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an integrated approach toward occupational therapy practice development

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Participatory change: an integrated approach toward occupational therapy practice development

Katherine Wimpenny

PhD

2009

Participatory change: an integrated approach toward occupational therapy practice development

Katherine Wimpenny

A thesis submitted in partial fulfilment of the requirements of the University's requirements for the degree of Doctor of Philosophy

Coventry University

July 2009

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Declaration

I declare that this thesis is my own work and has not been submitted for another academic award at another university.

Abstract

The implications of implementing evidence-based change in practice settings are complex and far reaching. Research examining ways to implement professional theory-driven approaches and support occupational therapists to advance their practice is limited. This participatory action research (PAR) study set out to investigate the implementation of an evidence-based occupational therapy conceptual model of practice, the Model of Human Occupation (MOHO) (Kielhofner 2002) across a mental health occupational therapy service. Methods used involved preparatory workshops and twelve months of team-based, monthly group reflective supervision sessions. In addition individual meetings with the occupational therapists took place every six months for the initial twelve months and a further year thereafter.

The findings present a fusion of theoretical positions which are integrated within a 'Participatory Change Cycle'. Emphasis is placed upon the development of a communicative space within which critical consciousness-raising occurred. This in turn enabled the therapists to take steps to advance their practice in light of theory. Fundamentally the therapists engaged in a process of re-negotiation of their professional selves in front of colleagues and myself as an external group facilitator and in the context of professional and political structures. The findings examine how learning occurs amongst people, within the contexts in which it holds meaning; I explore how disciplinary learning has occurred via praxis, which served to transform identities and ways of knowing and participating.

The study concludes with recognition of the need for an inclusive approach to practice development which embraces each individual therapist's personal stance and professional craft knowledge alongside the contribution of intellectual constructs. It is argued that those involved in practice development initiatives work to develop a sustainable group collective, a community of practitioners who remain committed to their professional development whilst remaining mindful of contextual issues including subtle individualistic efforts to effect change, which are not always visible at face value. Furthermore, practice development initiatives require collaboration between occupational therapists from education and practice to maintain perspective regarding the contribution of both propositional and practical know-how.

Chapter one

Occupational therapy practice: professional and political issues

Introduction

This thesis presents a participatory action research project undertaken with occupational therapists working within a mental health trust. It aims to investigate the impact of implementing the Model of Human Occupation (MOHO) (Kielhofner 2002), an evidenced-based conceptual model of practice,[1] as a means of advancing the occupational therapists' professional contribution within mental health. The research focuses on the experiences and learning borne out of this process.

In this opening chapter I set the scene for the reader by providing a brief background and rationale for the research. This includes defining occupational therapy practice and a discussion of the key professional and political concerns relating to occupational therapists working within mental health. A rationale is presented for both the use of the MOHO as the conceptual model of practice, and PAR as the research methodology. The specific aims and objectives of the research are then stated, followed by a synopsis of each chapter.

Background

I am an occupational therapist based in education. My prior practice experience has been within a number of settings, predominantly mental health. In June 2003 I was approached by an occupational therapy service manager who was keen to improve the evidence-base and theoretical knowledge of the occupational therapists working within the service. She was aware of my interests in occupational therapy theory and establishing closer links with practice.

At that time I was involved in lecturing in occupational therapy theory and was aware of the challenges faced by students on practice placement who had failed to see and/or experience the relationship between theory and practice. Equally, I appreciated through my own work experiences, the difficulties of making sense of propositional knowledge in a practice setting. I was keen to be involved, and also felt that it was a good opportunity to engage in collaborative research. As a collective comprised of practitioners, a manager and an educator/researcher we all became involved in the important task of delivering evidence into practice (Ilott & White 2001; Scottish Executive 2002; Forsyth, Summerfield Mann & Kielhofner 2005).

[1] A conceptual model of practice consists of an evolving set of theoretical arguments that are translated into a specific technology for practice which are continually refined and tested through research (Kielhofner 2002:3).

The following sections provide a definition of occupational therapy practice and describe the key influencing factors providing an important context in which to situate the research. Whilst the formal period of contact with the practitioners spanned September 2003 to December 2005, I acknowledge that the literature, which initially informed my journey, has subsequently been supplemented by additional research, opinion and policy.

Defining occupational therapy practice

Occupational therapy has a broad knowledge base concerned with the impact of disability, illness or disadvantage on a person's daily occupations; occupations referring to those of self-care, domestic, work and leisure pursuits, which are viewed as both purposeful and meaningful to the person who engages in them (Fisher 1998). This focus on the doing of everyday activities can lead to the perception that occupational therapy practice is straightforward. However, the challenge lies in understanding the complexity of factors that combine to influence and shape people's occupations and in enabling individuals to achieve their goals (Crepeau, Cohn & Boyt Schell 2003; Duncan 2006).

The definition provided by the College of Occupational Therapy (COT 2003:8) aptly embraces the scope of practice:

> Occupational therapy focuses on the nature, balance, pattern and context of occupations and activities in the lives of individuals, family groups and communities. It is concerned with the meaning and purpose that people place on occupations and activities and the impact of illness, disability or social or economic deprivation on their ability to carry them out.

At the core of occupational therapy is the commitment to focus on the person as an active agent who is central to the therapy plan. In brief, as articulated by David Nelson (1996:11) occupational therapy is:

> '[U]niquely devoted to helping people help themselves through their own active efforts.'

Occupational therapists work with people across many spheres of health care, across all age groups and can be found in a wide range of community and health-related settings, frequently working as the sole therapist as part of a wider multidisciplinary team (MDT). I believe that our role offers an essential ingredient to a

person's well-being and recovery and yet we are often unrecognised and undervalued for our unique contribution (Williams & Bannigan 2008). Suggested reasons for such concerns are visible within the professional literature outlined below.

Professional role uncertainty (within mental health)

Academics express widespread concern that occupation focused practice has yet to be fully realised (for example, Reilly 1962; Yerxa 1967; Clark 1993; Nelson 1996; Townsend 1997; Fisher 1998; Law & Baum 1998; Christiansen 1999; Wilcock 2001; Kielhofner 2002; Zemke 2004; Kielhofner 2005; Peloquin 2005). This is clearly evident within the field of mental health where professional insecurity and role uncertainty experienced by occupational therapists is well documented (Creek 1998; Lloyd, Kanowski & Maas 1999; Taylor & Rubin 1999; Finlay 2000; Fortune 2000; Parker 2001; Greaves, King, Yellowlees, Spence & Lloyd 2002; Wright & Rowe 2005; Pettican & Bryant 2007).

Reasons for this uncertainty are varied (for example see Peloquin 1991; Coleman 1992; Yerxa 1992) yet tend to be linked to the fact that the scope of our practice is both broad and individualistic. It is evident that the profession needs to justify its existence and prove its value (Creek 1998; Golledge 1998; Goren 2002; Krupa & Clark 2004; Wright & Rowe 2005;). Suggestions for enhancing professional contributions include developing research in the field of mental health (Case-Smith 2000; Tickle-Degen 2000), providing clear definitions and information on the scope of mental health practice (Krupa & Clark 2004) and better promoting our use of occupation (Hocking 2007). As Kaur, Seager and Orrell (1996) affirm, an inability to project an accurate professional role results in neither the provider units nor consumers of our service being able to make a reasoned argument regarding the need for, or development of, occupational therapy staff and facilities. Yet whilst occupational therapists can find it difficult to effectively attain, or retain an occupation focus to their work such "in-house" tensions cannot be divorced from the wider political context.

The political agenda

Government policy over the past ten years has continued to steer new directions within mental health, arguably prompted by the National Service Framework for Mental Health (DH 1999) shortly followed by Mental Health Policy Implementation

Guidance (DH 2000), and the Single Assessment Process (DH 2001a). Government initiatives have specified the capabilities required of all mental health workers (Sainsbury Centre for Mental Health 2001; DH 2004), rather than the specific contributions expected of individual professions. Each profession must therefore define their own unique role within this context.

More recently the Mental Capacity Act (2005) and the new Mental Health Act (2007) created more permeable boundaries across Psychiatry and the Allied Health Professions (DH 2005; DH 2007). Such policy and legislation denotes new opportunities for professional growth, however the levels of competence and confidence required by practitioners to deliver quality and equality of access to contemporary health and social care is substantial. Contemporary practice is a fluid, challenging responsibility, which requires practitioners to work with heavy caseloads, in complex situations often of an indeterminate nature (Higgs, Andresen & Fish 2004). Practitioners need to develop capacity to be knowledgeable about their specific contribution and to make explicit their professional understandings (Higgs *et al*. 2004; Richardson, Higgs & Dahlgren 2004; Pettican & Bryant 2007).

Occupational therapy literature concerned with current practice suggests that the profession has some way to go to meet government directives. For example, practitioners have been criticised for deviating from the delivery of profession-specific contributions due to the adoption of evidence-based techniques from outside the profession where funding is available and status recognised (Layard 2004). Elsewhere practitioners have been viewed as 'gap fillers' (Fortune 2000:229). Furthermore, an area of significant tension revolves around practitioners' adoption of generic skills for broad-spectrum mental health working whilst striving to maintain an element of profession-specific practice. This has been most notably experienced within community mental health teams where consensus regarding the optimal type of casework for occupational therapists has not been reached (*see* Craik, Chacksfield & Richards1998; Brown, Crawford & Darongkamas 2000; Hughes 2001; Parker 2001; Corrigan 2002; Dunrose & Leeson 2002; Forsyth & Summerfield-Mann 2002; Fowler Davis & Hyde 2002; Harries 2002; Lloyd, Bassett & King 2002; Smith 2002; Stone 2002; Cook 2003; Harries & Gilhooly 2003; Pettican & Bryant 2007). Indeed Finlay (2000) described the mental health practice arena as a frequent battleground where MDT members are in competition with each other as they jostle for role recognition and attempt to carve out role boundaries. It would therefore seem plausible that there should be some fundamental way of keeping occupational

therapy practice rooted in order that we are known for what we do, without trying to limit the complexity of our interventions.

Conceptual practice models: MOHO and the scholarship of practice philosophy

Since the 1980s the efforts of leading academics within the profession have focused on applied science by defining occupational therapy conceptual models of practice as a means of supporting practice. Occupational therapy authors (for example, see Hagedorn 1997; Creek 2002; McColl 2003; Forsyth *et al.* 2005) have recognised the value of linking theoretical and research knowledge to practice. The Model of Human Occupation (MOHO) (Kielhofner 2002) is an example of a conceptual model of practice, which arguably offers occupational therapists a means of realigning their professional contributions.

The MOHO uses theoretical concepts, assessment tools and treatment principles and programmes that have been validated via empirical enquiry. In addition, a commitment to the ongoing development of MOHO (2002, 2008) focuses upon a 'Scholarship of Practice' philosophy (Hammel, Finlayson & Kielhofner 2002; Kielhofner 2002; Taylor, Braveman, Forsyth 2002; Forsyth *et al.* 2005). This scholarship involves dialectic between academics and practitioners and the promotion of therapeutic alliances with service users in order to generate knowledge about what can and should be done in occupational therapy practice. Indeed the Professional Standards of Proficiency outline the requirement of occupational therapists to 'use the established theories, models… of the profession' (HPC 2004: 11). However, whilst conceptual models of practice such as MOHO may go some way to help resolve professional identity issues it is evident that practitioners often struggle to, or fail to see the relevance of occupational therapy theory within their practice (Duncan 2006).

The challenge of implementing professional theory: what is required?

The demands and constraints of the practice setting (Oxman, Davis, Hayes & Thomson 1995; Dunning, Abi-Aad, Gilbert, Gilliams & Livett 1998; McCluskey 2003; Wye & McClenahan 2000) are often cited amongst factors accounting for why practitioners struggle to implement theory into their practice. Despite the well-intentioned employer initiating and funding attendance at courses (Wye & McClenahan 2000; McCluskey & Cusick 2002) often the requirement to demonstrate competence within practice thereafter is not in-built (Usher & Bryant 1987; Eraut

1994). Professional codes of conduct may refer to an obligation to engage in continuing professional development (CPD), yet training courses alone cannot be assumed to result in practitioners being able to integrate (theoretical) concepts into their practice (Smith 1999; Roberts & Barber 2001; Roberts 2002). Moreover there is a common perception that training does not link theory with practice (Smith 1999) and little evidence that front-loading theory within an education process is efficient in such knowledge being integrated into the context of lifelong professional learning (Eraut 1994). CPD can often provide little more than another strand of separate, un-integrated and therefore minimally used professional knowledge, thus reinforcing the separation between theory and practice (Usher & Bryant 1987; Eraut 1985,1994).

As identified by Forsyth *et al.* (2005) a solution to the theory and practice divide needs careful consideration of the knowledge required to best support occupational therapy practice, and that this process needs to occur with those *in practice*. Indeed, the focus on a team or whole systems approach to the implementation and adoption of knowledge has been viewed as crucial by Chard (2006). Furthermore, despite rigorous evidence presented, practitioners themselves must recognise a need to want to change or be convinced that the alternatives suggested are worthwhile (Chard 2006).

The consequences of not meeting professional expectations can result in practitioners facing scrutiny and criticism within professional domains. However it is argued here that insufficient research has been undertaken into how to support theory-driven practice, and remove known barriers. Whilst there is considerable literature discussing what needs to occur, much of this work is descriptive with only limited studies (for example, Reeves & Summerfield Mann 2004; Boniface, Fedden, Hurst, Mason, Phelps, Reagon & Waygood 2008) focusing upon any proactive measures utilising professional theory to realign professional contributions. It is evident that understanding the processes necessary to support theory implementation in practice requires greater attention than it has done so to date (Forsyth *et al.* 2005; Perkins, Jensen, Jaccard & Gollwitzer 2007). Moreover, I suggest such investigation needs to occur within the context of practice using a participatory action research methodology with those directly experiencing the barriers in order for meaningful ways forward to be negotiated.

Summary statement

It has been noted that the profession of occupational therapy in mental health is in danger if research and development does not accelerate the utilisation of theory and research by practitioners (Welch 2002). The advancement of occupational therapy practice within the field of mental health deserves closer scrutiny at both theoretical and practical levels. Anecdotal practice is to be replaced with current evidence demonstrating an awareness of the inadequacies of practice based on tradition, untested hypotheses and methods gleaned from other disciplines (Welch 2002; Crepeau *et al.* 2003). In an era in which occupational therapists within mental health have raised concerns about loss of core skills and ultimately of professional identity (Craik *et al.*1998; Taylor & Rubin 1999; Hughes 2001; Parker 2001; Hayden 2004; Reeves & Summerfield Mann 2004; Pettican & Bryant 2007) I argue here that occupational therapy practitioners need to feel confident about what they are doing and why.

Recently the College of Occupational Therapy (COT) published a ten-year strategy for occupational therapists in mental health (Recovering Ordinary Lives, COT 2006), developed to ensure that the profession can keep abreast of policy drivers and be situated at the heart of modern mental health services. This document, which speaks to a number of key stakeholders, including occupational therapy practitioners, managers of occupational therapy services, occupational therapy educators and researchers, focuses on five areas for development: valuing occupation, the added value of occupational therapy, professional leadership, education and training and workforce development (COT 2006:ix). I believe that this thesis targets strategies as outlined in the COT document by offering valuable insights which address contemporary professional issues whilst providing evidence of how to progress partnership work. As such this study is unique in its methodology and aim to specifically strengthen practice processes in light of theory driven approaches. It is written for a range of different audiences, including those whose primary concern is to evaluate the theoretical value of the research and its contribution to knowledge; and to practitioners, managers and educators, like those involved in the study, who wish to consider how theory driven, evidence based approaches, such as MOHO, can be implemented to effectively influence practice development.

Aims of the research

The primary aim of this research has been to implement the Model of Human Occupation (MOHO) (Kielhofner 2002) across a mental health occupational therapy service. Within this broad aim were several objectives:

- To explore ways that barriers to theory integration might be removed
- To explore the role of the external group facilitator including the effectiveness of insider/ outsider roles
- To examine the ways in which the MOHO impacted upon the occupational therapist's perception of their role
- To examine the transitional experience of the occupational therapists implementing the theoretical model and assessment tools into their practice

Synopsis of the thesis

Chapters two and three address the theoretical underpinning of the thesis. Chapter two predominantly focuses upon professional practice debates regarding what forms of professional knowledge (practice epistemology) serve to guide professional contributions. Carr's (1986) typology is applied as a means of presenting the complex range of ways in which theory and practice relationships are evidenced within the occupational therapy practice arena. In addition, research studies conducted to date regarding theory utilisation within occupational therapy are critiqued. From this set of arguments MOHO is then presented as the model of choice for the study. The key concepts of the theory are outlined, including recognition of the scholarship of practice philosophy, within which MOHO continues to be developed.

Chapter three brings together a range of theoretical perspectives regarding how practitioners might be supported or restricted in their implementation of theory into practice. Focus is initially directed toward individual influences regarding propositional knowledge uptake prior to consideration of influences presented within the wider social context. This discussion includes how individuals essentially accept, or not, theoretical knowledge as a means of guiding professional expertise and how issues relating to an individual's personal and learner stance impacts on any future learning. The Transtheoretical Model (Prochaska & DiClemente 1982; Prochaska, DiClemente & Norcross 1992; Prochaska & Velicer 1997) is offered as a means of providing insight into the potential stages and processes involved in change. Bandura's (1977, 1982, 1989 1997, 2001) theories of self-efficacy and social

cognition are also examined prior to theories of learning, including theoretical perspectives regarding threshold concepts and troublesome knowledge (Meyer & Land 2006, 2008; Cousin 2006, 2008; Savin Baden 2006, 2008). The social influences upon knowledge uptake are thereafter critiqued. This includes theories which have focused upon situated learning and include the work of Vygotsky (1962; 1978), Friere (1970), Giddens (1984), Lave and Wenger (1991) and Wenger (1998). Finally, the practice development literature is addressed in the form of McCormack, Dewar, Wright, Garbett, Harvey and Ballentine (2006) 'Realist Synthesis of Evidence'. McCormack *et al.* study sought to examine the approaches, which have been used to support change in healthcare. The key findings from this literature provide opportunity to establish an argument regarding the contextual issues and theoretical perspectives within which this study is located.

Chapter four presents the participatory action research methodology adopted. Written in terms of first, second and third person action research/practice (Reason & Bradbury 2001:xxv-xxvi) this chapter explores the qualitative inquiry process. It includes the influence of my own personal approach toward the research and the challenge of engaging with the occupational therapists in a collaborative partnership. Particular attention is directed toward issues of power and relationships. The occupational therapy participants are introduced. Strategies for data analysis are presented and the qualitative criteria of trustworthiness and authenticity are considered. The chapter concludes with my reasoning for situating the research at the boundary of a social constructivist / social constructionist paradigm. In addition a prelude is included that briefly introduces the reader to the research findings and discussion chapters, and describes how the aims and objectives of the thesis are addressed.

Chapter five aims to capture how the team-based group supervision processes provided a vital learning space within which to engage in professional identity work through implementation of the MOHO. The chapter embraces the first two of the research objectives by exploring the ways in which barriers to integrating the MOHO were addressed. In addition my role as an external group facilitator is examined including the effectiveness of insider / outsider roles. The complexity of change processes as experienced and observed across the occupational therapy teams, including those challenges which required negotiation and careful handling, are at the core of this chapter. I focus upon the development and influence of the group collective, from disjuncture through to engagement. I suggest that over time, group

dialectic developed through nurturing a useable learning space via team-based PAR group reflection and action cycles. I argue how the group collective served as a community of practice. However, whilst the importance of the group dynamic is emphasised, it was increasingly apparent that individual identities also required recognition.

Chapter six explores individual journeys during the inquiry process through the presentation of two therapists' experiences. The therapists portrayed offer contrasting perspectives and opportunity to examine how MOHO impacted upon their perception of their role, addressing the third research objective. The chapter is crafted around the importance of recognising individual characteristics within a process of change. In particular, attention is drawn to issues concerned with personal agency and facilitator/participant relationships. The relevance of the change and learning theories, explored in chapter three, to the experiences of the individuals is examined and critically appraised.

Chapter seven illustrates both the therapists' and my own journey exploring the legitimacy of knowledge creation. Whilst the previous chapters have considered group processes followed by individual perspectives respectively, this chapter necessitates a reconnection with professional assumptions (both the therapists' and my own) regarding occupational therapy theory. Essentially in this chapter I address the fourth research objective by examining the transitional experience of the occupational therapists adopting MOHO and the associated assessment tools. I present a participatory model of knowledge construction. This conceptualisation of how the occupational therapists were seen to engage with MOHO within a participatory framework, importantly acknowledges the deconstruction and reconstruction of propositional knowledge in line with the therapists' other forms of knowing. In concluding this chapter I return to the evidence-based practice agenda and an argument is presented regarding credible strategies to implement evidence.

Finally in chapter eight I re-connect with the overall aims of the study in light of the key findings of the research. Whilst not presented as a conclusion, this chapter has two key purposes. Firstly it explores change factors, which are illustrated within a second conceptual framework. In this I identify the interplay of personal and contextual influences regarding the implementation of MOHO. Secondly it provides a summary that brings together all of the findings of the research and highlights the contribution made in terms of theory, practice and research. This chapter brings

together a final conceptualisation of participatory change factors, which provides an overall representation of the PAR inquiry and potentially provides a useful means of supporting practitioners, facilitators and managers in future practice development work.

Chapter two

Theory and practice relationships in occupational therapy

Introduction

This chapter examines occupational therapy practice epistemologies. Carr's (1986) typology considering theory and practice relationships is applied as a means of accounting for the range of ways in which practitioners view theory relevant to their practice. In view of such perspectives I develop an argument in which occupational therapy conceptual models of practice are viewed as offering a valuable contribution to support professional practice. Moreover, in addition to conceptual models of practice being viewed as offering a means of enlivening practitioners' commitment to engage in good practice, I advocate Carr's *critical approach* with regards to theory and practice relationships. Here the relationship between theory and practice recognises the *context of practice.* As such, practitioners are not confined to process or theory but can consider their actions grounded in a professional knowledge base, which can account for their unique contribution and the complexity of practice. The requirement of practitioners to involve themselves in challenging their ideas and beliefs about practice and theory in light of the critical approach suggests a particular position, which I believe occupational therapists might adopt when implementing conceptual models of practice such as the MOHO. Following presentation of the key conceptual arguments of the model, research conducted to date within the field of occupational therapy regarding theory uptake is critiqued. The chapter concludes by acknowledging that whilst barriers to theory uptake within professional practice have been identified in the occupational therapy literature, research into strategies to overcome such barriers is limited.

Occupational therapy practice epistemology

Practice epistemology is concerned with the nature of knowledge and the processes of generating knowledge for practice. Richardson, Higgs and Abrandt Dahlgren (2004:5) assert:

> "(H)ealth professionals need a judicious working knowledge of their practice epistemology in order to understand what drives their actions, to realise how they can demonstrate this understanding in their practice and to recognise how they learn from this understanding and develop their professional practice."

Reference to the *development* of professional practice is useful here as I argue that examination of our practice epistemology is central to informing professional role identity, a theme that requires attention within the mental health arena. I argue that examining our practice epistemology is an essential professional responsibility. We

need to gain greater understanding of the nature of the knowledge that underpins our practice in order to create a framework for professional debate to facilitate optimal practice. This argument provides a central theme which this thesis addresses.

Dimensions of professional knowledge

Richardson *et al.* (2004) assert that professional knowledge is built upon existing knowledge and the conscious and unconscious beliefs and values held by practitioners about what they do and why they do it. They argue that the extent to which professional practice is openly discussed and acknowledged by professionals is influenced by the value members place upon a number of factors:

- The extent to which the knowledge is recognised to comprise the professional knowledge base
- The recognition of the dynamic nature of the knowledge
- The acceptance to make credible and appropriate modifications to practice knowledge in response to changing contexts of care.

Whilst I agree that practitioners need to recognise how a knowledge base embraces professional assumptions and how such knowledge needs to be continually reviewed, I argue a key influence, which occupational therapy practitioners focus upon, is the *accessibility* of knowledge to guide and inform their practice.

A focal question for this chapter centres on what knowledge can best meet the demands of practice whilst explaining the relationships between occupation, activity and health (COT 2006:17). Indeed, the history of the occupational therapy profession has demonstrated that a major challenge of promoting occupational therapy practice has been the need to develop a theoretical knowledge, rooted in science that is consistent with the profession's assumptions (Yerxa 1992). This is viewed as a complex process. What has been repeatedly expressed is the need to unite practice and theory in an occupational framework; to conceptualise and implement practice in a way that explicitly links what we do to our unique focus on occupation as a therapeutic tool (Fisher 1998, Wood 1994, Trombly 1995, Nelson 1996, Peloquin 2005). However, the demands of two world wars and a perceived need to prove the validity of occupational therapy through more reductionist uses of measurement, such as range of motion and strength, pushed practice away from its original mission (Fortune 2000). It is clear that occupational therapy has had an ambivalent

relationship with medicine (Coleman 1992, Peloquin 1991) recognising a need to support the professions' practice through scientific research, yet attempting to deal with the complexity and breadth of human nature and occupation (Yerxa 1992). Kielhofner and Burke (1977) described the situation of occupational therapy's knowledge development as a conflict between two competing paradigms: one based on the paradigm of occupation and moral treatment, the other based on reductionism, a mode of thinking characteristic of the medical model. Whilst development of Sensory Integration (Ayres 1972, 1979) and Biomechanical theories (Trombly & Cole 1979; Wu, Trombly, Lin & Tickle-Degnen 1989, Trombly 1995;) arguably continued to progress occupational therapy's knowledge base, it was from 1980 onwards that more substantial progress was made toward developing *occupation-focused* theory to guide practice. Yet a focal question still debated today revolves around which epistemology is broad enough to encompass the scope of practice (Yerxa 1992) whilst strengthening professional perspective regarding our role. As Wilcock (1998) and Bannigan (2001) identify, discussion regarding what form(s) of knowledge can best support occupational therapy is healthy and necessary in order to develop a robust knowledge base and thus achieve excellence within the profession.

It is evident within the occupational therapy literature that different perspectives exist regarding how professional knowledge can work to inform practice. This has led to practitioners holding different views regarding the way in which knowledge is accepted as true, real and valid (Pallas 2001). In order to frame such perspectives I examine discourse from the occupational therapy literature relating to theory and practice relationships. I refer to Carr (1986) who articulated a typology with regards to the way practice and theory might be framed, which I believe has application here. Although Carr's assertions are directed towards educational theory, they have been examined to enable differentiation between the positions, which I suggest are held within occupational therapy practice, with regards to the perceived relationship between theory and practice.

A typology for understanding theory practice relationships (Wilfred Carr 1986)

Carr's (1986) four main approaches to understanding theory and practice relationships are the:

- Applied science approach
- Common sense approach
- Practical approach
- Critical approach

Whilst I may be guilty of artificially compartmentalising discourse from the occupational therapy literature into each of the four approaches, I believe this typology provides a useful means of examining theory and practice perspectives. Each is now considered in turn:

The applied science approach

Carr (1986) presents the 'applied science' approach as the contribution offered via the general rules and principles of formal theory. Theory in this light is viewed as knowledge, which has marked out the practice of a profession (Usher, Bryant & Johnstone 1997) and may suitably refer to the professional paradigms, basic sciences and conceptual models of practice which therapists have access to. The role of theory arguably has value for a profession such as occupational therapy, whose practice is often unspecified with a lack of clarity regarding where our boundaries lie (Larsen 1977, Wallis 1987, Reed 1984). Candlish (1986) likewise asserts that theory is vital to occupational therapy if we are to survive as a profession. Atkinson (1995) too suggests that occupational therapy theory provides an important means of communicating professional ideas and explaining the role and contribution of occupational therapy to other professions. Furthermore, within the classroom experience, students are introduced to a theory as a means of structuring participation in the therapeutic process (Steward, 1995). If we are to apply Eraut's (1994) perspective, occupational therapists need a distinctive theory base to distinguish the profession as having something unique to offer. Indeed, as Eraut suggests the power and status of a professional worker depends to a significant extent on their claims to unique forms of expertise. Furthermore the public's understanding of a professional's knowledge base can be viewed as a critical feature of the profession's public image (Forsyth *et al.* 2005).

Thus within Carr's applied science approach to the theory and practice relationship theory is viewed as providing evidence which can then be brought to bear on practice. Arygris and Schon (1974) and Mosey (1981) similarly argue that theory can be seen as a vehicle for explanation, prediction or control: a theory setting out a number of propositions from which events may be inferred. Whilst Carr's typology would seem not to differentiate between basic or applied science, the fundamental focus of the applied science approach is that theory is privileged within the theory and practice relationship. However, distinction regarding the contribution of a basic or applied science is worth consideration here as it is recognised that the profession is somewhat divided in terms of how occupational therapists might be best supported to assert their contribution by reference to either form of knowledge. An overview of this debate is now presented as I believe it provides the reader with necessary background information and justification for why an applied science knowledge base was selected for this research.

Since the 1980s, efforts of the profession's academic leaders have focused on *applied* science by defining occupation-focused conceptual models of practice to guide practice (Kielhofner 1997); for example, the Model of Human Occupation (MOHO) (Kielhofner, 1985, 1995, 2002, 2008), The Canadian Model of Occupational Performance (CAOT 1997); The Lifestyle Performance Model, (Velde & Fidler 2002); The Kawa Model (Iwama 2004). In parallel, in the late 1980s a separate proposal for knowledge development emerged, defined as a scientific discipline of occupational science (OS). It was proposed that such a *basic* science could provide explanations for humans as occupational beings (Yerxa, Clarke, Frank, Jackson, Parham, Pierce, Stein & Zemke 1990). Wilcock (2003: 157) similarly argued that an increased understanding by others of the importance and meaning of occupation in human existence would assist appreciation and development of occupational therapy philosophies, beliefs and practices.

Such perspectives link to positivist/post-positivist ideas, which contend that there is a reality which can be understood or at least approximated (Denzin & Lincoln 2000). Grounded in positivist assertions this form of knowledge, also described as technical rationality (Schon 1983), assumes practical action flows naturally from basic knowledge with a suggested certainty, which can be predicted by its use (Arygris & Schon 1974). OS may have a following from around the globe yet is argued here that its significance within the practice arena has failed to be sufficiently appreciated. Whilst Clark (2000) acknowledged OS was not conceived in order to offer guidelines

for practice (rather, practitioners would draw from knowledge generated to inform their practice), as noted by Peloquin (2002) the challenge of technical rationality in occupational therapy is that its emphasis is on knowledge generation but not how practitioners might use such knowledge. Indeed, Eraut (1994:70) and Mosey (1981) proposed that disciplinary knowledge cannot simply be 'mapped on' or applied to a field of practice.

In a bold keynote address at the World Federation of Occupational Therapy Conference in Stockholm, Kielhofner (2002) argued that occupational therapists fail to engage in occupation-focused practice, not because our profession lacks understanding about occupation, but that the field lacks sufficient knowledge of how to deliver occupation-focused practice. Kielhofner's position focused on the value of working with a finite number of conceptual models of practice to articulate our professional contribution and more effectively guide therapeutic practice. Yet in 2006 the College of Occupational Therapy (COT) directed concern at occupational therapists who continue to develop conceptual models of practice rather than build [OS] theories to explain the relationships between occupation, activity and health (COT 2006:17). Indeed, it is evident that polarised views regarding the contribution of OS versus conceptual models of practice pervade the professional literature. This is evident in a series of letters written to the Editor of the British Journal of Occupational Therapy between August 2001 and June 2002. However, what is of note is that whilst predominantly academics advocate OS, it is occupational therapy practitioners who vindicate the practical utility and support of conceptual models of practice (for example, see Melton (2001), Last (2001) and Summerfield Mann (2001).

Thus within the applied science approach, therapists are seen to have access to a range of theories, developed to different degrees, which are selected for application. However, I suggest that embracing openness, pluralism and eclecticism acknowledged by the different paradigms of knowing is potentially problematic. This is for two reasons. Firstly I believe that, aside from those practitioners willing to publicise their views, there is a lack of attention by occupational therapists to consider the necessary distinction between basic and applied science and theories which have been developed within and out-with the profession. I suggest that occupational therapists have not fully considered the consequences of this in terms of how such an approach to theory utilisation can maintain a clear professional identity. In outlining this argument I am not suggesting that occupational therapists should only use one conceptual model of practice. Indeed in 1985 in the Eleanor

Clarke Slagle Lecture, Anne Cronin Mosey (one of the pioneers within our profession) identified how no one comprehensive theory could aim to account for the diversity of our practice. Kielhofner (2002) likewise recognised that conceptual models of practice may well be used in combination. However, secondly, and perhaps more importantly, the therapists need to have a clear understanding of the theoretical arguments that each theory / knowledge base will address; where attention is devoted to considering how our philosophical assumptions can be achieved, or not, through *application of* such schema (Mosey 1985).

Finally, from another perspective regarding the applied science approach, practitioners who privilege theoretical knowledge over other forms of knowing can create an environment which precludes the recognition of people's personal experiences, looking only for the 'taken-for-granted' assumptions presented by theoretical principles. Thus theory can be viewed as offering a set of rules or 'regimes of truth' (Foucault 1980:131). However practice knowledge of this kind can have little relevance to an individual's well-being and may indeed serve to distort practice.

The common sense approach

In contrast to the above, the 'common sense approach' is more practice-driven. Here theory relates to practice uncovering concepts and skills implicit in good practice and using these as the basis for the recognition of practical competence. Here practice is pre-eminent in the theory practice relationship. Schon (1983) in particular has highlighted the value of reflection in raising awareness of tacit knowledge and transforming 'knowing-in-action' into 'knowledge-in-action'.

Richardson *et al.* (2004:7) refer to knowledge derived from professional experience as 'professional craft knowledge'. Their argument sets out how practitioners are continually engaged in knowledge creation through the processes involved in professional experience. Here practice wisdom can be seen through a therapist's clinical reasoning skills and professional judgements.

The common sense approach arguably occurs as a consequence of the changing nature of knowledge as it is applied in practice (Tillema 1995). Through experience and the accumulation of professional knowledge from real-life situations, the available knowledge becomes more personalised and stabilised (Bennett 1990) and

potentially less rule based (Gugmundsdottir 1991). Thus practice becomes more process-driven and less open to interpretation from a guiding theory base.

Whilst Richardson *et al.* (2004) emphasise the important influence of the experiential and tacit dimensions of practitioners knowledge, concern is raised here at practitioners whose interpretations of practice are not influenced by the evidence they base their practice on. Creek and Ormston (1986) likewise suggest that when therapists practise without a sound profession-specific theory base they are vulnerable. I believe that the ability of the profession to articulate a clear rationale for practice will be critical to its ongoing capacity to assert a professional profile and maintain a clear position within the wider healthcare team.

Practice can become pre-eminent to theory as a consequence of therapists not seeing the relevance for theory and research within their practice, as highlighted by Closs and Cheater (1999) and Higgs and Tichen (2001). The reasons for this are multifactorial but could be clustered into several domains. These domains are inter-related and complex and include issues around the education component and theory implementation, the expertise and knowledgeability of tutors and the expertise and knowledgeability of practising therapists. Examples of discourse considering key aspects of such issues are now presented.

Ikiugu and Rosso (2002) suggest that whilst occupational therapy philosophy, theory and practice might be considered in the classroom, a clear link between the three elements is not adequately emphasised to students. Arguably this results in the student failing to gain a clear appreciation of professional principles and the relationship between coursework and fieldwork. Indeed within the nursing literature, authors such as McCaugherty (1991) write about how challenging it is for the classroom environment to cater for the complexities of the clinical situation. Furthermore, Ogier (1989) comments on students who struggle to identify with theory alongside the potentially strained atmosphere in practice, which does little to encourage their learning. Craddock (1993) similarly highlights how opportunity to explore professional understandings is not encouraged in a hospital environment where routine and ritual prevail. Steward (1996) suggests the problem may lie with a lack of appropriate role models out in the field embracing theory, including excessive criticism of students' own theory building by their supervisors. In essence, professional practice experiences can be seen to militate against the approaches advocated within the university setting, resulting in a dichotomy between what is

learnt and what is practised (Landers 2000). Duncan (2006) feasibly suggests that occupational therapists may thus resort to more practice-driven ways because theory is viewed as being detached from the reality of their practice. Indeed, theory can be perceived as alien, incoherent and conceptually difficult to understand (Meyer & Lands 2006) and viewed as belonging to the world of 'the academy,' rendering it 'remote, irrelevant and unworldly' to practitioners in their day-to-day work (Usher *et al*. 1997:122).

Concern is not only directed at the struggling student but perhaps more importantly the ability of occupational therapy educators to present professional theory in ways which provide clear direction for occupational therapy practice (Barris & Kielhofner 1986). For example, tutors out of practice may develop a more abstract understanding of theory, which makes its links to practice questionable (Brown 1988). Theory can thus be viewed as potentially threatening and problematic for the developing practitioner suggesting that it is challenging for therapists to align themselves with paradigmatic constructs or specific bodies of knowledge (Mackey 2007). Furthermore, I suggest that the lack of clarity regarding which form of knowledge can best support occupational therapy practice may leave practitioners reluctant to persevere in teasing out meaningful ways forward. Indeed it has been identified how the demands and constraints of practice settings leave little time for reflection and innovation (Oxman *et al*. 1995, Dunning *et al*. 1998, McCluskey 2003, Wye & McClenahan 2000).

In summary, Brereton (1995) appropriately suggests there needs to be more effective communication between tutors and practitioners with enhanced cross fertilisation of ideas between the two in respect of their practice and educational domains. This concern corresponds to the COT (2006) strategy for Mental Health which identifies well-needed strategies linking academia and practice.

The practical approach

In the 'practical approach' Carr's typology considers theory as a form of knowledge as uncertain and incomplete. Here the theory and practice relationship is one in which theory informs practitioners' sense of what is right and just and in this way adds to the practitioners' practical wisdom. Theory enlivens the practitioner's commitment to engage in good practice since theory serves to inform (Carr 1986).

I suggest that the practical approach links with Nixon and Creek's (2006) focus on their four strands of thinking which relate to the interpretative and explanatory qualities a professional theory should offer:

- Theory has the capacity to challenge therapists' practice by suggesting alternative courses of action, or as a means of evaluating the consequences of a certain action.
- Theory enables a therapist to grapple with complexity by questioning if choices for action are compatible / incompatible with first principles.
- Theory can develop more sophisticated reasoning as a straightforward intervention can be critically examined.
- Theory provides a space in which we may take stock of our own and others actions and thus can help us explain ourselves.

In this approach I argue that theory has a role in problem setting and in problem solving. It is a tool that enables a therapist to 'name it and frame it' (Mattingly & Fleming 1994). Theory provides practitioners with words or concepts for naming what we observe and identifying logical relationships between concepts (Parham 1987). Yet in addition, I argue that this approach also recognises the limits of theory. Unlike the applied science approach, here theory is not privileged as answering all our questions (Reed & Sanderson 1990). A theoretical framework, as in a conceptual model of practice, is not a 'bible' or 'cookbook', which includes the recipe which should be followed (Barnett 1990). As Kielhofner (2002) identifies conceptual models of practice should *guide* practice not *dictate* it. As such, theory supports the therapist's clinical reasoning with the acknowledgement that belief in the uniqueness of an individual will preclude any model from having the solution to each presenting problem (Higgs & Titchen 1995, Kielhofner 2002).

In this approach to the theory and practice relationship occupational therapy theory is seen to facilitate but not stifle professional growth (Reed & Sanderson 1990). Rather, practitioners are seen to draw upon the professional dimensions of practice, to consider the use and soundness of the knowledge being applied and to reflect upon the experience to consider practice competency (Richardson *et al.* 2004). I argue that conceptual models of practice like MOHO (Kielhofner 2002) offer valuable contribution to the theory and practice relationship within this 'practical approach'. Indeed utilisation of MOHO is compatible with the notion that theory serves to guide

practitioners' sense of what is right and just whilst acknowledging the practitioners' practical wisdom. Yet it is within the critical approach that I argue the relationship between theory and practice in occupational therapy can be most appropriately embraced.

The critical approach

The critical approach represents an attempt to reconcile the applied science and practical approaches to knowledge contribution (Carr 1986). This approach focuses upon the relationship between theory and practice *in the context of practice*. This view recognizes that practice is a human and social enterprise and one that is inherently problematic. It acknowledges that practitioners are given insights and helped to understand the contextual basis and ideological influences, which give rise to beliefs and understandings.

The relationship between theory and practice here is to promote greater self-understanding regarding practice to increase practitioners 'rational autonomy' (Carr 1986:183). Theory here is viewed as a way of helping practitioners transform the ways they see themselves and the practice within which they operate. Such views relate to those proposed by Friere (1970) in relation to his work to support disadvantaged groups to overcome economic, social and political domination through increased self-awareness via educational processes. Thus the critical approach is able to interpret theory and practice by seeing critical self-refection as a valid form of knowledge. Here both novice practitioners and more experienced therapists are able to critique and challenge ideas and beliefs about their world (Steward 1995). Whilst practitioners may argue that they need to adopt an eclectic epistemology for practice to deal with the shifting nature of healthcare provision, the critical approach arguably works to offer practitioners an approach to working with professional theory in a dynamic way. As such, therapists are able to make judgments for practice on several levels; are not confined to process or theory, but can consider their actions grounded in a professional knowledge base, which can adequately account for their unique contribution and the complexity of their practice.

A critical approach to the theory and practice relationship presents a more relevant practice epistemology, which draws upon experiential knowledge, conveyed knowledge and ethical judgments regarding practice decisions (Carr 1986). Adapting Carr's perspective of a critical approach within occupational therapy, practitioners are viewed as working from a coherent theoretical base, which adequately responds to

the social context of practice. Such a location of theory with practice in context offers opportunity for praxis and an improved union between theory and practice; praxis being critical thinking with theory which does not separate itself from action (Friere 1970:64 -5). Yet within the critical approach Carr does not explicitly identify the potential for generating knowledge for practice. Indeed Richardson et al. (2004) argue that practitioners are less familiar within the processes involved in the generation of knowledge, which is mistakenly viewed as being the province of the academy. They assert that practitioners themselves continually engage in knowledge generation, particularly through processing and making sense of professional experiences. Thus within the critical approach where conveyed knowledge is critically examined in light of experiential knowledge in context, I argue the generation of practice knowledge can occur, developing the practitioners epistemology. The overriding argument is that occupational therapists who see their practice as a self-determined, dynamic and a critically valued process, rather than a process carried out under constraints imposed by others, will believe more strongly in their ability to influence advancement of practice.

There is a discourse within the theory and practice relationship literature which raises concern over thinking which asserts that scientific knowledge is different from and better than knowledge arising from practice. This distinction of knowledge, which originated with Aristotle (Eraut 1985), has dictated the course of professional education and added to the theory and practice divide by separating the two components of theory and practice rather than uniting them. Aygris and Schon (1974), Klemp and McClelland (1986), Usher and Bryant (1987), Eraut (1989), Cervero (1992) and Jenkins (1994) have all questioned the rationale for this separateness when evidence clearly demonstrates the interdependent and inter-reliant nature of technical and practical know-how in professional effectiveness. As such, there is a clear argument within the literature proposing legitimate forms of knowing as considered from both a practical and a theoretical sense. Indeed the notion of building knowledge actively through interactions with practice settings connects with Brown and Duguid's (1991) position regarding how working, learning and innovating are closely related forms of human inquiry. Brown and Duguid (1991:40) suggest that the conflict often experienced between working, learning and innovating lies in the 'gulf' between precepts and practice. Society is known to attach value to abstract knowledge and as a consequence the details of practice have come to be viewed as non-essential. In contrast, Brown and Duguid's (1991) perspective is that practice is central to understanding work. Furthermore they claim (1991:40) that:

> '(W)ithout a clear understanding of the intricacies of practice and the role they play, practice itself cannot be well understood, engendered (through) training or enhanced (through innovation)'

Moreover, from their 'practice-based' standpoint, Brown and Duguid (1991) view *learning* as the bridge between working and innovating.

The focus on professional artistry and personal experience are valid themes to examine here. Whilst the goals of practice are focused around expert knowledge and professional competency, the way in which a practitioner delivers such practice is viewed as an art form (Andresen & Fredericks 2001). Skilful practice requires the use of effective interaction skills (Fleming 1991) and what Gardner defines as 'interpersonal intelligence,' which can be illustrated in the following quote:

> "I want my children to understand the world, but not just because the world is fascinating and the human mind is curious. I want them to understand it so that they will be positioned to make it a better place. Knowledge is not the same as morality, but we need to understand if we are to avoid past mistakes and move in productive directions. An important part of that understanding is knowing who we are and what we can do... Ultimately, we must synthesize our understandings for ourselves. The acts of understanding which matter are the ones we carry out as human beings in an imperfect world which we can affect for good or for ill."
> (Gardner 1999: 180-181)

Andresen and Fredericks (2001) state that skill, competence and artistry cannot be easily faked. Therapeutic practice expertise is viewed as a journey. This can be examined by the way in which the clinical reasoning of expert practitioners is seen to be different from that of novices, in that more experienced practitioners knowledge base becomes deeper and richer, drawing on reservoirs of appreciating what works and what does not work. Eraut (1994) and Titchen (2000) both contend that experienced practitioners transform theory in a variety of ways to tailor it to individual needs. The capacity to provide artful practice can thus be viewed as an important element of professional expertise and can arguably be enhanced though integration of propositional knowledge with personal and practice experience.

Summary

Carr's (1986) typology has provided opportunity to examine different positions held within the profession regarding theory and practice relationships. Rather than focusing upon what an OS framework of knowledge can offer, I have put forward the contribution of conceptual models of practice (specifically MOHO, Kielhofner 2002),

as a useful means of supporting *delivery of* occupation-focused and evidence-based professional practice. Moreover I have argued for a particular approach to be adopted as a means of utilising conceptual models of practice in order to progress the relationship between theory and practice. Thus, I suggest that occupational therapy's developing practice epistemology is best considered within the critical approach in which the contribution of theory is examined *alongside* practitioners' beliefs, assumptions and practice repertoires. I maintain that occupational therapists (specifically within mental health) need to be able to explore their professional knowledge base in terms of how it supports delivery of professionally recognised, high quality, person-centred care. I assert that this requires investigation into 'professional knowledges' and the value of integrating a discipline specific theoretical foundation.

The next section of the chapter focuses on the key conceptual arguments of MOHO and then examines research to date exploring what is known about the utilisation of such theory.

The Model of Human Occupation (MOHO): an overview

Development of the theory: a scholarship of practice

MOHO is a conceptual model of practice, which aims to generate and test theory of relevance to the profession and develop and test strategies, tools and techniques for use in therapy (Kielhofner 2002:3). The theory has received much attention since the first version of the model appeared in 1975, including criticism, elaboration, application and empirical testing by occupational therapists throughout the world (Kielhofner 2002:7).

At the outset Kielhofner and his colleague acknowledged that:

> "The model presented is preliminary and exploratory and thus incomplete. It will require substantial empirical validation and conceptual refinement. It is presented to stimulate, rather than confine thinking in OT"
> (Kielhofner & Burke 1980:573).

Indeed, MOHO continues to be expanded and developed (Kielhofner 1985, 1995, 2002, 2008) as a result of consultation with therapists internationally regarding MOHO ideas and principles. In light of the debate presented in this chapter proposing legitimate forms of knowledge development, more recent versions of MOHO (2002, 2008) have focused upon a 'Scholarship of Practice' philosophy (Hammel *et al.* 2002,

Kielhofner 2002, Taylor *et al.* 2002, Forsyth *et al.* 2005) (see figure one). This scholarship involves dialectic between academics and practitioners and therapeutic alliances with service users in order to generate knowledge about what can and should be done in practice. This form of knowledge creation connects with more emancipatory approaches as described by Carr and Kemmis (1986). Kielhofner's argument for adopting a more collaborative, liberating approach to knowledge generation lies in the fundamental need to involve all stakeholders in occupational therapy in the generation and integration of knowledge development. Consequently, the scholarship of practice represents a commitment by academics to engage in theory building that directly supports occupational therapy practice and to work in partnership with the therapists directly applying the knowledge (Forsyth *et al.* 2005). The combined concern of MOHO for developing both theoretical guidance *and* practical tools for application arguably makes it a conceptual practice model with unique characteristics. The Scholarship of Practice community of learning strives to solve the very real issues facing the profession and occupation focused practice delivery (Kielhofner 2005).

Figure one: Diagram representing the scholarship of practice partnership

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A significant body of research (253 papers internationally to date) (see http://www.uic.edu/hsc/acad/cahp/OT/MOHOC evidence based practice link) demonstrates the growing field of research into MOHO. Not only have theoretical concepts been validated via empirical enquiry, but also assessments, treatment principles and programmes to develop occupational therapy practice have been

developed and empirically grounded. Furthermore, respect for the model can be seen by the range of occupational therapists who make use of it and share such application via Listserv (A web-based forum for occupational therapists internationally).

The central themes of this conceptual model of practice focus on the importance of the individual and how individuals are motivated to act in certain ways. Occupational therapy engages people in occupations, which help to maintain, restore, or re-organise their occupational lives (Forsyth & Kielhofner 2006). The value of therapy therefore needs to carefully connect with the context of the person's life (Scott, Miller & Walker 2004). These themes are organised to express the relationship between a number of concepts (see figure two*)* aimed at explaining aspects of engaging in occupation.

Figure two: The Model of Human Occupation: the process of occupational adaptation

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In essence, MOHO concepts address:

- The motivation for occupation (volition)
- The routine patterning of occupational performance (habituation)
- The nature of skilled performance upon a person's sense of their developing occupational identity and competence
- The influence of the environment on occupation (both from a physical and social dimension)

(Forsyth & Kielhofner 2006:71).
(Please refer to Appendix 1 for additional explanation of the MOHO concepts).

