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REVIEW ARTICLE

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Extension, austerity, and emergence: Themes identified from a global scoping review of non-urban occupational therapy services

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Abstract

Introduction: Rural communities contribute to national wellbeing, identities, economies, and social fabrics yet experience increased risk of mortality, morbidity, and disability, coupled with lower levels of income, formal education, and employment than urban citizens. Despite higher need, occupational therapy services are maldistributed to urban locations. Publications about non-urban services discuss predominantly outreach-based, individualist, rehabilitation for specified diagnoses/age groups. However, given this population level inequity, it is unclear why individualist focussed services are more commonly discussed. Understanding intentions expressed in publications about non-urban service design may identify assumptions/limitations to current approaches and contribute to improved future services.

Methods: Each of 117 publications identified in a scoping review was read by two reviewers to independently identify themes. Provisional themes were discussed and modified in an iterative process to develop final themes/subthemes. The first author reinterrogated the publications and coded data to identify relevant examples to support the identified themes.

Results: Three key themes and nine subthemes were identified. Hegemonic perspectives were found in the themes (i) *Extension of urban practice* and (ii) *Austerity*, particularly in the Global North. Non-urban services were typically extended to non-urban contexts underpinned by austerity and neoliberal values such that non-urban persons and their context were problematised rather than service or funding design. A counter-hegemonic perspective was found in the theme (iii) *Responses to situational realities* more commonly in Global South publications, which valued non-urban contexts, and focussed on developing non-urban communities and promoting justice.

Conclusion: The hegemonic paradigm links occupational therapy services with neoliberal notions of individualism, private provision of care, and efficiency/market value, rather than the occupational therapy values for justice. The profession must consider our role in perpetuating injustice for non-urban people and consider if and how more contextually tailored counter hegemonic place-based paradigms can be developed from and with regional, rural, and remote practice.

KEYWORDS
occupational therapy, policy, rural population, social justice

1 | INTRODUCTION

Nearly half the world's population live in regional, rural, or remote (hereafter 'non-urban') communities (United Nations Department of Economic and Social Affairs, 2019) that contribute significantly to global and national economies, wellbeing, identity, and social fabrics (Gebre & Gebremedhin, 2019; Tofeti & Dos Santos, 2020). Yet these same communities almost universally experience higher rates of mortality, morbidity, and disability and lower levels of income, formal education, and employment than urban citizens of the same nation (Taylor, 2019). Occupational therapists work with individuals, groups, and communities to improve health, wellbeing, and promote justice, particularly for those who are marginalised (Curtin, 2017), yet, where national urban/non-urban distribution statistics are reported, occupational therapists cluster in urban spaces at rates of 81.7% in South Africa (Ned et al., 2020), 94.1% in Canada (Roots & Li, 2013), 77% in India (Mani & Sundar, 2019), and 77.8% in Australia (Australian Government Department of Health, 2020). Maldistribution of health, social, and education workers to urban spaces is a global phenomenon impacting nations regardless of development levels and results in significant inequity (Education Commission, 2019; World Health Organisation, 2021).

For instance, non-urban living disabled people describe challenges accessing health care, including availability, geography, affordability, and poor perception of local service quality. Similarly, professional and researcher narratives commonly describe non-urban people, geography, and services as inferior/problematic, decreasing both non-urban professional prestige and interest in non-urban practice (Malatzky & Bourke, 2016). Thus, users may perceive non-urban services as inferior, and workers may reinforce this belief. Examining and challenging these perceptions require raising non-urban practice visibility (World Health Organisation, 2021). Our scoping review of more than a decade of literature identified relatively few publications describing occupational therapy services in non-urban spaces, with the majority of these published about populations in the United States, Australia, South Africa, and Canada (Hayes et al., 2022). Further, publications tended to discuss services stratified by age groups and diagnoses, focussed primarily on individualist rehabilitation, and provided by occupational therapists who lived remotely from the community served (Hayes et al., 2022).

