Contribution of the European Network of Occupational Therapy in Higher Education to the Debate around the Consultation Paper “Europe’s Social Reality” by Roger Liddle and Frédéric Lerais

ENOTHE

The European Network of Occupational Therapy in Higher Education (ENOTHE) is a thematic network, which has been funded by the European Commission, SOCRATES Programme since 1997. The network consists of over 200 members, including educational, professional and research institutions and clients organisations from at least 38 countries.

Occupational therapy is a 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 enabling people to do things that will enhance their ability to participate or by modifying the environment to better support participation. (WFOT, 2004)

The core of the European Network of Occupational Therapy in Higher Education (ENOTHE) is to promote the centrality of occupation in occupational therapy (education) and the recognition that humans are occupational beings, not merely that occupation is an important part of human life. This fits with the general aim of occupational therapy, which is to facilitate participation of people in all occupations of daily life in order to promote people’s identity, health and well-being.

Occupational therapy contributes to and is influenced by the development of the emerging discipline of occupational science. Occupational Science is a new social science or field of enquiry. It is a basic science focused on occupation. Occupational Science is concerned with furthering the understanding of humans as occupational beings and the relationship between occupation and health, including the need for, and capacity to engage in and orchestrate daily occupations in the environment over the life span. It incorporates the concept of ‘occupational justice’ – consideration of the need for all people to experience meaning and well-being through what they do.

Communities that are strong and inclusive lead to a better quality of life, a stronger sense of identity and belonging, and mutual respect and equality. This is central to the idea of a civil society on which democracy rests. Inclusion and participation of persons with disabilities and older people in society is still not common throughout Europe. The occupational therapy education and practice is in line with the idea of participation of the WHO, the EU Disability Action Plan and the policy: Towards a Europe for all Ages.
The general aim of ENOTHE is:

1. To enable European Occupational Therapy Educational Institutes, professional Associations and other stakeholders to liaise on Occupational Therapy in order to develop, harmonise and improve standards of professional practice, education and research as well as advance the body of knowledge of Occupational Therapy and Occupational Science throughout Europe.

2. To facilitate participation of persons with disabilities and occupational deprived groups in an enlarged Europe through the development of high quality occupational therapy education, research and practice.

Based on the above mentioned theory, practice and science, we will now answer some of ‘The Issues for Discussion mentioned on pg 41 and 42 of the consultation paper:

**TRENDS**

We agree with the trends set out in a number of areas and like to add some additional data to the analysis:

- **Service economy**

Major challenges to address within the occupational therapy education and several other allied health professional education are accessibility and relevance or the link with the society.

Higher education must address social needs, which could be defined as a social contract between higher education institutions and social and individual needs, because citizens make society. So, in that sense, the relevance of universities lies in building citizenship, and this must be done at a regional, national and international level. (UNESCO, 2006)

*Accessibility of Occupational Therapy Education and other Allied Health Education*

Ethnic minorities and persons with disabilities are notoriously under-represented in European occupational therapy and most of the allied health education. Students of different migrant or ethnic minority backgrounds often feel excluded by teachers and fellow students and don’t feel attracted to occupational therapy programmes. Furthermore, there is a high rate of dropouts.

An overall framework/ guidelines/ competences for a curriculum that is open to diversity needs should be developed in order to improve the quality of the service/care.

- **Values**

One of the descriptions of our ‘social reality’ is about the tendency to the *individualisation of the Europeans*. Individualisation means more individual freedom and less conformism to values of family, class or religion.