Therapeutic use of MOHO and associated tools

Kielhofner (2002) asserts that considering MOHO as a framework to support and guide occupational therapy practice requires reflection, active use of the concepts and engaging in discourse with others. He acknowledges the importance of understanding the limits of MOHO and the need for therapists to establish a relationship between the theoretical concepts of the model and their practice. Technologies for practice have also been developed to assist in developing this relationship. For example, at least nineteen different structured assessment tools have been systematically developed and studied. These evidence-based assessment tools include a specified protocol or guidelines for their use, including methods for rating and reporting upon the detail gathered. Within the set of MOHO tools are assessments developed to provide an overall view of MOHO concepts (for example, the Occupational Circumstances Assessment Interview and Rating Scale (OCAIRS) Version 2.0 (Haglund, Henriksson, Crisp, Freidheim & Kielhofner 2001) as well as those targeting specific areas (for example, the Volitional Questionnaire (VQ) (de las Heras, Geist, Kielhofner & Li, 2002). (Please refer to Appendix 2 for a breakdown of the assessment tools used within this study). In addition a wide range of other resources are available, including an interactive website.

Critics of MOHO

Critics of the MOHO are visible within the literature, although only one paper by Haglund and Kjelberg (1998) has been found which specifically critically analysed the model and its concepts in any great depth. As Haglund and Kjellberg’s (1998) critique relates to an earlier version of the MOHO, their perspectives have since been met with subsequent revisions of the model. Nevertheless they are somewhat unique in

their exploration of MOHO concepts and they opened up an important dialogue regarding the value and contribution of this professional theory.

Elsewhere within the literature criticism reflects individual perspectives on MOHO's contribution to the theory and practice relationship. For example, Goren (2002) questions why occupational therapists struggle to accept core theoretical constructs such as MOHO (2002). He asserts that such commitment may require a sacrifice of heterogeneity that therapists are unwilling to make. It would appear that certain therapists have yet to be convinced that the ideology that underpins theory makes sense in daily practice. Indeed, MOHO may threaten the inclusivity that attracted individuals to the profession in the first place (Mocellin 1996). In addition, Goren (2002) states that the more a theory lays claim to universal validity (acceptableness), the less it can do justice to individual circumstance. I would argue that were our professional role and contribution not in such a state of flux, we might have reason to be more receptive to Goren's perspective. However, I find it difficult to appreciate his stance when professional identity within the mental healthcare arena for occupational therapy is lacking in clear direction. Regardless of the fact that Kielhofner has never stipulated MOHO is to be applied wholesale, I argue that should MOHO be found capable of focusing practitioners' perspectives for their practice then I suggest this would be very beneficial.

Hubbard (1991) explored the difficulties occupational therapy has faced in explaining itself in terms of reductionist biomedical terms. He claimed that despite problems with a reductionist approach to occupational therapy theory, to reject a way of reasoning which has proved to be so successful at understanding the biological processes of disease is not wise. Hubbard challenges the inability of the MOHO to address this problem. He criticises Kielfhofner for dismissing reductionism as a valued thought process. As such, he states that MOHO only adds to further misunderstandings about the profession. However, it appears Hubbard has misinterpreted the application of MOHO as it is clear Kielhofner has repeatedly argued (1997, 2002, 2004) that use of MOHO can *be combined with* other, reductionist models such as sensory integration (Ayres 1979, Fisher, Murray & Bundy 1991) and biomechanical theories (Trombly 1995).

Debate regarding the MOHO's ability to generate legitimate professional knowledge has been spurred by Creek (2001) who highlighted that the model cannot be remediated without basic theory building, reminiscent of OS perspectives. Yet in

response to Creeks assertions, Summerfield Mann (2001) referred to the dialectical reasoning process (embraced within the scholarship of practice), which provides the opportunity for further development of the MOHO theory base. Moreover, Forsyth (2001) made reference to the twenty years of research literature supporting the MOHO, which Creek failed to mention.

In addition to formal papers criticising the model, a well-known barrier to adopting MOHO, commented upon by therapists and students anecdotally and referred to by Hubbard (1991), is the terminology utilised and concept areas presented, which can appear complex and inaccessible for colleagues within the multidisciplinary team. Indeed, Hubbard argued MOHO has stereotypical meanings which other professionals may hold which are not complimentary to occupational therapy. In contrast, Feaver (1995) investigated how the structure of the MOHO was useful in supporting colleagues' practice repertoires in a learning disability trust, ensuring occupational therapy plans and case notes were clear, which proved to have useful benefits both for service users and MDT professionals alike. Moreover, Feaver asserted the MOHO offered colleagues a more definitive understanding of their unique contribution to client care (Feaver 1995: 366). Indeed, Forsyth and Kielhofner (2002) suggest that occupational therapists should have confidence to articulate and make use of professional terms to convey complex issues and procedures in an immediate and concise way. Furthermore, they assert that often it is the therapist's own lack of confidence rather than resistance on the part of other professionals which prevents MOHO concepts / terminology being used in a MDT context (Forsyth & Kielhofner 2002:328). Finally on this point, as contested by Kielhofner (2002), we work with complex individuals who have many and varied needs, as such, how can we effectively embrace complexity with a set of simplistic guidelines?

Summary

I argue that MOHO offers a well-established theory with technologies for application and programme development. Whilst criticism draws attention to the language selected including the layers of theoretical argument presented, I maintain that MOHO offers credible support to therapists working with the complexity of factors that combine to influence and shape people's occupations. Furthermore the strategies used in the ongoing development of MOHO reflects the vital link required between academia and practice in advancing professional perspectives. However, despite practitioners having access to professional theory and whilst it is known that

occupational therapists are required to develop, update and advance their knowledge (HPC Standards of Proficiency 2004, Code of Ethics 2005, COT Recovering Ordinary Lives 2006) it is known that barriers to theory implementation exist. The research which now follows identifies with such literature and what is currently known about the utilisation of conceptual models of practice.

Research into occupational therapy theory utilisation

UK based theory uptake

From an initial search conducted there are few British-based studies examining the utilisation of occupational therapy theory across the profession (Metcalf, Perry, Bannigan, Lewin, Wisher, Klaber & Moffatt 2001; Walker, Drummond, Gatt & Sackley 2000; Boniface *et al.* 2008). No studies have focused predominantly on theory utilisation within mental health occupational therapy practice. A brief appraisal of this research literature now follows.

Metcalf *et al*. (2001) undertook a postal questionnaire amongst four allied health professional groups (dieticians, occupational therapists, physiotherapists and speech and language therapists). The number of respondents was high (80%) (N=572 out of a possible N=715). Results included that whilst each group believed theory use and the development of professional theory was important, barriers existed regarding its use. Barriers included insufficient time, professional isolation and resistance amongst colleagues. Although Metcalf et al's study suggests occupational therapists are not alone in their struggle to utilise professional theory, arguably a more focused study separating out issues pertinent for occupational therapy would have been of greater value. In addition, data triangulation would offer more detailed, personal perspectives regarding why barriers exist and how they might be removed.

Walker *et al*. (2000) similarly selected a survey design to ascertain the treatment approaches used in stroke care by senior occupational therapists from a particular region. From a total of 83 questionnaires sent 73% (N=61) were returned. In addition, a random selection of 14 therapists were subsequently interviewed and then asked to respond to a case vignette. Findings from the research identified that two approaches were commonly used: the functional approach and Bobath approach (both reductionist in nature). The reasons for choice of approach varied with no therapist selecting an occupation-focused conceptual model of practice. In addition, no therapist was able to cite any relevant research or published papers to support their

choice of approach. The authors identified their concern that despite the current evidence-based climate so many therapists seemed to rely on only a subjective evaluation of outcome. It is of note that the authors do not detail their methods of analysis for any of the findings presented. Furthermore, by requesting that the participants describe what *treatment approaches* were selected arguably reduced the opportunity to identify what overall theoretical framework guided their intervention.

Most recently Boniface *et al.* (2008) conducted an action research study to investigate how the Canadian Model of Occupational Performance (CMOP)(CAOT1997) was appropriate for supporting the practice of occupational therapy staff based within an integrated health and social care setting. A steering group, made up of head and lead therapists, which grew from 4 to 20 members, including a tutor from the local university, appeared to be the most active group in the study in terms of being trained in the use of the model and its outcome measure. These team-based 'champions' then engaged in cascade training of their colleagues across the service (n=270), including use of workshops, a training manual and a DVD with the practitioners. Action and reflection cycles are described in which practitioners reflected upon their desire to embed theory within their practice and the practical difficulties associated. The detail regarding methods used for analysing the data collected (over a four year period) is limited. Moreover, whilst the authors state the research was collaborative, it would appear that the steering group took most decisions regarding strategies employed. Whilst a more participatory action research model may have yielded alternate outcomes, the findings from the study provide useful insight for practice development initiatives. For example, in terms of the key implications for practice the authors identify that theoretical structures should be used flexibly and adapted to particular services; occupational therapy should demonstrate its theory through its practice; using models as a theory-base can enhance individual practitioners ability to reflect on their actions, and finally; implementing theory can take a long time but is worthwhile (Boniface *et al.* 2008:537).

International theory uptake

From an international perspective, a number of other studies have been completed focusing on therapists' selection of theoretical models and their knowledge of such professional frameworks. In the United States (US) Van Duesen Fox (1981) used a survey design to examine occupational therapists' knowledge of theory including their familiarity with key theories and concepts. Results indicated that recent graduates

could not confidently talk about major theories and did not place a high priority on theory development. In a similar follow-up study (1985) Van Duesen examined theory use and level of clinical experience. Findings revealed that recent graduates valued theory less than those who had undertaken post-graduate level study. Such perspectives support Barris and Kielhofner's (1986) review of theory uptake amongst practising therapists in the US. Similar to the previous study, in adopting a survey design, the authors' findings revealed that those who had undertaken occupational therapy programmes at postgraduate level recognised the value of theory more so than those studying at undergraduate level.

These findings, whilst interesting, arguably require more fundamental consideration of the occupational therapy education programmes, the approaches used to promote learning and the learning environments advocated on the respective programmes. Similarly, Law and McColl's (1989) study in Canada also examined graduate therapists' and undergraduate students' knowledge of professional theory via questionnaire. They identified how recent graduates were found to have lower levels of knowledge about theory than undergraduates. However, no critique of the strengths or weaknesses of their undergraduate programmes in relation to the graduate experience is offered, nor are suggestions offered in terms of what changes might or might not be required within education and practice settings as a result of this evaluation.

It is interesting to consider such findings in terms of the wider literature. Research into professional development suggests that the initial period during which novice professionals develop their proficiency in the general professional role continues well beyond their initial qualification (Usher & Bryant 1987; Eraut 1994). Indeed the first two or three years after qualifying are probably the most influential in developing the particular personalised pattern of practice that every professional requires. This has important implications for occupational therapy teams. Miles-Tapping, Rennie, Duffy, Rooke and Holstein (1992) and Tryssenaar and Perkins (1996) contend that a strong professional self-image comes from mentorship. Burke and Depoy (1991) likewise support this view acknowledging how novice practitioners need to observe experienced clinicians at work and talk with them to discuss actions taken. Indeed Morley (2006, 2007), Morley, Rugg and Drew (2007) have identified the importance of perceptorship programmes for occupational therapy graduates and the value of dedicated professional supervision.

Therapists' selection of theory for practice

In Israel, Javetz and Katz (1989) examined occupational therapy practitioners' knowledge of theories and the extent of theory application. Data were collected in two stages; whilst detail regarding the initial population sampled is vague and methods of analyses lacking, it would appear 98 occupational therapists engaged in a 30 minute semi-structured interview and 40 recent graduates were interviewed by telephone. The study identified a range of theoretical models used by the therapists, with theories selected on the basis of need according to speciality areas. An occupational therapy model was not consistently applied. The findings highlight a general lack of confidence evident amongst practitioners in articulating the theory which supported their practice. Whilst the authors suggest improved educational preparation is required, less focus was placed on the practitioner's own responsibility for taking control of their ongoing professional development and their ability to articulate theories in use with colleagues on a regular basis.

In a rare study investigating theory uptake within mental health practice, Haglund, Ekbladh, Thorell and Hallberg (2000) utilised a questionnaire to investigate which theoretical approaches and practice models influenced Swedish occupational therapists' daily work. Although the most frequently used model was MOHO, 75 % of respondents did not identify theoretical thinking based on models from occupational therapy. Such findings reflect concern directed at therapists utilising approaches from out with professional domains (Layard 2004). Similarly, Storch, Goldrich and Eskow (1995) sent a postal questionnaire to 72 paediatric occupational therapists' in the US. From the 70.8% response rate (n= 51) they concluded that the therapists used a multi-theoretical approach with therapists tending to select more reductionist theories than occupational therapy models such as MOHO. The key reason reported for not using such theory was due to a lack of familiarity. It is argued here that reliance on self-reported data is a limiting feature of survey designs and that additional research methods are required to explore the complexity of knowledge utilisation.

Finally Brown, Rodger, Brown and Roever's (2005) research into paediatric occupational therapy practice indicated therapists' use of a range of theoretical models. With the exception of the Sensory Profile, the assessment and treatment methods most frequently used were not congruent with profession-specific conceptual models of practice. Whilst limitations of all the studies are the authors' reliance on survey data, the results indicate that education in occupational therapy

must emphasise knowledge in its own field more than it has done to date. Moreover, findings from these studies take up the debate regarding therapists' pluralistic approach to theory utilisation (Mosey 1981, 1985) in that whilst embracing a range of theories and alternative tools for practice enables freedom to grow, such pursuits arguably lead to distraction from our professional purpose. Furthermore, Brown *et al.* (2005), similarly to Mosey, argue that it is critical that the assessment and treatment methods used are conceptually consistent with the theoretical assumptions of the models that guide individual's practice.

In terms of research investigating the direct application of MOHO into practice, Elliott, Velde and Wittman (2002) completed an exploratory study using phenomenology to investigate the use of MOHO in everyday practice as described by three occupational therapists. Although in-depth interviews were used, which had potential to enhance understanding of therapists' relationship towards theory and practice, the findings from this study were disappointing. The themes presented offered no additional insight regarding utilisation of MOHO for practice and served only to reiterate what previous studies had found in that therapists valued theory, but lacked understanding of it and did not implement it within their own practice.

The most recent survey study investigating MOHO theory use is by Lee, Taylor, Kielhofner and Fisher (2008) who investigated how therapists across the US used the model within their practice. Their findings support evidence within the literature (see Brown *et al*. 2005, Haglund *et al*. 2000, Law & McColl 1989, Wikeby, Lundgren & Archenholtz 2006) that the MOHO is the most widely used occupation-focused model used in the States (and internationally). Lee *et al.* study has furthered understandings regarding theory utilisation in that: MOHO was viewed as useful in supporting the therapy process and recording and reporting therapy outcomes; a major barrier identified was the therapists' lack of knowledge of the structured assessment tools, and; logistical issues in terms of access to the range of tools and the challenge of their application with clients were noted as barriers. In terms of the methodology applied it is again evident that the authors use of a survey design does not provide the depth of investigation required in order to adequately explore the tensions which clearly are apparent when considering theory and practice relationships.

Summary

From the studies conducted to date it is evident that research has not investigated in sufficient depth or longitudinal dimension the perceived value and contribution of conceptual models of practice such as MOHO. In addition, research examining theory uptake by occupational therapists working within mental health is sparse. It is of note that practitioners repeatedly identify confidence issues as a barrier to theory utilisation. Yet few studies focus upon therapists' making use of structures within work-based settings to consider ways forward. In line with the critical approach advocated earlier within the chapter (Carr 1986) I maintain that theory and practice relationships need examining *in the context of practice*. Furthermore, rather than researchers considering practitioners' uptake of theory at a distance, more supportive, collaborative research partnerships between education and practice are proposed.

Conclusion

The aim of this chapter has been to consider what is known about theory and practice relationships in occupational therapy. As Walker and Ludwig (2004) contest, such qualities are an important part of being a professional. I have argued that occupational therapists need to pay greater attention to what they know about the knowledge they assimilate in order to promote their professional perspectives. This has been framed in the terms of occupational therapy's practice epistemology. Carr's (1986) typology has been applied as a means of accounting for the range of ways in which I have understood practitioners to view theory as relevant to their daily practice. In addition, rather than focus upon occupational science as a form of professional knowledge which can adequately guide professional practice, I have argued that occupational therapy conceptual models of practice provide a practical means of strengthening service delivery. In particular, the Model of Human Occupation (MOHO) (Kielhofner 2002) was introduced as the model of choice for this study.

I identified discourse from research and opinion, which highlights that professional theory is viewed as potentially threatening and problematic for the practitioner to adopt. I explored the research conducted to date within the field of occupational therapy, which has sought to examine how a conceptual model of practice such as MOHO has been selected and utilised by therapists within the practice arena. Whilst barriers to theory uptake have been identified research into strategies to overcome

such barriers is viewed as lacking. As such, I argue that therapists who have been hesitant in adopting occupational therapy theory need to be encouraged and supported to 'test-out' a conceptual model of practice and examine the benefits it may offer service delivery from the key stakeholders involved. Similarly, as an occupational therapist in education I have responsibility to support useable theories and not sit in an ivory tower.

The College of Occupational Therapy (COT) (2006) has set out targets to be met within the next ten years (2007 – 2017) that aim to effectively address current professional concerns. Review of contemporary mental health service provision requires acknowledgement of two clear drivers from professional and political agendas: the requirement for the profession to reassert its belief that occupation is essential to health and well-being, coupled with the requirement to base practice on best evidence (COT 2006: 4). Whilst it is less obvious how occupational therapists are to equip themselves to deliver this agenda what is clearly called for is for practice settings and universities to work together in establishing supportive relationships (Forsyth *et al.* 2005, COT 2006:20). The issue now facing the profession is how such partnership work can progress.

The next chapter considers a range of change theories from outside the profession. This literature offers opportunity to explore the complex issues that require consideration when individuals and teams are encouraged to review their practice and consider changed perspectives.

Chapter three

Personal and social influencing factors within a change process

Introduction

The aim of this chapter is to offer perspective regarding how to support practitioners to integrate theory into practice through examination of change theories. It is of note that whilst healthcare practitioners consider ways to facilitate change when considering behaviours of service users, only limited attention has been devoted to better understanding clinician's behaviours when applying theory-driven approaches (Perkins *et al.* 2007). As Edmonstone (1995) identifies, the National Health Service (NHS) has been absorbed with how to manage change effectively for the past twenty-five years. Within this time a haphazard combination of clinician's self-motivation and a system of individual supervision and appraisal has been relied upon to bring about change (Ward & McCormack 1999). With this backdrop in mind attention is directed towards a number of theories which I believe offer useful perspectives when examining change processes. The influencing factors that affect the uptake of theory are reviewed; including those of the participants, the wider social context and the external facilitator.

At the individual level the key arguments focus upon examining what motivates a person to consider taking action to change. This includes focus upon a person's motivations to engage in action-orientated behaviours in the first instance and how a decision to act does not guarantee changed behaviours. Theories of learning are also considered in relation to a person's ability to make sense of propositional knowledge as a means of enhancing disciplinary understanding. Alongside such ideas I draw attention to literature acknowledging the influence of learner stance and personal worldview. Self-efficacy beliefs are also discussed in relation to how healthcare practitioners might gauge their practice performance as competent.

Wider social and contextual influences upon knowledge uptake are then examined, as well as theories relating to how social learning processes are generated and shaped, including the social persuasions individuals receive from others. Finally, the practice development literature is considered in terms of its applicability to this study to support change in healthcare. Although predominantly with reference to nursing practice, research findings from the practice development literature offers a platform for investigation on which this study builds.

Personal Influences upon knowledge uptake

> We cannot push anyone to develop, or "get them to see" or "impact" them. The causal metaphors hidden in English verbs give us a distracting vocabulary for pedagogy. The tone is Lockean and provocative of resistance. We can provide, we can design opportunities; we can create settings in which students who are ready will be more likely to make new kinds of sense. (Perry 1985:4)

This quote from Perry connects with the challenge facilitators are presented with when working with individuals to affect change. The agenda for change within this inquiry focused upon supporting a mental health occupational therapy service to implement MOHO (a theory-driven approach to practice). As Towell and Harries (1979) highlight change is often viewed as threatening. Of key concern is that healthcare staff can be made to feel undervalued in what they are currently offering. Change processes have been compared to painful experiences such as loss and bereavement evoking feelings of denial, anger, grief, resignation and acceptance (Kubler-Ross 1969). Individuals may resist change and potentially exhibit unproductive behaviours which undermine the process (Cavanagh 1996). In contrast, I argue here that change can also be experienced as liberating and strengthening as alternative ways of practising are considered.

The range of factors influencing individual response to theory uptake are considered in the following areas:

- Personal motivation factors (cognitive and affective behaviours)
- Knowledge utilisation: threshold concepts and identity shifts
- Epistemological beliefs and learner stance
- Self-efficacy beliefs and personal agency

Personal motivation factors (cognitive and affective behaviours)

The Transtheoretical Model of Health Behaviour Change (Prochaska & Velicer 1997) is a model that has been developed as a means of understanding the process of change for people with addictive behaviours. It seeks to explain intentional behavioural change along a temporal dimension that utilizes both cognitive and performance-based components. The model has gained widespread popularity in health psychology and addictions where it is used to guide interventions and allocate treatment resources in several fields. I considered it might have a useful application here in terms of recognising the cognitive and affective behaviours which impact

upon how practitioners make sense of and use theoretical knowledge within their practice.

Prochaska, DiClemente, Velicer and colleagues have, over a twenty-five year period of research, developed a recognised schema of *stages* involved in a change process. Their work has fundamentally questioned and explored what moves people to take action to change. Moreover, they consider what motivates people to begin *thinking* about changing behaviours - as this can be quite different from understanding what drives people to begin preparing for or to take direct action. Answers to these highly complex questions have been considered systematically using the Transtheoretical Model (Prochaska & DiClemente 1982, 1983, 1985; Prochaska, DiClemente & Norcross 1992; Prochaska & Velicer 1997).

The Transtheoretical Model or stages of change model, appears to provide a useful starting point when considering attempts to engage people within a change process. The model offers explanations for why certain individuals may demonstrate more action-orientated behavioural changes than others. Table one provides an overview of the stages of change identified, and the main theoretical ideas.

Table one: Overview of the stages of change ***(Adapted Prochaska & Velicer 1997)***

Stages of change	Overview
Precontemplation	Here an individual is unaware of a need to change despite others' perspectives. This may lead to the person experiencing pressure to change. However, any steps to demonstrate shifts in behaviour are short lived.
Contemplation	A person may be aware of a need to alter their behaviour but not as yet made the commitment to take any action. People in this stage can feel very ‘stuck’ and troubled by the amount of effort, energy and personal commitment required.
Preparation	Individuals intend to take action, but may not have established exactly how this will occur.
Action	Clear strategies have been attempted to modify / change behaviours. A clear commitment is visible. Here people tend to receive the most recognition for their actions.
Maintenance	Those who have worked to affect change consolidate their efforts and consistently engage in the new behaviour(s). This is not a static position, as maintenance is viewed as a continuous form of behaviour, which does not demonstrate reverting back to former ways.
Termination	In this stage, individuals are resigned to their new way of coping. (*This appears to be the least researched stage and repeats what is suggested within maintenance*).

The Transtheoretical Model acknowledges how most people's actions to effect change are not successful on their first attempt (Prochaska *et al.*1992). For example, with regards to smoking, taking three to four action attempts before long-term maintenance is achieved is a common occurrence (Schachter 1982). Relapse and recycling through the different stages regularly occurs (Prochaska & Velicer 1997). In addition, although some people will move through all the stages in a linear way, this is not typical and individuals have been shown to move from contemplation to preparation, to action but then relapse (Velicer, DiClemente & Rossi 1990). Relapse takes the person back to an earlier stage; individuals may become demoralized and resist thinking about change. However, relapse does not mean individuals regress all the way back from where they first began. Instead, it is suggested that each time a stage is not effectively completed, the person learns from their mistakes and tries something different the next time around (DiClemente 1991). Although critics such as Littell and Girvin (2002) and Callaghan, Hathaway, Cunnungham, Vettese, Wyatt & Taylor (2005) argue there is scant evidence detailing how people move through the discrete stages, appreciating the stage a person is situated within arguably offers a facilitator an improved ability to gauge approaches directed towards engaging people in change processes.

I was interested to know more about the Transtheoretical Model and if it could offer a means of examining the individual therapists' responses to the implementation of MOHO. I questioned whether certain early stages (as in precontemplation, contemplation and preparation) might be of more significance than other, later stages. Furthermore, in addition to the *stages* of change, the Transtheoretical Model identifies with a number of linked *processes*. These are viewed as contributory factors or processes, which represent a 'temporal dimension' (Prochaska *et al.* 1992:1107). The authors state that the processes have been confirmed through at least ten principal component analyses conducted on various response formats with diverse samples (see Norcross & Prochaska 1986, Prochaska & DiClemente 1983, Prochaska, Velicer, DiClemente & Fava 1988). Whilst Callaghan *et al.* (2005) undermine the reliability of the processes, research suggests the processes can be viewed as a means of explaining what *supports* a person to make shifts through and across the stages of change (Velicer, Prochaska & Bellis 1993). The processes have been summarised in table two (*adapted from Prochaska et al. 1992:1108-1109*).

Table two: Overview of the stages in which particular *processes* of change are emphasised

Stages of change	The processes observed	Explanation of the processes and observed response
Precontemplation		
	Consciousness raising	Individuals seek increased information about self and problem / issue
	Dramatic relief	Person expresses doubts, misgivings, concerns about situation
	Environmental re-evaluation	Assessing how one's problems affects the physical environment
Contemplation		
	Self re-evaluation	Assessing how one thinks and feels about oneself in relation to problem / issue
Preparation		
	Self-liberation	Choosing and committing to act, including a belief in the ability to change
Action		
	Reinforcement management	Rewarding oneself or being rewarded by others
	Helping relationships	Being open and trusting with others who care, sharing, offering support to others
	Counter conditioning	Substituting alternatives for problem behaviours
	Stimulus control	Avoiding stimuli that elicit problem behaviours
Maintenance		
	Social liberation	Advocacy and empowerment on behalf of others

The 10 processes of change are described as 'covert and overt' activities that people use to progress through the stages (Prochaska & Velicer 1997:39). Research related to the Transtheoretical Model suggests that interventions to change behaviour must be stage-matched, that is, matched to each individual's stage of change (Velicer *et al.* 1993). For example, as highlighted in table two, for movement to occur from precontemplation to contemplation, the processes of consciousness raising, dramatic relief, and environmental re-evaluation are emphasised.

In considering change Prochaska and colleagues refer to 'decisional balance' (Prochaska & Velicer 1997:40) a construct of the model which refers to an individual's consideration of the 'pros and cons' of changing. In addition, drawing on Bandura's theory (Bandura 1997, 1982) reference to self-efficacy beliefs are acknowledged, which they denote as being 'situation-specific' (Prochaska & Velicer 1997:40). By this the authors refer to the levels of confidence individuals require to enable them to cope with high risk situations without giving way to temptation and relapsing to a former habit.

It is evident that widespread criticism of the model exists regarding its practical utility and the validity of the named stages and processes to guide interventions. Research and opinion has typically focused upon the application of the stages and processes in relation to health-related behaviours. For example, Riemsma, Pattended, Bridle, Swoden, Mather, Watt and Walker (2003) conducted a randomised control trial with regards to smoking cessation. Their findings outlined that the stage based interventions were no more effective than non-stage based interventions. Horowitz (2003) investigated the effectivenss of the stages of change in the prevention of pregnancy and sexually transmitted disease amongst young adults. Horowitz concern was directed at the arbitrary dividing lines drawn between the stages. Furthermore she argued that the model assumes individuals typically make coherent and stable plans when condidering change behaviours, which she found they did not. In addition, Sutton (2001) and West (2005) raised concern over the frequent use of cross sectional data when considering the effectivenss of the stages and processes of change, whereas longitudinal study data is required to provide stronger causal inferences.

Taking into account the range of perspectives regarding the contribution of the Transtheoretical Model, I was interested to examine how the model might be applied

in this study. I believe the processes of the Transtheoretical model emphasise the re-evaluation of the self and the impact of the self on one's physical environment. However, I perceived a potential limitation of the model to be the lack of emphasis on the influence of the social environment. Indeed I suggest that the model can appear to be predominantly inward looking. Whilst Prochaska and colleagues' theory offers a framework which could enable the examination of the cognitive and affective behaviours of the participants towards change, I questioned if the model would be able to account for the breadth of issues which were likely to be experienced. As such I have looked to other theoretical perspectives, which I believe could offer additional means of embracing the complexity expected.

Knowledge utilisation: Threshold concepts, identity shifts & learner stance

Meyer and Land's theory of threshold concepts is useful for building upon the Transtheoretical Model and presenting another layer of theoretical argument examining individual transition, especially in terms of considering their perspectives on the uptake of propositional knowledge. A threshold concept has been defined as a conceptual building block, which can progress understanding within a subject area (Meyer & Land 2003). Such concepts are viewed as being central to the mastery of a subject. In relation to this study I believe a threshold concept within occupational therapy relates to the uptake and utilisation of conceptual models of practice such as MOHO. As in the previous chapter I argue that models of practice such as MOHO offer a valuable contribution to support professional practice and are clearly evident within the professional curriculum. However, just as mastering threshold concepts involves embracing forms of 'troublesome' knowledge often viewed as alien and incoherent (Perkins 1999), occupational therapy theory can likewise be viewed as potentially threatening and problematic for the developing practitioner (Mackey 2007).

Meyer and Land (2003, 2006), Meyer, Land and Davies (2008) have explored an individual's ability to deal with realisations about new learning pathways by focusing upon learners' difficulty grasping the ideas their tutors attempt to craft to make knowledge accessible. As such, threshold concepts can be viewed as 'gateways' and constitute a fundamental shift in thinking to advance disciplinary knowledge. Indeed once grasped, Meyer and Land (2006:7) suggest a threshold concept is likely to be *transformative* in terms of leading to a change in beliefs and attitudes or a 'reconstruction of subjectivity'. As identified within the Transtheoretical Model

(Prochaska *et al.*1992), working through the different stages and processes of change is not viewed as straightforward. I believe Meyer and Land's (2006:7) work on threshold concepts provides insight by suggesting how new learning can take individuals into territory which may seem *troublesome,* as in 'foreign' and conceptually difficult to understand. Furthermore, in contrast to the relapse and recycling which is suggested to occur between the stages of change (Prochaska & Velicer 1997), once a threshold concept is crossed any learning is *irreversible* in that the change of perspective acquired is unlikely to be forgotten (Meyer & Land 2006:7). Whilst I suggest that working through a stage of change and grasping a threshold concept will both bring forth new understandings, the threshold concept literature speaks more clearly about exposing the *interrelatedness* of a concept in terms of how it might advance disciplinary knowledge. In addition, Meyer and Land (2006) identify that threshold concepts also tend to be *bounded* in that they can serve to map out disciplinary terrain. In essence what is suggested by grasping a threshold concept is that as new knowledge is gained individuals are changed by it.

Meyer and Land (2006); Meyer *et al.* (2008) state that certain threshold concepts are more troublesome than others. They propose that learners who find certain concepts difficult involve the learner occupying a 'liminal space'. This state of 'liminality (Meyer *et al.* 2008:x) may be experienced as unstable space, prompting the learner to deal with the emotional and cognitive challenge of shifting between old and emergent forms of understanding. Successfully navigating through a liminal space, and thereby across a threshold, has been likened to a rite of passage into a discipline (Meyer & Land 2006) and as mentioned, can result in identity shifts (Cousin 2006). However, in contrast 'stuckness' and disjunction may occur which may result in the learner being in a 'suspended state', one that undermines the learner's confidence in terms of their current performance and any ongoing learning. This latter point has relevance for this study in terms of the level of commitment, which I believed would be required by the learners and myself as facilitator to persevere when learning becomes troublesome, with participants potentially 'stuck'.

Cousin (2006) identifies how teachers / facilitators need to be sufficiently receptive to learners needs. Moreover, she warns against the practice of 'mimicry' (as identified by Meyer & Land 2005) whereby facilitators may over simplify material in a vain attempt to make learning accessible. The impact of mimicry is significant here when considering opportunity for professional identity shifts, as I was concerned that superficial understanding of MOHO would only result in persistent barriers to the

knowledge and thus the discipline. I suggest that when occupational therapists' lack confidence with their professional knowledge the journey to master a coherent professional identity is affected. Cousin (2006) importantly advocates that facilitators need to tolerate and listen for learners' uncertainties and understandings in order to journey *with* students through liminal spaces to advance (discipline) understandings and avoid the rejection or mimicry of professional knowledge.

The threshold concept literature provides a potential means of accounting for what the therapists in the study might experience when embracing MOHO. However, emphasis appears to be focused predominantly at the teacher-learner level and although I can appreciate the sense of liberation which occurs when progress is experienced within a learning situation, the suggestion that learners may achieve shifts in identity requires further examination, especially when considering knowledge uptake within practice culture. Whilst I maintain that greater appreciation of threshold concepts enables facilitators and learners to acknowledge the complexity of mastering (new) forms of knowledge, greater emphasis is required to investigate why shifts in identity occur including other factors which shape and prompt such learning to take place. Certainly from my experience understanding the concept areas of MOHO would not, on their own, be sufficient to transform individuals' identity and practice repertoires.

Learner stance & epistemological beliefs

Savin Baden’s (2008) consideration of learner stance adds important perspective to the debate. She argues that threshold concepts are ‘dislocated’ from both the learner and the context and overly generalised. Instead, she asserts threshold concept theory needs to be ‘biographically and contextually situated’ (Savin Baden 2008:101) identifying the importance of seeing beneath any obvious resistance to change and appreciating the fact that learning is complex and specific to the *learner*. As such, a person’s ability to grasp new learning links to contributory factors such as the individual's life and their ‘stories.’ Savin Baden suggests that stances towards learning are usually formulated during school life and are influenced by parental expectations. Furthermore her focus away from the traditional concept of learning styles (as in deep and surface learning) for more ontological perspectives regarding learning is viewed here as helpful. Furthermore Savin Baden (2006) questions who makes the decision on what a threshold concept is. Rather than attention being drawn to a learning strategy individuals may adopt per se, Savin Baden implies the

challenge should be framed in terms of appreciating the conflict *individuals* may experience between their attitude, belief or disposition towards the knowledge, the facilitator and the learning context.

In the previous chapter I argued how practice can become pre-eminent to theory because students struggle to identify with theory as a consequence of their occupational therapy training, the expertise / knowledgeability of their tutors and the expertise / knowledgeability of practising therapists influential in their fieldwork experiences. Thereby students may fail to envision how theory can transform the ways they see themselves and the practice within which they operate (Friere 1970). In contrast, others will connect with the knowledge and move forward with their understanding with comparative ease. I suggest Savin Baden's perspective on learner stance provides a credible influencing factor when considering an individual's response to theory uptake. Furthermore Reed (1984) and Walker and Ludwig (2004) likewise raise important issues in terms of learner stance and personal beliefs and values when they highlight how theory is not value free. Such perspectives acknowledge how theory evolves from philosophical assumptions made by a profession, interpreted by others. Goren (2002) similarly questions why occupational therapists have not accepted core theoretical constructs proposed in conceptual practice models such as MOHO. Goren asserts that such commitment may require a sacrifice of heterogeneity that therapists are unwilling to make. This argument has been considered in the previous chapter and is addressed again here in terms of the importance of therapists and facilitators understanding one another's practice epistemology. Although advocates of the MOHO theory development have striven to respond to occupational practice needs, and this has been generated by collaborative efforts, the very nature of MOHO being a theoretical model will result in its value and contribution as a legitimate form of knowledge being held in question by certain members of the profession.

It was therefore interesting to observe within this study whether MOHO theory had to connect with the practitioner's own beliefs and values. The notion of learner stance, in terms of individual attitude and beliefs towards practice epistemologies is viewed as being a powerful determinant regarding a therapist's response towards MOHO. In addition, the therapist's conscious and unconscious beliefs, prejudices and prior learning experiences were likely to influence their perception of me as a facilitator and how they would relate to me. I would be keen to observe if MOHO could serve to challenge professional beliefs and values and shift professional identities.

Self-efficacy beliefs and personal agency

The theoretical perspectives presented thus far arguably capture the *motivational and contextual* factors, including prior experience, which influence individual learning and behaviour and provide an indication of how determined a person will be to commit to performing the new behaviour. Additional depth to such perspectives is provided via consideration of Albert Bandura's concept of perceived self-efficacy (Bandura 1977, 1982). I argue that a fundamental influence upon knowledge uptake not accounted for thus far is a person's *confidence* in their ability to perform. Self-efficacy beliefs arguably inform and dictate a therapist's choice of activities, including how well they are prepared to engage in an activity and the amount of effort expended during performance (Bandura 2001). Indeed, MOHO theory itself (Kielhofner 2002, 2008) clearly links to the understanding that motivation to perform is a combination of an individual's sense of self-efficacy and capacity, values and levels of interest toward the intended action.

Bandura's (1997:2) key contention regarding the role of self-efficacy beliefs in human functioning is that:

> *"people's level of motivation, affective states, and actions are based more on what they believe than on what is objectively true."*

Bandura (2001:10) claims efficacy beliefs are the foundation of human agency; agency being that which essentially enables individuals to exercise control over the nature and quality of their life. Bandura's Social Cognitive Theory is rooted in a view of human agency in which individuals are agents proactively engaged in their own development who can make things happen by their actions. Within his theory, the capability he defines as being most "distinctly human" is that of self-regulation. Through self-regulation people make sense of their experiences, explore their own cognitions and self-beliefs, engage in self-evaluation, and alter their thinking and behaviour accordingly. However, arguably not all practitioners engage in such rigorous processes of self-appraisal. This raises a question regarding what the occupational therapists would use to gauge their levels of competency as being acceptable.

At this juncture Giddens (1984) view of human agency has relevance. His work on structuration theory proposes that all human action is performed within the context of pre-existing social structures, which are governed by a set of norms and laws. As such, all human action is at least partly predetermined by contextual rules. This theorising of human agency suggests that vital relationships exist between a person and the wider social context. A structure exists which sets out rules and resources within which human agents (here the occupational therapists) know they need to operate.

Giddens suggests that such systems 'situate individuals' as they draw upon the structures, which are produced and reproduced during interaction. Thus agents and structures represent a 'duality' of structure (Giddens 1984:25). Furthermore, structure is not viewed as something external but is viewed as offering both constraining and enabling functions. Although Giddens' theory acknowledges that structure influences human behaviour, humans are capable of changing the social structures they inhabit. Giddens' structuration theory is therefore concerned with social life, human capacities and the fundamental conditions through which the course and outcomes of social processes are generated and shaped. I believe this provides an important context for this study, as it acknowledges the element of accountability, of which all the occupational therapists were aware. Indeed professional codes of conduct, standards of proficiency, and forms of professional knowledge all exist to determine what is deemed acceptable practice for a professional. Clearly such structures acknowledge the existence of power within the social context.

Yet, Giddens (1984) also identifies the various expressions of commitment and obligation toward such structures by those participating. Indeed individual agents are viewed as filtering information and (strategically) regulating their actions in light of the conditions and power strutures within which they view themselves as operating. Furthermore, Giddens asserts that what practitioners do today will be reinforced and regurgitated by practitioners tomorrow. He states that human beings are knowledgeable agents who know a good deal about their conditions and what they do. Giddens speaks of such knowledgebility being embedded in practical consciousness (1984:281). This can be related to what would be observed occurring within the occupational therapists' day-to-day practice.

Giddens' theory arguably builds upon Bandura's work in terms of considering wider contextual influences. Indeed, Bandura's theories of self-efficacy and agency are not all focused purely on individual interpretation of capacity, for example he states how:

> "Learning would be exceedingly laborious, not to mention hazardous, if people had to rely solely on the effects of their own actions to inform them what to do. Fortunately, most human behavior is learned observationally through modeling: from observing others."
>
> (Bandura 1977:22)

Furthermore, because individuals operate collectively as well as individually, Bandura acknowledges that people form their self-efficacy beliefs through the *vicarious experience* of observing others perform. In this light, self-efficacy is viewed as both a personal and a social construct. The influence of others would be particularly interesting to examine in terms of considering influences upon learning and how these occurred. Bandura acknowledged human agency is influenced by others, or *collective agency* (Bandura 2001): people work together on shared beliefs about their capabilities and common aspirations to better their lives. (In terms of this research, improved professional identity and role contribution being key incentives for change). Whilst I maintain that the influence of personal capacity upon learning is valid, collective agency as a conceptual extension of Bandura's theory is applicable to this study in terms of highlighting the importance of *social enterprise* when considering professional identity issues and the advancement of professional practice. This central role of social learning, set within Giddens' view on the influencing forces of the wider professional political context, links suitably to the final section of this chapter and a shift away from a focus on individual attributes.

Social influences upon knowledge uptake

Paulo Friere (1970) argued that dialectical learning involves co-operative activity involving respect for one another; working with each other; not having one person depositing too much information on another (i.e. not advocating a technical rationale approach to learning). Friere's work as an educator was concerned with *praxis*, or action that is informed and links to values. His theories espoused the importance of developing dialectic with others in order to build *social capital*, or learning, which encourages human flourishing. Furthermore, Friere called for situating learning in the lived experience of participants.

In relation to Friere's consideration of the educator / learner role an appreciation of

Vygotsky's ideas of the teacher / facilitator role are deemed useful here. As a Russian psychologist Lev Vygotsky took exception to many traditional ideas about education and child development (Van der Veer & Valsiner, 1991). His work focused on the claim that higher mental functions in the individual have their origins in social life (Wertsch 1985:113). Although he died at the age of 38 leaving his theories incomplete (Vygotsky 1896-1934), Vygotsky's work places emphasis on the fundamental role of social interaction in the process of learning (Vygotsky, 1978; Wertsch, 1985). Although critics of Vygotsky claim his perspectives can only be considered in terms of children, Tharpe and Gallimore (1988) argue Vygotsky's insights are equally applicable to adult learning.

One of the main principles of Vygotsky's work is the Zone of Proximal Development (ZPD) (Vygotsky 1978). This is defined as the distance between the *actual* developmental level as determined by independent problem solving and the level of *potential* development as determined through problem solving in collaboration with a more capable peer (or *more knowledgeable other*). Thus learning is viewed as dependent upon a specific teacher-learner relationship in which one partner is able to offer expertise and assistance to the other (Vygotsky 1978). In Vygotsky's view, peer interaction, scaffolding, and modelling were important ways to facilitate cognitive growth and knowledge acquisition. Such views complement Bandura's (1977) assertion that most human behaviour is learned observationally; in that individuals create and develop self-efficacy beliefs as a result of the *social persuasions* they receive from others. As a consequence, positive persuasions may work to encourage and empower, whilst negative persuasions can work to defeat and weaken self-efficacy beliefs.

Bandura's and Vygotsky's assertion that significant model(s) in one's life can help instil self-beliefs has served to both illuminate and complicate my understanding of the facilitator's role within a practice development initiative. Indeed, the concept of scaffold learning has been the cause of much debate and reflection within the literature in terms of transmission of knowledge from one who knows to one who does not. For example, Savin Baden (2008) views scaffold learning as problematic, due to its restrictive nature of tutors imposing their beliefs / attitudes onto students. In contrast, Tripp (1993) contends that teachers should not shift from their role of expert as this risks learners falling prey to the influence of the partial truths and lies of common everyday knowledge. The place of tradition and community, he insists, is not to allow learners to create their own interpretations but to teach the *correct* way of

knowing. Yet Brown, Collins and Duguid (1989:457) reject such perspectives and instead emphasize the need for 'cognitive apprenticeship,' whereby students learn both outside and inside school through *collaborative social interaction.* In this way, the student first gains an understanding of the abstract generalisable principles, which are then transferred to an authentic situation for enhanced learning to take place (Brown *et al*, 1989).

Learning theorists such as Lave and Wenger (1991) have likewise argued against theories of learning which isolate knowledge from practice. Instead they advocate learning as a 'social construction,' in that knowledge is best assimilated in the contexts in which it has meaning. Lave and Wenger (1991) and later Wenger (1998) maintain that learning together enables material to be related to local conditions. I believe such views embrace a social constructionist perspective, moving beyond a focus on individual knowledge construction, to exploring the processes involved in *social meaning making*. From this perspective learning is viewed as a social activity mediated by language, culture and history.

Jean Lave and Etienne Wenger are among the leading exponents of *situated* learning, having built their model on Vygotskyian foundations. Wenger in particular proposes that learning involves a process of engagement in a 'community of practice' which embraces a domain of human endeavour, a community in which people engage in joint activities and shared practices. Within the community are its routines, rituals, artefacts, symbols, conventions, stories and histories (Wenger 1998:6). Lave and Wenger's work teases out how communities of practice tend to reproduce themselves and change, as cultural novices slowly, with guidance from the veterans, move from the periphery to the centre – sustaining the community. The critical questions here revolve around the competence and effectiveness of the community, which continues to evolve.

The notion of learning as a situated activity draws attention to the concept of legitimate peripheral participation (Lave & Wenger 1991), which has been proposed as a way of describing the learning which takes place in social practice. The term peripheral suggests that there are multiple, varied, more-or-less engaged and inclusive ways of being located in the field of participation defined by a community (Lave & Wenger 1991:36). Furthermore, periphery suggests an opening, a way of growing involvement. Legitimate peripheral participation (LPP) is thus viewed as a conceptual bridge offering opportunity for the development of identity as people move towards full participation.

Importantly, rather than viewing theory as abstract and removed from practice, Lave and Wenger's stance on situated learning offers a point of departure for starting to explore and develop understandings of the abstract; the goal being to appreciate the relationship of theory to the person, the world, activity, meaning and knowing. This view embraces how learning, thinking and knowing are relations among people in, with and arising from the socially and culturally constructed world (Lave & Wenger 1991:50). Such concepts may prove valid in this inquiry with regards to the cultivation of a community to share its practices alongside the contribution of a formal theory. In essence, *social engagement* may provide an appropriate context for learning in which the participant's view of ways to engage and therefore act in the world may be shaped.

In his later text Wenger (1998) adds to earlier concepts, focusing on factors such as *mutual engagement* (a sense of membership in a community of practice); *joint enterprise* (a sense of responsibility toward the community and an ability to contribute to its pursuit) and *shared repertoire* (the ability to make sense of community coherence and make use of resources including, routines, language, gestures and actions which the group adopts over time, and which become part of its practice). Such dimensions are offered as a means of accounting for the supportive or restrictive responses participants may adopt when faced with new learning situations.

In addition, focus is placed on the processes of *reification* (1998:59). At first this concept appears quite abstract but has been interpreted here to mean that a community of practice is not just about doing or being with others, but importantly involves engaging in a range of different types of processes (for example 'designing, representing, using') in order that group members have a *tangible* opportunity to experience the new learning. Thus alongside participation is a requirement to share interpretations of the experience in negotiation with others. Wenger explores the connection between identity and practice, which he asserts is a layering of events of participation in which our experience and its social interpretation inform each other (Wenger 1998:151). When considered in the context of this inquiry, reification could be about the therapists developing alternate assessment pathways and piloting their use *and* then sharing the impact of such activities in group supervision.

It is evident that Lave and Wenger are not without their critics and have been accused of romanticising communities of practice (Tennant 1997). Whilst Wenger (1998) insists that communities of practice should not be misinterpreted as implying a

sense of harmony, criticism has focused upon a failure to consider the issues of power relations and the consequences of learning when a community of practice is weak or exhibits relationships that inhibit entry or participation (Smith 2003). Winn (1994) takes issue with situated learning's emphasis on learning from experts-as-mentors. Indeed, within the context of this research it is important to examine the way in which the concept of LPP translates into practice, including who would be regarded as the expert(s) and the relationship between 'cultural novices' and 'veterans'. I argue a number of possibilities may exist for the configuration of LPP. Furthermore, within a community of practice the facilitator may well be viewed as one amongst other 'mentors', their role becoming one of guidance rather than that of knowledge depositor (Friere, 1970). However, notwithstanding the criticisms described, I suggest that the notion of a community of practice provides significant pointers for practice development initiatives where the importance of exchange of knowledge and the building of a sustainable community of competent practitioners are viewed as all-important conditions for learning to take place and subsequent change in practice(s) to occur (Wenger 1998). As Friere (1970:61) contends:

> [I]n true dialectic, no one teaches another, nor is any one self-taught. People teach each other, mediated by the world.

In the final section of the chapter I turn to the practice development literature which provides a research perspective into explored utilisation of research / evidence-based practice within the healthcare arena. This body of work is viewed as offering a useful foundation for this study regarding what is known about strategies to support change.

Practice development literature

Practice development is a term used to describe particular approaches to supporting change in healthcare (to date this has predominantly been within nursing) (Garbett & McCormack 2002). In response to the range of theory and literature, which had emerged in the area of practice development, a substantial study, 'A Realist Synthesis of Evidence Relating to Practice Development' (McCormack, Dewar, Wright, Garbett, Harvey & Ballentine 2006) was commissioned by the NHS, Education for Scotland (NES) and the NHS Quality Improvement Scotland (NHS QIS). The purpose of the study was to examine the literature to date which identified approaches to practice development and to critically examine the evidence base that supports them. McCormack's *et al.* study considered the implementation of evidence

into practice from a realist perspective. In this section of the chapter an argument is presented which asserts a more relativist stance and the need for the negotiation of concepts identified from the practice development research. This argument establishes the context and research paradigm within which this study is located.

A synthesis of findings from the practice development research

The methodology for the review conducted by McCormack *et al.* (2006) adopted a realist evaluation framework (Pawson & Tilley 1997). This consisted of initially conducting a systemic review of 169 research papers exploring practice development initiatives internationally. Rather than traditional positivist underpinnings of systematic reviews, which tend to present evidence in terms of cause and effect relationships, this study sought to work within more realist perspectives (Redfern & Christian 2003; Greenhalgh, Robert, Bate, Kyriakidou, Macfarlene & Peacock 2004). This involved *examining* the causal effects of processes adopted in practice to implement evidence. Importantly, the *interactions* between the strategies employed were explored in order to identify their ability to generate clinically useful outcomes. In essence, the review recognised the complexity of the social world, and how techniques used can produce different outcomes dependent on context (McCormack *et al.* 2006). The fundamental realist goal of the review was to provide consumers of the report with knowledge about what strategies might be used in a particular intervention alongside details of their success (or failure).