While this provided an understanding of the global scope of services provided, it did not examine the factors influencing why services were provided in this manner. Given the population level of the issues as described above, individualist, health-focussed interventions, based on narrow diagnostic criteria, for small sectors of the population, appeared counterintuitive; likely, the inequity would remain despite these efforts. It was therefore necessary to understand what influenced service design in non-urban spaces. This article describes the results of a thematic analysis of the reasons expressed in the publications included in our global scoping review of occupational therapy services provided in non-urban spaces. Understanding the intention behind the discussed service design will support critical thinking in non-urban occupational therapy service design in the future.

Key Points for Occupational Therapy

- Rural communities and geography may be blamed for challenges experienced by urban providers in meeting needs.
- Rural people often must compromise service frequency, costs, and modality to support urban service models.
- A new place-based therapy paradigm requires development from regional, rural, and remote practice.

2 | METHOD

Data were collected using the Joanna Briggs Institute scoping review process (Peters et al., 2020). A protocol was peer reviewed and published (Hayes et al., 2021), and the detailed method described in Hayes et al. (2022).

In summary, four databases, *MEDLINE* (*Ovid*), *CINAHL* (*EBSCOhost*), *Emcare*, and *ProQuest Nursing & Allied Health* were searched for publications discussing occupational therapy services provided to non-urban populations across the globe, from January 2010 to September 2020, in English, Spanish, French, and Portuguese languages. The databases were chosen due to their extensive catalogues of occupational therapy literature (EBSCOhost, 2020; Ovid, 2020a, 2020b) and grey literature (ProQuest, 2020). As no globally agreed definition of 'rural' exists (Carson et al., 2011), this paper uses the term 'non-urban' to refer to all non-specified spaces outside of cities and mirror the terminology used by the cited literature, such as regional, peri-urban, rural, or remote, where this has been clearly stated. Duplicate references were removed, the titles and abstracts of 2050 publications screened for relevance, the full-text of 404 publications reviewed, and 117 publications were finally included in the review. Publications reporting student experiences/placements, recruitment, professional development access, or perspectives of being a rural occupational therapist were excluded. The overall search results, PRISMA diagram, geographic and temporal distribution and services provided, clients served, and methods of both provision and access are described in detail in Hayes et al. (2022).

This article presents results of a thematic analysis to identify patterns and themes to develop qualitative meaning (Guest et al., 2012) about the reasons described for service design choices. Thematic analysis is suitable for the large dataset under investigation, provides a rigorous, trustworthy, and systematic method for examining data, while allowing a positivist demonstration of evidence from the text, rather than relying solely on interpretation (Guest et al., 2012).

The scoping review process required full-text articles to be independently screened by two reviewers prior to inclusion (Peters et al., 2020); thus, all four authors had read a significant portion of articles. Further, the first author read all full-text articles to ensure trustworthiness of the results. Reviewers independently identified themes as they were reading. Provisional themes were discussed in four face-to-face meetings and additional communication and virtual meetings. As themes developed, they were discussed and modified upon agreement in an iterative process. Results were collated by the research team to develop revised themes and subthemes. Additionally, the first author reinterrogated the publications and coded data to themes using Nvivo 12 software (QSR International, 2021) to identify relevant quotes and examples to support the identified themes.

3 | FINDINGS

Three key themes with multiple subthemes were identified (Figure 1). The iterative process identified competing paradigms reflecting mainstream Northern hegemonic approaches, and emerging and counter-hegemonic ways of thinking about occupational therapy. The Global North/South are classifications based on national economic prosperity, equality, and power, rather than on geographic positioning, that is, while Australia and New Zealand are geographically Southern, their relative power and prosperity classify them as nations of the Global North (Lees, 2021). In occupational therapy literature, the Global North/South divide has been identified as influencing global differences in occupational therapy ways of thinking (Dos Santos & Leon Spesny, 2016; Hammell, 2019).

Hegemonic perspectives were found in the following themes: (i) *Extension of urban practice* and (ii) *Austerity* that were particularly common in publications about populations residing in the Global North. A counter-hegemonic perspective found in theme (iii) *Responses to situational realities* was more common in publications about Global South populations. Each theme will be explored in detail, including examples and quotes.

3.1 | Extension of urban practice

Many included publications, particularly from the Global North, discussed transplanting existing urban approaches to non-urban contexts to provide equity of access. Challenges were frequently reported due to unanticipated context and geographical differences in non-urban locations, particularly describing challenges of remote geography and difficulty of accessing specialist occupational therapists in non-urban spaces. Solutions to these challenges were commonly presented as stretching existing services to meet non-urban needs, providing outreach services from urban spaces to rural spaces, and services expecting compromise by the non-urban residents due to the difficulties the services experienced in meeting these challenges.

