective of the value of occupational therapy intervention with clients who are obese (College of Occupational Therapists, 2012a). A dual function for occupational therapy intervention is suggested both in prevention, by helping to change behaviours which can lead to obesity and, in treatment, at the point where the effects of obesity impact upon the performance of activity.

Treatment of obesity

Although even minimal weight loss can result in health improvement and a decrease in comorbidities, a review of evidence-based strategies for weight-loss by Laddu et al. (2011) demonstrates that the complexity of obesity can make it difficult to treat. An individual with obesity may need to modify their lifestyle to lose weight but maintaining this weight loss in the longer term requires permanent change from a personal and societal level (Laddu et al., 2011). A randomised controlled trial (Ross, Dagnone, & Jones, 2000) involving 52 men was used to analyse the impact of exercise on weight loss. Despite a small sample size, this trial confirmed that significant behavioural change, incorporating an increase and consistency of physical activity would be required to achieve significant loss of weight (Ross et al., 2000).

The use of non-pharmacological over the counter supplements are widely used due to affordable availability and not requiring individuals to undertake behavioural changes, (Laddu et al., 2011). However, a systematic review found that there is minimal evidence

available to support both the effectiveness and safety of using herbal remedies and supplements as a weight loss technique (Lenz and Hamilton, 2004).

Consensus suggests that the most effective method of reducing risks associated with obesity comorbidities, is prevention rather than treatment (Laddu et al., 2011). The safest and often most inexpensive way to address obesity is behaviour modification which requires personal commitment and a desire to change in the long term.

Role of occupational therapy in the treatment of people with obesity

Occupational therapy philosophy is defined by the notion of occupation, the environment in which occupation is performed and the importance of being person-centred, with the client's wants and needs being at the heart of any planned intervention (RCOT, 2021). Occupational therapists recognise that the needs of individuals and populations can be met through participation and engagement in purposeful occupation (Wilcock, 1999).

How people spend their time and the occupations they participate in is of key importance to health and wellbeing (Wilcock and Hocking, 2015). Understanding a person's habits and routines and using this knowledge to plan suitable interventions, is of great importance to occupational therapists (Clark, 2000).

Obesity is closely associated with several physical health conditions and the prospects of full participation in activity is often restricted because of this (Forhan, Law, Vrkljan & Taylor, 2010). Limitations in occupational participation can cause a lack of satisfaction due to the inability to complete occupations that are meaningful (Forhan et al., 2010).

The scope of the role of the profession in obesity interventions are wide-ranging and include assessment, modification of the environment and education (Haracz, Ryan, Hazleton and James et al., 2013.) Participation in meaningful occupations, achieving an occupational balance as well as the prevention of occupational deprivation due to stigma are all within the remit of occupational therapists working with adults who are obese (Haracz et al., 2013.) Occupational therapists aim to increase independence, assessing mobility, the performance of personal and domestic activities of daily living, ensuring that safe moving and handling techniques are recommended and identifying any other barriers impacting upon a person's day to day life (CAOT, 2015).

Within the UK, the impact of obesity on the NHS has been explored extensively in comparison to the impact of obesity on social care services. Occupational therapists are an under-represented profession within local authority workforces however the number of service users they come into contact with ensure that they have a key role in helping social services meet their statutory obligations (Riley, 2007). Due to occupational therapists having the ability to work across all lifecycle stages, addressing physical, mental and social needs, they can make a significant impact by reducing the drain on health and social services budgets and do so by enabling people to live independently and safely in their own homes for as long as possible. Forms of intervention include provision of equipment, planning of major adaptations, reablement, reducing costly care packages and preventing hospital admission (Riley, 2007).