A framework consisting of four key areas of investigation was developed as a means of examining the diverse range of data to be considered. This theory framework included:

1. A focus on individuals, teams and organisations involved in practice development
2. A consideration of the people involved in developing practice and their orientation
3. Identification of the reason for the practice development work and the impulse to engage in such work
4. Finally, a focus on the actual strategies / techniques employed including facilitation styles, theoretical orientations and knowledge utilisation.

In summary the theory framework was designed to consider how learning happens, how change happens and how knowledge is used and generated. The framework

was used alongside a set of custom-designed review forms to extract the pertinent data.

The second phase of the study analysed the grey literature (thirty-seven items and four books) using the same review processes as in phase one. In addition forty-seven telephone interviews were conducted with internationally recognised ‘experts’ within the field of practice development. The interview schedule was developed from the initial themes, which emerged from the review of the literature. Data analysis and synthesis followed a detailed process including extraction of the research literature onto theory synthesis forms for each of the four theory areas. The grey literature was also synthesised in this way to complete the data set (Pawson 2006). Finally, the telephone interview data was used to confirm, verify or contradict the claims made in the analysis of the literature and to identity other novel issues and themes.

The findings of the report are summarised here to highlight that practice development has an important role to play in the modernisation of health and social care services because of its fundamental focus on practice. Emphasis was placed on the role of practice developers as facilitators for change, although recommendations include that a greater understanding of the knowledge, skill and expertise required in successfully facilitating change in practice is required. Collaborative relationships with Higher Education Institutions (HEIs) were seen as key for developing effective partnerships for ongoing research. Finally, reflective learning and action learning strategies were viewed as offering sustainable learning opportunities. Whilst it is beyond the scope of this chapter to attempt to appraise the body of literature as presented in McCormack *et al.* (2006) study, one particular framework for guiding the implementation of evidence-based practice is examined here due to its connectedness with the aims of this study.

The Promoting Action on Research Implementation in Health Services (PARIHS) Framework (Rycroft-Malone 2004) is the culmination of a project team’s work over a six-year period having been first published by Kitson, Harvey and McCormack (1998). The PARIHS Framework is presented as a means of guiding the success of practice development initiatives via reference to three key elements based on a high to low continuum. The three ‘sub-elements’ are concerned with the *nature of the evidence* being used (including research, clinical experience, patient experience and local data and information), the quality of *context* (the environment or setting within which the research evidence or the proposed change is to be implemented) and the

type of *facilitation* needed to ensure a successful change process (for example, appropriate skills and knowledge to work with practitioners / teams). The most successful implementation appears to occur when evidence is robust and matches professional consensus and patient preference; the context is receptive to change with sympathetic cultures, strong leadership and appropriate monitoring; and where there is an appropriate facilitation of change with input from skilled external and internal facilitators (Rycroft-Malone 2004:298).

The PARIHS Framework sets out a summary of factors on a high to low continuum which the authors claim can predict the likely success of implementing evidence into practice. However, what is not sufficiently explored are the actual actions required in order to shift the sub-elements from low to higher status. Of more significance is the lack of focus on the actual participants involved in the change process. Here I argue that aside from considering clinical experience the framework does not advance knowledge of more personal factors that influence individuals to engage in practice development initiatives, nor how they implement the evidence presented. This lack of focus on participants or teams involved in practice developments is regarded as a serious omission. Nonetheless, the *possibility* of using the structure of the Framework to negotiate change and work to develop improved outcomes is viewed as useful in terms of considering context, facilitator and the content of what is presented.

It is evident that the project team of the PARIHS Framework intend to develop a self-assessment tool as a method for guiding services to review and subsequently plan their own unique development strategy (Rycroft-Malone 2004). Such a tool would provide scores indicating the type of environment and work required to facilitate change. Whilst this tool prescribes details of what is required, a difficulty still exists in terms of the reality and complexity of working with individuals to remove barriers that prevent individuals from participating in practice development initiatives. This requires fundamental acknowledgement that individual practitioners do not neatly sit in categories and whilst it may be advantageous to embrace the best evidence with the most expert of facilitators working with people who are poised for action, it is unlikely that such a set of choice circumstances naturally exist. As such, I believe that practice development initiatives need to embrace more relativist approaches in order to effect change in practice settings. This is to ensure that the subtleties and complexities of a diverse range of individual needs and contextual issues are not overlooked or inappropriately compartmentalised.

Summary

The McCormack *et al.* (2006) realist study was the first to focus on practice development. The approach adopted provided opportunity to review a wide range of evidence and data, bringing it together to achieve a sense of the whole. Furthermore, outcomes from the report provide a consolidation of evidence, which presents a useful platform from which the practice development agenda can continue to be explored. In terms of considering research paradigms, the ontology embraced within the realist study set out to reach a set of conclusions or recommendations, which would not be deemed appropriate from a relativist paradigm. However, as Guba and Lincoln (1989:16) acknowledge, whilst positivists may reject relativists views, relativists can acknowledge that whilst 'unsophisticated' the positivist view is not necessarily wrong or untrue.

Conclusion

In this chapter and the previous one I have examined a range of theories as a means of exploring clinicians' behaviours towards applying theory-driven approaches. This has included how individuals essentially accept (or not) theoretical knowledge as a means of guiding professional expertise. I have acknowledged that research into theory implementation requires more focus, especially research that is conducted with practitioners in the context of practice. In order to examine the complexity of reviewing practice and considering changed perspectives I have thus placed emphasis on theories that have focused at the individual level prior to examining the influence of the wider social context.

At the individual level I have considered the Transtheoretical Model (Prochaska *et al.* 1992; Prochaska & Velicer 1997), which, I have argued, offers useful insight into the potential stages and processes involved in change. In addition, the model recognises the decision practitioners themselves are required to make regarding the perceived need to change. Whilst this model offers useful insight into the relapse and recycling which can occur as individuals engage in action-orientated behaviours, I have suggested that additional perspective is required which goes beyond the identified schema when working with practitioners to implement theory-driven approaches.

The threshold concept literature (Meyer & Land 2003, 2006; Meyer *et al.* 2008; Cousin 2006; Savin Baden 2006, 2008) was selected to highlight the challenge facilitators face in working with learners to assimilate (new) propositional knowledge.

The sense of the journey that learners can be seen to experience in travelling across a threshold concept has connected with the conceptual challenge I believed individuals in this study might experience when implementing MOHO.

I considered Cousin's (2006) perspective regarding the mastery of knowledge by learners and how this may go some way to support a learner's entry into a discipline. Whilst I believe that understanding the MOHO concepts alone would not improve professional identity for the participants, I do acknowledge that diluting the theory for ease of use was not part of my plan. Rather, I believed that if therapists were sufficiently familiar with MOHO their ability to gauge its usefulness as a means of supporting their practice might be improved.

However, rather than considering the adoption of any new learning as specific to the learner I was interested in Savin Baden's argument in which she states that the threshold concept literature fails to recognise the importance of relating learning to an individual's personal / learner stance. As such, a person's ability to grasp new learning links to contributory factors such as the individuals' life and their 'stories'. I liked Savin Baden's perspective, indeed I believe she takes an element of criticism typically directed at the learner to more appropriately acknowledge other influencing factors which may well impact upon any future learning.

Maintaining a focus at the individual level, Bandura's theory on self-efficacy beliefs was then considered and I sought to explain the importance of recognising individual self-belief when faced with the possibility of embracing change. Bandura's theory, whilst acknowledging the importance of individual self-regulation, provides a level of theoretical argument proposing how people make sense of their experiences, explore their own cognitions and self-beliefs and alter their thinking and behaviour accordingly. However, should occupational therapists not engage in such rigorous processes of self-appraisal I questioned by what means would practitioners gauge their levels of competency as acceptable.

I focused upon issues of professional competency in light of Giddens' (1984) structuration theory. I discussed Giddens' perspective in which he proposes that all human action is performed within the context of pre-existing social structures. Therefore personal agency is contrasted with a view that influencing forces from the wider professional and political context also serve to determine views about practitioners beliefs / actions and sense of need to change. I again liked the opportunity offered by Giddens' theory to examine how we might understand

occupational therapists' perspectives on theory and practice when viewed in context. With that how change experienced at the micro level can impact at a macro level.

From focusing upon change processes at an individual level I then examined social theories of change and learning as described by Lave and Wenger whose work was built upon Vygotskian foundations. Such theories advocate that individuals create and develop self-efficacy beliefs as a result of the social influences they receive from others. The presentation of Lave and Wenger's (1991) and Wenger's (1998) theory regarding LPP and communities of practice was reviewed as a means of appreciating what influences learning and how learning takes place when situated within the contexts in which knowledge can be explored and put to use. Wenger's concepts of mutual engagement, joint enterprise and shared repertoire were viewed as a viable means of accounting for the supportive or restrictive responses participants may adopt when faced with new learning situations. From this position, Wenger (1998:137) argues that whilst not a static entity the ‘community’ establishes what it is to be a competent practitioner, an outsider or somewhere in between.

Finally, the practice development literature, specifically the Realist Synthesis of Evidence (McCormack *et al.* 2006) was referred to, as I believe this body of research most closely relates to what is known to date regarding research into the implementation of evidence-based approaches within healthcare. Whilst I argue that such research, for example the PARIHS Framework (Rycroft-Malone 2004) has not adequately focused upon individual practitioner responses toward change processes, the research findings do offer a useful means of emphasising the importance of a range of other key factors such as clarity regarding the nature of the evidence being used, the importance of considering the context, and adequate focus upon the type of facilitation needed. Furthermore, and perhaps of most significance in relation to this study, the practice development research findings have emphasised the importance of building collaborative research relationships with Higher Education Institutions (HEIs) including the use of participatory models for generating ongoing evidence for practice development strategies.

The overall purpose of drawing upon such a range of theories is to account for the sense of journey experienced during this research process and the complexity encountered throughout. They portray a sense of plot, which subsequent chapters will continue to uncover. Having presented my theoretical framework and key issues from the research regarding ways forward, the next chapter discusses the research paradigm and methodology selected, and details the processes that occurred.

Chapter four

Methodology: the quest for participation

"Those who wish to take the path of collaborative research be warned: this is no easy way forward..There will be doubt and mistrust, there will be disagreement and conflict, and there will be failures as well as success. For the birth of an integrated consciousness means the death of the old..It means learning to trust the wisdom of the unknown other."
(Reason 1994:56)

Introduction

In this chapter, I discuss the methodological approaches I chose to adopt during my work with the mental health occupational therapists over a two year period from September 2003 to December 2005, utilising participatory action research (PAR) (Reason 1988, Reason 1994, Park 2001, Kielhofner, Hammel, Helfrich, Finlayson & Taylor 2004, Kemmis & McTaggart 2005). I discuss the basic ideas that underpin the qualitative methodology (the guiding principles) and illustrate why PAR was viewed as a complex and challenging, yet essentially appropriate approach to take in conducting my research. I also wish to acknowledge the sense of journey experienced in trying to establish how to frame the research within a theoretical paradigm, however, rather than state this upfront I leave this detail to the end.

It has been important to examine the relationship between methods, methodology, theoretical perspective and epistemology (Crotty 1998) and I admit to feeling uncertain and uncomfortable in positioning myself. I have searched for texts that could illuminate my understanding yet I have been confronted with inconsistent use of terminology and contradiction. It is apparent that that there is not one way to analyse and understand a PAR process. I therefore attempt to find a balance between working with the literature on method and finding space for my own voice to comment on the practice of inquiry and what I feel is either missing or not well articulated in the literature. In this way I aim to present a coherent and defensible argument that illustrates how my thesis will contribute to understanding of the usefulness of PAR in professional practice settings.

Details recounting the conduct of the study and the opportunities and dilemmas encountered will be examined. In particular, I will explore issues of participation and power relations. I will present how data from the twelve months of participatory action and reflection cycles and from two years of participant interviews were analysed. Attention is paid to criteria for the evaluation of collaborative research. The chapter will conclude by examining the theoretical paradigms underpinning the research

methods adopted and my positioning of PAR at the boundary of a social constructivist and social constructionist paradigm.

Situating the method

At the outset there were two key aspects to the inquiry process; firstly, for the occupational therapists to adopt and implement the MOHO, and secondly to investigate the process of adoption and implementation. My role was twofold in that I was both supporting the therapists in adopting the MOHO, and I was the primary researcher examining the implementation process. I wanted to work with a methodology which would not only illuminate individual experiences but would be collaborative in nature. Importantly, I wanted such methods to sit comfortably with my own beliefs and assumptions, which as an occupational therapist embraced respect for partnership, empowerment and acknowledgement of reciprocal forms of expertise. The importance of collaboration and participation led to my selection of a participatory action research strategy (PAR). Occupational therapy has more recently begun to acknowledge the need for research using participatory approaches and PAR has been used when considering work with service users to identify values and issues of importance to them (see Townsend, Birch, Langley & Langile 2000; Cockburn & Trentham 2002, Taylor, Braveman & Hammel 2004, Suarez-Balcazar, Martinez & Casas-Byots 2005). However, PAR has not been employed with practitioners themselves.

Historical perspective

There are various approaches in the world of action research from which participatory action research is known. Action research itself began with an idea attributed to the social psychologist Kurt Lewin whose work on action research related to community action programmes in the United States during the 1940s. It was Lewin's work and reputation that gave action research its profile amongst other disciplines (McTaggart 1997). In Britain, a second generation of action research was created to support organizational development and can be seen in the work carried out by researchers at the Tavistock Institute (Kemmis & McTaggart 2005). In Australia, Carr and Kemmis (1986) recognised the British efforts within the field but called for more 'critical' and 'emancipatory' action research, which generated a third generation of action research. Further developments within the field would focus more upon *community-based* action research, which is implied within the methodological frameworks of fourth generation evaluation, embraced in this thesis,

which emerged via the link between critical emancipatory action research, and participatory action research (PAR) (Stringer 2007). Thus it is suggested that PAR has three particular attributes: the shared ownership of the research project, the analysis of social problems and a focus upon community action (McTaggart 1997; Kemmis & McTaggart 2005).

In its attempts to bring about empowering benefits for people at grass roots level, PAR is often associated with social transformation in the Third World and human rights activism (Kemmis & McTaggart, 2005). Examples of PAR approaches as empowerment rhetoric can be seen in Camilo Torres' work with disempowered groups in Columbia, Paulo Freire's work in Brazil, Mahatma Ghandi in India and Julius Nyerere in Tanzania (Fals-Borda 2001). However, in recent years the uses and understandings of PAR have broadened and rather than being seen as a method used when working with the powerless, the use of PAR has application to a much broader range of situations.

Focus of PAR

As an evolving approach to inquiry, a fundamental premise of PAR is that it embraces the concerns experienced by a group, community or organization (McTaggart 1997, Stringer 1996, 1999, 2007; Taylor *et al.* 2004). The purpose of PAR is to generate knowledge to inform action; the research methodology is premised on research conducted *with* people as opposed to *on* people (Heron & Reason 2001). Furthermore, PAR has been viewed by authors such as Kemmis and McTaggart (2005) as enabling focus upon the social, economic and political needs and opinions of ordinary people. PAR processes provide opportunity for those involved to interrupt what they are doing in order to consider questions of mutual understandings regarding practices and the influence of the wider practice context (McTaggart 1997). Such ideas link with Habermas's (1996) work around 'communicative action,' in which he identifies the importance of people finding a *communicative space* in which they might find solidarity as their understandings of their situation are jointly considered. Furthermore, in this space people might be able to reach decisions with 'legitimacy'. By this Habermas appears to be referring to how people can feel alienated from public decision and political process. Habermas asserts that through communicative action people are more able, in the context of mutual participation, to consider such issues as: what is comprehensible to them; what is acceptable in the light of knowledge; what joint commitment to understanding

may offer and; what can be judged prudent and appropriate to do considering the circumstances in which people find themselves. Such focus on the political sphere has emerged as an important element of this inquiry in terms of investigating the therapists' practice and the dilemmas of practice *in context*. As such, examination of the influence of professional and political structures, the policies, the practices, the procedures the therapists were working within required conscious exploration.

In this inquiry process PAR has provided opportunity to achieve a double objective: the first being for the occupational therapy participants to engage in dialogue about the nature of practice and to specifically target knowledge and action to enable improved forms of participation in their work settings; the second aim being consciousness raising or ‘conscientization’ (a term used by Friere in his seminal text *Pedagogy of the Oppressed* (1970)), which has enabled the occupational therapists to achieve improved sense of their ability to use knowledge for their own benefits. The research focus has centered on the occupational therapists' delivering a robust, evidence based and occupation-focused practice. MOHO was considered a potential means of realigning the therapists' practice. Thus the PAR approach would embrace both an educational and social process in that the reframing and reconstructing of professional practice would be the focus. Moreover, PAR would support a ‘knowledge creating system’ centered on the participants needs (Reason 1994:48). However, as Reason identifies, it is easier to describe the ideology of PAR than its methodologies, as PAR is characterized within the literature by a diverse range of methods. Although there is room for creativity within selected methods the *aims* of PAR remain consistent: increasing participant awareness of external forces affecting decisions in their lives, including the self-confidence and capacity to develop decisions which enable a new level of awareness and competence.

First, second and third person inquiry

In order to provide insight into the details and experience of how this inquiry was conducted, Reason and Bradbury’s (2001) three broad pathways of action research / practice have been considered. I believe the pathways provide useful opportunity to portray the layers of complexity involved in the inquiry. Whilst identified within action research per se, I believe first, second and third person inquiry/practice adequately relates to this PAR process. Although I add additional interpretation of the three pathways, my intention is predominantly to account for how the process of inquiry

progressed and to do justice to those who were involved. The three pathways include:

- First person action research / practice skills and methods. This pathway acknowledges the ability of the researcher to foster an inquiring approach, to act with awareness and to carefully consider the effects of action. In addition, I believe this places emphasis on the researcher playing a committed part within the inquiry process, not taking an outsider researcher role, but striving to be an 'involved other'.
- Second person action research / practice addresses an ability to inquire with others regarding issues of mutual concern. In terms of our research this involved improving professional practice at both an individual and service level. Second–person inquiry places emphasis on effective communication between those involved. The importance of dialogue enabled the development of communities of inquiry and learning, yet as easy as it is to espouse, our ability to develop a sound dialectic did not occur overnight and was fraught with challenge.
- Third person-action research / practice is arguably less easily defined. Reason and Bradbury suggest it includes building upon local issues to create a wider community of inquiry. I have interpreted this as combining the first and second person pathways, which can lead to development of new insights, and practices, which become shared with others not directly involved. Furthermore, Reason and Bradbury suggest the third person action research / practice pathway may include the writing and reporting of the process and findings of the inquiry. Whilst joint efforts to disseminate findings from this study have been evidenced via presentation at National Conference (COT 2006) and a shared publication (Wimpenny, Forsyth, Jones, Evans & Colley 2006) (see appendix seven) I acknowledge that the question regarding shared ownership of research findings when writing up a PhD thesis presents a very real challenge to PAR processes. Despite writing in the first person, which readily assumes ownership, my intention throughout has been to write this thesis with participants in mind. I thus view third-person action research / practice as an essential and healthy practice on the part of the primary researcher requiring honest and trustworthy reporting of the inquiry.

Each action research/practice pathway will now be considered as key aspects of our inquiry process are examined.

First person inquiry

As mentioned earlier I was playing a dual role as both external facilitator and researcher. As stated by Fals Borda (1991) and Kidd and Kral (2005), an area of specific challenge lies in the meeting place between the understandings and beliefs of the participants who are immersed within their working practice and the external action researcher as co-participant in the implementation process. From the outset I was aware of issues relating to unequal power relationships, possible anxiety, uncertainty and threat, which therapists' may have experienced as a result of my involvement. As Kidd and Kral (2005:190) highlight, "the researcher can, in very subtle ways, silence voices and undermine the entire process". I suggest tension centered on both issues of confidence amongst colleagues *and* relationships with the MOHO material and myself. MOHO was arguably positioned as being privileged above the therapists' own forms of knowing (Gaventa & Cornwall 2001). Indeed the service manager's request for the occupational therapists' to adopt an evidence-based conceptual model of practice carried an inherent implication that the therapists' current practice was in some regard lacking. In addition, I also acknowledge that I felt that MOHO was a laudable theory worth investigation.

I recognize that my role created potential to exercise power and control over others. Gaventa and Cornwall (2001) acknowledge that the role of PAR is to empower people through construction of their own knowledge. Yet the potential to achieve a sense of empowerment would require significant consideration of relationships amongst all those involved. For example, I can recall the amount of concentration group supervision sessions required of me. This involved listening intently to what the individual therapist was sharing in order to offer appropriate feedback, and yet I was also aware of the team dynamics around the room and how engaged / disengaged other peers would be. As an inexperienced researcher within PAR I felt the need to 'educate' the participants in terms of the principles of collaborative group working. This indicated a need on my to be in control and determine the agenda. Such research / process dilemmas are considered in more depth in chapters five to eight, but essentially acknowledge the ongoing balancing act regarding incorporating rather than imposing knowledge (Wimpenny *et al.* 2006).

First person research / practice with its 'inquiring approach' prompts the researcher to critically explore their own purposes, framings, behaviours and effects. This needs to be a continual process. Indeed I acknowledge experiencing an ongoing need to

examine my own voice and actions alongside the voices / actions of the occupational therapists. Wadsworth (2001) and Marshall (2001) identify this as 'inner and outer arcs of attention', which provide opportunity for the facilitator of a PAR project to pay attention to personal meaning making and the framing of the research experience.

Developing such a self-reflexive process is also considered by Reason (1988:11) who refers to the researcher as needing to embrace critical subjectivity:

> Critical subjectivity means that we do not suppress our primary subjective experience, which we accept provides perspective; it also means that we are aware of that perspective and its bias and we articulate it in our communications. Critical subjectivity involves a self-reflexive attention to the ground on which one is standing.

Developing such awareness acknowledges that I did not come into an inquiry with a 'clean slate'. Indeed, embracing critical subjectivity through first person inquiry has enabled me to find my own voice, which as an inexperienced PAR researcher has felt challenging to do considering the lack of clear direction on how to progress through the research. I argue that this journey required significant reflexive capacity in order to continually question my response to established theories, toward situations as they arose, to acknowledge that people think differently from one another, and importantly that one does not always know what is best.

Situating myself within the inquiry

In joining the occupational therapy service I entered into a fairly familiar situation, having practiced predominantly as a mental health occupational therapist prior to taking my current post in the university. In addition, I knew the majority of the therapists through the Trusts' involvement in providing student practice placements. I saw my attitude and approach to the participants to be crucial from the beginning in order that participants could appreciate my intentions and reasons for wanting to work '*with'* them in this essentially social process (Park 1999; Kemmis & McTaggart 2005). I believed myself to be an approachable person, who was genuinely committed to the venture and equally ready to accept that I did not have all the answers.

Indeed, Stringer (2007) suggests that the role of the researcher in the inquiry process is not that of an expert, but that of a resource who acts as a catalyst to assist the participants in defining their problems clearly and to support them as they work to

effective solutions. This requires that the facilitator does not assume expertise, yet is perceived to be nonetheless skilled, supportive, resourceful and approachable. As such, participatory action research facilitators need to focus on creating the conditions which mobilize participant's energy, engage their enthusiasm and generate activity (Park 2001). I suggest that combining such a fine mix of qualities is not to be underestimated – especially as I was bringing a framework of theory to the participants, some of whom were not familiar / confident with their understanding of it. Whilst I had a vision of what I hoped our inquiry would achieve, my preconceptions regarding the aims, methods and actions needed to be amenable to the participants. Nonetheless, during the entire process I experienced an incredible sense of responsibility for wanting to 'make it work' and effect meaningful change, which I was so determined to achieve with the therapists for their practice and this is explored further within subsequent chapters. Indeed, Stringer (1999) argues that if a (participatory) action research project does not make a difference in a specific way for the participants then it has failed to achieve its objectives. Although I acknowledge that honouring such principles places considerable pressure on the researcher / facilitator, it was nonetheless a key driver for seeing the process through.

I would come to realize that 'knowing' would be a product *of the therapists and myself coming together* to "share experiences through a dynamic process of action, reflection and collective investigation" (Gaventa & Cornwall, 2001:74). Through the PAR process our individual values and characteristics, limitations and abilities would become visible. However, it is important to acknowledge that our collective investigation would involve varying degrees of 'togetherness' and our relationships would continue to shift as the inquiry progressed. Yeich and Levine (1992) suggest that if the researcher who initiates the project conscientiously applies PAR ideology, the participants readily assume power and ownership. However, I argue that addressing issues of *power* and *ownership of knowledge* created tensions amongst participants throughout the inquiry process.

As participants we would not always pull in the same direction. Indeed the period of fieldwork was fraught with challenge. I came to appreciate the complexity of achieving *joint* ownership – certainly in terms of achieving this from start to finish. I now appreciate that there will be varying degrees of commitment to a research study, but despite this progress can still be achieved. Participants may not readily assume *joint* power and ownership (at least initially); indeed I experienced how certain

participants wished to remain at the 'periphery' of our study, which I more latterly came to recognize as an equally valid place to be. However, I suggest progress was observed in negotiating a way through the difference of opinion, which was visible as we engaged in 'authentic negotiation and confrontation' (Reason 1998:20). As this quote suggests, whilst not necessarily a comfortable process, PAR importantly prompts *all* participants to engage in genuine inquiry in order to take ownership for navigating routes forward.

Reflexivity

According to Lincoln and Guba (1985) the reflexive journal is an essential tool to record reflective and reflexive / subjective responses from the researcher's perspective and to provide information about the research journey and reasons for methodological decisions. From the start I was keen to make use of reflexive field notes, which are shared within subsequent chapters in relation to my personal responses as the researcher (Polgar & Thomas 1992). This would include:

1. Challenging my expectations of myself and the participants
2. Reflecting on monthly supervision sessions and the dynamics observed within the teams in terms of what was said and not said
3. Focusing on professional practice issues relating to implementation of the model; considering our ability to problem-pose, reason and problem-solve complexity in light of theory
4. Consider creative ways and means to encourage uptake of the MOHO assessment methods / tools / report formats
5. Work out ways to encourage dialogue, maintain enthusiasm and inspire

McNiff, Lomax and Whitehead (2003) argue that [participatory] action research is value laden and the facilitator needs to be aware how they might act in relation to such values. I suggest that in writing down my reflexive accounts my own subjectivity was made explicit, thus the reader is better equipped to critically analyse the thought processes involved (Conneeley 2002). Moreover, in addition to writing down my reflexive responses I would engage in an active form of verbal reflexivity with my supervisory team. For example, I had monthly telephone conversations with Dr Kirsty Forsyth, which required a very conscious reporting of my actions. In line with first person inquiry Finlay (2003) notes how we cannot help but bring our own involvement into the research process. Indeed being reflexive in conversation with

others prompted me to question my own bias toward MOHO; to not loose patience when the occupational therapists did not fulfil action points they had identified; to question my expectations of myself when experiencing a crisis of confidence. In addition, being reflexive fuelled my passion and commitment to the venture.

In summary, my engagement with first person inquiry would be evidenced within group and individual meetings with the participants. I acknowledge that I worried a lot about my role. Whether I liked it or not I entered into the collaboration viewed as some sort of expert in MOHO and facilitator of a research process. My ability to foster an inquiring approach would develop through my desire to demonstrate what I believed to be a genuine respect and openness towards the participants; to readily listen and attempt to appreciate individuals' personal practice context; to respond to particular requests therapists made and to negotiate difference and commonality with regards to theory and practice relationships. As Park (1999) suggests, the PAR facilitator needs to become an intimate knower and participant within the community. However, this *attitude* toward the inquiry process would not always ensure that the relationship between participants and myself was harmonious. Rather, the inquiry process would travel through high and low periods. I argue here that participatory action researchers / facilitators are often the ones who have most at stake in resolving problematic situations and steering an appropriate path through the PAR process, which can feel quite isolating.

Having identified key issues relating to first person inquiry pathways, the focus now shifts to how second person inquiry was conducted. I view this essentially as 'a quest for participation'.

Second person inquiry

The quest for participation

As Reason (1994) and McTaggart (1997) both identify it is easier to describe the ideology of PAR than its methodologies, as PAR is characterized within the literature by a diverse range of methods. Despite this, the aims of PAR remain consistent: increasing participant awareness of external factors impacting upon satisfactory levels of participation, including developing the ability to enable a new level of competence, which enables improved awareness. Second person action research / practice focuses fundamentally upon how such aims can be achieved, acknowledging the importance of inquiry with others regarding issues of mutual

concern, embracing forms of dialogue. Whilst fraught with challenge and complexity, Reason (1988) proposes a number of steps regarding a co-operative inquiry process, which has been applied here in order to detail the conduct of the study and development of the community of inquiry and forms of dialogue. It is important to add that this section aims to provide an overall sense of the methodological process applied, more focused attention on the development of group dialectic is presented in chapter six.

Overview of the steps within a co-operative inquiry process:

- Initiating
- The group
- Contracting
- Devising the overall research plan (The use of action and reflection cycles)
- Group facilitation
  - *Conducting individual meetings*
- Roles
- Meaning making*
  - *Capturing data*
  - *An attempt at interpretative analysis: interpreting the biographical*
- Validity procedures
- Writing

Each step will now be considered. (*Note that within 'Meaning making' I shift from considering analysis and interpretation at the group level to my own engagement with interpretive analysis).

Initiating

(How does an inquiry start, who is the research for? Is there a genuine possibility of a co-operative endeavour?)

Rather than the occupational therapy participants requesting to engage in the project (Fals Borda 1991, Reason 1994, Kidd & Kral 2005), the initial request to review practice and implement the MOHO came from the occupational therapy service manager. The study was introduced through an initial workshop organised for the mental health occupational therapy teams, and facilitated by Dr Kirsty Forsyth, a leading MOHO expert in the field (who thereafter became a member of my PhD supervisory team). During this workshop the key concepts of MOHO and its

assessment tools were presented and discussed in terms of their practical application by the teams. It was evident (via an evaluation questionnaire sent to all participating therapists) that the day had been positively received, and in order to maintain momentum I shortly after facilitated a workshop. As recommended by Miller (1993) and Kidd and Kral (2005) this provided an important opportunity to initiate dialogue and share preliminary ideas regarding our collaboration.

Although a 'top down' management approach for the practice development agenda might render the possibilities of co-operation remote, as Reason (1988) asserts *someone* has to have the idea and passion to change things in the first instance. Furthermore, it was not the service manager who would be directly involved in facilitating the inquiry processes. As such, whilst she set up the *possibility* for the inquiry process to take place, I would take responsibility for selecting and applying the principles of PAR as our guiding framework for action.

The group

(How does the group come together?)

I would take over facilitation of the team-based supervision sessions, which all of the occupational therapists were expected to attend. This would involve meeting with the three teams of therapists each month for two hours, for a twelve-month period: a total of thirty-six sessions were conducted. These monthly sessions were the only form of *profession-specific* caseload supervision the therapists received. Occupational therapy as a profession supports the use of peer supervision and offers guidelines regarding its process and structure (COT 2003). The importance of peer supervision can be seen in how supervision supports the recruitment and retention of staff (Craik *et al* 1998, Hunter & Nicol 2002), manages work-based stress (Sweeney, Nichols & Kline1993a, Sweeney, Nichols & Cormack 1993b, Leonard & Corr 1998, Edwards & Burnard 2003) and promotes learning and development (Spalding 2000, Boniface 2002).

However, whilst group supervision served as an important method for colleagues to engage in genuine inquiry with one another to develop practice (Errington & Robertson 1998, Henwood & Sidhu 2001, McDonald 2002), it is important to add that I also offered to meet with everyone on an individual basis every six months over the initial twelve month period and for a further twelve month period thereafter: a total of forty-two individual meetings. Furthermore, each therapist had individual opportunity for supervision provided by senior colleagues within their respective teams. This

strategy was intended to separate individual management issues from those of professional competency (Sweeney, Webley & Treacher 2001c).

All staff employed in the mental health occupational therapy teams formed the participants for this inquiry (n=11)[1]. Table three details the occupational therapists membership across the three teams, their grade / role and their relative experience of utilising MOHO prior to the commencement of our inquiry.

Table three: Occupational therapy participants within their respective teams

* NB. Pseudonyms have been used for all the occupational therapists involved

Team	Therapists*	Role(s)	Prior experience of MOHO
Community adult	Emma Heather Lisa (John)	All senior occupational therapists working as the sole therapist within Community Mental Health Teams (CMHT's)	Each therapist had studied the model during their undergraduate training and were aware of key concept areas. They did not appear overly confident in verbalising their understanding of / or application of the model.
Acute adult	Ellie Stephanie (John)	Ellie was head occupational therapist. Stephanie and John were senior therapists. All based within a department, working on the wards with other MDT colleagues (John would move across to the community team towards the end of the first ten months).	Ellie was well versed in MOHO, but less so with the tools for its application. John had studied MOHO during his training and was able to engage in discussion about the key concepts. Stephanie was least confident about theory, whilst the most recent graduate.
Older adult	Mary Susan Barbara Anne Clare	Mary was head occupational therapist with responsibility over the acute, community and day hospital occupational therapy teams. All other group members were senior therapists working as lone therapists within those services.	Mary, Susan, Anne and Clare all studied MOHO, and were similar in their perspective to the community adult therapists in terms of not feeling confident in verbalising their understanding or application of the model at the outset. Mary was keen to see theory used yet sceptical about MOHO. Barbara's training pre-dated study of occupational therapy theory, she knew of the model, but had not used it.

[1] Five graduate therapists joined the service at the end of the first twelve months but as they did not participate in the monthly group meetings they were not included in this research.

Although participation was not by invitation, during the first few months certain therapists did exercise agency by only grudgingly giving their time to the inquiry and taking the decision not to attend certain sessions. Whilst the value of working with existing groups within an inquiry process has been positively acknowledged by Brown and Duguid (1991), Reason (1998) appropriately identifies that existing groups already have their business together, which takes up all the time they have available. I came to appreciate each team was its own 'community;' a term which Hall (2001) identifies as a concept which hides powerful practices ranging from tension and disharmony to support and creativity. The way in which the groups would engage with me in the monthly sessions in light of their history and practices is explored in more depth as part of chapter five.

Contracting

(*The co-operative method is not well known, thus clear contracting is required)*

As suggested, the intention within a PAR process is for "all subjects to be fully involved as co-researchers in all research decisions " (Heron & Reason 2001:179). Whilst this assertion is idealistic I prefer Lewin's (1946) position, which talks more of *participation* in developing agreed strategies. Moreover, I have found Lave and Wenger's (1991) concept of LPP more realistic in terms of participants being *more or less* engaged. Nonetheless, from the outset I introduced the PAR process as striving to be collaborative in nature. Indeed, with regards to second person action research / practice and the intention to develop meaningful dialogue around the research agenda, it was important to start the inquiry with transparency regarding each others vested interest in the collaboration and to work to create an effective working environment. This included getting to know each other, exploring the PAR method and encouraging the 'emergence of participative decision-making' (Heron & Reason 2001:186) whereby openness could be expressed and trust could be expected.

I realised that regardless of my enthusiasm to invite all the therapists to view themselves as co-researchers of the study, this aspect of the process would need time and commitment to come to fruition. As mentioned, the research process did not appear to be of significance to the occupational therapy participants within the group setting. This concern has been highlighted in the literature by Rahman (1991), McTaggart (1997) and Kidd and Kral (2005) who acknowledge how most groups who engage in PAR are themselves accustomed to traditional research hierarchies and as such may resist the sharing of power that is offered. Indeed, it was during the

additional individual meetings that the therapists would indicate their improved sense of being involved in a research process. However, one indicator certain participants referred to which highlighted that the group sessions were *also* part of the research process was my use of a tape recorder. I admit that it was through my own need to capture all the richness of debate within sessions that led me to seek consent to record our interaction. Whilst I have questioned if I should have used such equipment, this small machine perhaps served a valid purpose in reminding participants that they were involved in an inquiry process. The teams knew I was involved across the teams and would be meeting with their peers. Furthermore, the occupational therapy service manager was keen for there to be consistency across the service. Maintaining a combined range of data records enabled sessions to be revisited and strategies considered with my PhD supervisory team. In addition, I remained open in referring to the research element of our work and my desire to disseminate findings in partnership with colleagues for professional purposes in addition to writing up the experience to fulfil the requirements of my doctoral research. I suggest that the use of the tape recorder therefore came to represent a means of extending our discourse together, by transforming understandings amongst individual practitioners across teams with the acknowledgement of the wider social / political context.

Devising the overall research plan

(Co-operative inquiry is not unstructured; it involves rigorous iteration between action in the world and reflection: the challenge is that people will come with different hopes and ideas)

It is important to note the advice of Park (2001) in that PAR research begins with what people bring to the enterprise; their familiarity with their working environment, their knowledge of each other and their commitment that their practice may change for the better. At the outset, it was assumed that all the occupational therapy participants were likely to have *some* level of investment in the study, which would be necessary to bring about any meaningful social change at a local level (Cockburn & Trentham 2003). (This had been articulated in both verbal and non-verbal ways during the introductory workshops and reported in the evaluation questionnaire).

As mentioned, Reason (1994:48) describes the two primary objectives of PAR as being the ‘production of knowledge and action directly useful to a community’ and ‘empowerment through consciousness-raising’. The overall plan in this inquiry was to advance professional participation via the implementation of a professional

conceptual model of practice. It was envisaged that examination of practice repertoires in light of MOHO would serve to liberate and strengthen the occupational therapists' sense of their professional role and contribution. Strategies employed within the PAR process to achieve such objectives involved engaging with the therapists in their respective teams, in a series of monthly group reflective and action cycles over a twelve-month period. During this time barriers preventing participation in professional domains of responsibility (for example, the screening of referrals and focused assessment processes) were targeted for change (Wimpenny *et al.* 2006). This included examining practice in line with the theoretical constructs of MOHO, considering alternative options for practice via investigation and subsequent piloting of a range of MOHO assessment tools (which enabled the theory to come alive). As with Swant and Vainio-Mattila's (1988) PAR inquiry, at any one time several such processes could be ongoing. In more straightforward terms this involved attention to a number of phases: planning a change; acting and observing the processes and consequences of the change; reflecting upon the these processes and consequences; re-planning; acting and observing again; reflecting again, and so on (McTaggart 1997, Kemmis & McTaggart 2005:563) (refer to figure three, appendix eight and figure four, which provides an example reflection and action cycle from the community adult team).

Figure three: Representation of the action and reflection cycle

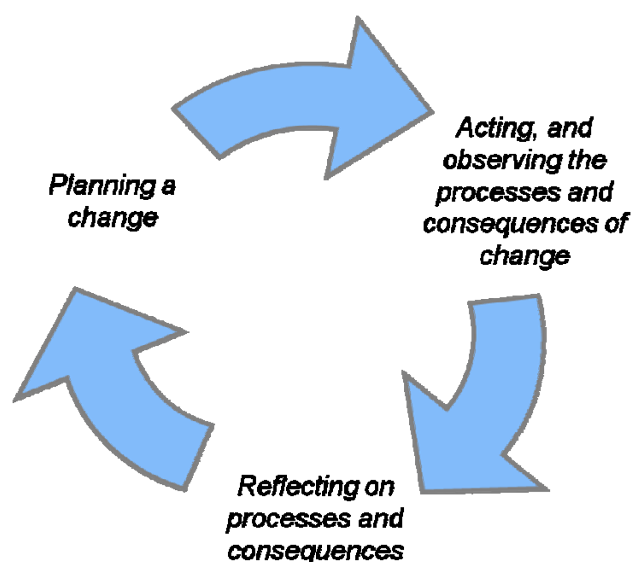


Figure four: Example action and reflection cycle from the community adult team

The community adult occupational therapists were reviewing their assessment processes in light of MOHO by sharing case based work. One cycle of reflection and action focused on the initial assessment process. The team members reflected upon their current action, which highlighted a variety of assessment methods and styles in use. An overarching MOHO assessment tool, the OCAIRS (Haglund et al. *2001), which can provide a useful initial assessment framework in a community setting, was introduced. Over subsequent sessions the tool was considered by the therapists and piloted as part of the practical action following reflection on their action (Schon 1983).*

Supervision contracts were used to keep track of the occupational therapists agreed action points. The therapists would share assessment outcomes and case formulation following use of the tool. They would reflect upon how the assessment was conducted, how ratings were scored, how long the assessment took to complete, how assessment outcomes were shared with the service user, how therapy goals were recorded. During this investigative cycle of action and reflection with the OCAIRS I would prompt the therapists in terms of techniques and suggestions by using problem-probing and problem-solving strategies (McTaggart 1997) regarding use of the tool. Those individuals using the tool supported those more reluctant. The outcome of this inquiry cycle led to all the therapists using the OCAIRS. Following group consensus regarding the value and contribution of this tool, the OCAIRS came to be adopted as one of the teams' initial assessments.

Whilst phases of the PAR process are known, as identified by Reason (1994) the cycling through the different phases of reflection and action is not straightforward. However, faithfully following a series of steps within a PAR process are not the criteria for success, but whether the participants have a 'strong and authentic sense of their development'. Kemmis and McTaggart (2005:563) maintain that this includes how the participants develop enhanced understandings of their practices and the situations within which they practice. Whilst I believe that our inquiry was essentially successful, the work involved in re-examining and re-framing practice was nonetheless fraught with challenge. Indeed whilst writing this chapter I am aware that the distance from the actual period of fieldwork has enabled clarity and arguably a more sanitized account. There is no doubt that it was hard going at times. This did not mean that participants were not keen to advance their practice; indeed I believe that the participants clearly cared about service users and the quality of therapy provided. Yet, disjuncture was visible amongst team members not least through the requirement that the therapists be open to their colleagues' views, whilst perhaps feeling vulnerable and challenged regarding their own perspectives on theory and

practice (Wimpenny *et al*. 2006). In summary, it was not a comfortable or tidy process and it would take time for participants to see the results of their efforts.

Group facilitation

In terms of *group facilitation* Reason (1994) suggests that it is likely the group will need some democratic leadership, which is both facilitative and educative: facilitative in terms of offering structure and processes which may help the group in its work; educative in teaching members about effective group working (and exploring MOHO). His three stages of group cohesion are briefly outlined in the following paragraphs.

Stage one (coming together)

As mentioned, PAR is a social process, it requires a deliberate process of discovering, investigating and attaining mutual understanding. It requires a degree of willingness of participants to engage in dialogue, which may uncover social practices. Thus PAR is concerned with a collaborative sense of agency (Kemmis & McTaggart 2005) and the facilitator needs to consider how to encourage development of such social practices. McNiff *et al.* (2003) identify that when people engage in action research for the first time it may appear that the techniques are nothing new. Yet PAR is more than reflection upon practice and problem solving. It involves examining values and questioning motives or problem posing. It involves committed action in which other individual's views and feelings are taken into account (McTaggart 1997; McNiff *et al.* 2003). Indeed, despite the fact that a culture of group supervision already existed and the therapists were already known to each other, my initial involvement prompted each group to re-examine its history and purpose. In addition, I suggest that in the early stages each of us would feel under the spotlight, each interested to determine the others practice and approach.

Stage two (the struggle for control)

Reason (1994) states that raising emotion is an essential part of co-operative inquiry, as the very business of collaboration with others resists and distorts perspectives. As the inquiry progressed a period of 'storming' (Tuckman 1965) was visible. I suggest this was due to the participants having to take risks, to make new choices, to interrupt what was going on and move out of their comfort zone. Difference of opinion was obvious; opposing cliques or sub-grouping were evident. Group members struggled for control. I saw my involvement here to encourage individual expression,

to help people listen to each other, to give and receive negative and positive feedback; essentially to acknowledge diverse perspectives and encourage authentic participation (McTaggart 1997).

Stage three (*Co-operative relationships)*

Following periods of disharmony a sense of *group practice* and periods of 'performing' (Tuckman 1965) would emerge, with more warmth and affection apparent. Individual group members' contributions were respected. Indeed facilitation of the group started to become more of a shared task. Nonetheless, even within this more mature period of group work the experience of being within the groups remained exciting yet upsetting. Participants would clearly express the emotional distress of trying out new practices which did not go as planned, coupled with the joy and sense of break-through the participants experienced as new practice was achieved (Reason 1988).

In summary, my experience of facilitating groups within collaborative inquiry was perhaps not that untypical. Nevertheless, the challenge of working with the occupational therapists across the three teams considering their history, existing group practices and dynamics was considerable. However, I maintain that the monthly reflective group supervision forum would provide an effective means of embracing PAR, becoming involved and focusing upon the MOHO agenda.

Conducting individual meetings

Part of the overall research plan also factored in the use of individual meetings. This would involve six-monthly meetings with each therapist over the two-year period of inquiry. I believed that it was important to follow up the participants for a further year following my direct involvement in their group supervision process to examine ongoing practices. The interview (or meeting, as I prefer) is a typical methodological tool for the qualitative researcher aiming to delve deep beneath the surface of superficial responses to obtain meaning, which individuals assign to events and the complexities of their attitudes, beliefs and experiences (Bowling 1997). The use of open-ended interviewing is based upon the assumption that meanings, understandings and interpretation cannot be standardized (Denzin 2001).

I assumed meeting with the participants would provide additional perspective and insight, material that would not necessarily be divulged during the process of group

supervision. I consciously attempted to use the individual meetings as opportunity to engage in *conversation* with participants rather than asking set questions, which I felt was inappropriate considering my ongoing involvement with the therapists and the co-operative nature of the work with which we were involved. Denzin (2001:66) acknowledges how open-ended interviewing fits naturally with interactional study such as PAR. Moreover, he argues interviews should be a conversation, a 'give-and-take between two persons'. Douglas (1985) likewise offers the term 'creative interviewing' to this process in which two persons creatively and openly share experiences with one another in a mutual search for self-understanding. As such, whilst I made attempts to maintain similar lines of conversation between participants, (*see Appendix 3 for an example schedule used within meetings*), I responded to each individual therapist's respective issues. I believe this experience offered opportunity for improved mutual appreciation as we became more aware of one another's perspectives, needs and aspirations. Denzin (2001) likewise identifies with the importance of the researcher sharing his / her own experiences, as this provides opportunity to transform the situation into a more situated conversation. For, as he asserts, those being interviewed may experience distrust if the interviewer only asks questions and listens.

In addition, and what I argue prompted greater levels of engagement within the inquiry, was how individuals would appear to be more comfortable and recognized within the group collective as a result of the individual meetings. Whilst respecting and not divulging what individuals had shared on an individual level within the group, I realized our dialogue (and relationship) became richer as a result of improved mutual understanding. I believe this enabled me to become a 'trusted listener' (Denzin 2001:67), or one who appreciated the situatedness of therapists' experience (personal context).

Each meeting with the therapists was transcribed and returned for individual member checking. During this process individuals were encouraged to add any additional reflexive notes of their own in the margins. The detail from these meetings was then supplemented with my own observations and reflexive field notes which fed back into the inquiry process.

Roles

(People will not be involved in identical ways)

Reason (1988) suggests that due to the fact that people are 'doing' their own inquiry rather than having research done 'on' them, the traditional roles of researcher and researched becomes less divisible. Instead, people join each other to become peers; co-researchers and co inquirers. I have considered such sentiments in light of this inquiry. On one level I agree with Reason that the PAR process was less visible as a research process to the occupational therapy group members, as it was built into existing structures of monthly group supervision. Whilst I was recognised in my role as the external facilitator of these monthly sessions, my role as researcher and theirs as co-researchers was less obvious. However, during the individual meetings my role as a researcher would be recognised. I suggest that there would be certain therapists who never considered themselves as a co-researcher, nor did they want to, yet they would identify themselves as co-participant, perhaps co-inquirer. In contrast I know that other therapists did recognise that they were involved in contributing to a wider research agenda, in which they had opportunity to add to an evolving MOHO theory base through the scholarship of practice partnership.

Yet, perhaps attempting to compartmentalise participants under ascribed roles is not necessary as long as participants feel that what they are involved in is worthwhile (McTaggart 1997). Indeed it was evident that participant's roles were focused upon their professional identity and sense of obligation toward perceived practice competencies. Nonetheless perspectives on the recognition of participant research-focused roles have been important to examine, especially when considering the ownership of findings and how such outcomes would be disseminated, and further discussion on these themes takes place in chapter eight.

Meaning Making

(The process of analysis within the period of the monthly group sessions)

The process of analysing information embracing second person inquiry occurred in the field, as is the norm within a PAR process. Meaning making was the ongoing process of sharing knowledge, discussion, refection, action and the consequences of action, which were deliberated upon within the respective group supervision teams as outlined within the cycle of action and reflection (Heron & Reason 2001) (see figure three and appendix eight). This provided continual opportunity between all for scrutiny, debate and discussion regarding what was experienced as it occurred

(Reason 1994). As openness across the group sessions developed, team members became more able to express their feelings, review their work, hear alternative views and practise newly reviewed skills (Howie, Kennedy-Jones, Lentin, MacDonald & Giffin 1995). I believe this commitment led to the enhancement of group cohesion and professional identity.

The experience of *being in* the sessions (immersed as a co-participant) required that substantial time be spent *outside of* sessions reflecting upon what had occurred. Thus meaning making would occur within different practice ‘spaces’. I argue here that focus on learning spaces within the PAR process has not received sufficient attention within the PAR literature and this is considered in more detail in chapter five.

Heron and Reason’s (2001) and Reason’s (1994) reference to four phases of reflection and action during a collaborative inquiry process connected to a degree with the shifting levels of interpretation, which were observed to occur amongst participants. For example, they suggest phase one is primarily the mode of ‘propositional knowing’. Here the occupational therapists explored knowledge about their practice as expressed by that of formal theory and their theories-in-use (Argyris & Schon 1974). In phase two the participants engaged in forms of action examining how their practice was or was not illuminated by MOHO theory. During this period of meaning making it was apparent that the participants developed varying degrees of openness to recognising what was going on in their practice through considering the practice of others and the potential vision of their practice in light of MOHO. This enabled shifts to occur in terms of developing their original understandings and attitudes towards the research agenda; for example prior assumptions regarding the complexity of MOHO and its practical utility within the practice arena were confronted. This experience (phase three) has been identified as the ‘touchstone of the inquiry method’ (Reason 1994:43) whereby participants move away from their original assumptions and misgivings (regarding MOHO) to enable new, creative insights to emerge. In the final phase (four) participants consider their original perspectives in light of their experience. Phase four is again linked to propositional knowing, yet experiential and practical knowing is identified as having enlightened participants’ understandings.