3.1.1 | Urban practice transplantation

Transplantation involved replicating an existing urban service in a non-urban community. Some examples included providing developmental support (Almomani

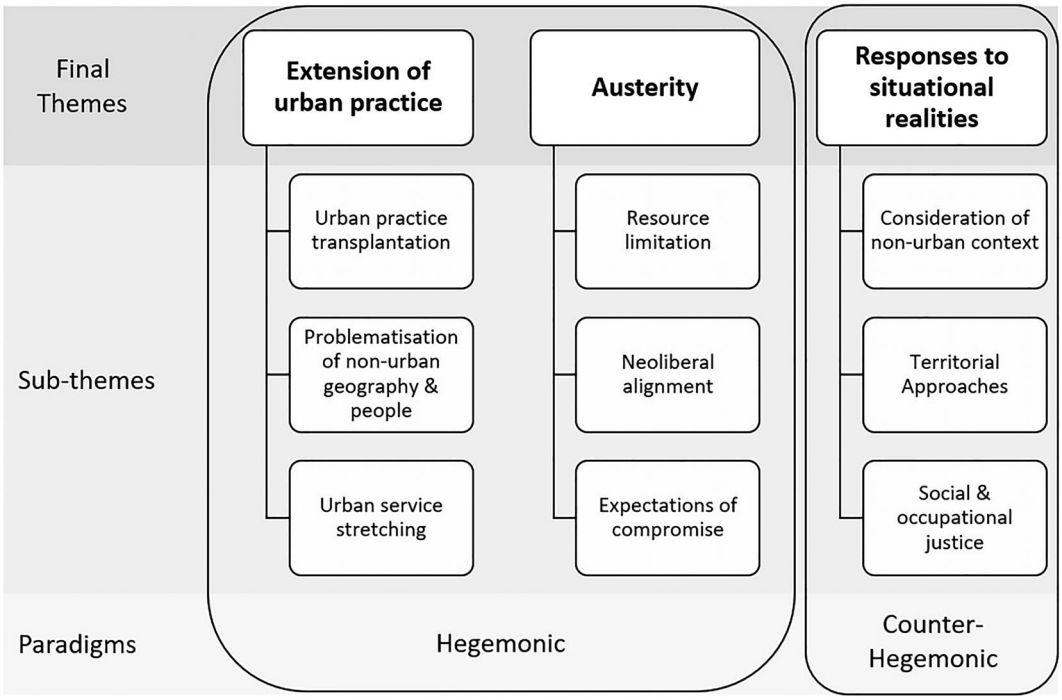

FIGURE 1 A hegemonic paradigm aimed to extend urban services to non-urban contexts, problematise the context rather than the service, adopt austerity measures underpinned by neoliberal political alignment, and expect non-urban communities to accept compromise. The counter-hegemonic response to situational realities valued non-urban contexts and focussed on territorial approaches and promoting social/occupational justice.

et al., 2014; Bartie et al., 2016; Cronin, 2018a, 2018b; Haring & Lovett, 2010; Keightley et al., 2018; Maxwell, 2010; McGuire et al., 2015; Wagner et al., 2017), assessment and screening services, workplace rehabilitation (Fontana, 2017; Hildebrand, 2015; McCauley et al., 2015), hand therapy (Bell et al., 2011; Kingston, 2017; Kingston et al., 2010; Kingston & Gray, 2011; Kingston, Judd, et al., 2015; Kingston, Williams, et al., 2015; Maxwell, 2010; Worboys et al., 2018), rehabilitation (Carter et al., 2017; Danzl et al., 2016, 2013; Gauld et al., 2011a, 2011b; Hunter & Kitzman, 2018; Kim et al., 2019; Kitzman & Hunter, 2011; Sekaran et al., 2010), and driving assessments (Churchill, 2016). These services aimed to provide some access to services already available to urban clients.