The trend to individualisation is well supported by all kinds of new technology. The possibilities that ICT offers to people with impairments and elderly to live independently are enormous and are increasing every day. The possibilities of ICT could be more emphasised as an important factor of influence in our social reality; as well the positive aspects, like increasing independency, safety and alarm-systems as the negative ones,
such as loneliness and computer/ICT illiteracy. (see also the staff working paper ‘Ageing well in the information Society’)

*Individualisation* is connected to high rated values like client centeredness, question-directed approaches in care and cure, student-directed education programs etc. We don’t want to criticise these values, but we believe that emphasising these values means that the needs of some deprived groups may be forgotten and not observed. Not all people are capable to feel and express their needs for occupation and participation. Either because of the constraints in the (social) environment (discrimination mechanisms, lack of accessibility of societal services), or because of the constraints in people themselves (lack of education, lack of skills in language, lack of cognitive or social skills etc.). We like to emphasize the responsibility of health care services and social care services

- to detect health problems and social problems,
- to work *outreaching* with disadvantaged and occupational deprived groups and populations that are threatened by these problems and
- to take initiatives to enable policymakers to make decisions for a policy that diminishes the problems and enlarge the accessibility of work, education etc. on a local and regional level.

* Lifestyles

We like to add one other trend which is connected to the changing values, the evolution of lifestyles, and their implications for people’s quality of life and health, including children, youth, disabled and the aged.

*Combining private and working life and the transition from working life to retirement:* Impact of the changing patterns of time use (including work and leisure), occupational balance and imbalance, work organisation and flexible working hours on quality of life, including of the most vulnerable groups and elderly.

*Conditions of work:* Impact of employment precariousness and low-paid jobs on people’s health, attitudes, values and social behaviour, in particular of the youth.

*Societal dimensions of lifestyles:* Identification of the main features which characterise current lifestyles and analysis of their impact on quality of life and health, including of the most vulnerable groups in society.

In the report the threat of some diseases like obesities is mentioned, as well as the solution of some of these threats like the availability of cognitive behaviour therapy for people suffering form social and psychological stress. Although we like to support the idea to put this on the European agenda, we also like to promote the availability of *health prevention and promotion or healthy lifestyle programmes*, especially in the field of work related health problems like stress and depression, and health problems that are related to poverty.

**WELL-BEING**

The important key factors contributing to well-being from an occupational perspective are recognising humans as occupational beings who “participate as interdependent, active
agents in culturally defined occupations that determine their health and quality of life”\textsuperscript{1}. Our main area of study is the relation between occupation, health and wellbeing and the interaction between persons, occupations and environment regarding and respecting the diversity of age, gender or different cultural backgrounds. Participation through occupations for all is the core concept of occupational therapy and several studies and projects (like the well elderly study of Clark in the USA, the gardening project in Vic, Spain) have shown the positive relation between performing meaningful occupations and health and well being.

Occupational science is a valuable research area, that can contribute to the disability strategy and the strategy towards social cohesion and inclusion of occupational deprived and excluded groups in Europe.

\textbf{Obstacles}

Poverty and disability are inextriciable linked and major cause of poverty is unemployment (EDF, 2002). Attempting to fit ideas of wealth and poverty into a quantitative framework results in too many shades of the unquantifiable. Therefore Caritas Europe developed a definition of poverty as a multi-dimensional and multi factorial phenomenon, deeply affecting human beings’ identity and capabilities, not solely based on income, but including basic needs, basic human rights and such intangibles as vulnerability, risk, inequality, marginalisation, discrimination, exclusion, a feeling of powerlessness, and the circumscribing of options and choices (Caritas Europe, 2006).

Poverty reducing is a process which goes far beyond material and financial assistance. It needs to include strategies to diminish vulnerability and discrimination and to promote social inclusion or participation in all life areas.

In order to adequately address the specific occupational needs of disabled persons and vulnerable groups who are deprived from occupation, the strategy needs to be grounded in a comprehensive analysis of poverty issues.

\textbf{OPPORTUNITIES and ACCESS}

\textit{Education}

- 41% of disabled people of working age have no educational qualifications in comparison to 18% of non disabled
- One out of two disabled persons has never participated in leisure or sport activities in Europe (European Disability Forum)

Strategies for inclusive education, like adapting the educational environment (including working on attitude change of peers, teachers and parents) as well adapting the teaching and learning methods to the individual students as adapting the curricula should be applied by policy makers as by multidisciplinary teams.