Whilst detailed outcomes identifying forms of meaning making from participants are enlarged upon within the findings and discussion chapters, attention is now turned to

the processes of analysis I have engaged in to provide a level of meaning making from the data, which aims to fulfil the requirements of doctoral level study.

Capturing data

The monthly sessions were, with consent, tape-recorded (Polgar & Thomas 1995) and written up reflectively and reflexively by myself thereafter and shared with my supervisory team. It should be noted that any individual therapist's requests not to include tape-recorded material from group sessions during the course of the data collection period were to be respected at all times. (However, no such requests were ever made).

Data from the individual meetings were transcribed. The transcribing processes can be seen as ranging from that which attempts to record every detail of the verbal interaction, to that which preserves only the words that were spoken. For the first two rounds of meetings, 'clean transcripts' were used (Elliott 2005:52), in that false starts and utterances were removed and the transcript focused on the content of what was said. I found this made the material easier to read as I could recall the extra information including the manner in which it was communicated. In the third round of meetings detailed transcription was used, which recorded the delivery of what was said more faithfully, yet I found this did not offer any extra dimension; in fact, the nuances themselves appeared to affect the flow and thus my ability to read and digest what was being said. I therefore reverted back to the use of 'clean transcripts' for the final round. All transcripts were returned to the participants, for member checking. Individuals were encouraged to annotate the transcript to ensure they were agreeable with their accounts. Therapists would place notes in the margins to enhance what had been meant.

In addition, as a means of drawing together the outcomes from the PAR process, and making team based analysis more explicit, I organised a workshop at the end of the 12-month period of reflective group sessions. Here, the therapists' presented their individual and team-based perspectives regarding what had been experienced, unearthed and evidenced in terms of their practice. I too shared my perspectives and evaluation of our work together. This workshop provided interesting insights and opportunity to explore how each participant's views of the experience connected with my interpretation of all that had been achieved.

Thus a combination of longitudinal qualitative methods (facilitating twelve months of group supervision sessions, meeting individually with participants over a two year period, writing reflexive write-ups, use of reflective field notes, use of transcripts) was used during the inquiry process to capture the experience and essentially deepen, enrich and illuminate my understandings.

An attempt at interpretative analysis: interpreting the biographical

I admit to feeling troubled at not finding the 'book' I had hoped would advise me how to manage the volume of data generated and the complexity of analysis required for the PAR process. As such I have adapted methods as described by Wolcott (1994), Stake (1995) and more latterly Denzin (2001), by keeping close to the data and building portraits or biographies for each of the therapists prior to producing meaningful description and interpretation of the social processes involved.

The biographies were predominantly developed during the intense period of fieldwork and were further shaped in the subsequent period of analysis. Writing biographies, whilst rewarding, took great amounts of time as I found myself not only reading and re-reading the written accounts gathered, but also listening back over tapes and picturing the therapists in conversation, including their behaviours and interactions. Through this process I believe I became an 'informed reader' (Denzin 2001:67) in that I experienced a sense of familiarity with the language used by the therapists, I had sense of the person's perspective and 'situatedness' with regards to their issues of concern. I would re-experience the emotion of our work together each time I read over what was said. However, I was also aware of wanting to honestly portray participants whilst not seeking to offend or appear overly critical. With this, I acknowledge that value-free interpretation is impossible. Indeed as acknowledged earlier, I have recognised my own preconceptions and forms of bias with regards to occupational therapists' utilisation of professional theory. As such, in stating my stance, the effects of this upon the outcomes are acknowledged. However, what I am striving to account for has been realised through my direct observation *and participation* with the therapists in the world of work. This sense of immersion in the phenomena being interpreted is a necessary requirement of those using interpretative interactionism (Denzin 2001:46).

Five phases of the interpretive process are identified; deconstruction, data capture, bracketing, construction and contextualization, from which interpretation can be

considered (Denzin 2001:51). *Deconstruction* has arguably been considered within the proceeding chapters of the thesis, wherein I have provided a critical analysis of other relevant literature regarding the research agenda under question. Furthermore, in terms of *capture*, this chapter provides detail of how I have worked with the participants in both group and individual sessions to secure multiple perspectives of the experience being studied. However it is *bracketing* which requires more careful consideration as this involved identification of the essential features which emerged, which I have considered through the building of participant biographies prior to being able to reveal 'thick description' (Denzin 2001:52). By choosing to present participant voices using thick description I have sought to provide the reader with an image of what has been interpreted. For as Denzin (2001:52) states, understanding individual perspectives enables opportunity to consider the intentions and actions between people. As such, thick description and its interpretation address construction in that it provides opportunity to interpret the event or process more fully (in context). Finally *contextualisation* involves locating the outcomes from the inquiry back into the world of lived experience. I have considered this stage of the process to involve situating the perceived outcomes of the inquiry back within wider theoretical perspectives.

In more specific terms, bracketing and contextualisation involved the following processes. Having written the biographies, I was then able to look more closely at emerging themes across cases. At this stage I made use of Denzin's work on 'interpretive interactionism' (Denzin 2001:34) which, as a method of qualitative interpretative inquiry, involves the collection, writing and performance of thickly described personal experience stories to make the world of lived experience visible to the reader. The use of biographies would focus on the individual therapists' perspectives of their practice, of each other, of their sense of the experience of our work and essentially perhaps, their views around MOHO. My task was to capture the sense of journey experienced through use of such richly detailed descriptions and to try to account for the participants' progress through the inquiry. In addition, in considering biographies, I was drawn to focusing upon those moments which appeared to have made most impression on the participants (and myself): such moments are what Denzin refers to as transformational experiences or 'epiphanies' (2001:34). Through the identification of epiphanies, the turning-point moments for the occupational therapists became apparent. (Reference to such experiences are made in chapter five).

Displaying the units of text

I would write out key issues from each therapist's biographies on large pieces of paper and post these around my room. I would work to consider what appeared to be commonly held perspectives amongst the therapists using this method, as well as capturing more individual interpretation of the experience. As an informed reader I could then work to develop my interpretation of what had been said in the context within which it had been meant.

Analysing units of texts linguistically and interpretively

The language the therapists' used to explain and present their perspective was important to harness as this (not always eloquently so) captured their experiences. I would then relate the therapist's spoken word to my own corresponding journey through my reflexive field notes. This process provided invaluable opportunity to examine our corresponding perspectives.

Developing working interpretations of the text: obtaining subject interpretation when possible

Each data set felt equally powerful and important (that is, my actual participation with the individuals and the groups, listening over the group and individual audio tapes, my reflexive field notes, the interview transcripts). The personal effort invested in the fieldwork period was immense and the critical analysis, which then ensued, meant I continued to relive the experience. It would be inevitable that my influence upon meaning making would be visible in the write-up having been so involved within the inquiry process. Therefore, in order to ensure that I was not privileging my account of the research in the write-up I have actively sought involvement from my supervisory team, in particular Drs' Clouder and Forsyth, who I had spoken to on a monthly basis regarding the teams and group processes since the fieldwork began. Importantly I also met with a number of the participants (from each team) who were willing to review my interpretations along the way. Indeed, in chapter six I present two therapists' portraits, which the therapists themselves have seen and given their consent for me to include.

Maintaining focus on the participants' and writing in such a way as to not misinterpret or mis-communicate any of the participants experience required "commitment, care, time and skill" (Finlay 2003:116). Whilst I was aware of being respectful toward all participants within the interpretation process, it felt important to reveal my honest

evaluation of the inquiry, for example, regarding the frustration I felt toward therapists' lack of engagement with identified action points. I believe that any of the participants reading my interpretations would not have wished to read an account which glossed over what was experienced as a challenging process. Nonetheless, my experience of writing interpretations and sharing these directly with the occupational therapists felt like risky business.

Grasping the text as a totality

The combined data provided the important means of consciously identifying with first and second person inquiry research / practice and enabling examination into participant perspectives of the same journey. I was able to shuttle back and forth between the different data sets to enable new insights to emerge, which are presented within my findings. In addition, my version of 'hermeneutic reflexivity,' a term coined by Finlay (2003), was also used during this deeper period of analysis. Hermeneutic reflection whilst typically used within existential-phenomenological approaches, focuses upon how actual lived experience is never fully appreciated in the here and now, and interpretations are based upon our "openness and closedness to the world" (Finlay 2003:107). Indeed, I acknowledge that as distance occurred from the period of actual fieldwork I found myself increasingly critical of my style and approach. Finlay argues that carrying out sound reflexive data analysis requires critical self-awareness without unnecessary self-preoccupation. Indeed, Finlay (2003) warns against 'navel gazing', which can focus too much on the (primary) researcher's voice at the expense of other participant's voices. I therefore attempted to maintain perspective by combining my own reflexive write-ups from the monthly sessions with reference to the literature. Here a range of informing theories served to provide a critical gaze in which to situate the research and enhance the understandings of the issues under investigation (Finaly & Gough 2003). Although at times I recall feeling disheartened that what I had experienced had already been captured within the literature, on further reading and via thoughtful consideration it was evident that there would be additional perspective which this study offered. In addition, I believe I have brought together theories which have not previously been used in conjunction. The existing literature thus served to contextualise the findings to enable a deeper, fuller data analysis to occur.

Validity procedures: third-person inquiry

This methodological account would not be complete without attention to issues of trustworthiness and authenticity within the context of an ethical framework. The need for criteria for the evaluation of collaborative inquiry is well recognised (for example, Reason 1994; Guba & Lincoln 1989; Lincoln 2001; Stringer 2007.) Whilst evidence from the literature acknowledges a range of possible ways to successfully engage in a PAR process, like Marshall (1992) I was keen to avoid the view that ‘anything goes’. Thus whilst striving not to be judgmental but supportive, I also wanted to feel confident that the PAR process was sufficiently rigorous and that my ethical framework would be facilitative and protective (Cousin 2009:18). This would mean paying due attention to both the emerging knowledge from the inquiry and the processes to prompt effective use of the cycles of reflection and action. In particular, the ethical dimension was not viewed as an initial stage prior to the real business of research. Rather, maintaining integrity for all was considered throughout (Cousin 2009). This meant paying due attention to the dignity and sensitivities of the participants, acknowledging the presence of unequal power structures, and examining issues of beneficence, non-malificence, confidentiality and informed consent.

Stringer (1999:xviii) succinctly highlights that participatory / collaborative action research processes should be rigorously empirical and reflective (or interpretive); engage people as active participants in the research process; and result in some practical outcome related to the work of the participants. Guba and Lincoln’s (1989) principles for fourth generation evaluation similarly identify key attributes PAR fieldworkers need to embrace within their work (see figure five).

Figure five: An abridged version of Guba and Lincoln's (1989:263) principles for fourth generation evaluation

- Evaluation is a process whereby researchers / facilitators and participants can move toward or agree upon some shared outcome(s)
- Evaluation is a local process: its outcomes depend on local contexts, local stakeholders and local values (and cannot be generalised to other settings)
- Evaluation is a socio-political process whereby recognition of the social, cultural and political aspects are integral to the inquiry process
- Evaluation is a teaching and learning process, in that all the key stakeholders (researchers / facilitators and participants) both teach and learn from one another
- Evaluation is a continuous, recurrent and varied process because its findings are social constructions which are subject to re-interpretation
- Evaluation is an emergent process. It cannot be fully designed in advance for its focus depends on inputs from stakeholders and its activities are uncertain
- Evaluation is a process for sharing accountability rather than assigning it
- Evaluation is a process that involves researchers / facilitators and participants in a dialectic relationship

I believe that such ethical and evaluative criteria have been addressed throughout this chapter including the challenges I have faced in fulfilling such principles. However, as McTaggart (1997) identifies, consideration of validity procedures should be carefully considered not purely to satisfy academic processes, but importantly to highlight the complexity of implementing PAR successfully. As Lewin (1946) recognised, given the complexity of social situations, it is not possible to anticipate everything that needs to be done. I therefore recognise that in questioning if this study is an (ethical) example of PAR, attention will be focused at the participatory level and whether the occupational therapists have been viewed as taking an active part including their perception of whether their situation has improved, or not. Yet perhaps at a more fundamental level I will be questioned as to whether the inquiry has achieved as much as it might have (McTaggart 1997). I therefore believe that third person action research / practice (Reason & Bradbury 2001) is relevant here, as I suggest this focuses upon my reporting on the soundness of the group's endeavours and reporting of the process and outcomes of the inquiry. Having identified with the experience of first and second person inquiry, arguably the very process of writing this chapter attends to third person inquiry. Furthermore, the subsequent chapters, in particular chapter eight, articulates the third person pathway by addressing what has essentially emerged from the study and how research

findings might reach out to a wider audience. As such no additional focus is directed to this pathway here except from a brief account identifying with the experience of writing up a PAR venture.

Writing

(Does co-operative inquiry lead to co-operative writing?)

The most challenging part of writing this thesis has been in my attempt to recognise faithfully all of the involved participants: to honestly account for our interactions including the hours and hours of talking, asking, questioning and subsequent thinking that has taken place. I am aware that I do not provide detailed accounts of all the occupational therapists involved, and thus the reader is not privy to all that occurred. Yet, I have not omitted to share detail in order to obstruct the findings from accurately reporting what was experienced. However, I do acknowledge that there is no way of neutralising subjectivity in qualitative research (Cotterill & Letherby 1994). Thus my role and the effect of this on the research has been an important element to examine here and continue as the discussion chapters progress. However, as mentioned earlier, joint dissemination of the research findings has occurred via national conference and publication, which has felt wholly appropriate to engage in. Indeed further joint publications are planned.

Yet writing is not the only outcome which third person inquiry embraces. For example, there is no doubt that this research has extended my knowledge base, which I continue to discuss with colleagues and students within my role as lecturer on the pre- and post–registration occupational therapy courses. The occupational therapy participants have likewise shared their experiences with other occupational therapy colleagues across other services / trusts. In addition, the impact of the therapists' changed practices (as the inquiry process progressed) was noted by multidisciplinary team colleagues creating possibilities for the broadening of colleagues understanding of the occupational therapy contribution (see chapter seven). Furthermore, I received encouraging anecdotal evidence from students returning from practice placement within the Trust. In summary, the findings have been disseminated amongst people and between places of work.

From another perspective and for the purposes of this thesis, my attempt to engage in third person inquiry has been to provide an honest evaluation of the experience of the research process, sentiments which mirror Savin-Baden and Fisher's (2002:193)

assertion that the research process should be "transparent, (genuinely) collaborative and open to scrutiny." However, whilst I attempt to account for the experience of all, I acknowledge that I write from my perspective and thus I take responsibility for what is written.

Finally... my theoretical paradigm

Guba and Lincoln (1994) state how ontological, epistemological and methodological principles determine the shape and boundaries for any research study. In addition, presenting the underpinning framework of research theory arguably adds to the legitimization of the process and outcomes of the inquiry (Kakabadse & Kakabadse 2003). Yet establishing the philosophical underpinnings which relate to the methods / methodologies chosen has not been a straightforward process. I therefore decided that the most sensible place to start this chapter was to reiterate the purpose of the research prior to justifying the choice of methodology and methods used. Having established this research context it now feels more feasible to consider the theoretical perspectives which have informed my methodology.

Why qualitative inquiry?

A qualitative paradigm was chosen for the PAR methodology as this method of naturalistic inquiry was felt to be most appropriate in exploring the impact of adopting the theoretical framework of MOHO amongst the three teams of occupational therapists. Qualitative research was considered less obtrusive than positivist empirical quantitative forms of 'knowing,' which reduce the complexity of human experience by distancing the researcher from those who are experiencing the issues under investigation (Denzin & Lincoln 1994). Rather, in this research, I would be directly involved in examining theory and practice relationships along with the other occupational therapy participants. Whilst positivists assert 'legitimate' knowledge lies with the privileged experts and their dominant knowledge, my position was in line with Kemmis and McTaggart (2005) who argue that knowledge should be developed in *collaboration* with local expert knowledge. As the primary researcher in the inquiry process I did not want to set out to manipulate the research setting, instead the aim was to study the occupational therapists in their natural social settings and to collect information as it occurred (Bowling, 1997). Indeed Denzin and Lincoln (2005 :3) identify qualitative research as a 'situated activity that locates the observer in the world. It consists of a set of interpretive, material practices that make the world visible'. With this, attempts to make sense of, or interpret the meanings the

participants brought to the inquiry were of central importance. Furthermore, qualitative research places emphasis on the qualities of process and meanings that are being studied. Thus the intimate relationship between the participants and myself and what was being studied, including any contextual constraints were emphasized and served to shape the inquiry. As such I believe qualitative perspectives, with the emphasis upon process, context and experience sat comfortably with the principles of PAR.

Positioning PAR within constructivism?

Prior to and during the period of active fieldwork I had positioned myself as a qualitative researcher working within a constructivist paradigm (Guba 1990, Lincoln 2001). I had viewed the PAR process as enabling the participants and myself to come together to co-create our understandings of the issues under investigation. Within this paradigm the methodology places emphasis on individual meaning making (Crotty 1998, Heron & Reason 1997), the fundamental ideas of this tradition being to establish a science useful to the participant in their current action. In addition, I connected with the notion of the constructivist researcher being a 'passionate participant' who attempts to elucidate meaning via working with local experts (Guba & Lincoln 1994:112). I saw myself in this passionate role. Indeed I felt comfortable with what I viewed as the essentially inclusive nature of this paradigm, which accepts that reality can never be fully comprehended, only approximated (Guba 1990). Yet, working within this relativist ontology (Guba 1990) was not always straightforward and I would be faced with confronting my own values as a researcher in terms of considering how the participants' knowledge was created and/or understood and how such knowledge could be viewed as legitimate and in whose eyes (see chapter eight).

Constructivist inquiry acknowledges individual meaning making, in that participants socially construct their reality (Lincoln 2001). Furthermore, each person's way of making sense of his or her world is as valid and worthy of respect as any other. With this, knowing is expressed via the participants' 'thought-worlds' or unique interpretative repertoires (Dougherty 1992). In the practice setting I believed this to be evidenced via the participant's practical knowledge, their individual skills, competencies and their ability to problem-solve the issues they faced. Indeed, within a constructivist paradigm I had considered that what was emerging from our inquiry could be quite adequately accounted for in terms of the individual therapist's

perspective of MOHO. I believed this process was also recognised within the 'scholarship of practice' philosophy within which MOHO itself continues to be developed, whereby the theory and the associated tools for application are tested out in the practice arena with those using such technologies contributing to its ongoing advancement. Moreover, constructivism with its extended epistemology, which embraces three forms of 'knowing' (Heron 1981, Reason 1988) appeared to satisfy the breadth of what was being examined within the inquiry process:

- Propositional knowledge *(the use of propositions, ideas and theories*)
- Practical knowing (*the use of skills and abilities*) and
- Experiential knowing or knowing by encounter (*which takes the form of sustained face to face contact and the use of tacit and intuitive knowledge*).

I argue here that in the practice setting I felt quite able to observe and appreciate the therapists' range of response to our inquiry process via this broad epistemology. This was evidenced via the therapists' response to the theoretical concepts offered by MOHO, the recognition of the therapists' practical knowledge, which I have considered in terms of professional craft knowledge (Richardson, Higgs & Abrandt Dalgren 2004); the therapists' individual communication and interaction skills, their competencies and their ability to problem-solve the issues they faced (Heron 1981, Kakabadse & Kakabadse 2003). In addition, I believed the participants unique interpretative repertoires accounted for the building blocks that the therapists employed to construct their different version of events, as they were experienced.

Observing and listening to each therapist's interpretations of events provided evidence of the very unique and individualistic way in which I believed participants were responding to the research agenda. However, knowledge development of this kind is often 'underground' or tacit and can be difficult to surface and Guba (1990) highlights the importance of democratic dialogue and the use of time and sustained effort to surface and share such experiential knowledge. Indeed, I assert that nurturing an environment within which the therapists would feel able to share their professional understandings and debate practice issues would be key to the success of our venture. This connection with dialogue and discourse became a catalyst for me to think again about what was emerging from the inquiry. In essence I would begin to appreciate the interrelationship of personal agency and influence of the therapists' wider social worlds.

Lincoln (2001) suggests that (participatory) action research and constructivism are sympathetic in a variety of ways. For example, constructivism and action research are both concerned with socially constructed meaning between and amongst participants. (Although action researchers are generally more interested in the historical nature of daily life and how it has come to be accepted as part of the social infrastructure). In addition, both call for more equitable voice in decision-making. Moreover, both acknowledge the commitment of ensuring participants' voices are heard. The blurring of roles between the researcher and the researched is also emphasised in both instances, both calling for a genuine sharing of interests which appropriately recognise community need and community interest (Lincoln 2001:127). Furthermore, both constructivism and action research communities recognise how the community of the academic researcher (traditionally comprising of knowledge and elitism) and the community of the researched (often not characterised as expert in knowledge generation) need to come together in a more 'communitarian way' (Lincoln 2001:127). This 'coming together' recognises the need to break down the old borders between knowledge producing and knowledge consuming elites. Improved interconnectedness demonstrates improved respect for others, dignity and an improved caring tone.

This improved connectedness sat well with my own personal and professional values; it made sense to me. However, as the inquiry progressed following the fieldwork, and I had opportunity to consider the research process in more detail, I started to realise that both my own and the therapists' knowledge and their interpretation of practice was being constructed as we reflected upon and spoke about occupational therapy practice in the *team-based locations*. I realised how powerful the group collective was in testing out understandings, equally how culture and tradition create habitual routines, which become entrenched and thus difficult to challenge and shift. I realised the therapists' 'talk' appeared to be situated within the structures of their immediate environment and within the structures of the wider political contexts. These included the multidisciplinary teams within which they worked on a day-to-day basis, the influence of the larger institution (Trust) through which they were employed, the professional context which has established standards for proficiency, and finally government initiatives, which continued to drive an agenda for delivering cost-effective quality services. In essence, I was aware that the therapists' response to the inquiry process could not be accounted for purely as 'meaning-making activity of the individual mind' (Crotty 1998:58).

Whilst constructivism appeared to embrace many of the principles respected within this inquiry process, it spoke less to me about the influence of social context and the political sphere, which I referred to earlier as being of importance when considering the world of professional practice. Indeed, Lincoln (2001) suggests that constructivism does not acknowledge the constraints of structure, which might serve to regulate or influence reality. It was upon reading this that I began to feel less secure in situating myself solely with this paradigm. As such I was prompted to extend my reading to consider social *constructionism* (Crotty 1998, Gergen 1999, Gergen 2003). From this theoretical perspective, whilst individuals are seen as engaging in their world and making sense of it, this is viewed in the *context of history and of social perspective*. As Crotty identifies (1998:54)

> 'It is not the case that individuals encounter phenomena in the world and make sense of them one by one. Instead we are all born into a world of meaning'.

Furthermore, the 'social' in social constructionism is not solely about being with other people, but encompasses interaction with other objects, spaces and political structures (Gergen 1999). Thus social constructionism, which is principally concerned with examining the processes by which people come to describe, explain or otherwise account for themselves and their world (Gergen 2003) began to say more to me about what was occurring. Indeed social constructionism attempts to articulate how people have come to understand why they do what they do. Moreover, the process of understanding is driven via active, cooperative enterprise with others (Gergen 2003). As such social constructionists do not view knowledge as "something a person has (or does not have), but as something people do *togethe*r" (Alanko-Turenen 2005:30). Finally, constructionism recognises the hold that culture has upon us in terms of shaping the way in which we see things.

Crotty (1998:58) provides a useful distinction between the two perspectives identified here in suggesting that constructivism focuses upon individual meaning making, whereas constructionism includes the collective generation (and transmission) of meaning. Thus when considering the inquiry process from a social *constructionist* perspective, both the *language* the therapists used to describe and defend their practice with one another in our team-based sessions and the *structures* which provided opportunities and challenges within the wider social context played inter-related roles in the therapists 'meaning making' in group sessions. In summary, I realised that a number of interrelated factors were influencing how participants,

myself included, were engaged with the research agenda: I therefore shifted ontologically to embrace social *constructionism* as my guiding paradigm.

As I have felt able to relate to both perspectives during the inquiry process I wondered if I should claim to be both constructivist and constructionist. However, Crotty (1998) warns that such claims may be perceived as empty rhetoric. Yet it feels challenging to have to pin my colours to one mast. Within the context of professional practice it appears wholly inappropriate not to recognise the constructionist perspective regarding the influence of external structure upon individual meaning making. Yet I argue that the therapists' personal craft knowledge, and what might be termed as the 'art of therapy' (illuminated by theory) accounted for what I still believe to be the therapists' desire to deliver an essentially individual approach to practice. Therefore, as identified at the outset, I position my experience of working with PAR within the professional practice setting as being at the boundary of a social constructivist and social constructionist paradigm. The implications this would have on my research would be to appreciate how the inquiry process would support the reframing and reconstructing of individual therapist's professional practice within a social and political meaning-making process.

Conclusion and prelude

Conclusion

The recognition of the value of a collaborative and empowering approach to manage the change process has led to the use of participatory action research strategies, whereby practitioners come together to discover what issues exist, why they exist and how they might be addressed (Savin-Baden & Wimpenny 2007, Welch 2002). Demonstrating the value of collaborative forums in promoting sustained changes by empowering members to facilitate *changes in practice* is what is called for (Ward & McCormack 1999, Brown & Duguid 1991, Lave & Wenger 1991, Wenger 1998). Although occupational therapy literature has recognized the value of participatory action research processes in the development of practice (Johnson & Griffiths 2001, Mattingly & Gillette 1991, Cockburn & Trentham 2002, Kielhofner 2005, Suarez-Balcazar *et al.* 2005) there is a lack of focused participatory research within mental health settings that considers efficient ways to *implement evidence* to advance practice.

This chapter has detailed the research journey in terms of providing a description of how the PAR inquiry process was carried out. Reference to first, second and third

person research / practice pathways have offered opportunity for the reader to appreciate the layers of complexity involved regarding reporting upon collaborative research practices. I have attempted to justify my research approach throughout, including my reasons for situating myself within the identified theoretical perspectives.

Although not an easy research choice, PAR provided a valuable opportunity for colleagues across practice and academia to advance their understanding and adaptability to take forward change and develop more robust, occupation focused, theory driven practices whilst feeling supported in their efforts. By means of summing up the experience of working with PAR I end by returning to the quote by Reason (1994) used at the beginning of this chapter, which aptly spoke about the challenge of engaging in collaborative inquiry with others, not least in terms of the disagreement and conflict, the failures as well as the successes which ensue. Certainly it has involved a new way of thinking and participating for myself as a facilitator in a PAR process. I have needed to be sufficiently pragmatic whilst reflexive throughout in being able to adjust and adapt, to neither take the lead nor sit back. However, despite all the challenges, what I have been offered is opportunity to be part of changing practice through collective wisdom.

Prelude: introduction to the discussion chapters

Navigating a path through the PAR inquiry process to meet the aims of the research is the subject of the following chapters, which are introduced in this short prelude.

Chapters five through seven present the themes which emerged from analysis of the data over the course of the inquiry whilst responding to the research objectives. These are presented in terms of the development of the group collective (chapter five); personal agency and facilitator / participant relationships (chapter six); and transitions, forging new meanings, identity shifts (chapter seven). Chapter eight draws together the different perspectives explored within chapters five, six and seven, and presents the key contribution made in progressing the advancement of professional knowledge implementation within a mental health occupational therapy service.

In chapter five group processes are explored, in particular how the PAR process enabled the development of a productive group collective, which allowed *barriers to*

theory implementation to be overcome. In addition I discuss the disruption inherent within the change process and the role of the facilitator in this. In chapter six interpretative analysis using biographical data is used to explore the experience of the individual therapist within the group collective. Two portrayals of individual therapists' experiences focus on the participant's sense of journey during the inquiry and *how MOHO impacted upon the therapists' perception of their role.* In addition, my *perceived effectiveness as an external facilitator* is considered in particular regarding my response to the needs of the individual participants. Chapter seven examines the construction of professional knowledge. Whilst the therapists' narratives consider *the transitional experience of implementing MOHO and the assessment tools*, at a theoretical level I discuss practice epistemology and the contribution of MOHO alongside the therapists' other forms of knowing. Chapter eight builds on the findings chapters to present a conceptual framework, which illustrates change factors. The overall findings are then summarised.

Throughout the findings chapters thick description is prevalent in order to provide an opportunity to consider what the stuck points have been, the realisations, and what ultimately has been revealed. The approach seeks to enable the interpretations of the findings to be more clearly shared with the reader.

Chapter five

The development and influence of a group collective

"Change means movement. Movement means friction. Only in the frictionless vacuum of a non-existent abstract world can movement or change occur without that abrasive friction of conflict."
(Saul Alinsky 1971:21)

Introduction

In this chapter I focus on the development and influence of a group collective. I will argue that during the occupational therapists' monthly meetings with myself as external group facilitator, critical debate and exploration of the MOHO took place. I suggest that the group collective served as a 'community of practice' (Wenger 1998:6) or community of inquiry, in that over time transformative learning took place as the occupational therapists re-negotiated their professional perspectives through membership to a group collective. In order to explain how the group collective developed the chapter will address the following three themes:

- The importance of disruption: perspectives regarding the MOHO agenda
- Negotiating contextual issues: the role of an external group facilitator
- The development of a group dialectic: nurturing a useable learning space

In discussing these themes I present the process of implementing MOHO as a journey, punctuated by the therapist's changing response toward the inquiry process. I share the sense of disruption which was seen to occur as the review of practice unearthed a range of concerns from personal struggles, to in-house tensions, to multidisciplinary team dynamics. My role as an external group facilitator is examined in terms of the difficulty I faced in negotiating agreeable ways forward and the conflict I experienced between stepping back and feeling the need to be in control.

The central message of the chapter is the importance of developing a dialectic with the three teams of therapists (the acute adult, the community adult and the older adult team) in which the PAR processes were initiated and therapists were openly encouraged to critically examine their practice. I identify the group sessions provided a necessary critical learning space in which barriers to implementing MOHO were discussed and perceptions challenged. In addition the use of other necessary learning spaces, which were seen to compliment and support group processes, are considered.

The importance of disruption: perspectives regarding the MOHO agenda

In line with contemporary health care demands (Lloyd *et al.* 2004) the Service Manager viewed the adoption of MOHO as vital in raising the service profile. As such, all the occupational therapists were requested to adopt MOHO as their evidence-based approach to practice delivery (McCluskey & Cusick, 2002). In terms of the MOHO agenda, and as articulated in chapter four, attempts were made to introduce the theoretical framework and tools for application in a gradual way. However, as noted by Smith (1999) much has been written and said about the need to link professional theory with practice but rather less on how to accomplish it. Whilst conscious of maintaining enthusiasm I was aware of the complexity of the task that lay ahead. A very real challenge to the process was how committed participants felt in terms of their readiness to engage, their attitudes towards the specific agenda of integrating a theory-driven approach to practice, and more subjective personal perspectives regarding investment of time and energy (Ajzen 1991). Even those who appeared positive about the venture at the outset would in turn experience personal and environmental barriers, which impacted upon their intentions to act (Armitage & Conner 2001).

Examples of early reactions to the MOHO agenda

> I think I don't like being told exactly what to do and what I must do and what I mustn't do and I'm quite wary of doing that with MOHO because I feel as a clinician I should have reasonable choice and I don't think that's very satisfying. I wouldn't want it to be, you know, you miss the person listening to you and it's also because I want the team to be able to make that choice themselves
> *(Mary: six months into the inquiry)*

At face value Mary's quote connects with potential concerns she held regarding the MOHO theory and evidence-based tools stifling her own and her colleagues' professional creativity.

Similarly, Susan's remarks highlighted the sense of anticipation and yet unease:

> My reactions to our supervision sessions are mixed really to be perfectly honest. I probably thought it was a good idea and it was you know that it would improve practice, or I think I felt it would just support me in justifying what I do and give me a more professional language and make me work more professionally. That's what I thought on the positive side. I suppose on the other side I thought it was time consuming and actually bringing it into practice, you know, between supervisions it is time consuming. Occasionally I suppose I thought that I'm not sure really about all this. Just occasionally I

> felt we were kind of making, it makes you think too much about things occasionally you know. You know everything is put into this professional language sometimes. I realise the emphasis is on MOHO and you know learning about MOHO and integrating it into practice rather than just our caseloads. So I can understand it. At first my expectation was, although I probably just got the wrong end of the stick, was that it was going to be like our usual supervision but it would have a MOHO slant on things I think.
> (*Six months into the inquiry)*

The disruption to the therapists' working lives involved a number of complex factors not least from the implications of being confronted with the need for them to review and as necessary defend their current practice in front of each other and myself. In addition, MOHO was being promoted as offering some form of gold standard, which potentially could negate the therapist's current practice as inadequate. This was a significant issue, which is considered in more depth in chapter seven. In essence, confronting practice issues and considering alternate ways of thinking and doing presented barriers; the need to debate the role and function of our group supervision sessions being one of a number which emerged.

Team based, reflective group supervision sessions provided the *forum* for reviewing practice issues and implementing the MOHO. Participatory action research (PAR) cycles of reflection and action were the *methods* used within group supervision to explore practice issues, agree upon some targeted action, to try out new actions, reflect upon the experience and share perspectives with peers. Whilst PAR processes aimed to open up a space for participants to communicate and share mutual understandings of their situation, such spaces could only be understood and utilised if the participants wanted to and felt able to share their views. This links suitably with views within the occupational therapy literature regarding the potential of group reflective supervision to enable opportunity for colleagues to engage in genuine inquiry with each other to develop practice (Errington & Robertson, 1998; Henwood & Sidhu, 2001; McDonald, 2002). As Heron (1992) aptly argues, learning is best achieved by self-generated interest, commitment and practice and attempts to instil or impose conditions negate or distort such opportunities. There was no doubt within our own inquiry that developing a culture whereby a sound dialectic was achieved between all participants would be both the greatest challenge to and greatest opportunity for developing new knowledge and change (Savin Baden & Wimpenny 2007).

In reality, the process we experienced initially was not a set of neat self-contained spirals of planning, acting and observing. Rather, as suggested by Reason (1994) and Kemmis and McTaggart (2005) our stages overlapped, the cyclical action was 'messy' and a number of my initial plans to focus participants became obsolete as more pressing team based issues required attention.

It was evident that the potential to use group supervision as a forum to promote learning and development (Spalding 2000; Boniface 2002) would require more attention than anticipated. This was especially evident within the older adult team, where the structure, purpose and value of group supervision was re-examined. This included focusing on attendance at sessions, which was not consistent, with individuals prioritising other work-based demands.

> I don't think it [peoples' lack of attendance] has impacted hugely. I think generally we have always enough people attending and I think everyone has taken a turn in not attending - that's probably reasonably equal I would have thought.
>
> I don't think it's a huge issue because I think we understand, I think it's to do with all the other things that are going on sometimes, like they have got to be somewhere else. I don't think it's just not wanting to come to supervision. That's the way I've seen it, that that person has got to be somewhere else rather than avoiding the supervision session. Their priority is elsewhere at that time or whatever it's their priority, it's something else they've got to deal with or whatever rather than devoting time to MOHO and I can kind of understand that – that need to do that. There is no choice sometimes.
> *(Susan: twelve months into the inquiry)*

Susan's comments reflect Schwartz and Davis's (1981:35) view of how work-based tradition is in-grained.

> Culture is capable of blunting or significantly altering the intended impact of even well thought out changes in an organisation.

Indeed, tradition and culture were two key areas of focus which I targeted. Group supervision was not a priority for certain individuals and I did not find this situation comfortable. From my perspective our sessions provided the only opportunity in the month for the occupational therapists to be accountable for their professional practice. Wenger's (1998) depiction of mutual engagement and joint enterprise provide opportunity to examine the *restrictive* responses certain participants adopted when faced with the new learning situation. I came to appreciate the influence of the community, including the therapists' routines, the language they used, their gestures

and actions which the groups had adopted over time that had become part of their practice. I began to appreciate that attendance in sessions was linked to dynamics between certain colleagues, which were strained. Moreover, my own involvement clearly added to levels of tension. However, situating our practice development initiative within the team's group supervision sessions was a strategic decision; the aim being to ensure that discussing professional practice issues could take on direct significance for group members and their respective practice contexts. Wenger (1998) and Brown and Duguid (1991) acknowledge the importance of working with teams / communities already formed. As Brown and Duguid claim (1991) this process of situated learning enables communities to see themselves anew and to start to overcome (cultural) barriers in their environment, which have prevented full participation. Although I set out not to disrupt the therapists' group supervision sessions more than was necessary it became evident that the disruption created by our collaborative efforts set the agenda for change.

Negotiating contextual issues: the role of the external group facilitator

I believed it was imperative to work to establish a non-judgemental peer-group environment (Errington & Robertson, 1998) where an honest range of views could be shared, thus reducing interpersonal tension and essentially allowing for the confident transfer of skills into the therapists' own work. An environment such as this is endorsed by Eraut (1994) as enhanced levels of communication are likely to help build participants' confidence, with the notion that all are facing similar workplace challenges. However, feelings and dynamics aroused in our group settings were complex where there were multiple layers of relationships (Winship & Hardy 1999, Finlay 1993). This not only included how the therapists' interpreted my participation within the teams, but also it became evident that certain therapists only saw each other at the monthly meetings, whereas others met both within the workplace and at a social level. Needless to say, the work within our groups was a gradual process, there were no short cut solutions, and at times the process was overwhelming (Wimpenny *et al.* 2006). My own reflections from an early session with the older adult team connect with feelings of unrest:

> *My positive feelings I had on entering the session were quickly quashed. I felt barriers around the room; my involvement was very much questioned as to its value and usefulness. They felt their time would have been better-used discussing cases. I was asked why had no assessment tool been produced, which they could all start implementing. I felt hot and flushed – especially at sharing my role and what I hoped to bring –I felt they wanted me to have answers to all their frustrations right there and then. I felt got at and*

> *vulnerable. I need to have strategies to cope with their frustrations. Should I reflect back how I have been left feeling next session? I feel I need to. I know I need to speak more clearly, reiterate the importance of building a good foundation.*
>
> *It was natural that not everyone would feel positive about the plan to implement MOHO. But at the end of the day it is up to them to commit themselves to our venture. Yet all responses are relevant, all feelings are relevant. Learn from them [the emotions]; see them as part of the process rather than a personal attack on me.*
> *(Reflective write-up older adults, session 1)*

Early team-based sessions focused upon introductions, establishing ground rules and individual roles and responsibilities. Participants were encouraged to share their expectations of the sessions. Supervision contracts were used to focus participants and share responsibility for meeting our agreed agendas. As sharing cases had been a previous means of structuring group supervision sessions I maintained this approach whilst simultaneously integrating concepts of MOHO as an anchor point from which professional issues could be explored. Alongside presenting MOHO, I spoke about the participatory action research (PAR) method, as I wanted the process to be co-operative, transparent, and to encourage the 'emergence of participative decision-making' (Heron & Reason 2001:186).

Yet I was also conscious of not focusing too much on the research agenda, predominantly because no one appeared interested in it. Indeed, despite my efforts to create discussion around their perspectives and bringing in a research article to share regarding two occupational therapists who had used a PAR approach (Cockburn & Trentham 2002), I felt I was creating more of a distance between the teams and myself by repeatedly referring to it. As such, rather than focus on articulating the research process per se I focused more on working to develop a culture whereby openness could be expressed and trust could be expected.

Henwood and Sidhu (2001) recommend that for occupational therapy group supervision to be effective therapists needed to be willing to invest both their time and energy into the process. I agree with this as the effect of not engaging impacts on many levels, not least in preventing a full team approach and shared ideology from being fully realised. Yet attitudes towards engaging in group processes are in themselves complex and needed to be teased out. Interaction between the therapists was a real obstacle at times impacting upon the ability of participants to engage in dialogue around practice issues. For example, in the community adult team I

observed two therapists' practice being scrutinised by the other, each appearing unwilling to tackle the problem:

> *Whilst one therapist would present her case, the other would consult her diary…*
> *(Reflective write-up session 5)*

I believed a contributing factor causing this disharmony and suggested disinterest in the other's practice was due to a culture of sub-grouping that had occurred (Finlay 1993). Although this could be seen as an advantageous process offering a source of strength and support to those involved, the therapist not 'invited' clearly viewed this situation as untenable and a way of her peers demonstrating a lack of allegiance and distraction from the main supervision group:

> It wasn't easy at first but I thought people do more than me and they also had a chance to meet beforehand as well and they are all full time as well and I wasn't either. So I think they had more of a chance to talk things through, whereas I felt quite isolated. I think that is still going on because I think they met last time as a group and I didn't know about that. But because I am happier with the tools I am finding it easier to contribute now. I certainly didn't feel like that before though, because Emma always had the [MOHO] book and I thought she was maybe reading up on it and they are all full-time and they have both more time to look at it. So I was a bit reluctant to feed back my work because I wasn't confident about my goals and hadn't been part of any discussion with them, but I don't know whether they picked up on that. Maybe it's because I'm not here I'm part-time.
> *(Heather: twelve months into the inquiry)*

Observing relationships within the teams and then reflecting upon how best to address areas of conflict in order to move the teams forwards proved challenging. My remit expanded; not only was I to focus on skill development in terms of developing therapists skills of critical reflection for practice but more fundamentally I became involved in sorting out team dynamics and negotiating ways forwards between colleagues. Lave and Wenger's (1991) theory of situated learning articulates the importance of *membership* to a community and the sense of engagement and joint enterprise individuals can experience from being present within the community. Implementing MOHO was not purely an individual cognitive task rather, learning involved participation in *social practice* (Lave & Wenger 1991:37/38). Nonetheless, like Tennant (1997), I argue Lave and Wengers theory, whilst attractive, does not articulate the consequences of learning and participating when the community exhibits relationships that inhibit entry to participation. I found myself uncertain of how to respond at times. I was conscious of not wanting to get involved in the

subtleties of team-based relationships. I questioned if this was even my role, and how it would be viewed if I did attempt to get involved. Identifying the tension I observed could potentially alienate me further from participants who may not have felt ready nor wished to reconcile their differences. Needless to say I became aware of the careful analysis required of both my external and internal role, which is now discussed in more detail.

A balancing act: an external group facilitator

A key factor that impacted upon the development of a sound dialectic with participants was, I came to appreciate, my ability to achieve the right balance between incorporating rather than imposing knowledge (Wimpenny *et al.* 2006). As explored in chapter three, in Vygotsky's view, a facilitator offers expertise and assistance to others. Applying his concept of the zone of proximal development (Vygotsky 1978) learning is viewed as dependent upon a specific teacher-learner relationship in which problem solving is done in collaboration with a more capable peer (or *more knowledgeable other*). However, I believe such a perspective is too simplistic and is in conflict with my experience of being the external facilitator within a practice development initiative where I was removed from practice and cognisant of needing to be respectful of individual professional craft knowledge *in context*. Indeed, I assumed that the therapists and myself had shared expertise. Thus navigating an appropriate path through the course of the inquiry required me to continually modify and adapt my approach.

In terms of using a PAR approach I was conscious of trying to work out what *participation* meant. In retrospect I like Wenger's (1998:55) suggestion that it refers to a process of 'action and connection.' At the time of being involved my approach to encouraging change included use of interpretative and at times prescriptive measures, as I was conscious of how certain individuals only demonstrated vague notions of willpower. Moreover, in terms of the PAR literature explored in chapter four, Reason (1994) suggests that it is likely that a group will need some democratic leadership, which is both facilitative and educative and which may help the group in its work. Therefore, alongside listening and being respectful to ensure participants' voices were heard, I found myself encouraging the therapists attendance at sessions, make use of learning contracts, preparing worksheets to explore MOHO concept areas and providing guidelines for good assessment techniques. Yet this strategy created disjunction in terms of participant's perceptions of the learning space.

This disjuncture was exemplified on two separate occasions within the older adult team, when I was referred to as 'teacher'. At the time I recall laughing this comment off, but inside I was troubled, especially as I believed I was so committed to a participatory approach. With hindsight I accept a certain level of justification for these comments. Whilst I believe them necessary, I admit my actions were viewed by some as restrictive and imposing (Savin Baden 2008). There was no doubt that I swayed between didactic and participatory approaches, the result being that at times it seemed I could not put a foot right:

> *As Stephanie proceeded with her case I felt unsure as to my role. I was conscious of John and Ellie's gaze upon me, as though they were waiting to see if I would stop Stephanie, intervene, and ask a question. I was very conscious of trying to do the right thing. In the middle of all this I was conscious that Stephanie might have felt vulnerable. I felt she was getting lost in her contribution. I wanted to keep things focused, but it was challenging and I felt I was being tested.*
> *(Reflective write-ups second session)*

The addition of myself within the teams, as an outsider from the local university, had to be taken into consideration. Indeed I was aware of the risks attached in being an academic colleague challenging the therapist's practice; I appreciated this could be perceived as a threat (Henwood & Sidhu, 2001). Although I strived to present myself as warm and non-judgmental, it became evident that I adopted a different style and approach to supervision from what was expected. In the following excerpt from John, issues relating to my acceptance as an external group facilitator in the acute team were clearly shared:

> I don't think that we can change just like that. It's almost like inviting a new member of the team in and obviously Stephanie will have felt that when she first came in and I think it is very much the same with you. We know you from outside of here but actually having you in supervision is going to take time before those dynamics become all encompassing with you. Before we feel totally comfortable to start talking to you as we talk to each other. I think we are starting to get more comfortable to be able to say things to you and to challenge what you bring in. That wasn't there initially but then I don't think you could have expected it to be.
> *(Six months into the inquiry)*

Heather also acknowledged her concerns regarding my approach within the community sessions:

> I think some of the initial monthly meetings we had I didn't find those positive particularly because I wasn't getting to grips with it and I sort of dreaded going

> until the OCAIRS was introduced and then I started thinking 'well this is what I do anyway, oh this is good' and I got to learn more about the tool - So the beginning ones I didn't find positive. I used to find it a bit intrusive actually. I used to find it intrusive to my other proper work to a certain extent whereas now it feels like it has become my proper work.
> (*Twenty-four months into the inquiry)*

Although there were certainly challenges connected with my involvement, equally I sensed my presence with the teams was a positive and energising experience on many levels. Indeed being an occupational therapist based in education provided a number of benefits. For example, I was not affected by in-house politics. I was able to act as a resource by bringing in different ways of thinking and doing via a MOHO conceptual model of practice. In addition I had routine access to a MOHO expert in the field. I was in a different position in many ways from the therapists, not only in terms of being in education and being an 'outsider', but also having a sense of the wider context of practice. In other words the therapists were immersed in day-to-day practice issues. Not being involved at this level enabled a more detached perspective from which I could observe process and structure. For example, it was beneficial to use material, experience and strategies already developed within one team to support another team's efforts. I believe that this cross fertilisation of ideas between teams provided another layer of connectedness, which supported our overall inquiry. This process of deep experiential engagement within the action and reflection cycles involving dialectic discourse, informed practice skills and new understandings, which grew out of the inquiry (Heron & Reason 2001). Moreover, a real advantage in terms of my position across the service was that I had three opportunities each month to work with the teams. I recall being privy to information, which could serve to help problem solve issues across teams and navigate me through difficult stages of the process.

Lave and Wenger (1991) and Wenger (1998) suggest participation within a learning opportunity is an active process, which involves our bodies, minds, emotions and social relations. When applied to this study whilst I acknowledge I was not immersed in day-to-day practice issues, I nonetheless felt I had an active role in the learning community under development. Participation for me was not something I could switch on and off. The effects from three meetings each month with the teams stayed with me. It was apparent that there were multiple levels of commitment to the venture demonstrated by the other participants, yet this was not about holding a static position. Rather I suggest that as the occupational therapists' reconstructed their

professional identities in relation to each other with support from MOHO, shifts in membership to the learning community occurred, which I now go on to examine.

Contextual issues

Kemmis and McTaggart (2005: 564) argue that 'PAR involves the investigation of *actual* practices and not *abstract* practices'. Similarly (Stringer 1996) maintains a fundamental premise of PAR is that it embraces the concerns experienced by the group. The experience from this inquiry saw the need for participants to identify with historical systems and traditional working practices, which prevented them from embracing change. As a consequence the teams in turn felt the need to off-load negative issues within sessions. For example, the occupational therapists would state feeling already overwhelmed from the constant stream of change within their daily practice without the extra pressure of navigating their way through the MOHO theory. They were aware of needing to meet the requirements of the modernisation agenda and Mental Health Policy Implementation Guidance (DH 2000), the National Service Framework for Mental Health (DH 1999), the single assessment process (DH 2001a) and developing new roles within strategic teams (DH 2005b). In parallel it became increasingly evident that a number of therapists were working as case managers within Community Mental Health Teams (CMHT's) and as a consequence had become more generic in their practice. As identified in chapter one, such practice raises concerns about loss of core skills and ultimately of professional identity (Craik *et al.* 1998; Taylor & Rubin 1999; Hughes 2001; Parker 2001; Hayden 2004; Reeves & Summerfield Mann 2004, Pettican & Bryant 2007). Adopting a profession-specific model challenged their generic working; the MOHO would require everyone to re-consider professional identity issues and question commitment to professional values, as evident within the following quote from Barbara:

> You can either embrace it or fight against it. If you fight against it you are out because this is what we are using, this is what we [the OT service manager and the OT service] wants so you are either going to have to be very good at what you think you are doing or join in.
>
> The challenges of group supervision are that now its more structured and we've identified what we are going to do. So when I've said I'm going to do something, it's a case of I can't be generic, I've got to do my part. In a way it's making me more of an OT. That's good.
> (*Six months into the inquiry*)

Aside from the acute adult team, the majority of individuals worked as the sole occupational therapist in a MDT and therefore did not have an opportunity on a daily basis to develop practice with other occupational therapists (Wimpenny *et al.* 2006). I appreciated how certain therapists' practice knowledge emphasised influence from a more experiential and tacit dimension. Whilst this practice knowledge was valid it was evident that the therapists were less able to articulate a guiding evidence base. I suggested that the two forms of knowledge required incorporating. Indeed, exposing staff to an alternative way of working utilising a theory driven approach as in MOHO, raised issues about professional responsibilities and the therapist's own 'theory in use' (Argyris & Schon 1974). It was apparent that certain occupational therapists started to realise that MOHO provided a way to articulate a clearer rationale for their practice that enabled them to assert their position within the wider healthcare team. For example, Mary identified with shifts occurring within her own thinking at that time but acknowledges others felt different to her:

> I didn't really have anything to tell me that I wasn't acting as an OT before… now at meetings I sit there catching myself thinking well we wouldn't have done that, we won't sign up to that, that's not in line with MOHO thinking. Whereas previously I might have thought well there is quite a lot that could link to OT there. Whereas now I would sit there and say well obviously that needs developing but it's not within our role to do it. But some people in our team don't like how it [MOHO] doesn't fit their own thinking.
> *(Twelve months into the inquiry)*

Whilst participants like Mary found MOHO connected with her practice I suggest that other therapists, particularly those working as case managers within CMHT's, did not. MOHO may have appeared relevant as we explored practice issues within professional group supervision, however, back in their CMHT's with generic working practices beckoning, the opportunities to deliver on the MOHO ideal became less obvious.