> In Alberta, occupational therapists are paving the way of the future with a new model to improve access to driving assessments for clients living in rural and remote areas. (Churchill, 2016, p. 24) [Canada]

While transplanting existing urban approaches to non-urban spaces was generally reported as being gratefully received by non-urban people, some articles reported unanticipated learnings about contextual differences between rural and urban spaces, which were often not initially considered by the urban therapists providing services (e.g., Jaboor, 2011; Kahanov et al., 2018; Kingston, Judd, et al., 2015; Schepens Niemiec et al., 2019; Sisson, 2015; Waite, 2015).

> ... the people in rehab were teaching him how to get dressed and be mobile, and he was thankful for that, but at night he'd lay awake, thinking about how he was going to get back to farming. (Waite, 2015, p. 12) [United States of America (USA)]

3.1.2 | Problematisation of non-urban geography and people

Contextual differences in non-urban areas were commonly reported as challenges/difficulties for urban services when transplanting or extending services. Multiple articles discussed the challenges of non-urban geographical features such as distance, remoteness, limited population numbers, and difficulty recruiting staff (e.g., Danzl et al., 2013; Dew et al., 2014; Gardner et al., 2016; MacLachlan, 2010; Merchant et al., 2016; Morgan et al., 2019; Palcu et al., 2020; Sullivan

et al., 2014; Visagie et al., 2013; Woods & Cronin, 2018). Often, it was the non-urban geography and population itself that was held responsible for limited service availability.

> Australia's dispersed population in rural areas contributes to poor access to therapy services and the inability of the existing rural therapy workforce to meet demand. (Dew et al., 2014, p. 309) [Australia]

Publications also descibed problems with the rural workforce including insufficient occupational therapists to refer clients to, and sometimes the perceived limitations of a generalist non-urban workforce (e.g., Burgman et al., 2011; Carpenter & Garfinkel, 2019; Cason, 2011; Merchant et al., 2016; Monz et al., 2019; Mroz, 2018). Further, therapists in non-urban spaces were described in some articles as deficient in the specialist skills possessed by urban-based therapists, which necessitated urban service intervention in non-urban areas (e.g., Danzl et al., 2016; Kingston, Judd, et al., 2015; McClure et al., 2010).

> ... aimed to assess the possibility that relatively inexperienced local practitioners could reach similar levels of reliability and validity in their ASD assessments as more experienced colleagues in a specialist team. (McClure et al., 2010, p. 592) [United Kingdom]

3.1.3 | Urban service stretching

Meeting the needs of non-urban communities was often seen as stretching existing and normalised urban services to difficult and unusual non-urban spaces, which impacted waiting lists, resulted in treatment delays, or therapist/service stress (e.g., Bellefontaine et al., 2015; Danzl et al., 2013; Dew et al., 2013; Hickey et al., 2011; McClure et al., 2010; Naidoo, Van Wyk, & Joubert, 2016; Schepens Niemiec et al., 2019, p. 7; Slaich, 2019; Smith & Cooke, 2017).

> A particular challenge is that therapists are also expected to offer rehabilitation services to communities at community healthcare centres and primary healthcare (PHC) clinics in addition to providing services at a district hospital level. (Naidoo, Van Wyk, & Joubert, 2016, p. 1) [South Africa]

Services were commonly stretched into non-urban spaces by using in-person outreach approaches or telehealth (e.g., Babikian et al., 2018; Coetzee, 2011; Doney et al., 2017; Jones, 2013; MacLachlan, 2010; McLoughlin et al., 2019; Pighills et al., 2019; Wagner et al., 2017; Watson, 2013; Watson & Duncan, 2010). In-person services were typically reliant on service provider availability and schedules and required the client to wait until the therapist was available to travel to them.

> I received the request for a power wheelchair in March but would not be visiting Pangnirtung until August. (MacLachlan, 2010, p. 5) [Canada]

Outreach via telehealth was suggested to overcome the difficulties experienced by urban service providers with non-urban geography, as the clinician could remain in the urban space and communicate with the client via phone or internet (Carpenter & Garfinkel, 2019; Cason, 2011; Cason & Jacobs, 2014; Hegel et al., 2010; Hermann et al., 2010; Hines et al., 2019; Justice, 2010; Little et al., 2018; Little & Wallisch, 2019; Palcu et al., 2020; Schein et al., 2010, 2011; Steultjens et al., 2013; Worboys et al., 2018). The use of these methods was often framed as increasing convenience for the client and carers rather than the occupational therapist.