It is considered that occupational therapists are well-placed to address issues of stigmatization and weight bias through personalized and client-centred approaches (CAOT, 2015). Such interventions may include providing advocacy, education and promotion of self-reflection and improvement of occupational performance and participation (CAOT, 2015). Occupational therapists have a key function in managing chronic health conditions and illnesses in a range of communities and settings and are therefore likely to work with service users who are obese (Forhan and Law, 2009). It is therefore suggested that when obesity causes an individual to have physical and functional issues, there should be a role for occupational therapy (Forhan and Law, 2009). There are no studies specifically related to the treatment and prevention of obesity within the social services sector in relation to occupational therapy. It is not known whether occupational therapists working in social services are aware of their prospective role in obesity management and if so, whether advice and intervention is being delivered correctly, efficiently and effectively. This research aims to demonstrate the enabler and barriers to practice identified by community occupational therapists, and could inform practice in a range of similar settings around the world.

The aim of this study was to explore and understand the experiences of occupational therapists working with adults with obesity in social services sector in South Wales. Specifically identifying enablers and barriers that impact on occupational therapists ability to work effectively with this population in social care settings.

Methodology:

This study relied on the interpretation of qualitative data identified to determine patterns and themes (Hammarberg, Kirkman & Lacey, 2016). The subjective view is considered as critical in research relating to human behaviour and this view also links closely to the person-centred approach that is vital to the practice of occupational therapy.

Purposive sampling was used to recruit eight participants. Inclusion criteria was that participants were registered occupational therapists, employed by the social care sector in South Wales. Recruitment emails were disseminated through a gatekeeper, the manager of a social services occupational therapy service, who distributed the study information to wider social services contacts across South Wales. The research aim, and interview questions were designed to collate information relevant to any occupational therapists working in community settings, so the outcomes could have potential for informing practice worldwide.

Eight participants were provided with a participant information sheet detailing the purpose of the research prior to interview and written informed consent was obtained.

Semi-structured interviews were carried out with eight participants using an interview guide designed with open ended questions (Table 1) drawn from the study objectives and the literature review (Ellis, 2016). Table 1 provides a sample of questions asked, to give a context to the semi structured interviews.

Can you explain your understanding of the definition and causes of obesity?	Do you feel that any of the causes of obesity are preventable from an Occupational Therapy perspective? Explain?
Can you explain your assessment and intervention process with _____? Did you look beyond a purely functional perspective?	In as much detail as possible, can you explain an experience of working with an obese client in your current role?
Do you feel that there are any barriers preventing you from providing adequate support and advice to obese clients in your current role?	Do you consider it part of your current role to provide support with treatment of obesity? Why?

Table 1: Sample of interview questions used.

A pilot interview was conducted with two community occupational therapists, who did not participate in the formal study, with the aim for reflection on the research design and ensuring

adequate flow and content of questions. Further discussion and advice was sought from the research supervisor before proceeding with the formal interviews.

The participants were all female and represented three local authorities in South Wales. The interviews lasted for between 30 and 55 minutes. Interviews were recorded electronically, and then transcribed verbatim in preparation for data analysis.

Thematic analysis was the method employed to find, classify and analyse any common themes or patterns within the data (Braun and Clarke 2006). This method was chosen due to its flexibility and its ability, if used correctly to provide a rich account of the data collected (Braun and Clarke 2006). This flexibility also allows for the interpretation of data.

Thematic analysis was used to find, classify, and analyse common themes or patterns across the data set (Braun and Clarke, 2006). The six phases of thematic analysis were undertaken (Braun and Clarke, 2006):

1. familiarising yourself with the data - The audio recording of each interview was transcribed verbatim, allowing opportunity for total immersion and familiarisation with the data
2. generating initial codes - researcher noted any ideas that emerged from the data. Codes were used to establish parts of the data the researcher found "interesting to the analyst" (Braun and Clarke, 2006, pg. 18), with the aim being to begin managing the data in an organised way
3. searching for themes – the researcher sorted the codes into potential, broad themes. Considering how the codes collated may combine to form "an overarching theme" (Braun and Clarke, 2006, pg 19) and creating a broad thematic map
4. reviewing themes - the researcher aimed to refine themes further and realised that some of the themes were not actually viable, as there was not enough data to support them. The whole data set was again reviewed to ensure that the thematic map accurately reflected the data (Braun and Clarke 2006)
5. defining and naming themes - This phase involved taking time to capture what each theme represented. Braun and Clarke (2006) refer to this as "define and refine" (pg. 22), involving considering each theme individually and in context to the other themes. During this phase, the name of each theme and its sub-themes were finalised and the researcher also revisited the research objectives to ensure that the themes were relevant.