> Back in the workplace it was less clear, more isolating, it gets lost somehow.
> *(Emma: twelve months into the inquiry).*

Whilst closer examination of Emma's experience is addressed within chapter six, in essence, integrating the MOHO brought to the surface a whole host of associated practice issues. There was a clear sense of upheaval. This created a challenging context to work within.

In addition, I sensed that in parallel to the external processes presented as barriers, the disruption to practice uncovered more subtle issues relating to learner identities. A focus on the individual and issues around personal stance when engaged in new knowledge formation is dealt with in more detail in chapter six. The point here is about the importance of seeing beneath any obvious resistance to change in the development of new understandings and appreciating learning as complex and specific to the learner linking to contributory factors such as the individuals' life and their 'stories,' (Savin Baden 2008:102). Furthermore, I argue that whilst practical strategies would be employed to remove practice barriers, a careful examination of the conflict that arose was required which was enabled by my direct involvement with the teams in their practice locations. Being *with* the therapists suitably links with Lave and Wenger's (1991) assertion that learning, thinking and knowing are relations among people in, with and arising from the socially and culturally constructed world.

Through the sessions it became possible to appreciate the relationship of theory to the person and the practice context: the rationale and justification for their actions. This view embraces that of Guba (1990) and Roberts (2002) in the importance within an inquiry process of democratic dialogue and the use of time and sustained effort to identify and share practice in order to deal with fundamental concerns for individuals regarding their expectations, [professional] identity and beliefs. Yet making time and space for the therapists to share their practice concerns added to the sense of disruption created by the MOHO agenda and my involvement. Certainly at times during the initial six months of our inquiry the sense of conflict regarding wider service issues and the competing MOHO agenda was experienced as a ''stand-off' between the occupational therapists and myself. Indeed I was told in no uncertain terms on two separate occasions from individuals representing different teams that I "did not know what it was like". Group sessions were experienced as 'troublesome' (Savin Baden 2008:104), not only in terms of connecting MOHO concepts within the reality of practice, but also the power relationships at stake between the occupational therapists and their multidisciplinary team colleagues and myself.

Yet interestingly all the participants shared (with hindsight) that confronting the barriers and the conflict, which emerged, was a necessary period of our journey together. Despite my fear that the barriers raised by the occupational therapists across the teams in group sessions would fuel high levels of negativity towards the change agenda, it appeared vital that the organisational difficulties the therapists experienced were noted and discussed as a context for change (Hunter & Blair

1999). Indeed I agree with Hughes and Pengelly (1997:6) who acknowledge that 'only when this context is appreciated can we begin to consider the place of staff supervision within it'. This period of 'storming' (Tuckman 1965) was thus viewed as a healthy phase that the teams needed to work through. Reason (1994) and Wenger (1998) likewise state that raising emotion is an essential part of an enterprise. Furthermore context is essential to any change process (Welch & Dawson 2005). Creating a sense of unrest proved to be an important catalyst as dissatisfaction with the current situation created the necessary energy to move forward (Moran, Baird & Brightman 1998). In addition, I maintain that through the process of managing conflict across the three teams I developed an increased sense of resilience, strength and determination within myself, which kept the MOHO agenda in focus.

When viewed in light of Wenger's (1998:73) concept of mutual engagement the occupational therapists were arguably negotiating difficulties regarding their practice with one another and me as a means of defining and defending their membership within the group. Perhaps detailing the barriers they were experiencing was a way of testing out *my* membership to the group. By this I mean they wanted me to sympathise more with the difficulties they were experiencing. Being included mattered to me, indeed Wenger (1998:74) asserts that to be a full member it is important 'to know and understand the latest gossip'. However, what is also worth noting is that what makes engagement possible is *diversity* as individual members influence one another's routine. In the following section I account for this by discussing my response to difficulties raised.

Persistence & resilience

An approach I adopted when addressing contextual barriers raised was to persevere with providing alternatives for action, which might broaden the therapists' ability to problem solve the issues that they faced. There was not one point within the inquiry when I backed down from the possibility that another option could be considered. I did not accept the barriers put before me – no challenge was viewed as insurmountable and this approach would extend over the two-year period.

I gradually introduced a range of the MOHO assessment tools (technologies for application) as a means of enabling the theoretical concepts of MOHO to come alive. Although this was not straightforward, over time the therapists came to appreciate the contribution of the tools within their practice. I believe that this gradual adoption of

the tools was enabled through the practical nature of the PAR cycles of reflection and action. This 'hands-on' approach dealt with the real, material and particular issues facing the participants in a given time frame. A shift from postulating on what could be was brought to life by the very tangible use of evidence-based assessment tools that were piloted by the therapists and reflected upon back within the group sessions. Such experiences connect with Brown, Collins and Duguid's (1989:457) emphasis upon 'cognitive apprenticeship' whereby individuals learn through *collaborative social interaction* and the *social construction of knowledge*. Moreover I believe Wenger's (1998) concept of reification is of relevance as this identifies with the importance of achieving a balance between participating and experiencing feedback from doing which I suggest validated the therapists' efforts and provided ongoing commitment to be involved. In this way, the occupational therapists first gained an understanding of the abstract generalisable principles of MOHO and tools for application which were then transferred to the reality of the practice setting for authentic application, where enhanced learning could take place (Wenger 1998, Brown *et al.* 1989).

Participants experienced a sense a commitment in knowing that the problems they faced were not ignored, instead they would observe real attempts being made to support practice and provide practical routes through problematic issues. Such practices equally compliment the concept of 'shared repertoire' (Wenger 1998) in terms of our attempts *together* to make sense of community. Sharing in a community of practice is what enables participants to negotiate the appropriateness of what they do (Wenger 1998:81). In addition, although not everyone would embrace the tools at the same time, seeing one person's experience of piloting a tool was in itself a motivating factor for other occupational therapists to become involved. I believe this provides authentic opportunity to apply Lave and Wenger's (1991) concept of legitimate peripheral participation (LPP) in that there was a sense of *growing* involvement by participants. Involvement would include either piloting a MOHO tool or less explicit actions of simply considering its use. This individual shifting of behaviours demonstrated the different pace at which participants involved themselves during the inquiry process and connects with theories of change as identified by the 'Transtheoretical Model of Change' (Prochaska *et al.* 1992; Prochaska & Velicer 1997) which is explored in the following chapter.

From my perspective, I can clearly appreciate the benefits experienced of being with the occupational therapists in their team-based localities for the duration of the study. Being present in the environments within which the therapists worked, and observing

the dynamics within teams was a crucial component of our work together and provided vital insights, which enabled our work to take on new forms. Furthermore LPP has deepened my understandings regarding how learning occurs across different social and physical environments. LPP makes the conditions of learning central to appreciating what is learnt. Furthermore the term peripheral suggests that there are multiple, varied, more-or-less engaged and inclusive ways of being located in the field of participation defined by a community (Lave & Wenger 1991:36). Moreover, periphery suggests an opening, a way of growing involvement. Importantly rather than viewing theory as abstract and removed from practice Lave and Wenger's stance on situated learning offers a point of departure for starting to explore and develop understandings of the abstract, the goal being to appreciate the relationship of theory to the person, the world, activity, meaning and knowing. In relation to this study the monthly team-based sessions provided the learning bridge in which each others thinking and knowing was influenced through the relations amongst us all relative to our interpretation of the socially and culturally constructed world (Lave & Wenger 1991:50).

Brown *et al.* (1989) also explored learning as part of a community and how individuals in this type of learning situation are 'enculturated' that is, the learners do not acquire explicit 'expert knowledge', but develop an ability to take more decision-making powers in order to participate as community members. With this more inclusive approach to participation, room for movement is suggested, which reflects how participants in this inquiry started at the periphery (in terms of engaging with the MOHO agenda) yet over time became more involved with the learning agenda evidenced by shifts within their thinking and participating and the articulation of this within group sessions.

Whilst it was important to be with the occupational therapists in their team-based locations, equally my external position was relevant. Promoting discussion around practice issues and refusing to accept the participant's barriers was made more possible because I was an outsider. Arguably this role would have been difficult for any of the team leads to adopt. As much as I wanted to be viewed as a co-participant, co-researcher and colleague within the community I had joined (as literature on PAR processes maintains), I had to accept that these were not roles which participants readily offered me. Instead I held on to the belief, which developed as a consequence of my efforts to deal with the negative attitudes often bestowed on me by the teams, that I was enabling the participants to 'become increasingly

conscious of their own actions and situations in the world' (Friere 1970). What was required to avoid my own feelings of isolation was accessing my own supervision. Regular meetings with my research team was vital for my own sense of self and provided much needed encouragement, validation for my efforts and a space to critically reflect on the processes as they unravelled. Furthermore, I argue that my own sense of capacity was enhanced through the positive feedback offered from my supervisory team, which strengthened my levels of resolve to persevere.

Development of dialectic: nurturing a usable learning space

What I came to appreciate that our practice development offered in terms of a learning opportunity was a process of encouraging the occupational therapists to become active learners who could explore and critically examine their practice in a range of environments (Boud, Keogh & Walker 1985, Kolb 1984, Schon 1983); the essential ingredient being the *learning* spaces the therapist would make use of to reflect and act and consider their experience.

The predominant learning space and anchor point were the monthly group supervision sessions, in which the PAR process was formally initiated and the therapists were openly encouraged to critically appraise current practice repertoires. Over time and as therapists chose to act, the learning space moved outwards into the therapist's work-based setting where alternatives for practice were considered, tested out and evaluated via involvement with service users and other MDT colleagues. Creating a sound dialectic across the three teams linked with a subtext which related to what was viewed as essential and non-essential within the therapist's own practice and a complex interplay between the participants' epistemological stance towards MOHO and what it might offer their practice; perceived needs regarding review of practice, views on group as opposed to individual supervision, citizenship and departmental culture. In addition the therapists' used their own personal space for reading and / or reflection.

Focusing on practice in a specific way via MOHO and the applied technologies enabled the therapists' experiences to be accessible for reflection, discussion and potential transformation back in group supervision where, amongst their peers, creative ways were found to move the therapists' practice forward (Wimpenny *et al.* 2006). The use of the combined learning spaces would enable contextual barriers preventing participation being removed. For example, the acute adult team struggled

with MDT colleagues forwarding inappropriate referrals, therefore strategies were developed to better educate MDT staff on a range of criteria denoting the scope of occupational therapy practice (see appendix four). In another example the MOHO guided the selection of a set of standardised assessment formats under the single assessment process used by the older adult occupational therapists (see appendix five).

Challenging current practice repertoires and persevering to offer alternative approaches to practice via the MOHO, over time, appeared to encourage individual therapist's engagement with the learning opportunity. The decision to act (to test out MOHO) led to evidence of participants becoming more critical and informed regarding their practice perspectives. As Adrandt Dahlgren, Richardson and Sjostrom (2004:86) argue individuals may learn propositional knowledge in common with other peers, but it is the experiential process of implementing that knowledge *in a professional context* which will dominate the development of their professional knowledge base. Indeed it was evident that through active learning opportunities a commitment to deliver more occupation-focused practice emerged amongst the therapists. I suggest this linked to the individual's sense of growing membership to the community of practice and their obligation to one another within that context.

> The other day I was talking to a client and I used MOHO language, you have to use your judgement, it depends on the client, but like the other day I was just talking to a client and he's very depressed and he's had lots of problems with being able to move on and you know we were able to talk about the fact that he's always been a working man and had that as his main role with all the responsibilities and obligations that go with it, and that his depression has coincided with a big change there with his retiring and loss of that valued activity. That's something that has obviously come up before, but we were able to talk about it in terms of his roles and responsibilities and his values and the impact of this on his self-esteem, so we used all that kind of MOHO language. He seemed quite reassured to hear that. His wife has just been trying to get him involved in any kind of activity and we were talking about the fact that he's never really been that involved in the home in the past. He needed something meaningful and you know purposeful *for him*.
> So I suppose it's gradually creeping in [MOHO]. That was quite useful, I did wonder if I would have used as much of the language as I did.
> *(Susan: twelve months into the inquiry)*

Susan's decision to use MOHO with a service user arguably reflects Carr's (1986) critical approach examined in chapter two which focuses upon the relationship between theory and practice *in the context of practice*. When working with theory for practice in this approach, practitioners are prompted to critique and challenge their

ideas and beliefs about their practice, and develop an improved union between theory *and* practice (Carr & Kemmis 1986). Moreover I maintain that the PAR processes within the monthly group sessions prompted the therapists to more consciously articulate such learning, and this involved praxis:

> True praxis can never be just cerebral, it must involve action, nor can it be limited to action, it must involve serious reflection (1972: 40-1).

Indeed the growing contribution of MOHO within her practice can be seen in the following quote from Mary. It communicates an energy, a developing sense of agency and voice seen to emerge for her practice, including a renewed enthusiasm for reviewing practice across the service:

> I think my depth of analysis of a person's occupational performance is much more effective now. But also, I want to see whether the MOHO assessments translate well across functional and organic and I want to become familiar with the range of tools even if I'm not able to use them all the time in practice. In addition, I want to use the supervision to get to know all about MOHO with the aim of better supporting newly qualified staff on the wards. I want to try them [the MOHO tools] all thoroughly and keep using some of them... The newly qualified OT's supervision will be through me so it will be my role to hand that [MOHO] over and mentor and develop the therapists in those posts. Then the next stage up will be integrating the community and day hospital services. That's my plan.
> *(Twelve months into the inquiry)*

I suggest Mary's enhanced relationship between theory and practice served to promote greater self-understanding regarding her practice, which in turn increased her 'rational autonomy' (Carr 1986:183). By this I imply that through the conscious articulation of her learning Mary recognised how MOHO supported her to review her role and contribution as an occupational therapist in context; MOHO informed her practice and impacted upon how she then chose to operate. Importantly such realisations grew from her own active efforts.

Change takes people near to the edge: significant moments

However, developing a sense of agency did not necessarily emerge in a smooth way. Rather, individual therapists dealt with unease and discomfort in confronting their practice with colleagues. There were significant moments experienced within sessions, and these proved to be turning points for individuals as documented in my reflections at the time:

> *I noticed that John was not sharing in Ellie's enthusiasm for re-thinking the acute service. He appeared more reflective and quite defensive when he spoke; always presenting the barriers, stating that he couldn't see this happening. There was a lengthy discussion regarding personalities on the ward. What impact could OT have when the consultants they worked with didn't listen and always went ahead with their decisions regardless of views to the contrary? When I asked John to consider ways in which he could alter perceptions through use of the MOHO framework and selection of potential tools, which the medics might respond to, John came up with more excuses regarding how previous attempts to change dynamics on the ward had not been successful. I could sense John was getting more and more despondent about the situation. His contributions and body language all portrayed his concerns regarding proposed changes. In contrast Ellie was enthused and projected a much more open stance to team discussions. John became more and more contemplative. I reflected this to him at the end of the session. Here John admitted to having come to the realisation that he had built his practice up in rather a defensive way - this had hit him hard. On our way out I spoke with John, I was concerned I had pushed him too far – John said no, but he didn't want to say any more to me about the session than this – I was aware of not wanting to pressure him but I was concerned I had tipped him over the edge. I was concerned about how he would recover from this.*
> (*Reflective write-ups session 4)*

I recall my dilemma of whether I should contact John over the following month. I decided against it. I felt John needed time outside of sessions to think. In the next group supervision John openly acknowledged how negative he had felt towards change. He explained he had completed a lengthy critical reflection regarding his reaction in the previous session. There was a change in John's demeanour. He spoke about this recent set of events as a turning point. Such moments are what Denzin might suitably refer to as a transformational experience or an 'epiphany' (2001:34). I suggest John's reaction relates to Denzin's definition of an 'illuminative epiphany' (2001:37) in that underlying tensions regarding John's practice were revealed. I argue that a combination of my persistence with the therapists to consider ways to confront practice barriers, coupled with seeing other peers connect with MOHO prompted John to confront the problems and troubles he was experiencing in relation to his practice. Denzin suggests that such troubles are always biographical, situated in the historical and structural processes that surround a person's life. John's acceptance that he had built his practice up in rather a negative way was his turning point moment. In acknowledging this to himself and to the group his problem became public. I argue that sharing such honest reflections was of great significance for John. I suggest it made him more aware of his tendency to refute suggestions from colleagues and myself to try out alternative practices.

Ten months into the inquiry John changed posts within the Trust and moved from the acute setting into the community adult team (where he continued to attend the monthly group sessions). I am not suggesting that John moved posts as a result of this incident, nor from my involvement, indeed he shared with me that he had been considering a move out into community practice for some time. (He hoped this could increase his opportunity to work with service users away from the time constraints within the acute setting). However, what I believe has emerged from John's account regarding personal practice realisations connect with Savin Baden's (2008) assertion that learning is always linked to the biographical. As such, a person's ability to grasp [new] learning connects to contributory factors such as their life, their narratives and thus their practices. Although not easy situations for individuals to deal with, I argue that having opportunity to witness turning-point experiences prompted each group member to re-evaluate their own sense of self, in terms of practice, beliefs, meanings and ultimately of their own professional identity.

With hindsight, it was possible to appreciate that creating dialectic with participants within the group collective was the crux of what PAR processes offered. Our group setting and the cycles of reflection and action provided the necessary opportunity for the participants to become more familiar with and aware of the constraints that prevented them from fully participating in their communities. I came to understand my task as enabling the occupational therapists to take action to eliminate or minimise those constraints (Cockburn & Trentham 2002). Yet this very process would create tensions and the learning space would be experienced as 'troublesome', where 'stuckness' and 'disjunction' was the reality for individuals (Savin Baden 2008:95).

Our inquiry process moved in and out of troublesome spaces, as disjunction was experienced at both the team and individual level. Participants expressed their feelings of confusion, which often surfaced as anger and resentment. This impacted on the group dynamics and I often felt responsible for rescuing the situation. However, at other times, although an individual would be visibly agitated, it was obvious that other colleagues within the same team appeared more comfortable and enthused with the content discussed (as in the previous example involving John and Ellie). Savin Baden (2008:95) suggests a number of reasons that may prompt individual movement into a troublesome space. Of most relevance to this inquiry is her consideration of 'modes of knowledge', for example, the therapists' ability to make connections between the propositional knowledge of MOHO versus their practical and experiential craft knowledge. Likewise, her reference to 'learning

difficulties' were evident, observed during the struggle participants experienced in applying MOHO concepts to help structure their report writing, including the amount of time this required. Furthermore, through the process of engaging with MOHO certain therapists' may have connected with previous experiences of applying MOHO as a student, which may have been experienced as unsatisfactory (referred to as 'prior learning difficulties'). Finally, 'threats to learner identity' (Savin Baden 2008:95) may have been experienced. For example, within the group supervision forum participants may have felt unable to engage in useful debate; their suggestions or comments may have felt uncomfortably scrutinised. In addition, I suggest another important factor, which prompted certain participants to move into a troublesome space was when their attempts to 'act differently' were not met positively by MDT colleagues. Despite this situation the therapist remained aware that 'things could not go on as they were'. I believe this is evident in Barbara's reflective dialogue below:

> I have been very generic. If there was somebody off, I'm quite happy to do a group... Because if I am only doing something with 3 or 4 (service users) and there are 8 or 10 people who will be sitting by themselves I'll do it. I will do the group and it's wrong in some ways but in other ways I've always wanted to fit in with the day hospital.
>
> I think that is what is causing the problems now. People see me as the generic team member because I haven't stuck up for OT. I am trying to get them to see (MDT colleagues) and I am starting to question is it OT? Is it occupation based? Is it going to move my patients forward? Things are going to change, it will change slowly but I think it will make me feel better about my role, what I'm doing and why. So I can go home at the end of the day and feel what I did was good, what I did was OT as opposed to what I did was good but where was the occupation?
> (*Twelve months into the inquiry)*

As in Barbara's excerpt a developing sense of professional responsibility appeared to force identity issues and concerns about job satisfaction to the surface; Barbara acknowledged issues required dealing with. These 'significant moments', which had been building up for individuals over a period of time, could be compared to the crossing of a threshold concept (Meyer & Land 2006). As discussed in chapter three a threshold concept is a conceptual building block, which can progress a person's understanding of their discipline. I suggest that MOHO could be compared to a threshold concept in the way that it offers a professional perspective on ways to deliver occupational therapy practice. Working with others to make sense of MOHO concepts constituted a shift in thinking and practising for individual therapists. There was no doubt that observing Barbara, John and others make realisations about their

practice served to be transformative in terms of leading the participants to a change in their beliefs and attitudes, or a 'reconstruction of subjectivity' (Meyer & Land 2006:7).

Yet, journeying through such thresholds was not straightforward, taking individuals into territory which was uncomfortable, potentially risky and in terms of MOHO knowledge conceptually difficult to understand. As identified by Perkins (2006) threshold concepts are usually forms of knowledge, which have previously been viewed as counter-intuitive, alien and incoherent. Yet what is important here is the idea of individuals successfully navigating their way *across* a threshold. Whilst I suggest participants such as John may have experienced an 'illuminative epiphany' (Denzin 2001:37), for others the process was more cummulative (Meyer and Land 2006). Indeed strategies to provide ongoing support to the occupational therapists (like Barbara) during monthly group supervision meetings were required for ambiguity to be dealt with and irreversible transformative behaviours to occur. For example, the validation of all efforts and the use of problem-probing and problem-solving strategies amongst peers. In addition Barbara shared how Mary met with her to offer support. Furthermore, a new build within the trust re-located Barbara with other older adult occupational therapists working on the acute unit which Barbara hoped would offer further chance to 'get together'. I argue that Barbara's example provides a sense of what Wenger (1998) describes as mutual engagement, shared repertoire and joint enterprise, which he suggests is what a community of practice can offer its' members. Yet I argue that membership is not as harmonious as the actual terms might imply.

The importance of viewing the team member as an individual: sharing of ourselves

Five months into the inquiry process a prolific period of unrest emerged. This was particularly evident within the older adult team where concerns regarding group supervision had been shared outside of sessions with the head occupational therapist (Mary). Certain individuals believed the group sessions felt disjointed and more like 'in-service training'. Moreover, the therapists wanted more autonomy to be able to decide for themselves if they needed to attend sessions or not. The following excerpt from the subsequent session (which arguably was one of the most challenging periods of the inquiry process for me within the older adult team) highlights the events at that time:

> *Three therapists had not turned up, one of who had booked annual leave. I was concerned how the therapists appeared to be disengaging. I sensed a distinct lack of drive and commitment. It was proving very difficult to connect with everyone. It felt as though it could all quite easily fall apart. I used the session as productively as possible with the two who had attended. I talked with them about my approach regarding the structure of sessions and getting the balance right. I was open about my concerns. Having fewer members provided opportunity for a richer, perhaps more honest discussion to occur. The two therapists identified the issues at stake from their perspective – it felt as though a whole can of worms had been opened and uncertainty existed regarding ways forward. Yet this also felt like a turning point. It was obvious that I needed to make a point of arranging to meet with everyone individually between that session and the following. I wanted a more personal opportunity to share perspectives regarding the work. I could explain my reasons for structuring sessions as I had and what I was about. I also could listen to and strive to find ways to respond appropriately to the teams' needs and individual preferences*
> *(Reflective write-up session 6)*

Developing the group collective required relations amongst participants based on accountability in terms of what mattered and what did not, what should be talked about, what needed addressing. There were periods where we did not share the same view of joint enterprise, the therapists did not see my involvement as improving their situation, and indeed I was perhaps making the situation more problematic. What was required was negotiation between the participants and myself to appreciate one another's perspective; a responsibility we each had to appreciate individual meaning and identity.

As well as being with the occupational therapists in their teams for monthly sessions, I began to realise how the PAR process might neglect to identify the importance of the *individual therapist* therein. Although I maintain that the group process was central in shifting professional perspectives, the importance of identifying with the individual in this context was required. (Indeed this realisation provides my focus upon individual journeys within the following chapter.) Moreover, a key approach, which I believe kept our venture alive at the most critical periods of the inquiry, was the importance of meeting with everyone individually, evidenced from their distinct change of tack within sessions thereafter. Such strategies resonate with Lave and Wengers' (1991:52) theory that learning as participation in social practice needs to retain focus on the 'person-in-the-world as a [valid] member of a socio-cultural community'. The following example aims to account for such perspectives.

Clare worked as a sole occupational therapist in the Young Onset Dementia Service (YODS). From the start of my involvement she appeared to struggle with the MOHO

and would miss group supervision sessions. She had been a therapist whom I believed resented the change in focus of supervision sessions and had wanted more freedom to opt out of the MOHO collaboration. Observing her feelings of unrest, I arranged to meet with her individually which she agreed to. Here it became apparent that the dominant discourse voiced by other colleagues within the older adult team had served to blot out more subtle differences of opinion, which clearly existed. On an individual basis I appreciated the significant tensions regarding roles and responsibilities within the YODS in terms of blurred disciplinary borders. Although distracted to implement MOHO by a range of other potential influences, it was clear that Clare was concerned about how her MDT colleagues would react to a change in her practice. In addition the consultant in the team was a powerful figure who undermined team members' perspectives. Needless to say finding empowering ways of communicating her contribution within the YODS would be key for Clare and I argue that our PAR process provided a real means of her finding her own voice (Savin Baden & Wimpenny 2007).

I argue that in this study developing a shared repertoire (Wenger 1998) involved ability to connect with the individual therapists within the wider group. Moreover, meeting with individuals outside of group sessions provided me with much needed reference material for participants. Having an appreciation of the tensions Clare was experiencing I became better equipped to connect with her practice and tailor MOHO application strategies with her within sessions thereafter. As a consequence, over forthcoming meetings Clare's commitment to the group appeared to change. She invested time to try out one or two MOHO tools as a means of restructuring her own assessment process. Clare's efforts to pilot the MOHO tools enabled her to build her confidence and, over time, to redefine her occupational therapy assessment process within the YODS:

> It's totally changed you know the way that I look at people now because I'm actually focussed very much on what is important to them but also how they've coped in the past with certain things. Now I use that knowledge, you know. There are a few issues that I wouldn't have picked up before. So yeah. I'm just thinking totally differently.
> My perspectives on practice have changed. Yes, yes they have. Since we started using the assessments…I think it, perhaps it's just I feel more confident in having the theory and I feel more able to articulate things and I feel that I have got that knowledge behind me and I think that's what's changed, I now feel more confident and I can actually go out and come back to the MDT and say I've been able to complete *my* assessment
> *(Twelve months into the inquiry)*

This identification with the group member as an individual provided a different platform from which relationships with team members could be nurtured and dynamics thus altered. Furthermore, Clare reciprocated a supportive relationship by offering additional support to her fellow colleague Barbara outside of sessions. Likewise individual meetings enabled me to articulate my intentions towards and reflections of our inquiry process and I believe this provided opportunity for participants to see me in a different light. I maintain that nurturing relationships with individual therapists led to a different period of 'performing' (Tuckman 1965) whereby a sense of trust began to develop and relationships were nurtured, for example:

> *Stephanie informed me she was pregnant, our joint pregnancies created a much-needed bond between us and we had a shared connection from then on*
> *(Reflective write-up session seven)*

This short excerpt is an example from a number across the teams regarding the value of 'human connectedness' which occurred between the therapists and myself as the inquiry process progressed. The connections made were typically about life outside of work. Indeed, Fals Borda (2001:31) states how PAR can "convert those who engage in its processes to become thinking feeling persons". There was no doubt that sharing of ourselves proved to have potency in terms of working relationships. I recall sharing a personal family issue at the start of session eight of the older adult group and sensing a change in participant responses towards me (and each other) thereafter. This sharing of personal news set a more caring tone within sessions. I would receive email feedback from individuals with regards to this. In addition, participants brought strawberries and biscuits to subsequent sessions. Yet I also maintain that sharing of ourselves took a necessary amount of time to emerge and that using personal material as a means of forging relationships would not have proved to be so effective if it had been used earlier on within the venture. Whilst Wenger (1998) does not capture such personable issues I argue that over time, our community of practice benefited from nurturing a caring space within its enterprise.

Embracing a PAR process was not only about getting on with problem-sensing and problem-solving the issues at hand, but also considering the ongoing well-being of all those involved (Stringer, 1996). As problem solving impacted upon new action, the impact of change needed to be taken into account for those involved. Indeed it was evident that in forging new meanings further disjuncture was experienced for the

participants. In one example Mary had her new style of assessment report handed back to her by the consultant on the ward. It did not meet with his approval; it was not what he expected. Mary shared her frustration at his reaction within the following group meeting and we talked through how best to respond to the situation. Her decision was not to re-write the report, instead she handed it back personally to the consultant explaining the different approach she now wished to take in acknowledging occupational therapy's contribution. This example illustrates the impact of change not only in relation to the occupational therapists but also for those in contact with the practitioners. Whilst it is acknowledged that further consideration of MDT and service user / carer perspectives is required, such views are not within the scope of this study. What is of note here is how the group collective provided an important means of support and ongoing validation of individual 's efforts. Such features compliment those described by Guba and Lincoln (1989) in terms of collaborative inquiry placing emphasis on actions that respect an individual's sense of pride and belief in themselves. Participatory involvement across the teams required a genuine commitment to such values and respected the participant's sense of loyalty in relation to themselves, their colleagues, their employer and their profession.

Encouraging participants to become critical and reflective of their practice

The measure of success within our PAR process was not about participants having to follow prescribed steps but whether they had a sense of how their practice, and understandings of their practice (*consciousness raising*) had developed (Friere 1970, Reason 1994, Stringer 2007). The group reflective and action cycles provided the space within which a dialectic discourse was developed, and meaningful change considered. This was expressed through the participants' 'thought-worlds' or unique interpretative repertoires (Dougherty, 1992). Through the continued application of skills, competencies and capabilities with our action and reflection cycle's experiential knowledge was gained by the participants (Heron, 1981; Kakabadse & Kakabadse, 2003). Such dialectic discourse unearthed assumptions leading to intellectual discovery and new presentational knowledge. Evidence of therapist's realisations and discoveries regarding their practice emerged through the sharing of individual experiences. This can be seen within the following excerpt by Susan:

> MOHO has opened up my thinking regarding the scope of my role. It has been positive. It's certainly got me thinking about things quite a bit more and it's made me realise the importance of our role. It's very relevant (MOHO)

> and significant and you know before I would sit and ponder what my role is in the team so it has been quite helpful there. ..
>
> I suppose it's making the time to actually sit down and think about it. When I've actually done it it's not been too bad. Its change isn't it? Managing change. It's doing things slightly different, yet progress can be quite effective once you started to use it…
> I think we all egg each other on. I think we all have mixed feelings at different times, sometimes we are all being quite positive about MOHO and there will be other weeks where it's not going well or it doesn't seem as relevant...
>
> It's good for students because they can get straight in there. It's easier to get them straight involved in assessments because you've got proper tools to give them. It makes you feel more confident as a fieldwork educator to give them that to do as well, so that's been helpful.
> *(Eighteen months into the inquiry)*

I suggest that Susan's reflection connects with the new learning opportunities the occupational therapists' experienced, which in turn led to a developing sense of agency. This sense of feeling strengthened by what the therapists saw they could achieve within their practice served to build the wider participants' sense of identity and belief that what they had to offer should be valued (Savin Baden & Wimpenny 2007). Realising that alternatives for practice existed that were viewed as having relevance and worth led to the therapists stripping away old identities and previous practice repertoires that had once suppressed forms of participation. Indeed reviewing practice [with support from MOHO] within the group collective, offered potential for a 'disempowered' group to identify new ways of thinking and participating (Friere 1970), and this is the focus of the final section of this chapter.

The crux of participatory learning: identity work

Rather than the conception of knowledge viewed as powerful and thus rendering the capacity of the therapists' current knowledge as less important, I argue here that MOHO was intended (and came to be viewed) as a resource, which offered a means of problem solving the therapists practice dilemmas and mobilizing and informing their decision-making. Yet I acknowledge that during the period of actual fieldwork this process paid less attention to the therapists' own forms of practice expertise (or professional craft knowledge). I entered into the collaboration viewing MOHO as a resource to be used by the therapists to increase their awareness of their capacity to act and experience improved role identity. However, now I can also appreciate that MOHO had potential to stifle the therapists' practice via issues of power and control linked to the wider professional agenda as outlined by professional and government drivers for the delivery of efficient, evidence based services (DH 2001; COT 2005;

COT 2006, HPC 2004). However, that said, through the process of uncovering professional issues via the MOHO, over time, shifts occurred for individuals within the teams. This was evident in both individuals articulation of their practice in group sessions and their levels of respect towards one another. Through this process the occupational therapists (re)-connected with an improved sense of professional worth and found improved meanings for their work (evidence of which is examined in more detail in chapter seven). In essence I argue that the learning experience through this social enterprise was fundamentally about identity work (Lave & Wenger 1991; Wenger 1998) in that the therapists were all challenged to review who they were and what they knew.

Despite practice barriers, which kept on emerging, including an ongoing sense of disjuncture for the participants, the majority of occupational therapists embraced MOHO, albeit to different degrees. I believe this was due to the developing sense of community including the use of a range of learning spaces (centred around monthly group supervision sessions), which provided authentic opportunity for the participants to examine their practice repertoires. The opportunity to engage at both an individual level and with peers in a period of prolonged shared learning provided a necessary level of momentum and demonstrated what could be achieved when appropriate structures are made available to prompt critical inquiry.

Notwithstanding the acknowledgement that situated learning is challenging to engage in, the notion of Wenger's (1998) communities of practice has enabled me to appreciate how learning in a community provides a valuable context in which [new] knowledge can take on significance and be sustained. Learning in this sense is thus viewed as a social process, which may initially be legitimately peripheral and gradually can increase through engagement. This is aptly highlighted by a quote from McDermott (1999:17):

> Learning traditionally gets measured on the assumption that it is a possession of individuals that can be found inside their heads. [Here] learning is in the relationship between people. Learning is in the conditions that bring people together and organise a point of contact that allows for particular pieces of information to take on relevance. Without the points of contact, without the systems of relevancies, there is no learning, and there is little memory.

Conclusion

This chapter has uncovered the complexity of change experienced across the occupational therapy teams. I have presented the sense of disruption which was seen to occur as the three teams of therapists engaged in the process of reviewing their practice in front of peers and myself. I identified how the influence of tradition and practice culture can serve to present barriers to considering alternative means of practising. I have examined the significant amount of time and commitment required to nurture team based relationships and re-negotiate the use of the monthly group supervision sessions as an effective (critical) learning space.

My role as an external group facilitator has been viewed as both holding the practice development together as well as creating disjuncture for participants. For example, I have examined the use of strategies used to present the MOHO concepts and assessment tools in a coherent yet accessible way and how this created tension for the participants. This was discussed in terms of the challenges I faced in achieving the right balance between incorporating rather than imposing knowledge. I did not accept that there were not ways forward to overcome barriers the therapists experienced at implementing theory-driven change. Yet such techniques adopted were not always welcomed and I believe I became a (necessary) irritation to all of the therapists at least some of the time.

The chapter acknowledges the importance of developing a group dialectic in which the shifting of professional attitudes and behaviours was prompted, which for certain therapists led to the experiencing of a personal epiphany (Denzin 2001), whilst for others change was more cummulative. The ongoing sense of journey included the challenge of the therapists' interpreting MOHO for their practice and this was considered in terms of the threshold concept literature. Nonetheless, it was also evident that as therapists chose to act, reification occurred which provided much needed validation for the therapists that their efforts where worthwhile.

Over time, I therefore argue that a group collective emerged, a community of practice (Wenger 1998), in which (MOHO) knowledge appeared to take on significance. Yet I believe what occurred ran deeper than just considering what influence a conceptual model of practice could have. At a more fundamental level I realised that the group collective served to shift professional identities through examination of 'what it [was] to be a competent practitioner, an outsider or somewhere in between' (Wenger

1998:137). For the occupational therapists working as the sole therapist within the MDT membership to such a community of practice played a vital role in realigning their professional perspectives.

Whilst resolutions to group tensions and contextual barriers have been considered predominantly in terms of the situated learning opportunity, the importance of focusing on individual perspectives within the group collective was highlighted and this forms the focus of the next chapter.

Chapter six

Personal agency and facilitator / participant relationships

Introduction

In the previous chapter I built an argument around the importance of harnessing *learning spaces*, one key learning space within our inquiry being that of the team based group supervision sessions. I suggested that the influence of the *dialectic* generated within the group supervision sessions provided opportunity for critical debate and exploration of the MOHO to take place. As a consequence individuals took steps to advance their practice. Moreover, in addition to the effectiveness of the group dynamic, which I referred to as the *group collective*, it was also increasingly apparent that individual identities needed to be recognised. In this chapter I focus upon individual journeys: two therapists responses to implementing MOHO over a two-year time span will be explored. In particular the focus of the chapter takes up issues regarding personal agency and facilitator / participant relationships.

The two occupational therapists have been chosen because they provide contrasting behaviours and characteristics which I believe are interesting to explore. Issues surrounding the practice context and professional boundaries were forced to the surface for one. Focus on the second therapist takes up such issues in more depth, including how a person's interpretation of their skills and capacities informs and often dictates an individual's choice to consider change. I suggest that what is presented is of importance to external (group) facilitators involved in practice development initiatives who are searching for ways of augmenting participatory relationships.

The chapter places emphasis on constructivist approaches to learning in which it is recognised that the occupational therapists needed to create or recreate knowledge for themselves (Perkins 2006). Implementing MOHO was not just a cognitive or behavioural act but involved knowledge construction by the individual therapist through her / his own experience of practice in context. It is necessary to add that any one of the (core eleven) therapists involved in the study could have been chosen for review in this chapter. The point here is that each therapist clearly brought their own highly individualistic characteristics to the inquiry process, which would in turn impact upon their response to implementing MOHO.

As a brief introduction to both occupational therapists, I suggest that Emma, whilst determined, was a therapist who encountered a good deal of 'troublesomeness' and 'stuckness' within her work, centred on projecting a clear role and identity for herself in her practice. Such concerns were evident as she progressed through the inquiry

process. However, whilst I believe Emma found integrating MOHO hard going, except from a two-week period of planned annual leave, she attended every session and met with me individually throughout. What has emerged from Emma's journey is how practitioners can be unjustly criticised for not being seen to 'engage' yet closer scrutiny of individual meaning making in context can prove otherwise.

Mary in contrast, presented as a more self-assured therapist who felt able to project her role and contribution. Whilst cynical of integrating MOHO at the outset, she became what I would describe as a 'champion of the cause' clearly finding value and worth through *embedding* MOHO within her practice. As head occupational therapist I suggest she approached the venture from a number of directions. For example, she did not have an in-depth understanding of MOHO and therefore needed time to acquaint herself as a novice with the theory and assessment tools, yet as a senior practitioner she was conscious of needing to project competency within her practice. In addition, it was clear she felt a great deal of loyalty toward supporting the occupational therapists to deliver more profession-specific, occupation-focused practices. In terms of our relationship, it flourished. I believe from quite early on we appreciated the others involvement.

It has been important to consider ways of expressing the dynamic experience of the therapist's engagement with the MOHO in ways that do not distort reality. Theories presented in chapter three have been used to analyse the detail of the experience. In particular Prochaska *et al.* (1992); Prochaska & Velicer (1997) Transtheoretical Model; Bandura's (1977, 1982, 1997, 2001) perspectives of personal agency and self-efficacy beliefs; and perspectives from learning theory in terms of the threshold concept literature (Meyer & Land 2003, 2006; Cousin 2006; Savin Baden 2006, 2008) are considered. I believe such literature provides a means of presenting outcomes from the study in a meaningful way, whilst embracing complexity.

Importantly I wish to add that I met with each individual therapist to share their portrait and my interpretations. They have been provided with a pseudonym and have consented to the detail being presented.

Emma: 'up and down yet the trend is upward'

Emma clearly articulated a desire to keep occupation core within her work and to practice as an occupational therapist. Yet her ability to carve out her role as an occupational therapist was repeatedly challenged during our time together.

Emma began her occupational therapy training as a mature student aged 25. She qualified in 1999. Her work pattern had predominantly been that of a sole occupational therapist working within a wider multidisciplinary team (MDT). Emma was aware of the challenges she faced as a lone therapist and how this impacted upon her sense of professional identity:

> Although I think I felt more comfortable and confident in developing my skills after I graduated, when I didn't feel pressured that I had to do it in a set time (unlike when you're on placement and you feel you need to prove yourself). In post I felt I had the time to soak in information, reflect on what I was doing. But I guess I was thrown in somewhat, not by other people, but into a role, which was a sole OT in a team and I guess I had to learn quite quickly. I think the down side of that is that I didn't have lots of OT around me in order to develop my sense of identity. I had to do the job and it was about justifying why I was doing it. I wasn't good at that, but that came the longer I was there. (*Six months into the inquiry*)

As the sole occupational therapist within her team Emma was aware of the fact that her colleagues did not have regular opportunity to actually see that what she was doing was occupational therapy. They were more likely to observe her use the generic assessment tools also implemented by the nurses and social workers. Emma acknowledged that her generic responsibilities diluted what she should be focusing on. She admitted her focus for her own discipline could 'float'. When we first met she was developing a new occupational therapy role for an early intervention service. It was evident that there were fundamental aspects to the service which had not yet been decided, for example where team members would be based and what assessment tools would be used.

As identified within the opening chapter, occupational therapists in mental health often struggle to promote their specialist contribution (Creek 1998, Lloyd *et al.* 1999, Taylor & Rubin 1999, Finlay 2000, Fortune 2000, Parker 2001, Greaves *et al.* 2002; Krupa & Clark 2004, Wright & Rowe 2005, Pettican & Bryant 2007). In terms of integrating MOHO Emma acknowledged this felt like a positive means of realigning her practice and promoting her specific occupational therapy contribution. Yet in

group sessions she also spoke about dilemmas in terms of the MOHO bringing a language to her practice, which could alienate her from MDT colleagues or service users; a criticism shared by Hubbard (1991). This conflicting sense of duty was potentially a reflection of the loyalty she had towards her MDT colleagues and the obligation to accept team responsibilities. Government policies, including the Community Care Act (1990), have encouraged interdisciplinary working for all mental health practitioners; yet arguably such policies do not support disciplines to maintain their unique roles (Taylor & Rubin 1999, Cook 2003). I suggest the practice development initiative forced Emma into making decisions regarding levels of satisfaction with her working practice. I sensed she felt marginalized in being a lone worker, yet uncomfortable in projecting herself as offering something different.

It was apparent there was opportunity for Emma to shape and mould a specialist occupational therapy role within the context of early intervention work. However, from Emma's perspective it was not so straightforward:

> Each of the different areas are at such different stages of development and they are all working quite differently, so there is no kind of standard within early intervention. There's lots of talk at the moment about using lots of assessment tools, which again conflicts with what I want to be doing. I want to be using occupation-focused assessments. Yet if their standards are set that early interventions teams need to be using this other set of assessments I'm a bit torn. Actually the last meeting we went to, and I think it was following our supervision, there was a talk about tools that are being used as in mental health assessments, symptom assessments. Frances mentioned the 'occupational assessment' and our approach in the meeting but it was just flattened. So not feeling very brave at the moment, but I mean it was mentioned [MOHO] and that's kind of a starting point.
> *(Six months into the inquiry)*

I believe that at the outset of our work together, Emma was between the stages of contemplation and preparation (Prochaska *et al.*1992) in that she recognised a need to review her practice but had only made limited commitment to take any action. As identified, such stages are beset with trouble where individuals may feel 'stuck' with efforts to promote change not necessarily being well thought through.

Tensions around 'transmission of knowledge'

Emma and I held differences of opinion regarding how she could map out her role and contribution within the early intervention service. She was not comfortable with my proposals to support her and meet with senior colleagues in the service to promote her contribution. From my perspective I believed MOHO and the associated

assessment tools offered a tangible means of addressing Emma's needs. With hindsight I am aware my approach could be criticised for not showing sufficient respect for her current practice (Moran *et al.* 1998). Nonetheless, I maintain that my involvement (examining MOHO) was cathartic in that it prompted Emma to re-examine her professional perspectives. My expectations of Emma establishing herself within the early intervention team were high, fuelled by my fundamental desire for her to assert her position. Yet at times I lost sight of Emma's needs in respect of my own agenda and fell short of embracing the philosophy of participatory action research, which I felt I was so committed to.

I became aware of issues around 'transmission of knowledge' (Brown & Duguid 1991, Lave & Wenger 1991). I was bringing in a theory-driven agenda, which was advocating change. Whilst Reason (1994) suggests that it is likely the group will need some *democratic* leadership, which is both facilitative and educative, I acknowledge that I tended to adopt a more educative / formal tradition of pedagogy and 'know-how' at times in that I was keen to impart my MOHO knowledge in a more technical-rationale way (Schon 1983). Interestingly when this style of facilitation occurred, the team, including Emma, rejected it. I believe this was a consequence of not giving adequate focus to truly listening to what was being said (and not said). The importance of participation in this collaboration was key to its success. Movement occurred when the individuals were active in the process and engaged in meaningful dialectic, which enhanced their participation and respected their experience and knowledge (Wenger 1998).

Whilst Emma regularly attended our monthly group supervision sessions and acknowledged that she thought embracing MOHO was the right thing to do, there was a hesitancy to test out MOHO directly with service users. Over the first few months a pattern emerged in which Emma identified action points for herself in the group (piloting a MOHO tool, recording and reporting on a case, communicating a draft referral system with MDT colleagues) but then did not appear to address such plans between sessions. As a consequence, when review of participants' practices was encouraged, Emma would not have a great deal to report. Kitson *et al.* (1998:152) have described facilitation as a 'technique by which one person makes things easier for others'. However, in terms of my relationship with Emma I suggest it was more likely that I created disjunction and fragmentation for her, which became evident when we met together *outside* of sessions:

> I've actually felt really negative over the past 2 or 3 [sessions] it has been hard. Oh, the last one I nearly didn't come. It is a learning process isn't it. Its not all going to be easy and I do feel the model is beneficial and will work within the teams its just getting it going. I've just felt like I've been whinging all the time. It's how I felt and it's been really difficult to be positive about it.
> *(Twelve months into the inquiry)*

During group sessions Emma's questioning approach suggested she was establishing a criteria for herself whether or not to take action (Prochaska *et al.*1992). For example, she wanted to know how the MOHO tools would enable her to be 'natural' within an assessment context with a young person. Emma's concerns potentially reflected a more fundamental tension relating to her own epistemological stance in utilising scientific know-how over more artful forms of practice. Whilst individual's epistemological beliefs will be addressed in the following chapter, the focus of my argument here rests more with attempting to appreciate what other possible personal influences impacted upon Emma's reluctance to implement MOHO. I believe the demonstration of her doubts and misgivings suggests self re-evaluation processes as identified within the Transtheoretical Model (Prochaska *et al.*1992) in that she was assessing the potential impact of MOHO on her practice and whether the personal commitment and effort required to change would be worthwhile. As outlined in the Transtheoretical Model such decision-making processes can account for why individuals may resist action-orientated behaviours.

As identified, I believe Emma was stuck between the stages defined as contemplation and preparation (Prochaska *et al.*1992). Furthermore, I suggest these are difficult states to shift from. Regardless of what might be viewed as a reasonable argument to consider alternative practices, ultimately the decision-making process to commit to change was purely down to Emma. Movement forwards would not occur until she made the decision. Yet I suggest that whilst the participant remains undecided, frustrated others (in particular a facilitator) can undermine the individual's skills and capabilities and sense of personal agency, which can further delay and complicate feelings of competency to act. Within the inquiry process I admit to feeling frustrated that Emma appeared unwilling to take active steps to test out MOHO and the tools for application. I felt time was precious; with hindsight I can appreciate more careful handling of the situation was required in order not to project a lack of tolerance. Successfully navigating a path through the contemplative stages was required - this would be a delicate process.

Meeting with Emma individually offered us both time and space to express, *and own*, our feelings toward our work together; to appreciate the personal and affective experience, which was not as evident within team based discussions. Such meetings enabled important time-out from the substantial effort required in group sessions to persist with the practice agenda. Yet at the time I admit I felt uncertain as to how to best support Emma. Cousin (2006:143) directs concern at teachers (facilitators) who require their students to learn too fast, this includes an appreciation that 'learning and teaching are always relational'. Emma's approach to her learning required sufficient respect for the difficulties she was encountering, which I suggest were a combination of the subject matter of MOHO, the challenges of MDT working and the pressure to integrate MOHO from both the Therapy Service Manager and myself. Emma's situation can be likened to working across a threshold (Meyer & Land 2003). Moreover, I believe Emma was for a period of time suspended in a state of liminality in that her understandings of MOHO had not reached an *authentic* state. Indeed, Cousin (2006:139/40) identifies with the troublesome nature of learning, highlighting how certain students can be seen to be 'going through the motions' of understanding yet have not entered the transitional state of liminality where transformation is achieved through mastery of what is being studied. For example during group sessions Emma's conversation suggested a readiness to engage with MOHO yet this had not been evidenced through 'critical engagement' (Cousin 2006:142) in her practice. I suggest this was because sessions offered a vision of what practice could be yet back in her team-based location, operating as a lone worker, it was not so straightforward. Emma wanted to and needed to work through what was being suggested at her own pace. This links suitably to Bandura's (1989) view that unless people believe that their actions can produce the outcomes they desire, they have little incentive to act or to persevere in the face of difficulties.