> ... to help decrease travel time and stress on families, decrease wait times for specialty appointments, and increase health outcomes for those children affected. Because of this need, occupational therapy practitioners (OTPs) ... are turning to telehealth as a means to supplement and streamline pediatric feeding therapy. (Carpenter & Garfinkel, 2019, p. 2) [USA]

3.2 | Austerity

Underpinning much of the perception of difficulty in providing services in non-urban spaces, particularly in the Global North, was a tacit alignment with austerity, that is, an understood, but not always directly expressed, requirement to provide services in non-urban spaces for minimal costs. This austerity alignment was noted in a discourse of resource limitations, occupational therapist acceptance of political ideologies such as neoliberalism, a minimal rehabilitative focus, cost and task shifting to non-urban people and communities, and an overall

expectation that non-urban people must compromise due to the difficulties presented by their geographies.

3.2.1 | Resource limitation

Lack of access to occupational therapy services in non-urban spaces was commonly acknowledged across nearly all publications. Non-urban spaces and populations were frequently identified as having less access to workers, services, and funding (e.g., Bellefontaine et al., 2015; Bunning et al., 2014; Burgman et al., 2011; Danzl et al., 2016; Dawad & Jobson, 2011; Dew et al., 2013; Gardner et al., 2016; Haring & Lovett, 2010; Johnsson et al., 2019; Kingston, 2017; MacLachlan, 2010; Paul et al., 2016; Smith & Cooke, 2017). Some publications noted that services were limited to bare minimums to allow the client to leave the urban space and return home and acknowledged limited support or follow-up in the non-urban space (e.g., Bunning et al., 2014; Danzl et al., 2013; Dew et al., 2013; Hyett et al., 2011; Kingston et al., 2010; Kingston, Judd, et al., 2015; Miller & Evans, 2013; Sekaran et al., 2010; White et al., 2016). Services were typically aiming to increase service access for non-urban people, while remaining resource efficient, cost effective, or sustainable, and particularly minimising human resource and travel costs (e.g., Carpenter & Garfinkel, 2019; Cason, 2011; Cason & Jacobs, 2014; Hegel et al., 2010; Hermann et al., 2010; Hines et al., 2019; Johnsson et al., 2019; Justice, 2010; Kingston, Judd, et al., 2015; Little et al., 2018; Little & Wallisch, 2019; Palcu et al., 2020; Schein et al., 2010; Schein et al., 2011; Steultjens et al., 2013; Visagie et al., 2013; Watanabe et al., 2013; Worboys et al., 2018). Again, the reasons cited for inequitable access to occupational therapy services were commonly linked to the perceived difficulties of rural geography for service providers and funders.

> The geographical areas and number of families they were expected to provide services for limited the amount of direct therapy they provided to one half hour twice a month. (Haring & Lovett, 2010, p. 10) [USA]

3.2.2 | Neoliberal alignment

Neoliberal values of self-sustainable, market based, financial independence, underlined by individual accountability, and lower cost processes (Daniel Pereira Andrade, 2019) appeared to be tacitly accepted, aligned with, and perpetuated within many publications. Expectations of financial viability of services were commonly linked to insufficient populations within a geographic space to allow economic sustainability, despite individual needs.

> ... development was hampered by perceived barriers associated with enrolling enough eligible individuals across large geographic areas to assure program financial viability .... (Bloom, 2019, p. 85) [USA]

Publications also framed issues of accessibility as an individual problem for non-urban people and their perceived challenging geography, rather than a systemic issue of limited service provision by service providers and funders.

> ... for populations who have difficulty accessing the services of a cancer center, such as rural patients, interventions which are feasible to implement are required. (Hegel et al., 2010, p. 2) [USA]

Acceptance of service availability limits also led services to prioritise the application of services to those perceived as deserving (e.g., Paul et al., 2016; Woods & Cronin, 2018).