6. producing the report - After finalising the themes, the researcher moved onto writing-up the report of the full data analysis. I paid specific attention to including enough data extracts to "demonstrate the prevalence of the theme" (Braun and Clarke 2006, pg. 23) to ensure the representation of data was clear and valid. A final report was submitted to Cardiff university as an MSc dissertation.

Reflexivity was used to both reveal and challenge the researcher's biases and experiences, in order to critically reflect upon how this may have impacted upon the study (Whitcombe and Clouston, 2010). The researcher (first author) acknowledged that her own experiences and values could limit objectivity and to address this, a reflective journal was used to detail the research processes and decisions made with regards to the methodology used.

To ensure trustworthiness, criteria created by Lincoln and Guba (1985) was used, which involved establishing credibility and transferability, dependability using audit trails and confirmability when undertaking the qualitative research (Lincoln and Guba, 1985).

Ethical approval for carrying out this study was granted through the Cardiff University School of Healthcare Sciences Ethics Committee.

Findings/ Discussion

The aim of the study was to explore the experiences of individual occupational therapists working within social services departments in South Wales, UK specifically in relation to working with adults who are obese. Four main themes emerged from the analysis of the qualitative data:

• Theme 1: Feelings of Competence and Duty

• Theme 2: Changing nature of practice in social care settings

• Theme 3: Managing complex relationships (client, management and other healthcare professionals)

• Theme 4: Accessing physical resources in the community

Theme 1 - Feelings of Competency and Duty

This theme refers to how the participants described their feelings of competency and sense of duty when thinking about their personal experiences with obese service users. Participants overtly mentioned that they did not feel competent or knowledgeable enough to broach the subject of weight with service users. They refer to feelings of competence in terms of training and knowledge.

Some participants revealed that they did not feel they had the level of skills and knowledge needed to actively address obesity in the assessment and intervention process, which is a clear barrier to practice. This impacted on practitioner confidence and competence in addressing issues related to obesity:

Jessie: *"We can only advise people regarding their lifestyle and diet. But we, I don't have the expertise a dietitian would to advise people on what is causing them to overeat and what they should and shouldn't be eating."*

Participant knowledge about obesity was generic with information gained through general media sources. They therefore felt they were not experts in the subject and would refrain from giving advice which may be incorrect.

Zoe: *"I wouldn't feel confident in having those conversations with a client because of my lack of training in that area. . .Due to not having the correct knowledge, especially because she had co-morbidities. I wouldn't feel confident giving that sort of lifestyle advice with regards to nutrition and dietary requirements with her being diabetic."*

Occupational Therapists in the UK are registered with the Healthcare Professions Council (HCPC), a regulatory body that sets standards that all professionals under its remit must meet (HCPC, 2013). As part of the standards of proficiency that occupational therapists must meet, it is directed by HCPC that individuals must not work outside of their "scope of practice" (2013, pg 4). This standard is further supported by the Professional Standards for Occupational Therapy Practice, Conduct and Ethics (2021) and the Standards of Practice for Occupational Therapy in the US (AOTA, 2015) which states that each individual therapist is required to work within the remit of their competencies. If any occupational therapist feels that they are working outside of their competency, it is their duty to raise this as a concern to their manager, and seek of continuing education opportunities to improve their knowledge in this area.

The Code of Ethics and Professional Conduct also directs that therapists should receive regular supervision (RCOT, 2021) where they can seek advice and expertise regarding difficulties faced within practice. Some of the participants felt that they had no one they could turn to for advice and the onus is therefore always on them as individuals to find the answers to complex problems that arise due to a client being obese.