Cousin (2006) has proposed a number of positions which learners may take with respect to levels of engagement: the spectator or voyeur learner, the defended learner, the victim-idenitifed learner and the self-reflexive learner. Whilst Emma does not appear to neatly fit any particular catgeory, features observed identify with aspects of each; for example, I believe she displayed tandency to 'gaze at a distance' without sufficient scrutiny / interrogation of her own practices, there was a degree of defensiveness observed. In contrast there would be signs of Emma inquiring into her own meaning-making in terms of sharing information with her peers in group sessions. Cousin (2006) suitably suggests that awareness of such positions is valuable for the teacher whose task is to create space to discern if, for example, the

defended learner has felt left out, or a victim-idenitifed learner has felt unduly exposed.

Such perspectives offer insight in terms of Emma's relationship toward MOHO and myself. Beneath the surface of our interactions (both at the group and individual level) I believe tensions existed for both of us. Whilst we could talk about the experience we shared, I suggest we had a competing need to feel in control. Yet rather than our behaviours serving useful effects it was evident that both Emma's and my own decisions were not beneficial for either of us. Indeed, Bandura (2001) implies that exercising agency will not always result in advantageous outcomes. It was apparent that she was not happy with how her role within the early intervention service was progressing and I was concerned at not making much headway within my remit.

Interestingly, a few months into our inquiry Emma decided to move her work-base in with the acute occupational therapists:

> Having the close proximity to the other OT's should provide a sense that you have more support around, and having that occupational focus as well. So listening to MOHO language on a daily basis helps. And I think that was my reasoning really to move back into the OT department when I got this role. I'm not sure it was the best move because they work quite differently, because they were working in an acute setting and I'm looking at working in more of assertive outreach community work. So maybe I had this little ideal in my head of what it would be like.
> *(Six months into the inquiry)*

I suggest Emma's decision reflected a desire to address her experience of being a lone occupational therapy worker: however, as acknowledged in this excerpt, this potential source of support did not work out as Emma had hoped and shortly after this she took a decision to move post out of early intervention. Bandura (2001) identifies how people set goals for themselves and select and steer courses of action to enable desired outcomes and avoid detrimental ones. Emma was not content with her situation and she took a decision to affect it. With hindsight it is possible to appreciate Emma's active pursuits to address concerns with her practice (Bandura 1989). Moreover I believe her actions are demonstrative of her attempts to navigate a course across a threshold concept (that being improved mastery of her professional practice). Furthermore, I argue the MOHO prompted the self-monitoring processes that influenced Emma's decisions to act.

The Transtheoretical Model also provides possible suggestions for Emma's response. From one perspective her decision to move posts could be viewed as a setback, a missed opportunity to develop a role for herself within a new and emerging team, and a shift back to *contemplation*. Such movement may likewise be representative of addressing her safety needs as a learner (Cousin 2006). However, Emma's decision could equally be viewed as evidence of movement forward toward *preparation*, of maintaining momentum to effect change, to keep on moving to a preferred set of circumstances (Prochaska *et al.*1992; Prochaska & Velicer 1997). From either perspective, I have realised the importance of the facilitator within a practice development initiative to be cognisant of the potential conflict and disjunction individuals may experience during movement within change processes. At the time I recall how difficult it was for Emma or I to make sense of the situation and work out how best to pool our resources.

In terms of Emma's ongoing journey, her next post interestingly was in case management as part of a CMHT. A senior occupational therapy colleague was already part of this team but would be on maternity leave for up to a year. As such, for the majority of time I was involved, Emma was again working as a sole occupational therapist. In the UK, case management is routinely provided for service users with severe and complex mental health problems (Parker 2001). Furthermore, taking a generic role is a common expectation in many community teams (Brown *et al.* 2000). At the time I admit to feeling confused as to Emma's choice of post. For a second time she was in the position of needing to promote a clear role for herself as the occupational therapist within a wider MDT.

In her new role, Emma's desire to engage with the MOHO fluctuated. It was apparent that her main focus was on establishing herself within her case management role. As such integrating MOHO into her practice proved difficult:

> At the moment, because previous to moving to this role I felt I really was getting my head round what I was doing in terms of the model - obviously still struggling but it was becoming clearer - and then coming to this new role and I feel like I'm really struggling now but I can also see the opportunities with it and the benefits of using it, and I am using the tools but maybe not as often as I would like to be, which means that the confidence doesn't grow as quickly as it could. So I sometimes come away [*from the monthly group supervision sessions*] thinking its like an extra pressure on me to do that although I really like it. I really like it as a model and it's a really good framework. I like the flowchart that has been developed to help us through the referral/assessment process. I do really like it but I am struggling a little bit.
> (*Six months into the inquiry*)

It was apparent Emma was influenced in part from competing environmental stimuli (Prochaska *et al.*1992) in terms of managing expectations from the occupational therapy service alongside pressure from her CMHT to take on generic work. As outlined within the literature a debate clearly exists regarding optimal type of casework for occupational therapists working in CMHT's (Corrigan 2002, Dunrose & Leeson, 2002, Forsyth & Summerfield-Mann 2002, Harries 2002, Stone 2002, Harries & Gilhooly 2003). Lloyd *et al.* (2002) acknowledge how occupational therapists need to carefully consider how they can achieve a balance between performing generic roles and discipline specific ones; whilst Cook (2003) questions if occupational therapists should be delivering a role that extends beyond the established professional remit. There was no doubt that Emma was caught up in the generic versus specialist debate. Yet Emma's behaviour appeared all the more confusing, as it was known that the occupational therapy service manager was in negotiation with the CMHT to take the occupational therapists out of case management. There would be an expectation that when this decision was accepted (if it was) the occupational therapists would need to prove themselves. From my perspective, implementing MOHO and the assessment tools would clearly support Emma in this occupational therapy role. I believe she recognised this too, evidenced by her continued attendance at monthly group supervisions despite the conflict sessions created for her. In addition, Emma took steps to pilot a MOHO assessment tool. Although any negative response from the service user was viewed as a setback and impacted upon her confidence:

> They [*the assessment tools*] were really helping until the last 3 months and I feel I've fallen down the ladder a bit again. It is bit of a roller-coaster really. I did feel like it was really coming together and then now again, I've dipped.
> (*Twelve months into the inquiry)*

> I think it is the naturalness of when you first use them it doesn't feel natural and I feel that it prevents you building up your rapport with the person you are working with and that you know you are just there firing questions at them as opposed to it being like conversation and people starting to have some trust.
> So I thought about using the tools more flexibly and I did the OCAIRS with a young guy and I transferred all the questions onto cards so it was user friendly, it didn't look complicated, and I asked the questions from the cards; I explained it to him and that was fine. He was very responsive to the questions, though the outcome was that really he didn't want to change and I think for me that kind of put me off really.
> (*Eighteen months into the inquiry*)

Relapse and recycling through the different stages regularly occurs (Prochaska & Velicer 1997) and the Transtheoretical Model acknowledges how most people's

actions to effect change are not successful on their first attempt. Emma's response towards the challenges faced when attempting to implement MOHO would be to revert back to former ways of working and maintain her within the *preparation* or *contemplation* phases. However, rather than regress back from where a person began, Prochaska and colleagues assert that when certain *processes* are employed, individuals are more likely to learn from their mistakes and try again.

The processes of change

Emma's reaction to her setbacks reflected more fundamental concerns regarding the amount of effort, energy and the levels of personal commitment that she realised would be required to effect any satisfactory outcomes for herself (Prochaska *et al.*1992). When considered in this light, the validation of any efforts Emma demonstrated to engage would be vital. On reflection it is possible to appreciate the motivational factors which influence individual learning and behaviour which provide an indication of how determined a person will commit to performing the new behaviour (Bandura 1977, 1982). Emma's efforts required more applause than she received from me. It was evident how much effort was required to keep going and to try again (Bandura 2001). This is especially of note considering how Emma's attempts to improve her sense of role and contribution had not, as yet, worked out that positively for her.

When such circumstances are examined in light of Prochaska and colleagues theory tangible explanations can be considered which relate to Emma's *ongoing* commitment that would be demonstrated in less obvious ways than traditionally expected. For example, her use of *open dialogue* in our group supervision sessions and fear of 'whinging' could be translated as a strategic process of *dramatic relief* whereby Emma expressed her feelings towards the competing challenges she faced. The 'outpouring' of such emotions in itself can lead to a recognition and desire to make change, and such processes have been identified by those attempting to change addictive behaviours (DiClemente & Hughes 1990; Prochaska & DiClemente 1985; Velicer *et al.* 1990). Indeed, Prochaska *et al*. (1992:1109) have recognised such processes from their extensive research and detail that:

> 'As individuals are known to become more conscious of themselves and the nature of their problems they are more likely to re-evaluate their values, problems and themselves both affectively and cognitively. The more central their problems are to their self-identity, the more their re-evaluation involves altering their sense of belief'

Arguably this review of personally held beliefs towards a given behaviour enabled Emma to take small steps toward considering implementation of MOHO and more direct action-orientated behaviours. In essence it appeared Emma had started to grasp the integrative nature MOHO offered her practice (Cousin 2006). When viewed in this light, I believe it is possible to envision wider application of The Transtheoretical Model as a means of *praxis*, of enabling a person to become more conscious about their situation within the world and how they can work to remove [self] imposed barriers. In relation to Emma this could be linked to how she used our individual and group sessions as learning spaces wherein she engaged in a process of *self-evaluation* and *environmental re-evaluation* (Prochaska *et al.*1992).

At this juncture I believe the focus on re-evaluation of the physical environment alone within the Transtheoretical model is inadequate in capturing the influence of the practice context and I contend that in this study re-evaluation occurred within both Emma's physical and *social* environment. Within the context of the group collective, or community of inquiry, Emma could appreciate how her current practice repertoires impacted upon her satisfaction with her working environment; this occurred through engaging in dialectic with her peers. Furthermore Emma spoke of the contribution of the monthly group sessions as a means of supporting her to cope on an individual level to persevere with the MOHO. Without such support Emma stated her commitment to the venture would have 'fizzled'.

My direct involvement with the group ended after thirteen months. Approximately six months later I met with Emma and found that her perspectives had shifted:

> Yes my practice has changed. I think in fact - remembering what we talked about last time - I think there were quite a lot of anxieties about my role and learning new skills in terms of case managing as opposed to occupational therapy skills. So I feel that's developed much more and I feel much more comfortable within the case management role and I feel that I am able to focus on occupational therapy now whereas I felt that that was getting pushed out quite a lot
>
> I think actual progress with MOHO and the tools has felt quite slow actually but I think that's probably how it had to happen, but I certainly feel this time when we meet it certainly feels different to the previous meetings and I don't know whether that's happened for any of the other individuals or whether you know it was personal circumstances, but I certainly feel that I've come on much further in confidence in using the tools.
> (*Eighteen months into the inquiry*)

Importantly, Lisa (a senior occupational therapist who had been on maternity leave) returned towards the end of the second year of our collaboration. This certainly appeared to be a positive event for Emma:

> Having the time to concentrate and focus on the model and balance that with the generic responsibilities, that's been the biggest challenge and to try to do this on my own within the team, which has generally been the case, are the hardest things I've had to do. It is different now and it feels different, it feels like a weight has been lifted with Lisa coming back. To have someone in the same room as me to discuss cases, to come back to the model and reiterate, reinforce what we're doing is positive
> *(Twenty-four months into the inquiry)*

In addition, two key MOHO tools were established within Emma's practice and a structure was in place for the occupational therapy process. Specific referrals came to her. The MDT team were supportive and she did not speak of feeling alienated. Moreover, Emma agreed to be named on a paper in the British Journal of Occupational Therapy, (Wimpenny, Forsyth, Jones, Evans & Colley 2006) (see appendix seven) and presented findings from aspects of our work at a National Occupational Therapy Conference in Cardiff that same year (Wimpenny, Forsyth, Jones & Colley 2006).

Bandura (2001) states that facilitators have the challenge of improving the learning and practice confidence of the practitioners in their charge. Furthermore he asserts how facilitators need to improve practitioners' emotional states and to correct their faulty self-beliefs and habits of thinking (personal factors), improve their professional practice skills and self-regulatory practices (behaviour), and alter the structures that may work to undermine therapists' success (environmental factors). When viewed as a whole Bandura's role descriptor for the facilitator presents a daunting range of practices to absorb and implement. In addition, I argue such assertions promote the view that the facilitator knows best. At the time of my formal involvement I believe I aligned myself to such principles in an honest attempt to support the occupational therapists, including Emma. With distance from the event, I have realised that inherent within Bandura's perspectives resides an apprentice-type learning model, which is troublesome not only because of the prescriptive nature that such learning imposes on a person, but in addition is the concern that individual ability to develop autonomy and responsibility can be stifled. I therefore realise that a facilitator needs to be mindful of their own exercising of agency; indeed an important element of the facilitator / participant relationship is for the facilitator to gauge their response so that

it is the *participant* who is empowered in the decision-making process. Furthermore, I maintain that the *group collective* proved invaluable in terms of negotiating changed perspectives within this inquiry; where team members could adequately exercise their views and review their respective practice repertoires. It certainly was not all about the influence of myself as the group facilitator; indeed I acknowledge that my role clearly had its boundaries.

Summary

Whilst Emma's portrait identifies with how the relationship between participant and facilitator can both enable and hinder the implementation of any new knowledge, Emma's shift into an *action* phase (Prochaska *et al.*1992) clearly occurred *following* my direct involvement. I believe that Emma's account demonstrates important learning points about the challenges faced by lone working and implementing change processes. For Emma, issues surrounding the practice context and professional boundaries were forced to the surface. Personal strategies employed to navigate change required validating.

From a facilitator's perspective, Emma's story provides realisation of the importance of not measuring change by standard means alone. By this I mean that whilst it is understandable that facilitators become disheartened when those individuals involved in practice developments agree to action points which they then do not follow through (despite repeated attempts of those around to support, encourage and coax), more inclusive consideration of individuals' behaviours (or *apparent* lack of behaviour) needs acknowledgement.

Prochaska *et al.* (1992); Prochaska and Velicer (1997) theory offers such inclusive arguments, which acknowledge subtle behaviours within change processes. However, whilst useful, the Transtheoretical Model did not account for the breadth of issues which were uncovered. Moreover, as the Transtheoretical Model was fundamentally developed for use with individuals with substance misuse issues, it appeared less able to speak to the agenda regarding the influence of group dialectic on professional identity and knowledge assimilation. Whilst the stages offer insight, I argue insufficient emphasis has been placed on detailing how the processes serve to shift a person across the stages of change, especially those processes regarding self re-evaluation and environmental re-evaluation (Prochaska *et al.* 1992:1108-9). How a person thinks and feels about her / himself in relation to a problem or issue requires further in-depth consideration. Such issues have been examined here with reference

to the threshold concept literature (Meyer & Lands 2003, 2006; Cousin 2006). In addition, Bandura's understanding of personal agency has been considered to enable insight into the importance of individual projection of autonomy. Focus on the second therapist takes up such issues in more depth, including how a person's interpretation of their skills and capacities informs and often dictates an individual's choice to consider change.

Mary: The powerful nature of self-belief

I suggest Mary was within the *contemplation* stage (Prochaska & Velicer 1997) when we first started our inquiry process in that she was rather sceptical of occupational therapy theory. It was apparent there had been a time when she viewed occupational therapy models as quite limiting. Moreover, she stated that she didn't initially like MOHO as a graduate but would use it with students as a 'starting point'. Interestingly, rather than a lack of confidence per se in embracing MOHO, Mary's scepticism was based on her awareness of the lack of a direct evidence base for MOHO within her speciality (older adults with organic / functional mental health problems).

Mary was the head occupational therapist responsible for managing the older adult mental health teams, which included therapists working within acute, community and day hospital settings. She had a strong sense of identity as an occupational therapist. I was interested to explore how her competence and confidence within the profession developed. Unlike Emma (and indeed the majority of other occupational therapists within the mental health service) Mary had worked in a variety of other Trusts. In previous posts she had worked alongside and been mentored by other confident and competent therapists (locum / agency therapists from Australia and New Zealand). Mary admitted learning a lot from these individuals.

> I think the mentor role and the good supervision is essential for newly qualified OTs. I think that is from my own experience and working with lots of different qualified staff, some who have been mentored really well and some who haven't. I think newly qualified staff need some direction and some structure as well. I think not too much because they need to develop their own ways of doing things, but I think having some guidance as to what would be the way to do things or what would be expected is almost essential at that point.
>
> The other side, not just of my basic grade but of my senior II as well, was that I worked in departments which were very under staffed and we had lots of agency OT's or OT's that had trained in different cultures and so they had quite different theory bases and ways of working and I picked up a lot of that without realising it. Then moving out of London, my reflections are that I had

> learnt quite a lot of different stuff at that time. I don't know whether it is because the agency OT's were people that travelled and they had to come up with the goods to keep their job, but they would always have a framework that they were working through and they would be able to put it onto paper either for group work or individuals therapy, and into notes - they were confident in explaining it as well. A lot of my confidence and pragmatic skills came from working with that group of people.
> *(Six months into the inquiry)*

The above experience is important to explore as Morley (2006, 2007) suggests the initial period spent as a newly graduated occupational therapist influences their therapeutic performance and retention within the workplace. Common problems faced by new graduates include the development of self-confidence, development of proficient therapeutic skills, the application of theoretical knowledge and development of their professional identity (Paul 1996, Parker 2001, Lloyd *et al.* 2002). In their research to investigate challenges experienced by newly qualified graduates in mental health settings, Morley *et al.* (2007) identified the importance of seeking out mentors and use of quality supervision as paramount in ensuring development of competent, confident therapists. Burke and Depoy (1991) and Miles-Tapping *et al.* (1992) similarly contend that a strong, professional self image comes from mentorship. Without wishing to take anything away from her own personal skills and qualities, it would appear Mary's socialisation into practice as a graduate benefited her greatly, including the exposure of working in forward-thinking departments.

Examining how change occurred

Six months into our collaboration Mary openly stated how she had started to like MOHO because she 'could see what was coming from it'. Mary appeared to like the structure MOHO was offering her practice. Interestingly, she shared how theory was starting to feel central to her practice and not just 'tagged on' at the end.

> Looking at MOHO for me has complemented what I've tried to do before and maybe it takes about the same amount of time as what I was doing anyway. I was already doing more in depth stuff. Now I want to challenge other people's referrals, other MDT's colleague's opinions. I want to look at the occupation bit as the main area and I've got some tools to do that with now – whereas before I used to do that in my head and scribble a few notes down on paper. But I feel that my occupational therapy practice and the service has been strengthened and developed through the use of MOHO - that's how I feel.
> *(Six months into the inquiry)*

The point Mary raised about her practice not having to shift too much was worth noting, as I had believed that integrating MOHO into practice should not have

required individuals to make dramatic change within their practice *if* they were practising occupational therapy. I believe this is the reason why Mary appeared in tune with MOHO in comparison to Emma who, as a consequence of generic working, found it much more of a challenge to unite profession-specific theory into her practice. Mary clearly grasped the relevance and integrative nature of MOHO concepts (Meyer & Lands 2003). In a relatively short period of time she moved from *contemplation* and being somewhat sceptical about MOHO: to considering and then piloting MOHO tools (*preparation*); to taking direct *actions* that demonstrated a clear commitment to the MOHO agenda (Prochaska *et al.*1992). Mary appeared pleased with how MOHO could strengthen her practice. Her scepticism had been replaced with more *liberating* views on the contribution of occupational therapy theory for her practice.

Two aspects to Mary's character, which I believed assisted her to shift so quickly through and across the stages as outlined within the Transtheoretical Model, were her pragmatic nature and her approach to learning which are now both considered in more depth.

Pragmatism: the ability to self-regulate

In terms of being pragmatic Mary did not appear to view the opportunity to review her practice as part of our collaboration as a big ordeal. Whilst sceptical of MOHO she was interested in the proposal and interested in research. Mary knew that continuing professional development and an ability to articulate an evidence base for her practice were requirements for professional practice (COT 2003, HPC 2004). Bandura (2001:8) defines the most "distinctly human" capability is that of self-regulation. Through self-regulation people make sense of their experiences, explore their own cognitions and self-beliefs, engage in self-evaluation, and alter their thinking and behaviour accordingly.

Bandura's concept of perceived self-efficacy (Bandura 1977, 1982) offers insight into self-regulatory practices and essentially focuses on how a person's *confidence* in their ability to perform strongly influences their actions. This provides a useful interpretation for understanding an individual's behaviour as being determined by not only his / her *attitude* towards and *readiness* to perform a given behaviour but their *intentions* to effect change, intention being considered to be the immediate antecedent of behaviour (Ajzen 1991). Indeed Bandura (2001:10) claims self-

efficacy beliefs are the foundation of human agency. Applied here, through self-reflection Mary explored her own cognitions and efficacy beliefs regarding the contribution of MOHO to her practice. She appeared to alter her perception of her practice and her approach within practice accordingly.

Taking this point further, Bandura's theory on self-efficacy *perceptions* illustrates what individuals select to do with the knowledge and skills they have. In light of self-efficacy, it becomes feasible to appreciate that people's behaviour can often be predicted by the *beliefs* they hold about their capabilities rather than by what they are *actually capable of accomplishing*. As such self-efficacy beliefs inform and often dictate an individual's choice of activities, how well they prepare to engage in an activity and the amount of effort expended during performance. (MOHO theory itself, Kielhofner, 2002, 2008, clearly links to the understanding that motivation to perform is a combination of an individual's sense of self-efficacy and capacity, values and levels of interest towards the intended action.) Mary's sense of self-efficacy played a pivotal role in her ability to self-regulate and change her practice in ways which were self-strengthening:

> I think the impact of MOHO on my role as Head OT has been that I'm now critiquing through supervision and critiquing other people's decision making in service and in practice using MOHO as my measuring stick.
> *(Twelve months into the inquiry)*

I sensed that as the lead occupational therapist for the older adult service, Mary's drive to improve the effectiveness of the team provision challenged her on a number of levels. She wanted the team to deliver occupation-focused practice. Yet she would not steamroller individuals into embracing MOHO unlike the occupational therapy service manager's approach. Mary's presence in the monthly meetings was crucial. I feel this was especially important in terms of her ability to share her own practice concerns whilst actively supporting colleagues in their personal struggles with the theory, and maintaining an awareness of her management responsibilities. Mary was able to keep pushing forward the professional agenda whilst supporting and advocating on behalf of her colleagues.

On another note it was clear that aside from internal issues, there was a need to keep MDT colleagues abreast of the changes occurring across the service. It was in this capacity that I believe Mary experienced a different level of impact MOHO was having on supporting her practice. Unlike Emma, Mary had a confidence to say what

was *going* to happen. However, it was evident that she was not prepared for the accompanying impact this had on her personally:

> I took the flow chart in to the meeting and they were like 'ooh that's really good' because it showed how the OT assessments were all set out, because before I had just verbalised the tools, which to them was just a load of words, and then you have to try and get a reaction from them – So I did it on paper format and they were quite impressed, I would say it was the best organised [in respect of all the teams represented at the meeting] as none of the other wards or teams have anything like it and that was seen to be quite impressive.
>
> I've thought I've come across so much more able to say things, but then I thought I've looked as if I know everything and I don't want to come across like that in the meeting, so I had a sort of had mixed reflections on that, but in my own practice I've been really pleased that I know what I am talking about without trying to sort of cover up that it was just preferences and different options that were available. On the other hand I thought that's so unexpected from an OT that they might start thinking 'oooh so you've got a theory base now!'
> *(Mary: twelve months into the inquiry*)

What I believe to be of note in this excerpt was Mary's sense of agency and voice (Savin Baden & Wimpenny 2007) in feeling able to articulate the rationale for her practice, which was seen to be impressive. Arguably, in terms of the threshold concept literature, she was transformed (Meyer & Land 2006) in that as MOHO concepts were grasped Mary experienced a shift in her perception of how she viewed occupational therapy's contribution within the older adult team. Moreover, Mary's adoption of the MOHO assessment tools provided her with a different language, which appeared to play a significant part in her re-locating her discipline as being 'organised'.

Meyer, Land and Davies (2008:67) refer to how a new way of understanding a phenomenon 'socially re-positions the learner' and as a consequence they can be transformed. Similarily Cousin (2006:264) suggests that 'mastery simultaneously changes what we know and who we are'. Interestingly Meyer *et al*. (2008) also suggest that this re-positioning may reduce acceptance to participate within another community. It was evident from Mary's narrative that her reflections of her actions and her colleagues' responses were troublesome for her and arguably alienating. Savin Baden (2006:200) suggests grasping a threshold concept is never just a cognitive shift, but a re-positioning of the self in relation to a subject. Mary appeared to be prompted to re-examine her position within the context of the MDT. In doing so, whilst perhaps troublesome, I argue Mary was able to experience an improved sense

of professional worth. Lave and Wenger (1991) similarly discuss that learning involves the whole person and the (re)construction of identities. By this I believe they are proposing that learning can involve becoming a different person. In relation to Mary, implementing and then embedding MOHO within her practice supported her to experience an evolving sense of membership or connectedness to her profession. Mary's self-efficacy beliefs appeared to be strengthened from such experiences, which I suggest led her to take on more challenges within her role (Bandura 2001). An example of this resolve can be seen in how she dealt with subsequent challenges within the practice setting.

The implementation dip

In terms of the collaboration, thirteen months in I no longer facilitated group supervision, and Mary had taken on this role, which included restructuring membership to create two groups, which accommodated the junior staff (who had since joined the Trust and who not been part of the original group). When we next met (eighteen months into the work) I sensed Mary was feeling overwhelmed. Indeed, like Emma, there were competing demands from the environment within which she was operating and her own learning needs seemed to be on pause whilst she dealt with the increasing demands placed on her role.

Having effectively 'stuck her neck out' to promote occupational therapy in front of the wider MDT, there was the need to deliver. Despite acknowledging that she enjoyed focusing on staff and service development issues, Mary had managerial responsibility for all the older adult teams. I sensed Mary felt she was not able to achieve anything of substance at this stage of the collaboration. Indeed it almost appeared as though things had come to somewhat of a standstill for her especially in terms of her own development and ongoing learning, which I sensed she found very crushing personally considering all the work which had been carried out to date. Essentially, her management role had taken priority over her clinical work.

> My views are very similar - they haven't evolved very much further because my clinical experience hasn't evolved very much further. I'm very pro using a model, I'm very pro MOHO, but I think it's less about how my understanding has evolved. I've just kind of stopped where I've got to.
> *(Eighteen months into the inquiry)*

Mary spoke of an inability to do the work necessary in order to keep moving things on and the unfortunate situation she found herself in where she felt unable to delegate

work to the senior occupational therapists as a result of issues around their confidence and competence. For example, the junior staff were more au fait with integrating MOHO and using the structured assessment tools leaving the more senior staff (with more ingrained working practices) struggling at times. Indeed there was role reversal evident in junior staff facilitating the learning of the seniors. As a consequence Mary met with everyone and had to hold on to more responsibilities than was realistic or appropriate. She saw that this situation needed addressing and yet adequate resources prevented this. Being a pragmatist Mary reconciled herself to the situation by acknowledging that it was a case of ‘riding the storm’.

> I am quite realistic that if there is a clinical lead in each area things will actually occur, but with a head post covering all those areas currently, including intermediate care, there’s no chance - so you know it’s not going to happen for a while.
> *(Eighteen months into the inquiry)*

Mary’s response highlights that whilst personal agency tends to be considered at the individual level people bring their influence to bear on events in collective ways (Bandura 1986, 1991, 2001). As Bandura acknowledges, people do not have direct control over the social circumstances and institutional practices which affect their day-to-day lives. Arguably Mary could not continue to carry the burden of responsibility for trying to shape the teams development. As Bandura suggests, trying to take personal control takes long hours of arduous work, and it was apparent that maintaining proficiency under the ever-changing practice context demanded significant investment of Mary’s time and effort which could not be sustained. Lewin (1947) notes that change towards a higher level of performance is typically short lived. Furthermore Welch and Dawson (2005:235) highlight how the pace of change can leave the therapist with ‘initiative fatigue’. Mary could not promote MOHO to the wider MDT on her own; the ability of MDT colleagues to observe renewed clarity regarding occupational therapy’s role and contribution could only be achieved through team effort. Indeed Mary had to review her action-plan to secure what she could not achieve on her own.

Arguably whilst frustrated, Mary’s response suggests what Bandura (2001:10) refers to as ‘self-reflectiveness’, wherein a person considers the soundness of their thinking against the effects of other people’s actions. By this I mean that Mary was able to reconcile and shift her expectations, to transcend the dictates of her immediate environment and to persevere in the face of difficulties whilst maintaining an image of

a desirable future. Bandura argues that the most central and pervasive function of agency is that individuals exercise some measure of control over their functioning by regulating their behaviour and generally disregarding unrewarding or punishing outcomes (Bandura 1997). Perceived self-efficacy is a pivotal element within agency as it enables individuals to measure their own effectiveness and in doing so a person is able to adapt their self-regularity beliefs. In doing this a person can influence whether they think pessimistically or optimistically. Mary recognised the efforts of her occupational therapy colleagues and that albeit slow, progress across teams was still the trend.

Bandura (2001) argues that efficacy beliefs lead people to choose what challenges to undertake, how much effort to expend, how long to persevere and to evaluate whether failures are motivating or demoralising. A strong sense of efficacy reduces vulnerability in challenging situations; indeed efficacy strengthens resiliency to adversity. Engaging in such rigorous processes of self-appraisal is not an activity each therapist would be prepared to do. However, I contend that Mary engaged in such personal self-reflective processes. Furthermore, I suggest her early graduate experiences and progress through subsequent posts appeared to have instilled in her a responsibility, an obligation to question her practice and engage in professional self-regulatory activities. I argue here that if developing practitioners are encouraged to engage in critical examination of practice from the outset, justifying the rationale for their practice via sound clinical reasoning will be the norm rather than the exception.

The final point to acknowledge within this section relates to how I believe Mary's ongoing progress with MOHO tailed away somewhat as my involvement in facilitating monthly sessions ended. Indeed, my departure resulted in Mary taking on increased levels of responsibility for supervising her peers within the older adult service. The implications of practice development initiatives building a sustainable community and developing team-based champions were viewed as vital (Boniface *et al.* 2008). Yet there is the acknowledgement that experienced senior staff in head positions still require space to grow and learn. Indeed, it is of note that Mary went on to study an MSc in Occupational Therapy around this time.

Whilst the importance of ongoing relationships between education and practice are addressed in chapter eight I now turn to discuss a second aspect of Mary's

character, which I argue enabled her to gain so much from the inquiry process, which was her willingness and openness to learn with others.

Learning with (rather than from) others

Mary suggested that having mentors around was one of the ways in which she liked to learn. Furthermore, she stated how she was pleased to be receiving professional occupational therapy supervision as it was apparent as a head occupational therapist her own professional practice needs had been overshadowed by managerial responsibilities. Having experienced the impact the work with MOHO was having upon her own practice, Mary's adoption of the theoretical concept areas and tools for application took on a new focus. She became committed to drive the MOHO agenda forward for the rest of the occupational therapy team within older adults. She was keen to link in with me, wanting to use me as a resource; emailing me with her ideas and suggestions outside of sessions. There was no doubt this sharing of ideas enhanced our working relationship, for example the benefit of having insider / outsider knowledge provided a sense of us both sharing the load (for the older adult service) and task ahead (of supporting other peers to strengthen their professional repertoires).

Making use of *helpful relationships* is a known process individuals may choose to use within the Transtheoretical Model. Bandura (2001) likewise acknowledges people form their self-efficacy beliefs through the *vicarious experience* of observing others perform. In contrast to Emma and the disjuncture I appeared to cause for her, Mary seemed to like my style and approach. My focus here lies with Bandura's reference to learning from *observation of others*. Arguably such views link with those of Vygotsky and his reference to the 'Zone of Proximal Development' (Vygotsky 1978). Both Bandura and Vygotsky view peer interaction, scaffolding, and modelling as important ways to facilitate cognitive growth and knowledge acquisition. Indeed they assert that most human behaviour is learned observationally: individuals create and develop self-efficacy beliefs as a result of the *social persuasions* they receive from others.

I suggest that I did try to persuade and coax the therapists to try out alternate practices in light of MOHO. However, I maintain that my intention was to prompt the participants to engage in critical discourse about their practice in light of theory. As such, I do not believe what occurred was scaffold learning, which I argue, similarly to

Savin Baden (2006, 2008), does less to prompt individual autonomy in problem-solving practice issues. Yet Mary was not averse to my suggestions. Indeed, I recall her using similar terms and expressions to myself during team-based discussions. However, although my influence was arguably noted in group sessions I was not observed integrating MOHO directly with service users. Perhaps I am taking scaffold learning too literally, yet one clear active part of the learning process required Mary to take the decision to *authentically examine MOHO for herself*. Therefore whilst I aimed to facilitate cognitive growth, I argue that this was achieved through prompting the occupational therapists to be autonomous practitioners.

When we met for the fourth and final time (in terms of the research period - two years in), Mary finally had the job which she believed she had applied for two years previous. There was a renewed sense of energy despite the fact that her role had shifted again. Interestingly, it was as if she was at the start of a whole new journey in terms of establishing herself within a MDT context, where she needed to educate and articulate again what she viewed as her unique role and contribution. Yet this did not appear torturous; in fact, I recall sensing that she was quite looking forward to rising to the challenge of clinical practice; armed with the MOHO-therapy process, the structured assessment tools and the recording / reporting templates she now had at her disposal. Moreover, the depth of therapeutic reasoning, which was embedded within her practice, liberated her to define the role she wanted to portray:

> I think my depth of analysis of a persons occupational performance is much more effective now. Better quality. Working as a sole OT means that I need to have confidence, I know I have an evidence base behind me that checks what I am doing. I know what I am doing is OT. I can explain with more depth, what is difficult for a person with regards to their occupational performance.
>
> I think I was quite sceptical about what the model could offer and I didn't understand what it could offer – so it has offered more than I expected – definitely.
> *(Twenty-four months into the inquiry)*

I suggest Mary's sense of agency enabled her to be conscious of her active development, her ability to adapt and self-regulate expectations and to achieve a sense of self-renewal with changing times (Bandura 2001:2). In addition, as well as studying on a master's programme, Mary was a co-author along with Emma for a practice evaluation paper in the British Journal of Occupational Therapy (Wimpenny *et al.* 2006) and presented aspects of the research journey at the national

conference. I believe the following excerpt, taken from our last interview, appropriately captures her sense of journey:

> I feel I have been involved in many different aspects of this project. Things have developed quite significantly for me in quite a short period of time. That wider thinking has made sense of a lot more things in practice and has critiqued my practice and I wouldn't do a lot of the things I previously did. I would take a different tack now to explain what I am doing. I have worked in quite forward-thinking departments, but with hindsight, what we actually did in practice was quite reductionist stuff. Now I can do the reasoning for myself, its not a philosophy hanging around me any more, I can do it, that's what's changed.

Summary

Mary's account considers what can be achieved when an individual is ready to commit to a learning opportunity. It suggests that Mary's attitude toward her professional responsibilities was an important foundation upon which she demonstrated a self-regulatory approach to the collaboration. I believe this enabled her to deal with the discomfort of being a senior colleague having her practice reviewed with others (in light of theory). Making use of learning spaces (monthly group sessions, individual meetings with myself, MDT forums, service user interactions) and taking the necessary time to critically reflect on those experiences enabled Mary to forge new meanings, strengthen her professional identity and transform her practice.

Conclusion

The two occupational therapists presented were observed to respond toward the practice development initiative in varying ways. However, despite reactions differing in terms of resistance and / or postponement, levels of engagement with the MOHO were observed for both. Mary believed herself to be capable and effective as an occupational therapist from the outset, yet she actively sought to embrace the learning opportunities, used feedback and persevered to advance her practice in light of theory. In comparison Emma, whose role involved generic working practices, displayed a tendency to shy away from opportunity to assert her profession-specific abilities. Nevertheless, she demonstrated a determination and willingness to persist despite the challenges the inquiry process presented.

Although I maintain that development of the community of practice or group collective

was central to the success of the venture, the importance of identifying with the individual in this context was required. This enabled the occupational therapists to examine their practices through the lens of professional discourse within different learning spaces. As such, through enhanced understanding gained by appreciating how each of us responded and contributed, views of one another shifted and our (potential) capabilities were harnessed. In essence, both individual and group sessions proved to be powerful personal motivators for the participants, myself included. I believe such practices resonate with constructivist thinking. Constructivist approaches to learning emphasise authentic learning in which the goal is to create learning communities, which are closely related to the collaborative practice of the real world (Perkins 2006). Knowledge is not fixed but is constructed by an individual through her / his own experiences. Furthermore, when people work collaboratively in an authentic activity, they bring their own framework and perspectives to the activity. As Perkins (2006:35) identifies, 'an individual always has to construct and reconstruct what things mean'. I suggest that constructivist thinking embraces what was observed to occur within this inquiry process as therapists re-negotiated their professional perspectives. Yet as Perkins (2006) acknowledges such constructivist practices are time consuming and the level of cognitive demand encouraged can result in not all learners responding well to the challenge.

The role of the facilitator also has relevance here. Perkins (2006:44) refers to teachers using pragmatic constructivist strategies to suit individual learning needs. My interpretation of such ideas is that in recognising an individual response to learning, facilitators of professional practice development initiatives likewise need to embrace constructivist approaches to support learners. Within this study I arguably attempted to lure Emma into engaging with MOHO, an approach Perkins (2006:45) refers to as 'intellectual seduction', whereas with Mary 'teaching by telling' (Perkins 2006:45) appeared to serve her well. I agree that facilitators need to carefully adjust their approach to suit individual need and that this requires a high degree of reflexive awareness throughout (Polgar & Thomas 1992).

Yet it is at this juncture that my views regarding constructivist thinking become more troublesome as I believe the paradigm fails to capture what this inquiry process has discovered. Whereas constructivism suggests learners assume the responsibilities of their own learning (which includes approaches to monitor and guide their learning and performance with support from others) (Perkins 2006), arguably not all the practitioners engaged in rigorous processes of self-appraisal like Mary. This raises a

question regarding what the occupational therapists would use to gauge their levels of competency as being acceptable. Here I contend that wider competing forces were also at play, which governed the therapists' actions. Indeed I suggest that authentic learning environments within practice settings require consideration of the influence of the social context and the political sphere. What is confusing is that constructivist views suggest that knowledge is not 'about' the world, but rather 'constitutive' of the world (Sherman 1995). I agree with this assertion, yet I suggest this formative task is not purely an individual's or a facilitator's responsibility. Indeed I argue that whilst Mary was quite open about her responsibility to engage in professional development activities, Emma's ongoing determination with the MOHO agenda was because she too considered review of her practice a necessary professional obligation. Thus *constructionist* perspectives are also seen to have resonance with how learning occurred; Mary and Emma engaged in active participation with others, which recognised how their practice was shaped through socially, culturally, historically, and politically situated contexts (Crotty 1998). The recognition of constructionism is required as offering important focus regarding 'the hold' that the therapists' practice culture had upon shaping the way in which they participated. The following two chapters consider such informing paradigms in more depth; specifically in the next chapter I examine issues regarding the message of MOHO and what the conceptual model of practice was viewed as offering the therapists' role and contribution within the context of professional practice, including how such knowledge was (re) constructed.

Chapter seven

Transitions, forging new meanings, identity shifts

"Theory without practice is sterile [and] practice without theory is blind".
(McCaugherty 1991:1061) - *<u>but how is sense made of the two?</u>*

Introduction

The previous chapters explored the reciprocal relationship between the group dynamic and individual identities in the context of change. The focus of this chapter is a more in-depth examination of the change process itself and the types of change that occurred for the participants in relation to professional knowledge construction in light of MOHO, and the legitimacy of such knowledge.

I begin by presenting the occupational therapists' depictions of their learning and how this was translated into new ways of thinking and participating within their respective (MDT) teams. This provides a sense of the therapists' perception of their practice in relation to MOHO, and evidence to support my later discussion. I then present a participatory model of knowledge construction (see figure six) that aims to clarify the cyclical process through which the participatory inquiry operated. The model draws together the findings of the previous chapters as well as identifying some additional aspects, which will be explored in more detail. Specifically this chapter examines how the MOHO was incorporated into the therapists existing schemas (personal stance and theories-in-use, or professional craft knowledge) through a process of deconstruction and reconstruction of knowledge. I illustrate how the therapists, over time, demonstrated conscious connections with their professional craft knowledge in order to make sense of and utilise MOHO, and to forge new meanings for their practice. The legitimacy of the therapists' knowledge construction of MOHO is then discussed in light of my own realisations regarding the contribution of theory for professional practice. This discussion then connects with issues regarding professional practice knowledge and the evidence based practice agenda. I conclude by suggesting that the therapists' implementation of MOHO offered potential to deliver an evidence based and professionally orientated *approach* to practice.

The occupational therapists' depictions of their learning: new ways of thinking and participating

The following narratives are from a number of final group sessions and individual meetings held with six of the occupational therapists from across the three teams. These quotes, which are rich and substantial, provide opportunity to consider individual therapists' views regarding their practice in light of MOHO (and its associated assessment tools). Each therapist's quote is linked to a corresponding

theme that is then represented within the participatory model of knowledge construction. It is important to add that these individuals were not the select few who identified with changed perspectives, as any of the occupational therapists views might equally have been used.

Heather: agency, engagement in learning opportunities and significant moments

The first therapist presented is Heather from the community adult team. Here Heather reflected upon how she had been searching for a means of support for her practice, which MOHO appeared to have offered:

> At the start I think I would have probably said I just don't get it. I think it was the OCAIRS[1] that really clicked with me. When I used that with somebody I realised these things are the things that I had already been asking clients. Obviously it's about a rationale when you get more confident with it.
>
> I did definitely want something that was about OT and I wanted it in black and white. It [MOHO] has given me a framework. That is what it is giving you. I need it as an OT because of getting lost in generic working and because of the pressure around within the [CMHT] team. It is especially relevant at the moment because there is an awful lot of pressure with caseloads and stuff....
>
> Instead of me saying I'm an OT and I should be doing this, I've actually got this model now to support me in saying this is how I work. I think people can see that as well so that is quite good. It's [MOHO] given me more confidence to say this is what I do and this is how I want to work. I am definitely more confident in terms of multi-disciplinary team working.
>
> I wanted a model to work towards and have done for ages and ages but I think I found it, it felt like extra to my work. I think I found it difficult first because it didn't click, but it did eventually a few months down the line.
> *(Eighteen months into the inquiry)*

In this excerpt it appears that Heather had been searching for some time to be able to identify with a 'body of knowledge' for her practice which was not only sufficiently established and respected but importantly was also accessible. Heather acknowledged a significant moment, or an 'illuminative epiphany' (Denzin 2001:37) (referred to earlier with respect to John) when she connected with the OCAIRS and realised her practice did not have to shift too dramatically to embrace MOHO concepts. She realised integrating theory had value for her. The very act of engaging with the learning opportunity and piloting a MOHO tool, followed by formulation of the assessment outcomes, provided Heather with the necessary link between the

[1] The OCAIRS (The Occupational Circumstance Assessment Interview and Rating Scale) (Forsyth *et al.* 2005); an overarching MOHO assessment tool (See appendix 2)

theoretical constructs of the model and the implications they held for her practice. In experiencing this connection, Heather received some vital feedback that she needed in order to continue and persevere with her own 'theory building', which I will explore further as the chapter progresses.

In addition, we see Heather acknowledging how she was at risk of 'getting lost' in generic work within her community role from not having a strong rationale with which to defend her occupational therapy practice. She was not comfortable with this situation. Refocusing her professional perspectives with the support of MOHO appeared to have provided her with the tools and the confidence to reassert herself as offering something different within the MDT. Indeed Heather went on to embrace a number of MOHO tools.

I believe Heather provides an example of a therapist who was not that comfortable grappling with theoretical constructs per se. She was more focused upon straightforward solutions, which had the required level of impact she was looking for. Furthermore, she demonstrated how she would 'pick and choose' from the knowledge base to suit her needs.

Stephanie: perceived need to change

Stephanie had been on maternity leave for a period of months during our collaboration. I was keen to ask Stephanie if there was anything about her colleagues' practice that felt different since her return to the acute adult setting. Coming from her perspective as an 'insider' I believe she could offer a unique response:

> I think generally people's confidence. The tools we've been using are now much more part of everyday practice, rather than needing to get that familiarity in order for them to become everyday tools. So I think the way in which the other OT's have become familiar with the MOHOST[2] has made me aware that I've not been here for 6 months. So I think general confidence and the use of the tools and the model as a whole has changed.
>
> I think it's good. I think it's good for the service in terms of consistency between us for what we're doing and in terms of presenting that to the [MDT] team. I haven't had lots of opportunity to introduce tools to the teams I'm working with yet, but I think it's very useful to have them there. I'm that much more confident in terms of knowing I can use a tool as the basis for a report, and in handing that report over to somebody. I mean we quite often just put

[2] The MOHOST (the Model of Human Occupation Screening Tool) (Parkinson, Forsyth & Kielhofner 2004); a flexible, overarching MOHO assessment tool (see appendix 2)

> the reports in the notes, but it's useful to actually give to somebody and to explain it to them rather than getting them to read the notes that you have written.
>
> It [MOHO] keeps you on track with the OT process rather than our old system of doing a summary of the group at the end of a week and it just being part of the green notes and being long and wordy – so I think its definitely helps keep us more focused
> *(Twenty-four months into the inquiry)*

Stephanie saw a change in the way her colleagues operated and this was again with reference to the value of the structured assessment tools and how use of such MOHO tools had now become an accepted part of routine practice. In this sense the therapists' adoption of the theory and use of tools had become embedded within a natural repertoire. This suggests the process of making new learning tacit, which will be subsequently explored within the context of clinical reasoning.

In addition, Stephanie spoke of MOHO providing a consistency and clarity for the teams' work. Individuals and teams developed an improved 'criticality' for practice and with that a more refined rationale and justification for their role and contribution within multidisciplinary team working. I sensed that Stephanie was keen to work with MOHO and the tools in line with her colleagues. Moreover, I argue participant's perceived need to change was influenced by seeing others act.

Interestingly, there was a confidence to share the detail of occupational therapy reports with MDT colleagues on the wards, rather than have separate green notes kept in the case file which, Stephanie hints at as not being valued by the therapists themselves. I believe this provided evidence of a developing sense of agency and voice for the acute team as levels of communication and confidence increased with the notion that what the occupational therapists had to offer should be valued and shared with others. This in turn offered the potential of liberating and strengthening participants' sense of [professional] identity (Savin Baden & Wimpenny 2007:341).

Barbara: Disjuncture and the perceived value of ongoing support

As a therapist for older adults Barbara, like Heather, also identified with a more generic role; Barbara also demonstrated a commitment to address this and MOHO appeared to support her to recover a more obvious occupational therapy process. Change in her practice was visible in the way colleagues now referred to occupational therapy. Yet Barbara provides an example of how change can take people into 'troublesome spaces' (Savin Baden 2008:95). Such spaces can be

experienced as uncomfortable, where the individual is somewhat 'stuck' in terms of connecting with the new learning which has occurred. Barbara acknowledged how difficult it was for her to adopt new learning as her practice was entrenched and personal issues got in the way along her journey (both Barbara and her husband experienced periods of ill health during our two-year inquiry). Interestingly Barbara also compared her experience to that of the newly qualified occupational therapists who quickly adapted to MOHO. Although this is not surprising considering new graduates are most recent in exposure to theory, Barbara referred to a 'tension' which existed for her whereby she felt threatened by junior colleagues questioning and observing her practice despite her seniority. Although she was able to identify with a change in her attitude towards her professional practice, her confidence in articulating that was still noticeably ongoing:

> I think my practice is far more specific now. I say I'm an OT. I seem to be coming back – you loose your way, you can become very generic, you do the best you can like that, you think it's the best at the time, and then you say right, lets be an OT. It does make a difference. The biggest difference to us now is that they [the MDT] refer to us. Whereas in the past people would be in the system 3 weeks, 6 weeks, 9 weeks before they referred to OT, but now it's a case of 'we want an OT assessment the first week they're here', which is good... The earlier they refer, the quicker we can pick them up. I am doing home visits and I am doing follow-up visits once people have been discharged to see how they are. I need to do more of that. I think that's where the future lies. I can see the benefit of that.
>
> I think the basic grades picked it up [integrating MOHO and using the structured assessment tools] almost immediately and could run with it, whereas I'm older and there was a different system already in place, or just a combination of everything and as I said the ill health at one time didn't help me any.
>
> I think your involvement had made me continue with it, if you know what I mean. It's easy to think oh this is getting on top of me let's stop and you think no, because you need to do this. So there has been momentum with it which helps.. and I do occasionally read the journal articles. I open my journal now, which has got to be a good thing! My practice feels better. When I have students I feel as though I know nothing again. I just feel oh no! I'm going to explain this all wrong. But yes, I think I'm getting there. I think everything was there to help with momentum. The support was there and yes the other Mary was excellent then as well. I don't think we could have asked for more.
> *(Twenty-four months into the inquiry*)

Barbara connected with the value of continued support during a significant period of time where she was experiencing transition. I believe she portrays the picture of an individual who was navigating through a liminal space (Meyer & Land 2008), persevering with the emotional and cognitive challenge of implementing MOHO.

Whilst she could identify positives from aligning herself with professional theory, MOHO was not altogether 'natural' within her practice. Yet there was a sense that sufficient shifts had occurred to prevent Barbara from reverting back to former ways of working. This sense of 'disjunction' (Savin Baden 2008:95) is viewed as a necessary place to be in order for transformations to occur and will be subsequently explored.