> ... to identify the most deserving senior citizen who could be helped through the recreation facility, a qualitative study was done .... (Paul et al., 2016, p. 220) [India]

3.2.3 | Expectations of compromise

The challenges service providers experienced managing the geography and perceived additional cost of servicing non-urban spaces were often framed as reasons that non-urban people must compromise on service delivery method, frequency, or type of occupational therapy services received, in ways that were not required of people in urban spaces (e.g., Bellefontaine et al., 2015; Cason & Jacobs, 2014; Cronin, 2018b; Fishpool et al., 2011; Haring & Lovett, 2010; Hickey et al., 2011; Hines et al., 2019; Johnsson et al., 2019; Kingston, 2017; Monz et al., 2019).

> Delivering occupational therapy services of the same scope and quality as elsewhere in Canada is difficult. (Bellefontaine et al., 2015, p. 21) [Canada]

Papers often described compromises required of non-urban people between significant travel costs to access services or accepting an alternative approach to interventions such as telehealth (Carpenter & Garfinkel, 2019;

Cason & Jacobs, 2014; Little et al., 2018; Worboys et al., 2018), self-managed rehabilitation programs (e.g., Hickey et al., 2011), or waiting for outreach to arrive (e.g., Pidgeon, 2015). Publications also described non-urban people compromising on environmental supports such as prescription of wheelchairs unsuitable to rural environment, (Visagie et al., 2015), provision of equipment without sufficient time to train clients in its use (Cronin, 2018b), or community members building home modifications that could not otherwise be provided (Danzl et al., 2013). These compromises were commonly framed as binary choices between the client accepting the compromise or no service at all.

> Ideally, tele-therapy should not replace in-person services; however, it is necessary when no other comparable service option is available locally. (Johnsson et al., 2019, p. 2) [Australia]

3.3 | Emerging responses to non-urban situational realities

In contrast with extension and austerity, an emerging theme appeared, particularly in Global South publications, which considered the geographical, cultural, and social realities of non-urban spaces and the agency of non-urban communities when defining needs and designing services. Rather than problematising the people and place as being outside the norm, these publications conveyed a sense of commitment to the situated nature of people's ways of living and their environment (e.g., Bartie et al., 2016; Cloete et al., 2015; Costa, 2012; Gomez-Galindo et al., 2017; Macedo et al., 2016; Mahmud et al., 2014; McAdam et al., 2019; McAdam & Rose, 2020; Naidoo, Gurayah, et al., 2016; Naidoo, Van Wyk, & Joubert, 2016; Santos & Aiache Menta, 2016; Watson, 2013; Watson & Duncan, 2010; Zango Martín et al., 2015). In the Global North, only therapists working with First Nations communities discussed contextually designed services based on situated realities to work with non-urban communities (Gauld et al., 2011a, 2011b; Keightley et al., 2011; Kiepek et al., 2015; Pidgeon, 2015; Wrisdale et al., 2017).

3.3.1 | Consideration of context and populations

Rather than transplanting or stretching individually focussed, urbanised approaches to non-urban places, some publications situated services contextually from a community or population level to better understand local contexts and needs to align services with context (Bartie et al., 2016; Gomez-Galindo et al., 2017; McAdam et al., 2019; McAdam & Rose, 2020; Santos & Aiache Menta, 2016; Watson, 2013). These articles, rather than problematising the context and population, acknowledged difference and the systems/structures, which contributed to these differences.

> The occurrence of [alcohol abuse] in the Western Cape has been linked to the history of farm workers. Historically, farm workers were employed by the Dutch and subsequently English colonialists. They used to be paid for their labour with tobacco, bread and wine. Although the effects of alcohol on the body were already commonly known, farm workers still received large amounts of low quality wine (with higher ethanol concentration) as payment. (Cloete et al., 2015, p. 34) [South Africa]

3.3.2 | Territorial approaches

Coupled with acceptance of non-urban difference were interventions that valued local geography and population knowledge and aimed to engage with non-urban communities to seek ongoing and appropriate outcomes (Gauld et al., 2011a, 2011b; Gomez-Galindo et al., 2017; Kim et al., 2018; Lauckner & Stadnyk, 2014; Lorenzo et al., 2018).