Janet: *"We do the research if we need something. . . because nobody knows in the office. None of the other OTs will know, even our trainers, they won't know either. So, it's up to us really to go and find the solutions"*

Sandra: *"It's almost like you have to do your own research to be able to find that information out and sometimes, I just don't know where to start with that research."*

Participants also confirmed that they had received no training with regards to the causes, prevention, treatment or management of obesity, despite receiving in-depth training on other chronic health conditions.

Jessie: *"I don't think we have ever been on a course to look at obesity. We look at all other conditions, like MS, motor neuron, we go into those quite in-depth. But not obesity, no. Doesn't actually come on the radar."*

Maisie confirmed that she had never received any training related to obesity prevention and management and when asked if there was any training in this area she would like, replied:

"I would like any training to be honest. Particularly with moving and handling as that is such a major issue and the cost implications are absolutely huge if we can't get that right. And the indignity to the client as well particularly with moving and handling."

The need for training in moving and handling and the availability of bariatric equipment was mentioned by other participants. This need was often mentioned in relation to protecting the dignity and well-being of the client. This highlights a need for continuing education that is tailored towards the difficulties identified by practicing occupational therapists, and clinical supervision should be used to identify such needs by occupational therapists and their managers.

Theme 2 - The Changing Nature of Practice

Most of the participants had been working as occupational therapists within social services in Wales for more than ten years and this theme relates to their perceived changes in practice over a longer period. The participants noted an increase in complex caseloads, including an increase of referrals regarding service users who are obese.

Jessie: *"... we do generally say, that a lot of our cases are, people are overweight. Not so much morbidly obese but are overweight. we are meeting a lot of these people."*

Janet described a referral that she received for an obese service user who has lost weight-bearing ability. Due to the complexities of the client's personality and the environment, the case has been ongoing, with multi-disciplinary involvement but is still not solved adequately, identifying a need for early referrals to be made in such cases:

"We did a sling assessment – me, the rep and carers – because this lady could not roll very well either – lots of pain. We are going to put tracking in – ceiling tracking hoist, which she has now agreed to. . . we need the Welsh Ambulance Service on board to do that, so she gets stretchered out. She needs to go into respite. . . she'll need a nursing placement, and the cost of that is going to be enormous."

It was mentioned in several interviews that there were difficulties involved with clients becoming trapped in their homes due to their size and shape but positively, the participants are very aware of their role in protecting the client's dignity:

Zoe: *"If they are being admitted to hospital and they are having to have their window broken through and their door taken off and a lot of the time they're in bed with not much clothes on and things, neighbours watching to see what is going on."*

Obese service users often already fear embarrassment and stigma (Law and Forhan, 2009) and as a result can delay hospital admission to protect their own dignity. Nonetheless, at such times, teams and agencies are perceived to come together in collaboration, to ensure safe discharge: Jackie described her involvement with a client who could only be removed from her home by having a wall knocked through. When ready for discharge, she was able to contribute ideas effectively as part of a multi-disciplinary team to facilitate a safe return home:

"She was medically fit to go home. But we knew that the property wouldn't be suitable for her. . . I had to work with the housing officer to look at suitable accommodation for her. We

found the property… but, we had to adapt it. . . And I was working closely with the housing officer, the ambulance service, the fire brigade. .”

In 2007, the UK Health and Safety Executive (HSE) published a report detailing process planning and risk assessment for bariatric patient movement. This identified issues related to emergency hospital admissions for bariatric patients, exploring equipment availability and ongoing difficulties faced within health and social care settings (HSE, 2007). In terms of discharge, five key issues including patient factors, building design, equipment and furniture, communication, and organisational and staff issues were identified (HSE, 2007). Although this a generic report, not specifically aimed at or written by occupational therapists, the guidance within it can be used by all health professionals worldwide, to consider the five key issues related to discharging adults with obesity back into their community environments.