John: MOHO is the message

The need for the occupational therapists to have sufficient confidence to justify their practice in front of colleagues was also visible within the next narrative. John had worked both in the acute setting within the occupational therapy department and then moved out into a CMHT as a lone therapist with case management responsibility:

> It [MOHO] helps me personally, because it provides the structure for what I do. It provides the language for what I do. I don't think it's a huge selling point for managers - for my line managers. But it enables me to articulate OT. So it's good from that point of view.
> MOHO has a role to play in my day-to-day practice. It offers the structure. I think I would have liked it to make my report writing easier. It makes it [report writing] more time consuming - but I don't think I do enough reports at the moment to make it that natural, but I've got great faith in it!
>
> Working generically has allowed me to gain an awful lot. It's expanded my understanding of working with people with a mental health difficulty an awful lot, so it's been really worthwhile. But I think I've come to the conclusion that really we should be working as specialists and not generically and I think it confuses the people that we work with and service users to see us with two different hats on and yes it's not helpful.
>
> When you're trying to work as an OT with somebody as well as case manage them there's conflicts there and I think different expectations – certainly from seeing the other disciplines working – they push people a lot harder. There's the inclination to put in services to support people whereas we are trying to work with people to create independence so there's that conflict there and it does mean that somebody who I would spend an hour with minimum in terms of therapy session whereas you will find that a nurse will go in and out probably within twenty minutes. But I think I'm cost effective – because I'm not putting a lot of resources in with my people – but yes there is that conflict there definitely.
>
> As a model it's [MOHO] really helped my clinical reasoning and I can only see that as a positive. And again that's something I can and do articulate with the team. They don't always appreciate that it's coming from MOHO of course but it sort of sets me apart from the rest of the team.
>
> I had a student from the first year in the earlier part of this year I would have had a third year now but she dropped out. Having the model no doubt helped the students. It helps them I think and it certainly helps me. It enables me to

> say what I do and why I do it. That's something I've noticed over the years – that my confidence in having a student has increased. Knowing what the model is and what it's all about. I think I would feel quite pathetic really, if we didn't have a model – because the students come out expecting it.
> (*Twenty-four months into the inquiry)*

I have drawn from John's reflection a connection with the importance of holding onto his professional identity via support from MOHO. Although generic work had developed additional skills for practice, which were valued and at one period of time may have satisfied his view of this role, John then articulated how he had come to realise his profession-specific contribution was in fact more valued and had greater 'pay-offs' for a range of stakeholders. Such perspectives connected with a desire to assert occupational therapy over previously held boundary-less roles.

Interestingly, John referred to having 'faith' in MOHO. I wondered where this 'faith' had come from John had been working with MOHO for some years to varying degrees. However, a reference to faith suggests that John accepted MOHO had something valuable to offer his practice. It signified an allegiance and loyalty to MOHO, which arguably had developed over time. MOHO had not yet let him down and potentially had more to offer. From another angle, John connected with his professional responsibility to use profession-specific theory, which he suggests provided his work with a necessary kudos, which students deserved to see when out on their practice placements. Such belief and commitment to MOHO raised interesting observations regarding his epistemological and personal stance with regards to [MOHO] theory, which I argue require adequate consideration by participants and facilitators alike when approaching a learning venture.

Emma: MOHO offered a means of reviewing her theories-in-use

Whilst a short excerpt, Emma connects with what I believe was an important and valid learning outcome; this was about MOHO and the assessment tools confirming parameters for her occupational therapy contribution. Emma was now able to confidently articulate why an individual did not need occupational therapy intervention instead of trying to be all things to that person. MOHO offered her clarity about what she should and should not focus on in terms of the therapy process:

> In terms of significant aspects of what I've taken on with the MOHO work over the last 2 years I think one thing is it feels easier to say no, no that's not appropriate, because we have quite a clear and thorough assessment of an individual which then helps us say actually at this point in time I don't think this person is appropriate for OT. It's been the most significant thing for me

> because I did find it difficult to think about and [would tend to say] maybe yes there is a bit of a role for us here and not be able to be specific. So this has really helped that.
> (*Twenty-four months into the inquiry*)

Ellie: Transitions, identity shifts

Finally, Ellie's excerpts reflect a developing perspective of her role in context. Here, over a two-year period, I believe Ellie re-defined her professional contribution within the acute setting via critically appraising her practice in light of MOHO. Ellie's use of the PAR cycles of reflection and action (demonstrated through her contributions to our monthly meetings) offered her space for this criticality to emerge. Yet I believe Ellie's journey also suggests the level of thinking required at a deeper more personal level, for transitions in learning to occur. Indeed, Ellie clearly identified how time consuming and demanding the work has been of her both personally and professionally. I suggest new meanings associated with her role provided a level of coherence for Ellie, in that she was able to interpret the shifts which have occurred and could subsequently value her professional contribution:

> *Six months into our collaboration:*
>
> The absolute musts to be addressed by OT, I think the must is offering people the opportunity to engage and offer people the opportunity to have the beginnings of an assessment or initial assessment of their occupational needs. I suppose in terms of offering people treatment, we are able to offer people stuff in relation to supporting volition, so their motivation for occupation. So that is a good starting point. That is something that largely we are able to provide. The way things have been in recent times anything beyond that in terms of specific goals, performance goals is not often possible so I don't know if you can say that is enough.
>
> *At 12 months:*
>
> I think, at this stage, the absolute musts OT should address is working with people who appear to have clear deficits in terms of being able to do what they need to do in order to manage themselves within the support and the environments that they're headed to.
>
> It's the basics in terms of maintenance and not necessarily occupational balance or life satisfaction, so its perhaps not an emphasis in terms of the occupations in life that make your life more satisfactory or more rewarding, it probably focuses purely on the minimum in terms of what people need to be able to manage.
>
> *At 18 months:*
>
> I can't remember what I said back then, I haven't read the transcript recently but I think at the moment my role is to work with individuals who have probably functional barriers which prevent them from being discharged from

> hospital, so it's working with those individuals who have occupational deficits that prevent them from moving forward from this setting.
>
> To pick up the difficulties and strengths that aren't really recognisable unless people are engaging in occupation, so we provide information to the team. That's very useful in understanding why people are stuck or aren't able to move forward or why people continue to fall into the same patterns in terms of not being able to cope without the acute environment. I mean without going into all the barriers and stuff like that about what I'm not able to do, I'm not able to see the people, all of the people who I think require OT. I'm not able to do the extent of work that I think that people would benefit from in order to have the best outcome in terms of a successful discharge.
>
> *At 24 months:*
>
> We have become more focused about what the remit of the service is. So that's a shift. I remember talking about this with you early on in the monthly sessions and what was our role [in an acute setting]. Now, its definitely about supporting people through this episode of care towards discharge and so we have pulled ourselves back from trying to achieve more than is feasible in terms of the timeframe within acute. In terms of practice there have been lots of shifts, e.g. the tools we use, definitely there is an OT focus now, which is very clear in our minds as an OT group. There is some shift from an MDT perspective in perhaps having more respect for us and what we do. This has been evidenced in people's relationships and people's perceptions of OT. Within the medical team this has been evidenced in team meetings via discussion and requests for OT to have more input. It seems as though the medics would like more opportunity to have OT input. There is also feedback in terms of our assessment, which has been very positively commented upon, they would like more intervention now, they like the assessment process.

Summary of occupational therapists' depictions of their learning

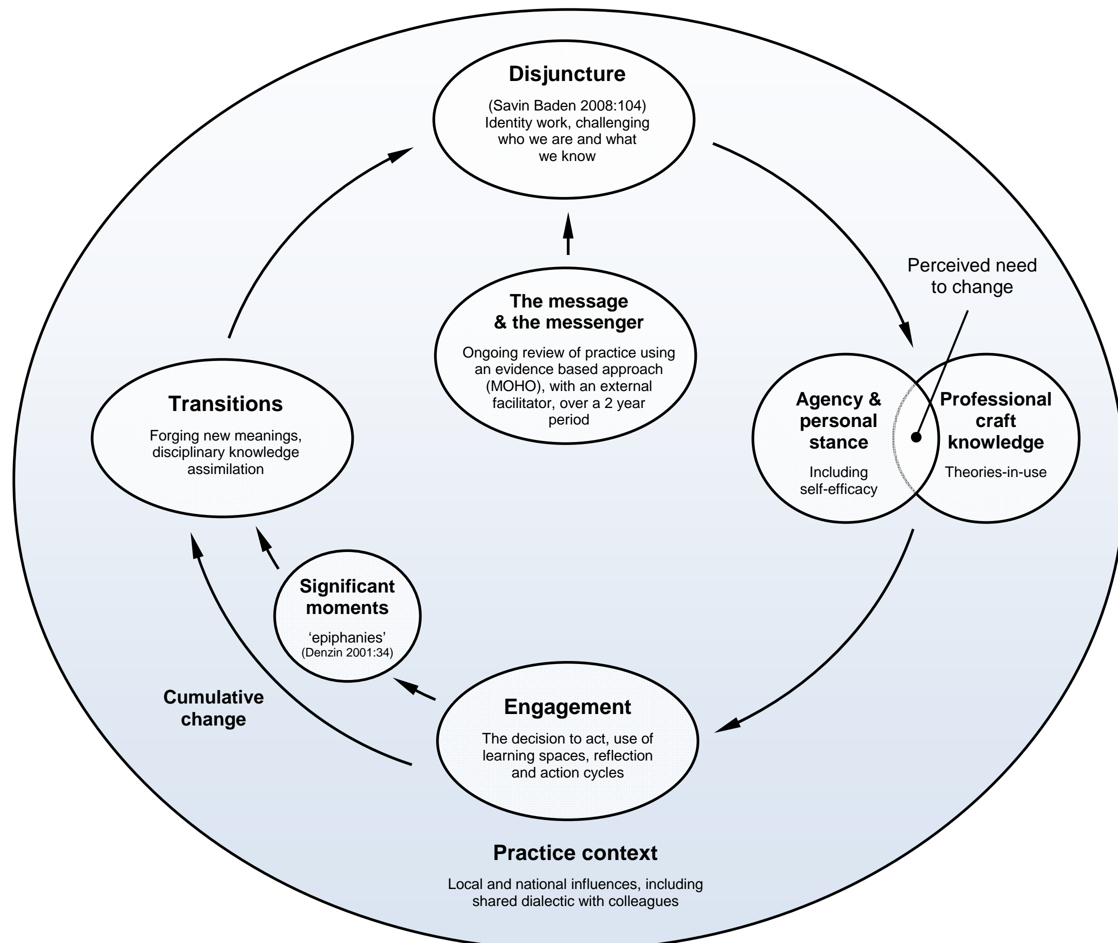
I believe the occupational therapists' quotes provide rich evidence of the ways in which they identified with the experience and impact of implementing MOHO, over time. In summary, their depictions highlight a series of key emerging themes which relate to the implementation of MOHO. These included how the therapists' recognised that MOHO had value and shifts occurred as they forged new meanings for their practice. Yet the theory created disjuncture and ongoing support was required. Through ongoing engagement with the PAR cycles the therapists reviewed MOHO in line with their current practice and theories-in-use. Individual agency was demonstrated as the therapists set their own pace in terms of the selection of and the testing out of the theory and assessment tools in the practice arena. Furthermore, it was evident observing others engage led to personal decisions to act. These themes are included within a participatory model, which I now go on to present.

Transitions, forging new meanings, identity shifts: a participatory model

As a means of drawing together the key themes portrayed a participatory model of knowledge construction is presented (see figure six) that aims to clarify the cyclical process through which the participatory inquiry process operated. This model embraces the findings from the previous chapters in terms of the development of the learning environment and the perceived influencing factors prompting the therapists' uptake of MOHO at both a group and individual level.

The participatory model accounts for those individuals still caught between previous and emergent ways of understanding how MOHO might best account for or underpin their practice, to those more able to connect with an increased sense of professional identity in light of theory. I argue that this conceptualisation offers an inclusive means of examining knowledge construction for professional practice.

Figure six – Transitions, forging new meanings, identity shifts: a participatory model



Within figure six *the message and the messenger* refers to myself as an external facilitator prompting review of practice in light of MOHO, wherein a clear sense of upheaval was evidenced by individuals within their respective teams. Identified as *disjuncture* this relates to the 'troublesome learning space' (Savin Baden 2008:104) which emerged as the therapists engaged with the propositional knowledge of MOHO along with their practice knowledge. The degree to which the occupational therapists engaged is reflected in terms of participants' sense of *agency and personal stance* towards the inquiry process and their *perceived need to change* their current practice repertoires, which I denote as being the therapists' professional craft knowledge or theories-in-use. Whilst consideration of these latter concepts will be discussed presently, examination of the therapists *engagement* with the learning opportunities has been considered in previous chapters, for example in terms of the use of learning spaces including the therapists directly piloting MOHO tools within a therapeutic encounter with a service user, to use of the monthly supervision sessions as a forum for reflection and debate.

In addition, I have articulated how *transitions* occurred for certain individuals following *significant moments,* which I have also referred to as 'epiphanies' (Denzin 2001). Such moments offered new insights and realisations for the therapists' in terms of knowledge construction and identifying alternative ways of thinking and practising. However, not all the therapists would demonstrate changed perspectives in such obvious or dramatic ways; for others transitions in their practice knowledge were more *cumulative*.

Nonetheless, I suggest that for all participants the process created *disjuncture* (Savin Baden 2008:106) and this was experienced in both constructive and challenging ways. For example, through reflexive examination certain therapists appraised their relationship between theory and practice with a renewed sense of satisfaction as they shifted towards a greater degree of integration. Others meanwhile, were less decisive and still grappling with changed perspectives on how to manage engagement with MOHO including consideration of how the theory complemented or was at odds with their *personal stance* and / or current *theories-in-use*. In addition, disjuncture included the consequences of new action and the impact of changed practices upon others (for example service users and MDT colleagues).

Finally, and what I believe to be key in prompting individuals to engage in knowledge construction was the influence of the *participatory context* including the situating of

the inquiry process within the practice setting and the vision for enhanced professional contributions crucially supported by the Occupational Therapy Service Manager (Wye & McClenahan 2000; Chard 2006).

Whilst the final chapter will embrace and build upon the full implications of contextual issues within the inquiry process, attention here remains with participatory model of knowledge construction and how the therapists were seen to construct new meanings for appraisal and renewal of their practice. I will examine how transitions occurred in the therapists professional practice knowledge by interpreting how the therapists appeared to embrace MOHO in line with issues of agency, personal stance and theories-in-use.

Professional theory, agency, personal stance and theories-in-use

"Occupational therapy is not just about doing things but doing things 'thoughtfully' "
(Professor Jon Nixon, Unpublished lecture, COT 2003)

I begin this section by considering the perceived contribution of MOHO for the participants. This includes how examination of MOHO prompted the therapists' tacit knowledge to surface. I move on to explain that the participants did not adopt MOHO wholesale. Rather the processes by which the therapists deconstructed and reconstructed MOHO for their practice in line with issues of theories-in-use and personal stance will be discussed.

The contribution of MOHO

MOHO as a means of promoting our professional identity

In light of the occupational therapists' excerpts presented, I argue that MOHO prompted the practitioners to engage in professional discourse about their practice. I suggest MOHO provided a necessary 'benchmark' from which they were able to critically appraise their professional 'performance'. It provided the occupational therapists with a means of evaluating their work: providing an explicit rationale from which their practice performance could be scrutinized (Richardson *et al.* 2004). The relationship between what MOHO advocated and how the therapists were practicing enabled them opportunity to critique and challenge their ideas and beliefs about their world (Steward, 1995). The therapists were able to make judgments for practice grounded in a professional knowledge base, which challenged them to account for their unique contribution and the complexity of their practice.

MOHO is as an international conceptual model of practice bringing with it a respected body of knowledge developed within the multinational, multicultural occupational therapy community (Lee *et al.* 2008). Indeed, within the context of our study I argue that awareness of the model's reputation provided a necessary level of impetus for all concerned to at least consider it. I nonetheless questioned whether MOHO was viewed by the occupational therapists as a credible theory against which their practice could be evaluated. I agree with Usher *et al.* (1997:122) that when theory is linked solely to the world of 'the academy' it may feel 'remote, irrelevant and unworldly' to the practitioner. However, MOHO has not been developed by academics sitting within their ivory towers, and certainly in recent years (Kielhofner 2002, 2008) there has been a concerted effort to collaborate with colleagues in practice as well as develop the theory by embracing the perspectives of those with disabilities. The idea of professional expertise based upon some form of elite knowledge is replaced by a more favourable approach of recognising scholarship in knowledge development generated by those involved in its everyday use (Hammel *et al.* 2002, Kielhofner 2002, Taylor *et al.* 2002, Forsyth *et al.* 2005). Indeed during the inquiry I was keen to share with the occupational therapists that through using MOHO they were in a position to contribute to the ongoing development of the theory and its evidence base. This included encouraging the practitioners to share their experience of integrating MOHO with other therapists on the international web-based forum (Listserve), which I was aware Ellie engaged with. In addition, twelve months in, the acute adult team designed a MOHO group evaluation tool, which we shared with Dr Forsyth, who in turn forwarded the material to the MOHOST authors, where it was included (with written acknowledgement) within a subsequent version of the tool. I suggest the knowledge-creating system through the scholarship of practice enabled certain therapists to take a different perspective toward MOHO. It enabled them to have a greater sense of ownership of the knowledge they assimilated to promote their professional perspectives. In turn I argue this provided those participants with an improved awareness of their practice epistemology (Richardson *et al.* 2004).

The therapist's perspectives clearly highlighted how MOHO provided a means of articulating their professional involvement by providing a structure and language to define their contribution (Heather, John, Ellie). Such assertions support previous research and opinion regarding the contribution of professional theory (for example, Parham 1987, Atkinson 1995, Steward 1996, Nixon & Creek 2006). Uncovering, challenging and reconstructing the therapists' working knowledge for practice through MOHO appeared empowering for the therapists, not only in terms of providing a

renewed energy and focus for their work, but also a sense that what they had to offer should be valued and more readily shared with others (Stephanie). In addition, the feedback received from MDT colleagues was (latterly) more positive and provided much needed validation for the changed processes (Ellie); importantly such processes were seen to strengthen the participants' sense of professional identity (Savin Baden & Wimpenny 2007:341) with the knowledge that their hard work had been worthwhile (Wimpenny *et al.* 2006). Such findings suitably link with Habermas' (1972) knowledge framework, which suggests that practice knowledge should be sufficiently technical, practical and emancipatory.

During this practice development initiative I have been very conscious of my own views regarding professional identity and what is required to better portray and strengthen occupational therapy practice. My belief that professional theory is vital for providing a theoretical framework to guide our professional endeavours has not changed, if anything it has been strengthened, as I have been able to see visible signs of how MOHO has realigned and also advanced individual therapists and team practices across the mental health service. As Eraut (1994) argues the power and status of a professional worker depends to a significant extent on their claims to unique forms of expertise. I argue that MOHO embraces a well-researched theory, which captures the potential to exercise such expertise. However, as Nixon and Creek (2006:79) question, what is theory in the context of professional understanding. Kielhofner (2002) himself suggests that although theory can inform our clinical reasoning it is not there to determine it. As such, whilst I argue that MOHO has offered an indispensable resource for the occupational therapists, the process of embracing the theoretical framework has been influenced by a number of competing characteristics, not least the learning that has derived from the therapists' practice experience, the intricacies of which shall now be examined.

Professional practice knowledge: tacit knowledge

Tacit knowledge has been defined by Polanyi (1966) and Schon (1983) as inexpressible knowledge which enables us to get on with what we are doing enabling naturalness and flow. In contrast Shanahan and Meyer (2006) maintain that tacit knowledge is troublesome due to its personal and often unexamined understandings. However, Higgs, Andresen and Fish (2004) contend much of our tacit knowledge can be expressed if practitioners find ways to unravel and investigate it. Furthermore new understandings can emerge through heightened awareness of tacit knowledge, a

task that has been likened to a process of critical self-monitoring (Higgs & Tichen 2001).

By encouraging the therapists to review their practice in light of a formal theory I suggest the occupational therapists' tacit knowledge surfaced and became accessible for debate and challenge (Wimpenny *et al.* 2006). This presented rather awkward but nonetheless critical and intense periods during the inquiry process as the practitioners became more consciously and critically aware of how able they were to justify their practice and its 'relativeness' to professional domains of concern. By this I imply that MOHO steered an occupation-focused path and it was possible to appreciate where practice had strayed. As Senge and Scharmer (2001) suggest practitioners continually share their tacit knowledge with one another, but to renew practice, new theories and tools, which challenge current assumptions and practices, are required. It was evident that the therapists felt the need to defend their theory-in-use, which prevented a number of the participants from moving forwards with integrating MOHO. Reasons for this have been considered in the previous two chapters but include epistemological stance regarding formal theory (Savin Baden 2008) to a more pragmatic stance revolving around self-efficacy beliefs (Bandura 2001) and perceived need to change including the amount of effort and commitment therapists believed would be required (Prochaska *et al.* 1992).

I argue that our practice development initiative prompted investigation of therapists' tacit knowledge through 'dialogic learning'. In essence the learning spaces which the therapists engaged with during the inquiry process became dialogic spaces. As identified by Savin Baden (2008:54) dialogic learning denotes the use of written and verbal communication with others and one's self in order to discuss and debate professional and personal positions. In addition, dialogic spaces provide opportunity for 'critical conversations' to occur; where change and challenge can take place (Savin Baden 2008:53). Savin Baden suggests that such spaces are not always about being in direct contact with others, rather learning takes place through reading and drawing meaning from such reading. In addition I contend that dialogic learning took place in the *action* learning spaces where therapeutic encounters took place with service users and MDT colleagues. Dialogic spaces therefore have relevance for formulating disciplinary positions. I suggest by formalising the use of space for dialogic learning, over time, practice repertoires were confronted and open to change, illustrated here by Mary's experience:

> I think the moments of learning for me have been when I've had the time to actually take things home to read them and then have a go back at work and then come back again and reflect again in our group sessions. Also I've had to be very specific with myself so, for example, I've not been able to do the VQ[3] and I've made myself do one or two and I've had to be quite specific with myself as I really didn't want to do it . I thought it was a bit too complicated, yet when I sat down to do it, it was in a five-minute space during the day, and I wrote the information down following the assessment and it was really kind of satisfying. I appreciated there was more for me to feedback on when I used this assessment, rather than it just being based on my own information. I think that reflection is also vital at the end of day and I think probably part of getting to grips with all this is having that time to reflect, if you had more time to reflect you might be able to get on better, and move the service on further.
> (*Mary: twelve months into the inquiry*)

In summary, MOHO and the assessment tools offered opportunity for the therapists to explore and challenge previous practice assumptions and routine actions. This questioning of the therapists' clinical reasoning encouraged a critical approach to theory and practice relationships (Carr 1986) by focusing upon the relationship between MOHO theory and the therapists' practice in the context of practice. However, this relationship recognises that practice is a human and social enterprise and one that is inherently problematic. Indeed having examined a number of issues relating to MOHO and its potential contribution for practice, I now move to consider a more critical view of knowledge construction, focusing upon how MOHO theory has gone through transformation as it has been used.

The reconstruction of professional theory in line with theories-in-use

The relationship between theory and practice is often portrayed as a dichotomy between academics being too removed from their practice, and an acknowledgement that theoretical knowledge is an essential element of professional self-understanding (Barris & Kielhofner 1986, Brown 1988). Unfortunately, it is often the practitioner caught in the middle of this debate (Bromme & Tillema 1995). It is challenging as such, for practitioners to be expected to embrace established theories (which should be constantly renewed), whilst identifying with the knowledge they generate in action (Schon 1983). This connection between professional action and theoretical knowledge is therefore all-important to the practitioner in forging meanings between the two forces (Bromme & Tillema 1995).

[3] The VQ is the Volitional Questionnaire (de las Heras, Geist, Kielhofner & Li 2002) (See appendix 6): a MOHO tool which gathers information on volition from observation

An integral element regarding the integration of MOHO depended upon the extent to which the participants viewed MOHO as a valid theory in the first instance (Richardson *et al.* 2004). As already emphasised, theory has to make sense and connect with a persons own beliefs and values if it is to be genuinely embraced. The occupational therapists would need to ask themselves how much they valued practice as outlined by the theoretical constructs of MOHO. Indeed, considering individuals' epistemological stance in terms of the contribution of theory is useful for facilitators to be aware of in considering congruence issues between what is being suggested and how it will be received. As Chard (2006:56) outlines, practitioners may or may not be convinced to embrace forms of practice knowledge despite rigorous research findings. She states that practitioners must be sufficiently dissatisfied with some aspect of their practice to want to change or be convinced by others. At the outset of our inquiry it was evident there was not consensus, nor a shared ideology regarding MOHO as the chosen theory. I came to appreciate that the therapists held varying views regarding their perceived need to change. Participants would consider what they liked and disliked about the theory and elements of the theory would be rejected as a consequence (arguably before such elements had chance to be considered*).*

Argyris and Schon (1976) discussed issues around the relevance of a theory to an individual's practice in terms of how it may be inadequate in meeting their needs. Although I have articulated that MOHO has attempted to address this gap through the scholarship of practice philosophy and the continued development of the assessment tools, Arygris and Schon's (1974) work regarding theories of action still provides a useful perspective from which to consider an understanding of knowledge construction. Theories of action are theories that consist of an interconnected set of propositions, which usually include 'theories of intervention', or theories aimed at 'enhancing effectiveness' (Arygris & Schon 1974:6). In our inquiry MOHO was arguably the theory of action *and* intervention. However, MOHO and the structured assessment tools (technologies of application) were not adopted wholesale. Indeed there is acknowledgment within the literature that a theory requires transformation in order for theoretical concepts to become useful to an individual in a practical sense (Bunge 1967, Richardson *et al.* 2004). Tillema (1995) also refers to the changing nature of knowledge as it is applied in practice. Through experience and the accumulation of professional knowledge from real-life situations, the available knowledge becomes more personalised and stabilised (Bennet 1990) and potentially less rule based (Gugmundsdottir 1991). In essence, it was apparent that the MOHO

theory and application of the assessment tools underwent a process of deconstruction and reconstruction in line with the therapist's personal stance and theories-in-use. This act of sense making of the MOHO raised issues regarding the theory's relevance and appropriateness for the practice setting (Higgs *et al.* 2004).

It has been interesting to explore the role of theories-in-use as a means of maintaining constancy (Argyris & Schon's 1974). By this I imply that our theories-in-use specify which variables we are interested in (as in our commitment and sense of obligation to our practice and the amount of effort and energy we are prepared to expend). They are used to set boundaries for action and link to the constraints in our environments, especially those which we feel we can do nothing about. As an example, I suggest John was a therapist who did not wish to make too many changes which would unsettle his theories-in-use; from an epistemological stance he was in favour of professional theory, yet I suggest fundamentally he sought stability in his practice (Argyris & Schon 1974).

Savin Baden (2008) maintains a person's ability to grasp new learning links to contributory factors such as the individual's life and their 'stories.' She identifies the importance of appreciating the fact that learning is complex and specific to the learner. I suggest Savin Baden's perspective on learner stance provides a credible influencing factor when considering an individual's response to theory uptake. Indeed Barbara was a therapist whose training preceded occupational therapy models. Whilst Barbara may be criticised for not keeping up to date with developments within the profession (COT 2005), from an historical sense her theories–in-use had stemmed from her training as an occupational therapist in which she had not been required to practice using a professionally orientated theoretical framework. Reed (1984) and Walker and Ludwig (2004) likewise raise important issues in terms of learner stance and personal beliefs and values when they highlight how theory is not value free. Such perspectives acknowledge how theory evolves from philosophical assumptions made by a profession, interpreted by others.

Disjuncture

In terms of knowledge construction, I believe that by reviewing the therapists' theories-in-use disjuncture occurred for all the participants; prompting the occupational therapists to deal with the emotional and cognitive challenge of shifting between how they had been practising and how this connected or was discrepant

with what MOHO suggested, and how *they* wanted to take their practice forward. Meyer *et al.* (2008:x) discuss this unstable position as learners occupying a 'liminal space'. This state of liminality has been likened to a rite of passage into a discipline (Meyer & Land 2006) and can result in identity shifts (Cousin 2006). However, in contrast 'stuckness' and disjuncture may occur which can undermine the learner's confidence in terms of their current performance. What I wish to draw attention to here is Savin Baden's (2008) depiction of the forms of disjunction which may occur. Here I return to the tension Barbara spoke of in response to the 'junior' occupational therapists questioning her practice (theories-in-use). I suggest Barbara was in a 'hermeneutic cycle' of disjuncture (Savin Baden 2008:105) in that she knew her practice required renewal yet in reconsidering the once familiar in light of MOHO she shifted between feeling clearer, then less certain about how the theory supported her changing practice. Furthermore, the difficulty for Barbara appeared to relate to her identity as a senior therapist in not being familiar with MOHO and her need to access ongoing means of support.

I believe the concept of Legitimate Peripheral Participation (LPP) (Lave & Wenger 1991) has relevance here in terms of considering how senior colleagues and junior staff identities conflict as they generate competing viewpoints on practice and its development. In light of LPP I suggest that the student and graduate occupational therapists in contact with Barbara were caught in a dilemma, in that they wanted to engage in practice, to understand their role as mental health occupational therapists, to participate and thus become fuller members of the team. In contrast, as Lave and Wenger (1991: 115) suggest, 'they have a stake in developing forms of membership in order to establish their own identity for the future'. Referred to as the 'displacement contradiction' (Lave & Wenger 1991:116) it is feasible to consider how Barbara was challenged by junior staff who more readily identified with MOHO yet were not experienced in its application. Recognising Barbara as a senior therapist they wanted to learn from her practice. I believe the concept of LPP becomes challenging when senior colleagues do not demonstrate professional mastery. I am not suggesting Barbara was not a competent worker; Barbara herself identified that her practice had become generic. If we consider learning in terms of LPP novice learners at the periphery need to observe masters at work in order to help them move toward fuller membership within a discipline. I therefore contend that senior occupational therapists working within mental health need (to have opportunity) to practice professionally orientated practice. Whilst I appreciate local and national politics have played a part in encouraging generic roles within mental health. I argue that

occupational therapists are essential members of the MDT. Moreover I believe that MOHO offered Barbara a tangible means of considering what the contribution of an occupational therapist could be. The conflict that I suggest Barbara experienced emerged through her attempts to share her theories-in-use with others. For Barbara, adopting MOHO was never simply the transmission of theoretical knowledge or the learning of new skills; rather I argue knowledge construction around MOHO involved identity work. What is commendable is that Barbara did not resist the implementation of MOHO but continued to engage amidst disjuncture.

On a final note, Lave and Wenger (1991:117) propose that LPP is 'crucial for naive involvement and invites reflection on ongoing activity'. Importantly, rather than suggest Barbara's theories-in-use should be dismissed, the continual interaction of everyone's perspective needed to be respected. Indeed Barbara's contribution within LPP was her ability to draw upon her considerable practice experience of working within mental health. I suggest that everyone's participation in the inquiry process was legitimately peripheral to some degree due to the changing nature and negotiation of knowledge being constructed, which I now go on to discuss.

The reconstruction of professional theory in line with agency and personal stance

I admit I was critical of the therapists diluting the properties of the theoretical constructs and not adhering to the guidance for using the structured assessment tools accurately. I was keen to avoid the mimicry of professional knowledge that Cousin (2006) warns against. Yet I contend that the practice of mimicry is complex to unravel. Cousin (2006) herself recognises that it can be a first stage of understanding. I was aware of certain therapists selecting from the range of MOHO concepts, I suggest that this might be explained by the participants' need to personalise and reconstruct MOHO in line with their own personal stance and theories–in-use. Indeed, it is recognised that 'practice is an inexact science' (Kennedy 1987:68). A pivotal component of professional judgement is the contribution of professional artistry when dealing with the 'messy practice of real-world settings' (Schon 1991:16). For example, the occupational therapists expressed their knowledge and experience of MOHO in different, individualised ways, which suited the situation at hand, and 'sat most comfortably' with their view of the world (Fook 2002). This view, which I refer to here as personal stance, recognises the individual with his or her own identity, agency and views. It suggests an attitude or disposition towards a particular context. As Savin Baden (2008) asserts, personal

stance goes further than having a certain attitude, but also embraces our unconscious beliefs or prejudices, our prior learning experiences, our perceptions of those who have taught us and a sense of our past, present and future selves. Moreover Carper (1978:20) suggests personal stance 'promotes wholeness and integrity in the therapeutic encounter'.

Whilst I was keen that the therapists were able to master an understanding of the full range of the MOHO concepts I suggest that the deconstruction of the theory and the assessment tools was to personalise and enable integration of MOHO to be 'natural' within their practice. Such individualistic personalising and tailoring of MOHO links to constructivist values wherein the occupational therapists were seen to exercise a freedom and autonomy to use the theoretical knowledge as they deemed appropriate; to be modified and adapted in order to meet both their human needs and practice needs (Higgs *et al.* 2004, Richardson *et al.* 2004). Furthermore, Bandura's (1989) theory of self-efficacy suggests practitioners who do not feel restricted [by theory] but are able to be self-determined, have greater interest in expanding their knowledge base. It was interesting to explore this fusion of linking personal stance alongside MOHO theory to advance practice. Heather certainly comes to mind as one of the therapists who appeared strategic in taking what she wanted from MOHO without getting caught up in a need to connect with the scope of the theoretical constructs. I believe personal stance offers unique professional perspectives, which originate from a variety of sources of knowledge and which impact upon the individuals' engagement with new knowledge and learning. For example, in the previous chapter it was apparent that both Mary's and Emma's personal skills and attributes, their practice experience, their involvement in discussion and reflection with colleagues, their attitude and knowledge toward conventional practice as well as other influences they were less consciously aware of played an important role in their adoption of new skills (Chard 2006, Savin Baden 2008).

The focus on professional artistry and personal experience are valid themes to examine here. Whilst the goals of practice are focused around expert knowledge and professional competency, the way in which a practitioner delivers such practice is viewed as an art form (Andresen & Fredericks 2001). Indeed, Mary's comment at the outset of the inquiry reflected her concern that integrating MOHO might stifle her creativity. Fleming (1991) likewise considered skilful practice as artful practice. However I argue that professional artistry can be enhanced though integration of propositional knowledge *with* personal and practice experience.

In addition to the personalising of formal theory a concern I held was with regards to the 'accurate use' of the structured assessment tools. A wide range of evidence-based structured assessment tools has provided a technology for application of the theoretical arguments of MOHO. Indeed I maintain that the MOHO tools proved to have relevance and made vital connections for therapists in terms of making the theory come alive (Heather) and providing much needed boundaries as part of the assessment process (Emma and Stephanie). However, unlike the Assessment of Motor and Process Skills (AMPS) (Fisher 2003) (an evidence-based performance evaluation tool associated with MOHO), therapists are not required to undergo any formal training course to become certified with use of the majority of the MOHO tools. However, Kielhofner (2002) and colleagues assert their use still requires appropriate selection, use and interpretation. As such protocols detailing guidelines for use accompanies each MOHO tool.

I was aware that placing the MOHO assessment manuals into the participant's hands for them to study would not have constituted the learning of new skills. Evidence suggests that when practice guidelines or proven interventions are provided to an individual or group without support (including that of management), or providing opportunities to try out an innovation before putting it into practice, there is little if any evidence that practice results in any change (Davis & Taylor-Vaisey 1997, Oxman *et al*. 1995, Chard 2006). Indeed, a good deal of time was spent in monthly group sessions examining the range of tools we considered (see appendix 2), working through the guidelines for administration, considering where flexibility was feasible and developing a consistent approach to use in rating and reporting.

There are obvious reasons for a formal assessment process to be constructed: for example, to ensure the individual service user can monitor levels of progress, and appreciate where therapy is heading. The completion of a tool within a stated timeframe arguably provides punctuation to the therapy plan to prevent the assessment process losing its momentum and focus. For the therapist too, rating the assessment and outlining the ongoing therapy plan can provide clarity and focus regarding areas of strength and need (Forsyth & Kielhofner 2002). Yet, evidence suggests the use of structured assessment tools can be viewed as stifling and time consuming as therapists learn and practise new skills whilst encountering barriers in their use (Chard 2000, 2004, 2006). Within this study it was evident that it took time initially to work through the tools and substantial encouragement for participants to

pilot the tools in the first instance. Following their use therapists fed back on the experience, which included the highs and the lows:

> When I went out on a home visit I used the OCAIRS. The questions I was asking meant I got quite a lot of detailed information back from the client and then I asked the client's husband and I got the totally opposite answers, its wonderful isn't?! But my view has changed in that I focus on the patient now rather than just the house, which has got to be good, but I still need to move on to how I report it all. I haven't quite got onto the rating bit. I haven't got that far yet
> *(Barbara: six months into the inquiry)*

> I think people have been assessed so much by the time they get to us that I think people can find that they are being over assessed. I think some of the assessment tools don't make sense to service users and I wonder if that is because of our explanation or whatever, so when I have used the OSA[4] I think it is an awful lot of information for something so basic in terms of intervention. I think we have only just started really. I like the idea of them all. I just want to explore them really. The only one we have used in the past is the OSA and I didn't feel that was particularly useful.
> *(Ellie: six months into the inquiry)*

> Well the assessments have been very useful at times. I've completed an assessment and I've thought to myself well that was really helpful and really useful, like the ACIS[5] which just allows you to really structure information, which we are often asked to collect, in a much more formalised structure and thorough way; a more professional way. So there have been times when I thought yes that was really worthwhile doing. But, its taken time, but now I've got this information organised in a real clear way that I can share.
> *(Susan: twelve months into the inquiry)*

Clearly certain therapists felt less confident and / or uncomfortable with using the rating scales and disregarded this step within the assessment process. The point about theory and its formality, which certain participants rejected by not completing the tool in its entirety suggests a number of issues connecting to the therapists' epistemological stance, including a dislike of assigning numbers in boxes and the effort and diligence required to see the tools through to their conclusion. In addition, I suggest the majority of the therapists perceived the assessment manuals to be overly complicated and lengthy (Lee *et al.* 2008). As a consequence I designed workbooks that identified the key guiding principles to accompany the assessment protocols (for

[4] The OSA (The Occupational Self Assessment) (Baron *et al.* 2002) a self-report tool which enables service users to rate how competently they do things and how important this is to them

[5] The ACIS (The Assessment of Communication and Interaction Skills) (Forsyth *et al.* 1998): a MOHO observational tool designed to measure an individual's performance within a social group.

example, see appendix six). However, despite a number of targeted resources, certain therapists still adopted a more pragmatic even 'maverick' style and chose alternative methods of administration. Whilst I recognise that individual attributes play an important role in the adoption of new skills I argue that ongoing service monitoring of practices are required to keep our practice aligned and rooted in professional concerns.

On reflection it appears that I have been grappling with the contribution of a formal theory base for professional practice. The focus of my involvement was not about questioning whether the participants were competent practitioners per se but rather to examine if their practices were representative of occupational therapy. I have felt a tension and responsibility in promoting the use of MOHO which I now go on to consider in relation to my own ontological stance.

Guiding paradigms: constructivist / constructionist perspectives

At the outset I realise that I positioned myself with an ontological view that MOHO required less subjective interpretation in order for it to be sufficiently embedded and successfully applied. I believe that this perspective developed as a result of my own frustration with occupational therapy's professional image externally. Criticism comes from the general public who are unsure as to our role; equally tension is felt within the workplace within professional ranks. I am aware that my move into education was not only to challenge myself professionally but also to have some hand in developing competent graduates who can effectively deliver our occupational role. Yet Fook (2002) articulates how there are multiple ways of knowing and constructing knowledge for practice, which in turn places an emphasis on diversity. It has been interesting to reflect upon how the therapists demonstrated ways of embracing MOHO theory without stating that they felt constrained to use it in prescriptive ways. As an academic influenced by an expert in the field, I was arguably the most constrained by the theory not only in how I was advocating its use but also in how I would be reporting on the outcomes of our inquiry to other scholars. I also acknowledge that although I was able to reflect upon previous practice experience, I was not in a position of being directly linked to practice at the time of the inquiry. Rather, my construction of the MOHO theory had been more recently from academic texts. It is also appreciated that separation from the field results in more abstract and idealistic ways of thinking and acting, suggesting that professional knowledge can be built into structures which are prone to self-strengthening (Kagan 1990). However, I

contend that my decision to be involved in this inquiry acknowledges my own sense of obligation to keep abreast of practice.

Bannigan (2005) suggests that occupational therapists need to be prepared to open themselves to scrutiny by putting their ideas into the public domain. I argue that this inquiry process has clearly required *all* the participants to be open to scrutiny, to be questioned about one another's practices and to be challenged about personally held ideas. As Fook (2002) asserts it is when a theory is applied without thinking and theorising, that theory is in danger of subjugating a person's own experience. Thus it is important not to rely too heavily on privileging explanations and discourse from formal theory that can serve to restrict opportunities to learn and grow by limiting one's ability to see the applicability of one's own experience in context.

By re-acquainting myself with practice I have been importantly involved in examining professional structures regarding who we are, what is valued, what is not, what is useful knowledge and what established values inform knowledge integration. Moreover I have recognised the value of a profession as a community of inquiry, or practice (Wenger 1998, Abrandt Dahlgren et al 2004) and the importance of social participation in identifying valid forms of professional practices. With this I have appreciated the contribution of four essential components of learning and knowing as proposed by Wenger (1998), which I have applied to the findings of this study, which include:

- *Meaning - individual and group dialectic regarding the experience of being in the (practice) world*. Having each other's practice 'uncovered' in front of peers and identifying with a professional agenda proved to be a necessary motivating factor for all participants to review their professional membership and obligation towards occupational therapy. I suggest personal stance reflected issues around professional and personal integrity and a need / desire to deliver sufficiently robust practices (Ellie, John).
- *Practice - sharing a history of practice perspectives* There was a realisation for some that a unique professional approach could have greater pay-offs and a significant challenge was raised with regards to rejecting generic working patterns. Through developing an improved sense of professional esteem and seeing the benefits of contributing something tangible whilst unique to the service, the momentum to challenge previously held values and beliefs was harnessed (Both Heather and John spoke about this).

- *Community - participating with others to consider and recognise what is viewed as competent:* Through prolonged engagement, the occupational therapists became more open to hearing one another's views. MOHO was critically examined in line with the therapists own theories-in-use and the practices of their peers. Ongoing individual and team monitoring processes took place within the group collective.
- *Identity – critically examining professional images and challenging perspectives through active learning*: Learning and identity work go hand-in-hand. Certain participants became more open to challenge and be challenged about their 'theories in use' through a personal acknowledgement that they were not comfortable / satisfied with their current practice (Heather, Barbara, Emma, John).

I believe that these four components can be embraced by the notion of being a 'professional practice connoisseur' (Eisner 1985), as in developing the art of 'noticing,' of developing a critical appreciation for practice (manifested through therapeutic reasoning). Such practice connoisseurship draws upon both propositional and procedural knowledge recognising the strengths and limitations of both. Furthermore I argue that practice connoisseurship can embrace both constructivist and constructionist perspectives in that it denotes individual artistry and expertise of critical appreciation (process, language and form) when practised within the context of a critical community (Higgs *et al.* 2004). In essence professional knowledge and what is deemed acceptable is determined within a socially constructed context, shared by a community of practitioners (Schon 1983:33).

As a means of drawing together the points raised thus far in relation to my participatory framework and how disciplinary learning was seen to occur, I return to discuss the legitimacy of the therapists' knowledge construction of MOHO. The question being could MOHO be legitimately articulated as the evidence base underpinning the therapists' practice?

The call to deliver evidence based practice

The literature included within the opening chapter referred to the shift to evidence based practice (EBP) believed to be required for our profession (Cusick & McCluskey 2000, Lloyd *et al.* 2004, Taylor 2000, 2007). I have spent time reflecting upon the value that occupational therapists, myself included, place upon EBP. I have read

about the importance of EBP in terms of ensuring decisions made about therapy interventions for a given service user are effective and based on best evidence (Law & Baum 1998, Cusick & McCluskey 2000, McCluskey 2003). I know EBP has kudos in a health care culture to demonstrate professional accountability in conjunction with ensuring health care funding is used in the most cost effective way (Law & Baum 1998). In addition, I am aware of reports from service users themselves that they expect interventions that are effective, appropriate to their needs and preferences, which are provided by competent therapists (Law & Baum 1998: 132). However, as commented upon by Gilbert and Logan (1996:465):

> "Is evidence based health care just a passing fad, promoted by managers and purchasers enjoying their influence over clinical practice, but doomed to fail as a far too cumbersome method for dealing with the complexity and imprecision of real-life clinical decisions?"

Despite a strategy produced by the COT (Ilott & White 2001:276) affirming 'explicit links between theory, research, education, continuing professional development and practice', occupational therapists in the field of mental health have encountered difficulties in using evidence to underpin their role (McCluskey & Cusick 2002; Lloyd *et al.* 2004, Pettican & Bryant 2007). The barriers to EBP and the use of research information in practice are well documented in the professional literature. For example, Barta (1995) and Haynes (1993) acknowledge a lack of administrative support and inaccessibility of research evidence within the field, whilst Nolan, Larson, McGuire, Hill and Hallor (1994), Upton and Lewis (1998), Upton (1999a; 1999b) and Wood (1998) identify barriers of therapist's time and lack of skill and comfort in applying research findings to be major hurdles.

However, aside from resource issues I believe there are more fundamental challenges at stake for members of our profession to embrace the EBP agenda. I believe this connects with our ability to stay true to our professional philosophy and achieve a sense of humanism and artistry in occupational therapy practice. By this I imply that what has attracted individuals to the profession in the first place is the very creative and person-centred nature of our work. Staying true to such values has been acknowledged by Cusick and McCluskey (2000) who identify that certain practitioners' primary concern is client care; as such uptake of research has a low priority for them. Furthermore, I contend that members of our profession do not want to feel constrained by having to utilise tests and formal procedures, which Smith (2006) argues, do not enable them to get close to service users. Seeking the known,

and trying to fit service users into frameworks arguably has more to do with therapists' own needs than with the reality of people's lives (Smith 2006). There is no doubt that such personally held worldviews are deeply ingrained (Cusick 2000) and I believe that certain therapists I have been working alongside in this study have felt this tension.

Deciding not to take up the mantle of becoming evidence-based practitioners means therapists will be faced with potential legal, ethical and economic consequences that could harm the profession as a whole (Cusick & McCluskey 2000, Welch 2002). Indeed, this vulnerable position opposes government policy targeting professional accountability and governance of healthcare resources demanded by consumers (DH 2005b). I agree the shift to EBP is required for our profession as I believe that uncertainty in terms of our unique role and the lack of evidence integrated to support practice has led to therapists feeling disillusioned and embracing other roles (Duncan 1999).

Yet as Taylor (1999) and Cusick and McCluskey (2000) state the move to EBP will require high levels of personal change not least in therapists' own values, habits and expectations of themselves. Smith (2006) identified that a good therapist is able to allow him / herself and the service user to be in the position of uncertainty. This 'emancipatory narrative' (Smith 2006:307) sounds compelling and I agree with him that we should not be focusing on illness narratives, although I reject his assertion that embracing theories and models provides certainty for our practice. For as Alsop (1997:504) proposes, professional judgements have to be informed by but not dictated to by the evidence. However, as I read Smith's work and from listening to his powerful keynote address delivered at our National Conference June 2006, I felt in myself a desire to want to practise with this degree of freedom and uncertainty, by looking for what we think we know and what we can learn through working with people. Indeed, it is evident that professional judgement is valued in complex situations where there is no single right answer, yet paradoxically value is placed on evidence-based practice where there is an over-reliance or expectation that a correct answer exists (Stiwne & Abrandt Dahlgren 2004).

Smith (2006) speaks about not privileging theory over practice and I have spent time reflecting on this assertion, as I have been left thinking at times that this is exactly what I have been doing. However, the theoretical model we have selected for our research advocates the importance of combining experiential and procedural

knowledge (Bradbury & Reason 2001). Indeed, the model emphasises knowledge creation, which is grounded in the realities of the practice context (Kielhofner 2005). This relationship between theory and practice which MOHO has built itself upon is of utmost importance embracing my ontological perspective. As such I feel that Smith's message, attractive as it may sound, clearly lacks the robustness for practice, which I believe our profession and most importantly the occupational therapy practitioners within it need. Good occupational therapy relies on an ability to work alongside service users and connect with their narratives, addressing what is important for them to achieve so they can become who they want to be. However, in contrast to Smith's (2006) assertions, I believe this can be achieved by working with the framework of a sound evidence-based, occupation-focused model of practice.

Since the introduction of EBP, it would appear from the literature that the most credible strategies to implement evidence are those which are locally focused and have a number of integral elements, for example; *e*ducational components promoted by prominent figures within the profession; an approach employed which is rigorous but attractive and; strategies which involve audits of practice. With reference to this study, I suggest other elements which have relevance include the use of support systems as part of a normal work routine; a focus on the needs of service users and the use of accessible, useful information (Grimshaw, Freemantle, Wallace, Russell, Hurwitz, Watt, Long & Sheldon 1995; Oxman, Davis, Hayes & Thomson 1995; Law & Baum 1998).

In addition I add the following, which bring together themes drawn in light of the findings presented here illustrated within my participatory model of change:

- The acknowledgement of the disruption and 'troublesomeness' as well as the transitions new learning brings
- A recognition of the fusion of propositional forms of knowledge in line with practitioners' personal stance, theories-in-use and perceived need to change
- A focus on active learning through engagement in cycles of action and reflection and the sharing of such experiences with peers
- Validating all efforts by those involved
- Focusing on the development of a group collective or community of practice which can support new learning and transition

In summary, I argue that there will always be a ‘balancing act’ regarding the use of evidence based practice with regards to the deconstruction of propositional knowledge in line with perceived quality of the evidence, personal stance, theories-in-use, service user information and contextual factors. Indeed I refer to the evidence of ‘theory building’ as a combination of such contributing factors including the necessary ‘testing’ out of such knowledge with others in order to better determine how we see and act in the world. This in turn then feeds into our theories-in-use.