> ...territorial approach requires greater presence in the regions and cultural sensitivity. Strengthening the work carried out with the population that was linked to illegal armed groups through occupational resignification processes allow to make progress in the expected economic and social reincorporation. (Gomez-Galindo et al., 2017) [Colombia]

In contrast with unpaid task shifting to unskilled and unresourced community members, some publications discussed building non-urban community expertise and employment, such as developing therapy assistants and general health-care workers to work with distant occupational therapists (Bellefontaine et al., 2015; Dawad & Jobson, 2011; Dew et al., 2014; Schepens Niemiec et al., 2019). This allowed for context to be both understood and valued in the therapy interaction.

> When allied health practitioners are in town, Sharon [assistant] acts as a language interpreter during their in-person client visits. Sharon also supports these therapists, who have relocated to this region from southern parts of Canada, to develop a more nuanced understanding of local practices and knowledge in relation to health and health care. (Bellefontaine et al., 2015) [Canada]

Paid task shifting was noted to develop community knowledge, resilience, and employment while providing the necessary services to the non-urban community (Dawad & Jobson, 2011).

> There is significant potential for HIV-related task-shifting to adopt what we term a 'broad' approach in the medium to long-term as a means of integrating the social and medical spheres of HIV treatment, care, and prevention .... Critical aspects of [Community Based Rehabilitation], including its focus on poverty reduction, equalisation of opportunities, social inclusion and community participation, provide guidance for more inclusive approaches to task-shifting in HIV.

3.3.3 | Social and occupational justice

An emerging dissatisfaction with non-urban situational realities was also noted in some publications, which called for justice. Rather than accepting and/or problematising the geography or people who lived in non-urban spaces, these publications highlighted the systems and process, which resulted in the inequality and outlined the need for change (Costa, 2012; Lauckner & Stadnyk, 2014; McAdam & Rose, 2020; Watson & Duncan, 2010).

> Traditional Peoples and Communities have their historical origins in social-environmental conflicts, based on struggles for collective rights to the land, tradition and use of natural resources, in contrast to the advances of capitalism, which invest in the direction of the right for private use of the land, resources and knowledge. (Costa, 2012, p. 43) [Brazil]

4 | DISCUSSION

Our analysis identified a hegemonic way of informing practice that is dominant, powerful, and normalised, particularly in services in the Global North. This hegemonic paradigm is rooted in neoliberalist values and results in attempts to extend or transplant existing urban designed and/or facilitated services into non-urban spaces, which are then described as difficult and expensive to provide. The misalignment of perceived urban norms with non-urban people, needs, and geography is then used to justify reduced service levels, alternate and sometimes inferior delivery modes, increased cost to the client, or no access to services at all. This privileging urbanity as the norm and non-urban location as difficult, negative, and unusual align with previous findings in non-urban medicine (Malatzky & Bourke, 2016).

This Northern hegemonic paradigm links occupational therapy service provision with notions of individualism, private provision of care, cost efficiency, and market value. These findings support previously identified trends particularly in the Global North, of occupational therapy accepting and adopting the austerity values of neoliberal politics (Dos Santos, 2022; Gerlach et al., 2018; Hammell, 2021; Malfitano et al., 2021; Taff & Putnam, 2022). Austere neoliberal policies are by nature competitive and result in those who are structurally limited losing against those who are structurally supported (Barakat et al., 2011). In the urban/non-urban case, the competition will always favour communities with sufficient populations to support a free market, which by definition, limits or excludes non-urban communities with insufficient population to self-sustain profitable services (Barakat et al., 2011). Actively or tacitly embracing a neoliberal competitive view problematises the very people we aim to serve (Farias, 2020; Malatzky & Bourke, 2016). Rationalising limits on non-urban occupational therapy services and accepting poor outcomes for non-urban people, as a logical result of perceived choices to live outside of the city, do not align with occupational therapy's expressed commitment (Hocking et al., 2021) to human rights and occupational justice. As a profession, we must consider our role in potentially perpetuating injustice for non-urban people.