It may be assumed that this increase in complex caseloads experienced by the interviewees, indicates a wider issue faced by social service settings, it is also apparent that the occupational therapists strive to meet the needs of the service users at all times.

Theme 3: Managing Complex Relationships (client, management and other healthcare professionals)

This theme related to the management of complex relationships within practice. Communication is a key component of the occupational therapy process and gaining an understanding of the service user’s difficulties is a fundamental part of the assessment and treatment process (Kielhofner, 2008). Although communication can provide access to understanding, many of the participants described that they had reservations with discussing sensitive topics within people’s own homes and had to work quickly to build a rapport to do this:

Mary: *“I have to work and gain that rapport so within that hour or so they can comfortably tell me whether they can wipe their bottom or not. That’s the sort of level of trust that I need to be able to gain in that short period of time…people can be very defensive, so you have to make sure that you don’t tread on their toes too much, because you are in their own homes.”*

Zoe talked about receiving a day of training related to making every conversation with service users matter and this impacted positively upon her communication skills and time with patients:

"We have since had training called "Making every conversation matter" so that involves sort of lifestyle questions, so giving advice on smoking, diet, healthy lifestyle…if I feel that [weight] could be a contributing factor I would discuss it with them, especially since I've now had this training…on how to maintain a healthy lifestyle… now I feel I would approach that subject."

The participants discussed having difficult interactions with management over cost issues and with other members of multidisciplinary teams, with disagreements apparent between the National Health Service (NHS) and social care staff. Ellie stated she found being challenged by district nurses very difficult after reducing a care package to single-carer from double. Ellie had introduced equipment to enable single care and subsequently had to complete a joint visit with the district nurses after they challenged her assessment outcomes. After a demonstration, Ellie's clinical reasoning and skills were perceived positively and there was a positive outcome for the service user:

"My assessment was challenged by district nurses for this particular lady…district nurses expressed concerns with how they would manage the cleaning of her skin folds but they came and did a joint visit with us and observed the care task being undertaken…they were satisfied that it was being done to a good standard and that lady felt more dignified."

Theme 4 - Accessing Physical Resources in the Community

This theme represents the issues that the participants described regarding having access to the resources that they need within the community setting. Such equipment includes bariatric profiling beds, commodes, shower chairs, wheelchairs and hoists. Difficulties described included accessing equipment due to its size and weight, issues encountered due to the physical environment and accessing equipment that meets the needs of obese service users. Every participant had experience of having to manage issues that arose due to the above issues, which caused stress and difficulties to the therapist and the service user.

Zoe describes the difficulties involved in obtaining the bariatric correct equipment quickly: *"…we do [have bariatric equipment] but not as standard stock. If we identify that someone [needs] a piece of equipment that's required and they exceed the weight limit of standard stock then I would arrange a joint visit with one of the reps…the costing of bariatric equipment is a lot more costly than standard stock because it is classed as more specialist and out of the ordinary."*

Janet confirms that sourcing bariatric equipment can be more difficult process than obtaining standard equipment and these issues have both time and cost implications for the service and the client:

"…I would probably get in touch with…if it's a chair – our seating rep, to get something especially made. And that would take a lot longer…we'd have to get something specially made."

Although it appears that accessing physical resources in the community can cause problems for community occupational therapists, Sarah iterated that when such issues arise, she continues to use her traditional problem-solving skills, which is a facilitator to her practice:

"Obviously at this moment in time I use my skills as an OT really just to problem solve in the same way that I do with all my clients, so I'm really looking at my existing skills that I have to try to resolve these problems for these individuals."

It is apparent that the occupational therapists are required to use "intense reasoning" (Robertson and Griffiths 2012, pg. 2) throughout the intervention process, involving revision and constant evaluation of the process, until a suitable solution is found. This is a skill that the participants have built upon to facilitate their practice.