\textit{The workplace}

- 6.8 million people of working age (or nearly 20% of the working age population) have a disability (LFS, 2002)

• 38% of disabled people aged 16 - 34 across Europe have an earned income, compared to 64% of non-disabled people (European Disability Forum)
• 41% of disabled people of working age have no educational qualifications in comparison to 18% of non-disabled (EDF)
• A recent survey revealed that one in six (15%) young disabled people said they had been turned down for a paid job, and told it was for a reason related to their disability or health problem
• Up to 28% of employees in Europe report stress at work (Merlie, 2001)

Occupational therapists in particular demonstrate competences in assessing the occupational needs, the environment and the occupational performance as well in guiding and training the persons with disabilities towards work as in taking safety and risk measures in the working environment in order to prevent work related disabilities. Furthermore occupational therapists demonstrate advocacy for people with disabilities and other vulnerable groups who are occupational deprived\(^2\) like e.g. older working people, elderly, disabled persons, people with work-related illnesses and migrants and their participation in all sectors of social life: work, leisure and living circumstances as well as their participation in an accessible (social, physical, cultural, institutional) environment and being part of an inclusive society.

**Society and Social Relationship**
From an occupational perspective a main challenge concerns the inclusion of the above mentioned occupational deprived groups. This is resulting in new occupational developmental strategies which are not only focusing on the treatment and training of the persons with disabilities but on new strategies like capacity building of the whole school-, work- or living community and enabling all people to participate in all sectors of social life: family, school, work, free time, mobility.

The newly developed strategies must lead to:
- social inclusion of the above mentioned vulnerable groups of people;
- a society wherein people from different cultural and socio-economic backgrounds can participate adequately and live and work together;
- a social and built environment that enables vulnerable groups in European countries to participate and to stay active in their social context;
- health promotion and prevention (including adaptations) in work situations;
- accessibility to decent/meaningful work for the millions of disabled persons in the working age, so that they can lead a satisfactory life.

The social consequences of self perceptions of failure in our unequal societies may be causing new stress and problems in terms of family dysfunctionality, crime and anti-social behaviour, mental illness and the new diseases of affluence.

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\(^2\) Occupational deprivation is defined as “a state of prolonged preclusion of engagement in occupations of necessity and/or meaning due to factors outside the control of the individual”. The factors that produce occupational deprivation may be social, economic, environmental, geographic, historic, cultural or political in nature. Occupational deprivation is closely related to social exclusion. (Whiteford, 2000).
Poverty is still a serious problem for Europe (15% are at risk) experienced as a form of absolute deprivation. Most vulnerable are elderly, single under 30-years old living alone, families with children; children in single parent families, jobless households, large families. Poor children experience various disadvantages, bad health and bad school outcomes that result in low opportunities for the future, and what is more serious – risk of transferring them to their children. It is assumed that poverty is a result of injustices and that there is clear relationship between poverty and inequality. The trends for significant widening of inequality in some EU states have negative consequences mainly on the young people. Therefore it is important that policies and intervention are focused on early intervention (mainly education) to reduce the risk of future negative outcomes and social exclusion.

Migration has long been part of European experience - the pressures that led to the great emigration to the New World also led to population movements within Europe. Currently migration has unquestioned positive impact – diversity has culturally enriched Europe, migrants have serious contribution to social welfare. Nevertheless they still face serious problems like discrimination, low employment opportunities, lack of access to public services, housing, education, poor integration in host community. They are based mainly on negative attitudes founded on misunderstanding. EU has taken a lead in fighting discrimination that requires urgent need for dialogue and common understanding.

We hope by offering an occupational perspective on health and well being and the importance of inclusion in education and employment of vulnerable groups to have contributed to the debate on social reality. Please do not hesitate to contact us in case you like to have more information.

On behalf of,

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