Rather than extending urban occupational therapy services to non-urban contexts based on biomedical knowledge and individualistic approach, we suggest a critical stance and a commitment to overcome and 'resist the tendency to individualise the causes and solutions' as argued by Farias (2020, p. 218). This critical stance would include the counterhegemonic paradigm consideration of unique contexts and communities to develop services, which transcend the individualistic perspective. These approaches were particularly prominent in the work of occupational therapists from the Global South (e.g., Gomez-Galindo et al., 2017; Macedo et al., 2016; McAdam et al., 2019; McAdam & Rose, 2020; Wrisdale

et al., 2017) and with First Nations peoples (Gauld et al., 2011a, 2011b). These approaches considered local context, privileged community voices, and engaged communities in designing and solution while focusing on grassroots movements, which met non-urban needs. These few publications represent a large tradition of counter-hegemonic and praxis-based epistemologies among occupational therapists in the Global South (e.g., Souza et al., 2021; Bianchi & Malfitano, 2022; Córdoba, 2021; Correia et al., 2021; Dos Santos, 2017, 2022; Lopes & Malfitano, 2021; Monzeli et al., 2021; Paganizzi, 2007).

Southern occupational therapists have engaged in counter-hegemonic, territorial (geographically considerate), and community-focussed therapies for over 30 years (Bianchi & Malfitano, 2022). While initially enveloped in Northern biomedical models, Southern occupational therapies evolved in place as a resistive response to recognised local realities of social inequity (Díaz-Leiva & Malfitano, 2021). Southern therapies include consideration of external structural and political factors and mobilise agents to action beyond the health sphere, to have measurable impacts on the social factors limiting opportunity (Correia, 2018). While counter-hegemonic discourse is also present in the Global North, with increasing calls to consider and respond to structural impact of structures, cultures, and white supremacy (e.g., Beagan et al., 2022; Grenier, 2020; Hammell, 2021), this review demonstrates that hegemonic, neoliberally influence approaches continue to influence occupational therapy service design. However, human activity is situated (Galvaan, 2015), and similarly occupational therapy cannot be separated from the place in which it operates (Cardinalli & Silva, 2021). Indeed, practice will likely benefit from further embedding and responding to place, as demonstrated by the Southern experience (Díaz-Leiva & Malfitano, 2021). Occupational therapy therefore must embrace a paradigm shift to develop regional, rural, and remote occupational therapy beyond its urban roots to develop in-place approaches considerate of structural inequity and community needs, rather than transplanting urban practices to non-urban contexts.

5 | LIMITATIONS

While rigour has been applied to this data analysis, limitations remain, including potential omission of relevant sources from this scoping review, which may have provided additional data. Particularly, we did not search databases, which may have included more global South publications such as RedeSciELO databases (SciELO, 2022a, 2022b, 2022c). The lack of global consensus on what constitutes a non-urban space (Carson et al., 2011) may have contributed to article omission if alternate terminology was used. It must also be considered that not all publications included in the analysis were written exclusively by occupational therapists and that perspectives from other professions may have influenced framing in the articles. Further, applied thematic analysis of articles may overlook some of the more nuanced data that may be found in grounded theory or phenomenological approaches (Guest et al., 2012), and the retrospectivity of analysing publications does not allow clarification of meaning by original authors. Finally, we have not made extensive consideration of cultural issues; while urban life seems to hold similarities, the classification of non-urban and/or rural encompasses a wide spectrum of ways of living (Moran et al., 2021).

6 | CONCLUSIONS

Despite nearly half the world's population living in non-urban areas (United Nations Department of Economic and Social Affairs, 2019), and non-urban communities significantly contributing to the prosperity and social fabric of the countries in which they are situated (Gebre & Gebremedhin, 2019; Tofeti & Dos Santos, 2020), we found many non-urban occupational therapy publications, problematise non-urban geography and populations. A hegemonic paradigm to transplant/extend urban services to non-urban contexts may heighten this problematisation by framing urban contexts as normal and non-urban contexts as abnormal. The hegemonic paradigm links occupational therapy services with neoliberal notions of individualism, private provision of care, and efficiency/market value. In contrast, a counter-hegemonic paradigm was identified particularly in the Global South and in some occupational therapists' work with First Nations communities, which considered and valued non-urban contexts and engaged local voices to design service approaches, which meet local needs. A paradigm shift is required to develop in-place regional, rural, and remote occupational therapies considerate of structural inequity and community needs.

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CONFLICT OF INTEREST

The authors declare no conflict of interest.

AUTHOR CONTRIBUTIONS

All listed authors have significantly contributed to the design, data collection, data analysis, and writing of this research paper and approved the final version.

DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available from the corresponding author upon reasonable request.

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