Discussion:

This study has identified the enablers and barriers that community occupational therapists experience when working with service users with obesity. The barriers included:

- a lack of specific training in relation to the needs of bariatric service users, indicating that occupational therapists do not have the knowledge required to treat and manage obesity in the home environment and other community settings.
- an increase in complex caseloads, with the implication that occupational therapists do not have the time to explore anything other than basic functional issues. This means that occupational therapists can not focus on other occupational needs to improve the service user's health and wellbeing.
- difficulties accessing equipment in a timely manner, which can delay hospital discharge and inhibit a service user's ability to participate in meaningful activity and functional tasks.

- a need for opportunities for continuing education so that occupational therapists can be made aware of the scope of their role, and improve on their competency level to best help their target populations.

However, there were also several enablers to supporting adults with obesity in the community setting:

- training is being provided on how to approach difficult conversations with service users and carers, enabling occupational therapists to feel more confident in addressing sensitive public health issues within the service user's own home.
- occupational therapists are becoming key members of multi-disciplinary teams, working together to protect the health, wellbeing and dignity of service users with obesity
- occupational therapists are actively utilising problem solving as a facilitator to effective and safe practice.

Implications for Practice:

It is suggested that occupational therapists are well placed to become involved with the obesity agenda, due to their holistic approach (WFOT, 2012) and their concordance with using occupation to promote health and wellbeing (Wilcock, 1999). Obesity has been established as a complex issue which requires a multi-disciplinary and collaborative approach (National Institute of Clinical Excellence, 2015) meaning that all health care providers, in all settings should be using every contact with service users to support the prevention of ill-health (NICE, 2015). This study identifies what current occupational therapists are doing well, and what improvements need to be made, to ensure that people with obesity are able to participate fully in their occupations in the home and other community settings.

Conclusion:

This study aimed to explore the experiences of community occupational therapists working with obese service users in South Wales, UK. The first objective aimed to identify whether these experiences reflected those suggested in the literature, and from these interviews, it is

clear that occupational therapists in community settings are not fully aware of the role they are expected to play in the prevention, treatment and management of obesity. The second objective aimed to understand enablers and barriers experienced by the occupational therapists within their practice when working with adults with obesity.

From the interviews, four themes emerged, providing insight into facilitators and barriers experienced by the community occupational therapists.

Based on the findings of this study, the following recommendations are made:

Service Recommendations – recommendations for service providers:

1) Community occupational therapists require standardised training on providing advice and lifestyle interventions to clients in relation to the prevention, management and treatment of obesity.
2) Local authorities need to consider the increasing numbers of adults with obesity referred into their services and plan accordingly to tackle issues faced by occupational therapists in the home environment (including equipment provision, and space limitations in the home environment that can impact on the provision of safe care).
3) Community occupational therapists would benefit from having an established point of contact to a supervisor or colleague that has expertise in obesity (equipment and management) to ensure that relevant advice and intervention can always be offered.
4) Occupational therapists need to assess service users holistically, and use the problem solving process to facilitate safe participation in meaningful occupation. This could include providing information and advice to carers and family members if necessary.

International recommendations – recommendations for policy makers, advisory bodies and occupational therapy professional bodies:

1) Community occupational therapists require further clarification on their duties of providing such advice as part of their role – this should include increasing awareness of any local or national strategies provided by public health bodies.
2) The provision of bariatric equipment should be streamlined to meet increasing need and prevent delays for clients who require such equipment, this includes having increased stock available for immediate ordering, and contingency plans for delivering such equipment in a timely manner.

3) Planning and procedures need to be put in place to enable wider multi-disciplinary collaboration between in-patient and community settings in order to prevent delayed or unsuitable discharges.

Limitations and further research

The views of eight occupational therapists were considered, covering a small and culturally specific geographical location. Such a small sample size, along with the exploration of individual and subjective experiences, means that the results cannot be generalised.

It would be useful for a quantitative survey-based study to take place to capture the experiences of Community Occupational Therapists on a national scale.

Key findings:

Community OTs experience a range of enablers and barriers to their practice, when working with service users who are obese.

Additional specialist training and equipment availability could support Community OTs in their practice.

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