In this inquiry I maintain that the therapists were supported to communicate their professional practice through a legitimate knowledge source. I have also considered how valid is the reinterpretation of such knowledge (Fook 2002). Did it really matter if certain therapists using the MOHO tools did not diligently complete the rating scales, if the service users were getting an improved service and the therapists themselves felt more confident and empowered within their practice? Was this not sufficiently legitimate practice? Perhaps the answer to this question is yes, the therapists can claim they are using evidence-based *approaches*. They will not however, have the necessary outcomes (numbers) their managers require of them to articulate service outcomes. But the value of numbers is not all that an evidence-based service should be about. What I believe does need to occur is the critical appraisal of any new theory building against recognised evidence-based conceptual models of practice such as MOHO. Indeed, I argue that the use of good evidence (professional orientated theory and tools) with clinical judgement, reflective practice and a person-centred philosophy will go some way to prevent practice becoming prescriptive and unaccountable.

Conclusion

Twenty years ago Henderson (1988) spoke about our professional philosophy and theories as essential to the practice of occupational therapy whilst acknowledging their separateness. That is, although professional beliefs and values tell us what we should do, it is the *technologies* which tell us how to do it. Henderson argued how appreciating this distinction enables the acceptance that both philosophy and theories of application are *essential t*o practice and cannot stand-alone. Henderson (1988) asserted that the profession should ensure a professional dialogue is maintained regarding our fundamental values and beliefs which permeates through our practice and the ways in which we communicate our contribution to the wider team. Henderson’s assertions sit comfortably with the values of this inquiry. In

parallel, within the literature there is a call for evidenced-based practice (EBP) with particular reference to the education and training of therapists who will be prepared for such practice (Holm 2000, Stern & D'Amico 2001, Tickle-Degnen 2000a, 2000b). Indeed, EBP should be emphasised in practice and professional education. It is argued here that MOHO provides a means of delivering both an evidence-based (approach) and professionally orientated agenda.

Within this chapter I have presented the therapists' perspectives on what has been achieved at a personal and service level during this inquiry. Our collaboration has provided a much needed space in which therapists have been encouraged to reflect on the contribution of MOHO to their practice. I have identified with a number of key influencing factors which were seen to be involved when participants were prompted to engage in an active form of learning. I have articulated that the practice development initiative served to broaden each therapist's horizons regarding their clinical reasoning and articulation of their practice. The consequence of refocusing practice appeared to enable changes in practice and behaviours with perceived benefits for service users and MDT colleagues (Wye & McClenahan 2000). The therapists' reflections also highlighted what they hoped MOHO would (and could) contribute to their practice, which speaks about personal requirements and if these had been fulfilled. There is no doubt that time factors are of note as was the support of a manager who provided the necessary resources and impetus for the venture in the first instance. Indeed, the sustained effort from all those involved is not to be underestimated and speaks about the length of time and commitment required of professional staff to challenge previous repertoires in order to consider alternative ways of thinking and participating.

My views regarding the value and contribution of occupational therapy theory during the course of our inquiry process have not changed significantly. What has occurred is that I have formed a stronger allegiance for theoretical models such as MOHO, which attempt to make obvious the links between academia and practice by encouraging collaborative efforts between colleagues across settings to create meaningful dialogues with regards to theory integration.

There is a popular discourse with which I identify that suggests that theory not only benefits students and graduates by providing a framework, which enables them to participate in the occupational therapy process, but similarly more experienced therapists are able to critique and challenge ideas and beliefs about 'their world'

(Steward 1995: 361). We need formal theory as this provides a language and discourse that enables us to communicate and reason with our actions. Yet I have appreciated more fully through this inquiry process, that theory is best seen as a useful facility to us rather than a set of prescriptive principles. I feel strongly that students and new graduates entering the profession need adequate mentorship and confirmation for their professional role and that this needs to be nurtured through critical reflection of our professional knowledge and subsequent practice encouraged by senior colleagues, supported by managers. Whilst the subtleties of individual's personal qualities including perceived need to change are recognised, I argue that fundamentally transitions occurred and new meanings were forged as a consequence of the community of practice which was realised.

Finally, I argue that our preoccupation with evidence-based practice needs to include acknowledgment of the fact that available knowledge to guide ongoing practice (theoretical constructs, assessment tools, protocols) will be transformed through its use. Therefore I acknowledge that alongside the requirement of utilising formal theory must be recognition of personal stance and the fusion of experiential learning. However, practitioners need to unravel the processes they engage in when carrying out their practice (Richardson *et al.* 2004:206) prompting questioning of what values and forms of knowledge serve to guide their practice including the influence of professional and political drivers.

Chapter eight

Participatory change: a dynamic interplay of personal and contextual relationships

"(H)uman activity consists of action and reflection, it is praxis, it is transformation of the world. And as praxis, it requires theory to illuminate it" (Friere 1970:106).

Introduction

The previous three findings and discussion chapters have explored this research study from three different perspectives: the development of the group collective, individual journeys, and the construction of professional theory with personal stance and theories-in-use. This chapter will present how my thinking has developed from my original starting position to address how the study advances knowledge of the implementation of an evidence-based occupational therapy conceptual model of practice. Opportunity to further advance theoretical knowledge is identified throughout the chapter and new insights are offered, which I believe may be of benefit to a wider practice development audience, in addition to occupational therapy managers and practitioners.

I begin by reviewing the original aims and objectives of the research with presentation of the key findings, which are mapped across to the previous three chapters. In addition, subsequent realisations beyond the scope of the initial aims are presented. A framework is then offered as a means of bringing together what has emerged from the data in order to make sense of the whole. I present a detailed examination of the change factors that affect individuals undergoing change. These factors are represented as a number of inter-connected relationships consisting of self, peer, contextual, theoretical and facilitator. Each of these relationship areas will be considered in turn. In terms of the facilitator relationship I present an appraisal of the experience of conducting PAR including where further research is indicated.

The final section of the chapter is a conclusion, which summarises the research study as a whole, and outlines the key contributions of the research in relation to theory, practice and PAR.

A review of the research aims and objectives

The primary aim identified at the outset of this study was to implement the Model of Human Occupation (MOHO) (Kielhofner 2002) across a mental health occupational therapy service. Within this broad aim were several objectives: to explore ways that barriers to theory uptake might be removed; to explore the role of the facilitator including the effectiveness of insider/outsider roles; to examine the ways in which the MOHO impacted upon the occupational therapists' perception of their role and finally;

to examine the transitional experience of the occupational therapists (newly) implementing the theoretical model and assessment tools into their practice. The findings which have emerged, whilst responding to the overarching aim and objectives, have brought forth new insights in terms of understanding the complexity of working with people within practice development initiatives and examining how theory can respond to practice demands through collaborative partnerships.

Whilst I had initially set out to examine the transitional experience of the therapists (newly) implementing MOHO into their practice, I had not entered the study foreseeing that the impact of the *group collective* on the individual's response to participation would be so significant. I realised that the team based monthly group supervision sessions provided a necessary 'critical space' within which the occupational therapists' practice was explored via development of a group dialectic. Furthermore, praxis occurred as therapists became increasingly conscious of their work-based situation in light of MOHO and sought ways to actively negotiate improved levels of participation within their respective practice settings.

In addition to the influence of the group collective, it became evident that group members also needed to be viewed as individuals within the PAR process. Whilst I set out to examine the occupational therapists' perception of their role, our inquiry process served to unearth a considerable range of issues around professional identity. In the previous three chapters I spoke of the importance of connecting with individual therapists' needs. This included considering issues of learner stance; the notion of capacity building; threshold concepts and significant moments (chapter five); to self-efficacy beliefs and personal agency (chapter six); to epistemological stance regarding the nature of and reconstruction of knowledge (chapter seven). As a consequence I have appreciated the importance of working with participants to develop group dialectic and praxis whilst ensuring adequate attention is afforded to participants at the individual level. I argue the facilitator's role is key to ensuring these elements hold together.

The influence of myself as an external / internal facilitator was considered in some depth in both chapters five and six respectively. In chapter five my focus as the facilitator involved being a necessary catalyst prompting the participants to engage in critical thinking about their practice repertoires. I became involved in negotiating contextual issues and working to establish a learning environment in which openness could be expressed and trust could be expected. I came to appreciate the unique

position I held in working with the three teams each month and the benefit of being able to apply problem-solving techniques found useful with one team as a platform from which I could navigate through difficult stages experienced in the other team(s).

Although I anticipated there would be degrees of commitment towards the MOHO agenda, I believed that all the occupational therapy participants had *some* level of investment in the study, which was necessary to bring about any meaningful social change at a local level (Cockburn & Trentham 2002). However, conflict did emerge and in chapter five I considered my reaction towards the barriers which therapists put before me regarding reasons why alternatives for action would not work. As a practice development facilitator I realised the importance of being resilient and persistent in that I would not accept there were not ways forward (assisted by MOHO).

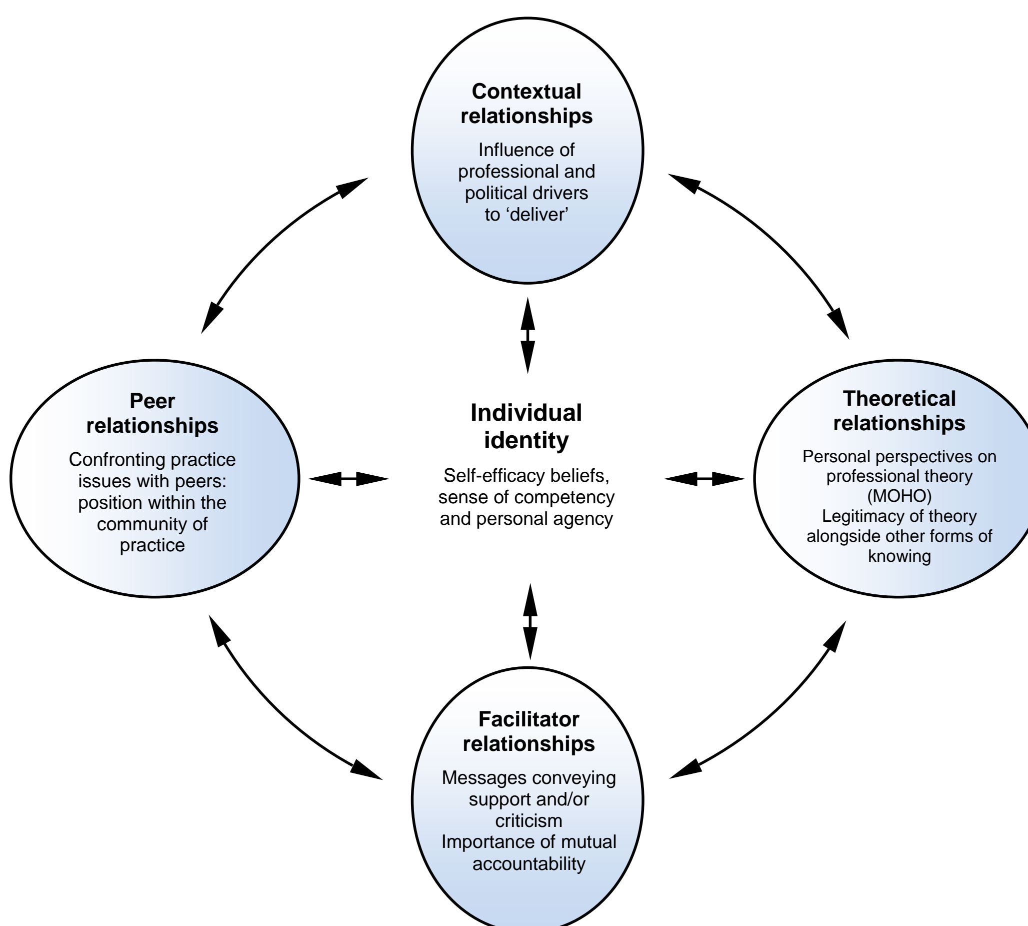
That is not to say that the experience of working with the therapists was always one of tension and conflict. Although challenging work, there was mutual respect. Fundamentally, I felt valued for my efforts and recognised that responses which emerged were, under the circumstances, not unreasonable. Key points of learning have centred on striking the right balance between incorporating rather than imposing knowledge (Wimpenny *et al.* 2006). In chapter six I acknowledged that my involvement could potentially undermine individuals' efforts (Kidd & Kral 2005), whilst in parallel I believe I was recognised as a 'mentor'. I argue that as a facilitator my own reflexive supervision was paramount to maintain critical awareness of my position and role within the process.

Finally, determining the practicality of MOHO and its influence upon the therapists' perception of their professional role and contribution was the main focus within chapter seven. MOHO provided a means of realigning the therapists' practice. I discussed how MOHO was deconstructed and reconstructed in light of the occupational therapists' personal stance, theories-in-use and artful practice. I considered the contribution of propositional knowledge alongside other legitimate forms of knowing within a *participatory context*. This connects with Carr's (1986) representation of the critical approach within theory and practice relationships. MOHO enabled the practitioners to achieve greater insight toward their practice by providing a sound theoretical base from which their working methods could be reviewed with other peers, thereby increasing the therapists' 'rational autonomy' (Carr 1986:183).

Realisations

As this research journey has progressed I have realised that beneath the primary research aim a subtext emerged which has, more latterly, taken precedence within my thinking. This essentially focused on my assertion that as a consequence of considering MOHO as a means of realigning their practice, the occupational therapists were prompted to engage with their peers (and myself) in a process of re-negotiation of their professional selves. Moreover, this dynamic process of the therapists' reviewing, reflecting upon and acting in order to explore professional identity issues has been interpreted as a dynamic interplay of change factors represented by a set of interwoven relationships involving a variety of personal and contextual influences (see figure seven).

Figure seven – Change factors: a dynamic interplay of personal and contextual relationships



This conceptual framework presents a number of interrelated concept areas. It builds on the participatory model of knowledge construction presented in chapter seven in its acknowledgement of the complexities of participatory change and the significance

of contextual issues. Indeed implementing MOHO across the teams emphasised not only the importance of the individual participant within any practice development initiative, but illustrates that *learning* does not occur in isolation but is an active, contextually situated process involving others.

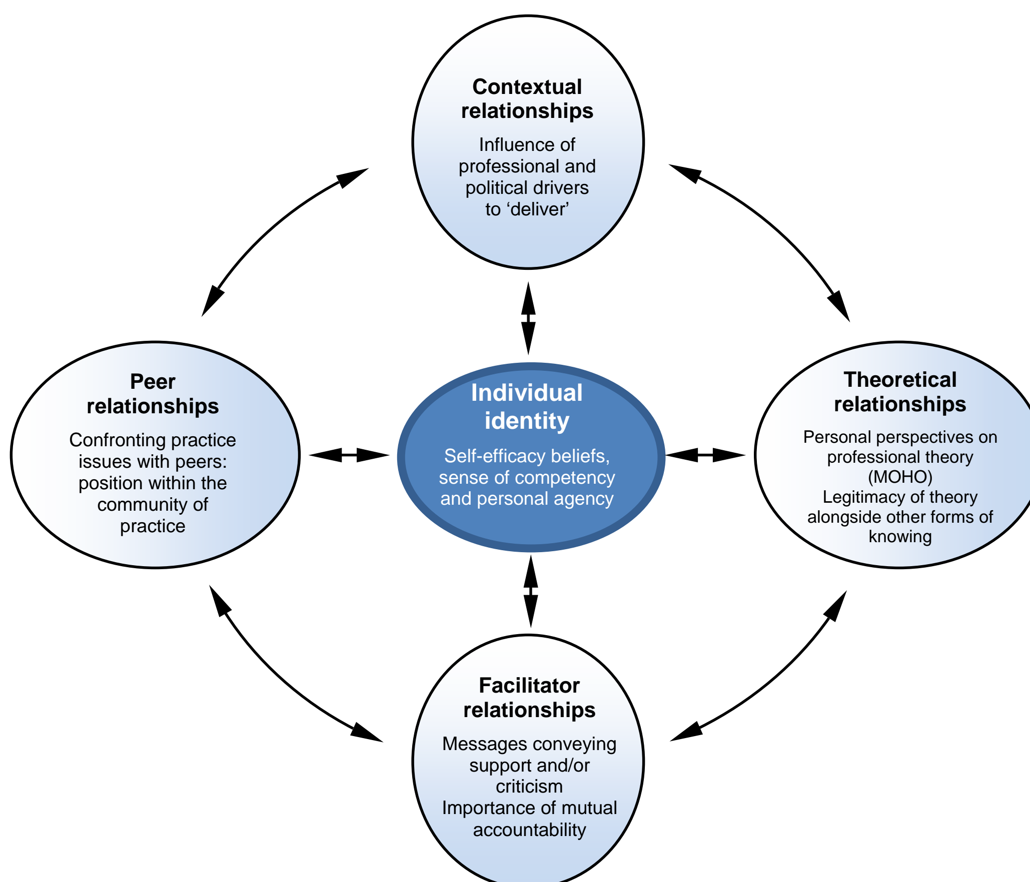
It is important to add that although the framework presented appears two-dimensional and potentially static, it has been developed with the ever-changing nature of our communities of practice in mind; dependent upon the nature of circumstances at any given time, the relevance / significance of each of the concept areas will (continue to) shift. Furthermore, I argue that praxis is the driving force within the model; praxis being a critical form of practice, an integration of theory and practice through reflection and practice in a dialectic process, which acknowledges political struggle, but can lead to liberation and enlightenment (Carr 1986:144). In addition the model represents a process for professional self-understanding, and reference to role theory (Kielhofner 2002) is relevant. MOHO itself acknowledges that who we are is intertwined with the roles we have and is reflected in the attitudes and actions of others towards us (Kielhofner 2002:72). Finally, coming from a relativist perspective, I offer the framework as a (useful) platform from which further negotiation is required.

In terms of signposting the reader through this next part of the chapter, each concept area from the framework will be considered with reference to potential new directions for theorising on the implementation of propositional forms of knowledge.

Concept areas

Individual identity and the relationship with the professional self

At the outset of this thesis I focused upon professional insecurity and role uncertainty for occupational therapists working within mental health (Creek 1998; Lloyd *et al.* 1999; Taylor & Rubin 1999; Finlay 2000; Fortune 2000; Parker 2001; Greaves *et al*. 2002; Wright & Rowe 2005). At the last meeting with the participants it was evident that their perception of themselves as occupational therapists had shifted and this was demonstrated through the therapists' improved levels of confidence. All the therapists spoke about delivery of a more tailored, occupation-focused contribution. This in turn made an impression on other MDT colleagues evidenced by an increasing number of specific referrals for occupational therapy services (see *Ellie's quote, chapter seven*).



During our actual period of contact, I considered that each participant would bring her or his own particular skills, attributes and personal motivations to the inquiry process. Participation would be influenced by the therapists' perception of their practice repertoires and belief that they could be enhanced (via MOHO). I thus considered change as a personal choice, which suggests a sense of personal agency. At one level this sense of citizenship and having the fundamental right to engage (or not) was made evident to me during the early stages of the inquiry, by the range of reactions and emotions displayed from participants, for example resentment through to healthy optimism. Yet I came to appreciate that it was not so straightforward as to base the therapists' reaction to our practice development initiative on issues of personal choice alone.

In chapter six I argued that the Transtheoretical Model (Prochaska *et al.* 1992; Prochaska & Velicer 1997) offered opportunity to explore, in a more inclusive framework, awareness of the subtle or alternate behaviours which denote why an individual might be more or less inclined to act. Mary and Emma's portraits illustrated how the motivation, commitment and energy to engage in the MOHO agenda were at one level a personal dilemma, linked to the individual's perception of their own

practice competence in relation to other peers and wider contextual influences. This led me towards social constructivism as a guiding paradigm; social constructivism emphasizing that one individual's meaning is as valid and worthy of respect as any other individual's meaning (Crotty 1998). This paradigm appeared to have resonance with my observation of the very individualistic way in which the occupational therapists were seen to participate and embrace MOHO. Continuing this theme further I became interested in the fact that whilst the Transtheoretical Model offered insight for considering the stages and processes involved in change and the potential process of relapse individuals may experience, the theory did not sufficiently address the therapists' sense of their underlying *belief* and *capacity* to move through and across the stages of change, which I linked to self-efficacy beliefs.

At one level I considered self-efficacy beliefs as being developed by the individual therapist, based on their interpretation of previous experience, which served to determine the therapist's sense of competency and ability to act. I believed it was feasible to evidence therapist's self-efficacy beliefs via their expressions, their behaviours and via the articulation of their practice within group sessions and individual meetings including their reporting and recording. I had considered self-efficacy as a personal issue, linked to the individual therapist's belief in their underlying capacity to (decide to) take on board the propositional knowledge being explored. This interpretation of the individual's response could quite legitimately be linked to the therapist's acknowledgement of their intellectual ability but also their perceived skill level through previous experience and encounters with MOHO and theory application (for example within the classroom or practice context) (Abrandt Dahlgren *et al.* 2004).

The importance of self-efficacy beliefs was considered within the work of Albert Bandura (1977, 1982, 2001) and essentially focused on how the occupational therapists' *confidence* in their practice competence influenced their response to implement MOHO. Such themes were the focus of chapter six and enabled opportunity to reflect upon the research objectives exploring transitional experiences as the two therapists portrayed considered their professional role and contribution in light of MOHO. Yet self-efficacy beliefs also linked to personal agency, informing and often dictating the therapist's decisions regarding how prepared they were to engage in the learning opportunity including the amount of effort required. As my thinking has developed around the influence of self-efficacy I have been drawn towards Giddens' reference to *human agency* (1984:9) with the notion of human agency as being able

to act, to intervene in the world. As such, if a person does not have the capacity to perform or make a difference they fail to be an agent. I believe that Giddens' theory offers a valid interpretation of the potential frailty of self-efficacy whilst a person is in transition (considering new ways of thinking and doing) and why the occupational therapists were vulnerable to revert to former ways of practising, as acknowledged as part of the relapse process identified within the Transtheoretical Model (Prochaska *et al.* 1992).

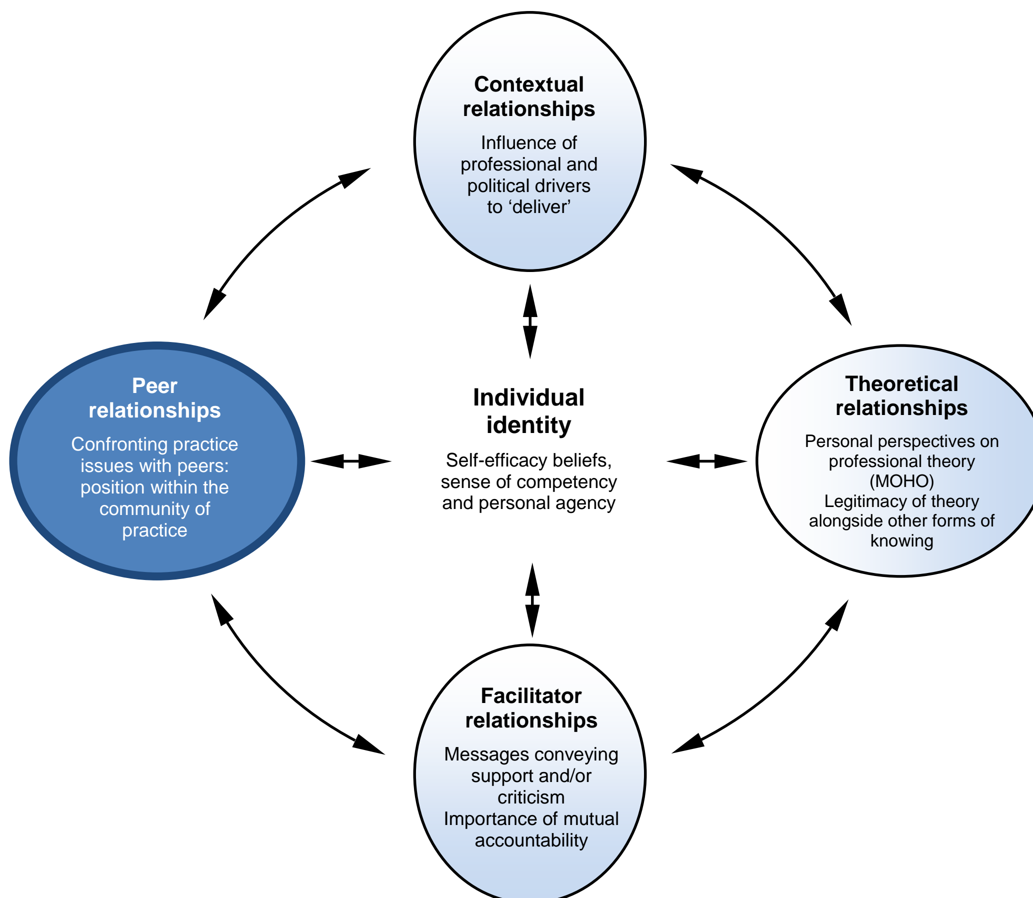
In this study individual self-efficacy beliefs were malleable and therapists' efforts would fluctuate. Whilst Bandura's (1997) theory maintains that self-efficacy beliefs provide the foundation for human motivation, well-being and personal accomplishment, I argue here that development of self-efficacy involved a temporal dimension wherein partcipants would experience dissatisfaction and disjunction in applying MOHO before progressing to more positive responses. In chapter five the threshold concept literature (Meyer & Lands 2006, 2008; Cousin 2006) was considered as a means of illustrating the challenge that the therapists' encountered at understanding how MOHO might translate into their practice. Implementing MOHO was never just a cognitive exercise, but importantly related to the therapists' perception of their professional role identity in context.

Whilst the aforementioned theories provided support for the use of social constructivism as a guiding paradigm, I realised that this perspective was unable to embrace the whole learning experience. Although I cannot deny that individuals would have their own personally held views about their practice and how they viewed themselves (Abrandt Dahlgren *et al.* 2004) it appears more feasible to acknowledge self-efficacy beliefs as a social construct. I am not disputing the presence of self-belief; indeed the therapist's sense of their professional competence and identity has shaped the participant journey (for example, the therapists demonstrated a need to feel in control, to question and to engage over time). Yet reviewing their professional-self in front of others was observed as being a *shared,* whilst personally emotional journey. MOHO theory itself identifies the development of self-efficacy and personal capacity as occurring as *people seek out opportunity to use feedback*, to correct performance and persevere to achieve goals (Kielfhofner 2002:46). Thus more latterly I have examined the powerful nature of self-belief and the notion of individual meaning making relative to *social context* (Giddens 1984). By this I imply that meaning making is already influenced socially and culturally. This perspective draws upon social constructionism and what has emerged as a potentially powerful

argument, which suggests that the occupational therapy participants were (already) influenced by contextual influences observed by individual's reaction towards and response to the MOHO agenda.

Social constructionism thereby acknowledges that knowledge is not "something a person has (or does not have), but as something people do together" (Alanko-Turenen 2005:30). Yet, I argue here that engagement in the MOHO agenda was not just about the power of the group collective. Whilst enhancing self-efficacy required the building of skills relevant to roles and the review of practice repertoires with others, fundamentally I have been examining the building of professional perspectives. I believe the therapists' (re)negotiation of their professional selves ran deeper than individual meaning making in light of the group experience. Moreover, I will go on to argue that personal decisions to act were already influenced by the social, environmental, cultural, educational, familial relationships that each person was exposed to and continually confronted with prior to, throughout and following the venture.

Peer relationships



Peer relationships predominantly focuses upon the influence of the group collective and the community of practice, which I spoke of as emerging during the inquiry process (referred to in chapter five). The notion of communities of practice has provided a means of illustrating what essentially the monthly group supervision meetings offered, an opportunity for the occupational therapists to come together to re-negotiate their professional selves.

Social constructionism focuses upon dialogue, which revolves around communal interchange (Gergen 1999, 2001). The tradition of the individual knower, as a self-directing and a 'knowledgeable agent of action' is thrown into question. Instead social constructionist perspectives invite an appreciation of relationships as central to knowledge and human well-being. Individual minds are not the source of knowledge, but communities of people in action (Gergen 2003). Within our community, the group collective consisted of the teams of individual occupational therapists who came together to explore and develop their understandings of one another as competent professionals in light of MOHO. Learning took place through the therapists' engagement in action and interaction prompted by this community. Moreover, the therapists' engagement within the group collective was embedded in culture and history (Wenger 1998). Our inquiry process was concerned with the therapists' everyday practice, but this also required emphasis on appreciating the systems through which the therapists had organised and interpreted their practice, including their relationships with peers and other MDT colleagues. Over time the collective learning resulted in practices that reflected sustained pursuit of a shared enterprise (Abrandt Dahlgren *et al.* 2004).

Giddens (1984) reflects on the powerfulness of practice culture, which is continuously constructed and reconstructed through social structures. An individual's tacit understanding of 'knowing how to behave' reproduces practice culture (Abrandt Dahlgren *et al.* 2004). The therapists' knowledge about what was collectively known within their teams or their department culture influenced their practice (Higgs *et al.* 2004). Giddens asserts that cultural messages build in power as they are reinforced by behaviours which accept the credibility of current practice. Although this may account for how people 'behave' in practice, Giddens acknowledges that people can choose to do otherwise.

I believe the reproduction of practice culture and the influence of peer relationships within this was evidenced as our inquiry process progressed. For example, in chapter

five, it was apparent that the older adult team had not been prioritising attendance at group supervision. I argue this was as a result of participants not finding group supervision adequate in terms of addressing their practice needs. I am not suggesting that the therapists did not value and respect one another, rather, the culture of supervision was not set up to effectively navigate a way through professional practice concerns. I believe our inquiry provided opportunity for an alternative community of practice to emerge. This occurred as we developed dialectic knowledge in practice through the shared experience of implementing MOHO.

Cultural conditioning shifted as therapists' explored their practice repertoires with one another in an environment which challenged individual values and beliefs and offered alternative professionally orientated ways of thinking and participating. This process could be described as being simultaneously human, social and political: human in the sense that it involved active knowing by those involved, social in the sense that it was influenced through dynamic social processes of communication and interaction, and political in that what was done reflected the social processes of knowing and doing in context (Carr 1986; Habermas 1996). Indeed, as Wenger (1998) and Senge (2006) suggest, learning is always about social practice. The team learning opportunity prompted the therapists to look at the 'bigger picture' beyond their individual perspectives.

This study has shown that peer relationships, nurtured within the group collective, enabled opportunity for participants to examine their professional identity with one another. Furthermore it has been noted that this was not always a smooth and pain-free process. For example, early on within the community adult team there was a sense that the sharing of individual efforts to integrate MOHO was not always met with encouraging sentiments by peers. However, a commonality of purpose did emerge and the same colleagues came to appreciate that a more open and trusted sharing of one another's practice offered an improved means of developing confidence in their own professional judgements. Indeed, over time and across situations the therapists' perspectives on practice became more malleable. The point here is that stepping out of the familiar into less known terrain arguably opened up the therapists' horizons to explore a *range* of possibilities for new practice routines. The individual therapist was not gaining a discrete body of abstract knowledge which they would apply in later contexts, rather, a renewed vision and interest in professional domains was created through the process of *participating.*

In terms of the context of group supervision and peer relations, it was significant that the group members where all occupational therapists, sharing a cultural understanding of their practice. Implementing MOHO was both a social and cultural learning process (Abrandt Dahklgren *et al.* 2004). For example the therapists shared similar tensions regarding development of a valued professional identity and how that was perceived amongst MDT colleagues. I believe that the therapists came to see that their view of professional identity was fairly consistent with MOHO. This became more evident as they administered and interpreted the MOHO tools. The therapists' accounts of how change occurred (and how it continued following my direct involvement) revealed that the collective of individuals came to see the *groups'* capability to attain goals and address desired tasks.

Collective efficacy was experienced amongst colleagues and the group came to exercise empowering and vitalizing influences on one another (Bandura 1997). This in turn served to shift culturally grounded values and beliefs regarding work-based tradition (Schwartz & Davis 1981). For example, Stephanie's comments (chapter seven) reflected how the acute adult team wanted to define their contribution within the MDT rather than having this dictated to them. Collective efficacy links suitably to the notion of sustainable communities of practice in that it was not just me and my influence, it was not just Mary or Ellie's influence, (although team based champions are discussed) but the sense that it was a shared responsibility. They engaged for and with one another. Perhaps more cynically they engaged because they believed they had no choice but to. Nevertheless, I came to appreciate that what we achieved within the monthly group sessions was associating practice with community (Wenger 1998). What was taken-for-granted knowledge was critically examined in light of MOHO. As acknowledged by Lave and Wenger (1991) Abrandt Dahlgren *et al.* (2004) and Senge (2006), learning is mediated by the differences of perspective amongst those participating. It includes the language, the tools, the documents, the specified criteria, the regulations, but also the implicit relations, the subtle cues and the untold rules of thumb (Wenger 1998), most of these are never articulated yet nonetheless are unmistakeable signs of membership in a community of practice.

Wenger (1998:73) refers to 'mutual engagement' as an essential component for any practice. However, a shared sense of practice is complex, not least because of the relations between participants and mixtures of power and dependence, expertise and helplessness, resistance and commitment. Yet I argue that having such a diverse

range of perspectives and experience of practice enriched dialectical learning between peers.

Dialectical learning

Friere (1970) espoused the importance of developing dialectic with others in order to build *social capital*, or learning, which encourages human flourishing. This resonates with how the therapists were encouraged to engage in an open reflective process in sessions which aimed to offer benefits to all (Carr & Kemmis 1986). Referred to as dialogic learning by Mezirow (1985) the process involved the therapists' incorporation of prior experience to inform current learning. Such principles encompass Friere's (1970) work and Habermas's (1984) theory of communicative action: the monthly group sessions interrupted what the therapists were doing, to question what they were doing, its dynamics and worth. Furthermore, situating the learning process within the practice context was a conscious strategy to renegotiate practice whilst acknowledging the cultural / historical practices within those contexts.

Through shared experience and re-interpretation of practice, the occupational therapists were encouraged to develop a critical stance toward their practice. Moreover, I believe that articulating alternative options for the delivery of occupational therapy practice encouraged them (Senge 2006). Social constructionism embraces and encourages critical thinking with the requirement of this being practised with others. I believe that amongst peers, during dialectic learning, the occupational therapists experienced what Friere defined as 'conscientisation', the examination of one's own interpretations and their openness to revision (Friere 1970). This enabled the therapists to consider options for their practice in new and different ways. Importantly this process did not just take place at an individual level, but 'in fellowship and solidarity' (Friere 1970:83). Action and reflection in fellowship and solidarity is precisely what Friere means by dialogue.

Yet Friere's notions of solidarity, whilst attractive are somewhat idealistic. Certainly the occupational therapists did not display solidarity, but rather more pronounced periods of *conflict and tension*. This I acknowledge represented therapists' agency in that engagement with MOHO was observed as occurring to varying degrees of being more or less engaged, from those at the periphery to those more involved. Indeed, Gustavsson (2004) relates praxis to inclusion of an ethical dimension, which speaks more about individual practitioners social and political values, or worldview, which are

likely to impact on action. Yet I argue conscientisation still took place, and I agree with Friere that it is a joint project. It takes place in human beings amongst human beings and true dialogue cannot occur without critical thinking.

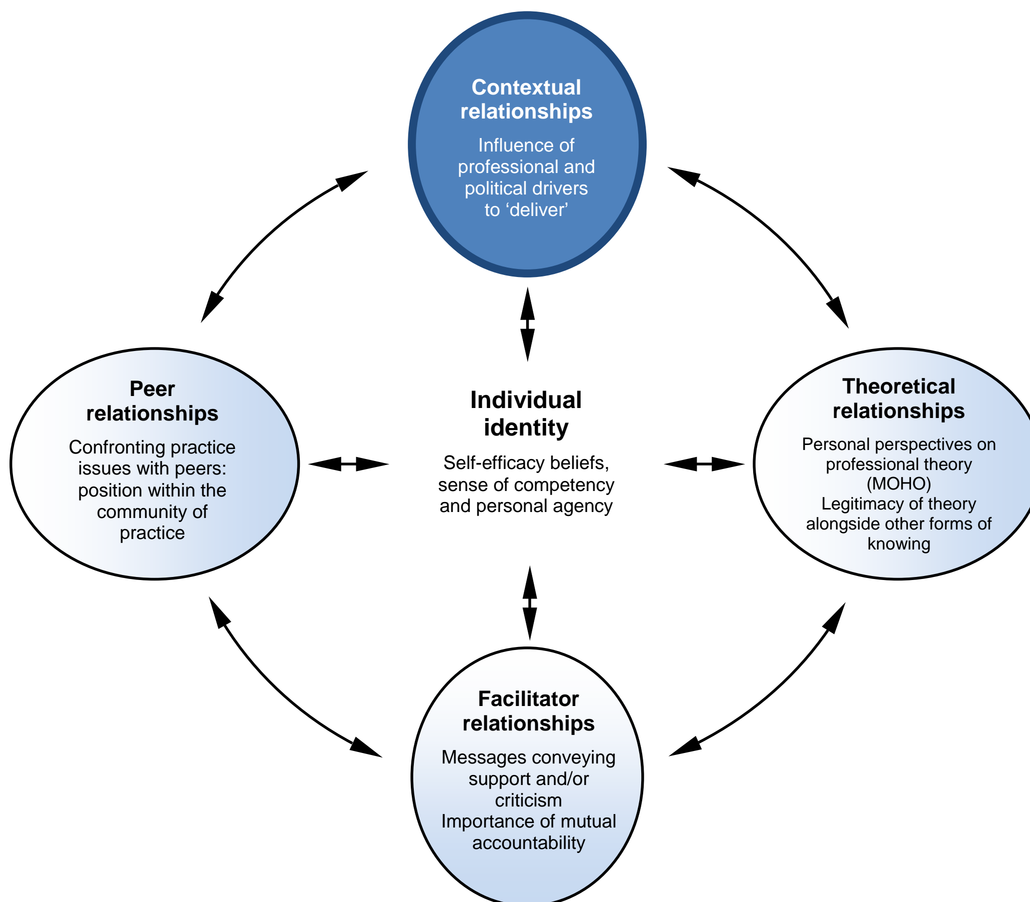
Finally on this subject, Friere speaks of this dialogue as being a 'permanent process of self-scrutiny' (1970:83). As a facilitator of a practice development initiative I agree that a process of self-scrutiny was key to advancing the therapists' practice. This was apparent within monthly group sessions as the therapists considered action, as they chose to act and importantly as the interpretation of any experience was brought back to the group forum for discussion and potential transformation. Self-scrutiny still occurred for those therapists who I suggest started at and potentially continued to operate at the periphery. Yet over time, as outlined via therapists' narratives, the review of practice and observing other colleagues response to the change agenda enabled contextual barriers preventing participation to be shifted as alternate practices were considered and tested out. This process demonstrated collective efficacy *and* praxis.

> *The more the group divide and reintegrate the whole the more closely they approach the nuclei of the problem (Friere 1970: 93).*

Although peer relationships and the power of the group collective was viewed as a powerful means of influencing changed perspectives, the therapist's engagement in the inquiry process demonstrated a relationship with other contextual factors. Professional and political drivers also served to shape the therapists response to the implementation of MOHO.

Contextual relationships

As part of the research objectives, I was keen to examine the *transitional* experience of the occupational therapists (newly) adopting MOHO into their practice. The contexts within which the occupational therapists practiced were brought to the attention of the monthly group sessions. This included acknowledgement of wider professional responsibilities and government policy, to more local Trust politics and (multidisciplinary) team-based dynamics, to the therapists' view of competent practice. I have no doubt that the participants were influenced by my involvement and the agenda for change (the role of the message and the messenger) however, fundamentally I believe that the therapists were aware of the political systems within which they were operating and to which they were accountable.



In this study it has been possible to appreciate the therapists' relationships toward the professional context. For example, certain therapists felt alienated by the language of professional and political agendas, including how such agendas translated into their day-to-day practice. Arguably this was in part because the language used was not attuned to the therapists' work-based situation. A major focus of social constructionism is to uncover the ways in which individuals and groups participate in the creation of their perceived social reality (Gergen 2001). It involves looking at the ways social phenomena are created, institutionalised, and made into tradition by humans. Socially constructed reality is seen as an ongoing, dynamic process; people acting on their interpretations and their knowledge of it reproduce reality (Crotty 1998). In essence, learning is fundamental to the social order by which we live (Wenger 1998).

> *"Human beings make their own history, but not in circumstances of their own choosing" (Marx 1963:15)*

Through opportunity to work with the therapists in their team-based locations, it became increasingly evident that barriers existed which, over time, had impacted

upon the therapists' perspective of their role and contribution within their teams. The therapists 'talk' appeared to be situated within the structures of their immediate environment and the wider political context. These included the multidisciplinary teams within which they worked on a day-to-day basis, the influence of the larger institution (Trust) through which they were employed, the professional context, which has established standards for proficiency and finally through government initiatives which continue to drive the agenda for delivery of cost-effective, quality services. From a social constructionist perspective, both the language the therapists used to describe and defend their practice with one another in our group sessions and the structures which provided opportunities and challenges within the wider political context played inter-related roles in the therapists 'meaning making'.

In chapter six the barriers the therapists identified as preventing participation were consciously considered. For example, the pressure Emma experienced to balance case management responsibility with opportunity to take on occupational therapy referrals. I became aware of the importance of determining how practice repertoires had been built and influenced by social and cultural conditioning (Friere 1970; Giddens 1984; Abrandt Dahlgren *et al.* 2004) and the interpretation of government directives (DH 1999; DH 2001a). Friere (1970) identified how people need to decode the world, to think about the way they think and face the world (for example they may do this fatalistically). Indeed not acknowledging the therapists' situation would likely have prevented action (Hunter & Blair 1999). As Welch (2005) suggests context is essential to any change process. Indeed, Giddens (1984) argues that what practitioners do today will be reinforced and regurgitated by practitioners tomorrow. Such perspectives imply that we can be oppressed by the attitudes others may have of us. In contrast, Giddens like Friere (1970) acknowledges the power of the human agent to intervene in a course of events or social practice.

At the outset the occupational therapy service manager was influential in requesting that all the occupational therapists implement MOHO as their evidence-based approach to professional practice. Recent change of emphasis in national policy from quantity to quality and the introduction of clinical governance have all encouraged more interest in clinical effectiveness (Lloyd *et al.* 2004). Employers require practitioners to practise effectively and efficiently and to communicate and defend the rationale for their action (Stiwne & Adrandt Dahlgren 2004, COT 2006). Arguably all human action is performed within the context of pre-existing social structures which are governed by a set of norms and/or laws (Giddens 1984). Yet unlike those who

espouse structural determinism (agency is determined solely by external structures), or social constructivism (the capacity of the individual to construct and reconstruct their world) Giddens views structure and agency as complementary forces. Although structure influences human behaviour, humans are capable of changing the social structures they inhabit. In this sense agency is human action. Thus agency can lead to both the reproduction and the transformation of practice.

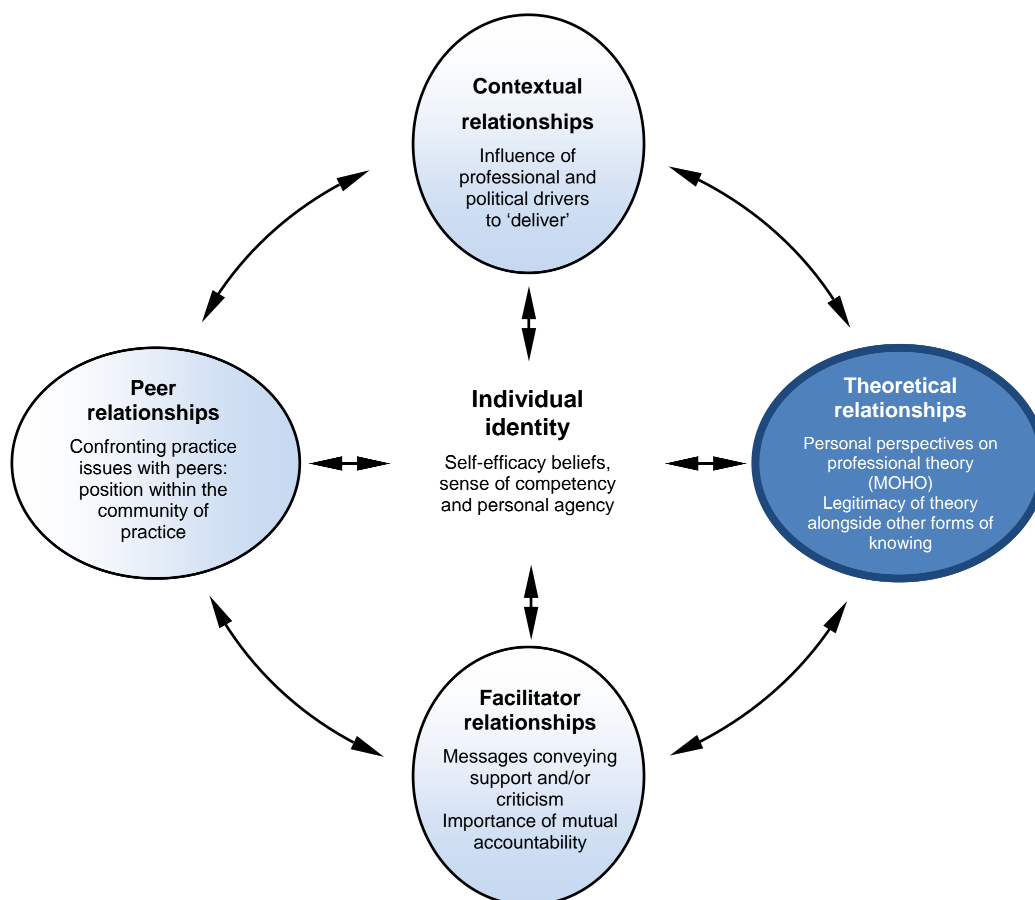
In relation to our study deliberate action focused upon addressing, and on occasion removing, the social structures or barriers, which had created 'stuckness' for certain therapists in delivering the requirements of their professional agenda. For example, the acute adult team replaced the existing referral system for occupational therapy services, which had been developed through MDT interpretations of what the service could offer, with an occupational therapy priority referral process. The older adult team identified a set of MOHO assessments under the single assessment process. The community adult team promoted their specific contribution by attaching cover letters attached to summaries of completed MOHO assessments to all GP/consultant referrers detailing any further occupational therapy contact.

Giddens work appears to sit comfortably with Friere's views regarding reflection upon 'situationality' (Friere 1970) and Carr's (1986) perspectives on critical thinking in which people discover and learn from each other in a situation. I suggest that like Friere our strategy was to acknowledge the 'professional world' and its influences (which may create a sense of feeling oppressed). However, rather than responding in frustrated or passive ways, the therapists were supported to problem-solve how to effect participation and deliver practice which could be accounted for. I argue that what was key in supporting such changed perspectives was the influence of theory (MOHO).

Theoretical relationships

Higgs and Titchen (1995) have explored professional knowledge in terms of propositional knowledge, professional craft and personal knowledge. I suggest that prior to my involvement, the team's approach to problem solving practice issues relied predominantly upon *professional craft knowledge* (or theories-in-use) and *personal knowledge*. The former was embedded within their practice and included knowledge studied during pre-registration training programmes, knowledge gained from the healthcare arena, their practice experience and their knowledge about

particular clients and their situations. The latter (personal knowledge) had developed through knowledge acquired through life experience and more personal / cultural influences. I am not suggesting the therapists practice knowledge was non-theoretical (Carr & Kemmis 1986) and I agree with Higgs and Titchen 1995; Higgs, Andresen and Fish (2004) that the importance of personal knowledge should not be underestimated, yet it appeared that the therapists' occupation-focused knowledge for their practice required strengthening.



During the two-year period of my formal contact with the occupational therapists I admit that I was overly focused on promoting the propositional knowledge of MOHO in order to redress the balance. Friere (1970) argued for 'informed action' acknowledging the role of theory. Yet, critics of Friere have focused on his tendency to make everyday situations pedagogical (Torres 1993), centred round a predefined set of concerns and activities. This can arguably work against the notion of dialogue. Perhaps I too could be found guilty of wanting to transform the therapist's monthly group reflective supervision sessions into a particular type of pedagogical space. As acknowledged in chapter five I was referred to as "teacher" and certain therapists complained about group supervision feeling more like in-service training. However,

as I have illustrated in chapter seven I believed MOHO provided a *necessary* guiding framework, a benchmark for evidence-based occupational therapy practice. Over time MOHO was viewed as having both practical utility and offering a necessary level of kudos (see John chapter five and Mary chapter six). Yet it was apparent that whilst the group collective supported the therapists to examine and implement MOHO, individual team members each had their own unique relationship to the theory.

At the end of the two-year period of my involvement it was apparent MOHO became *valued* and was embedded within the practice of several of the therapists; I believe those therapists' view of their professional identity *was consistent with MOHO*. For others arguably MOHO was perceived as being useful and 'the right thing to do', but further evaluation of the theory and tools was required. Wenger (1998) asserts that the relationship between theory and practice is always complex, and practice is not a mere realisation of theory. Embracing MOHO was challenging and created 'stuckness' and disjuncture for each of the occupational therapists along the way (Savin Baden 2008). The level of commitment required by both participants and facilitator to persevere was substantial. However, whilst interpreting MOHO might be complex for any one person to master, collective intelligence was brought to bear on the situation (Lave & Wenger 1991). Thus, personal attitudes and values towards professional theory became the collective issue addressed by the community of practice. I believe this process is summed up in the following quote:

> "When you listen to somebody else, whether you like it or not, what they say becomes part of you ... the common pool is created, where people begin suspending their own opinions and listening to other people's ... At some point people begin recognising that this common pool is more important than their separate pools"
> David Bohm (1985)

I acknowledge that I had overly privileged MOHO as a means of supporting the therapists to review their professional contribution. Higgs *et al.* (2004) argue that practice should be *theory-based* not theory driven. They contend that practice knowledge depends upon both *artistry* and *science.* Denzin and Lincoln (2005) similarly assert the importance of honouring personal experience as the touchstone of valid psychological inquiry. Abrandt Dahlgren *et al.* (2004) likewise value the repeated focus on professional experiences within the practice context, where cues for professional action can be explored to illustrate the qualities of being professional.

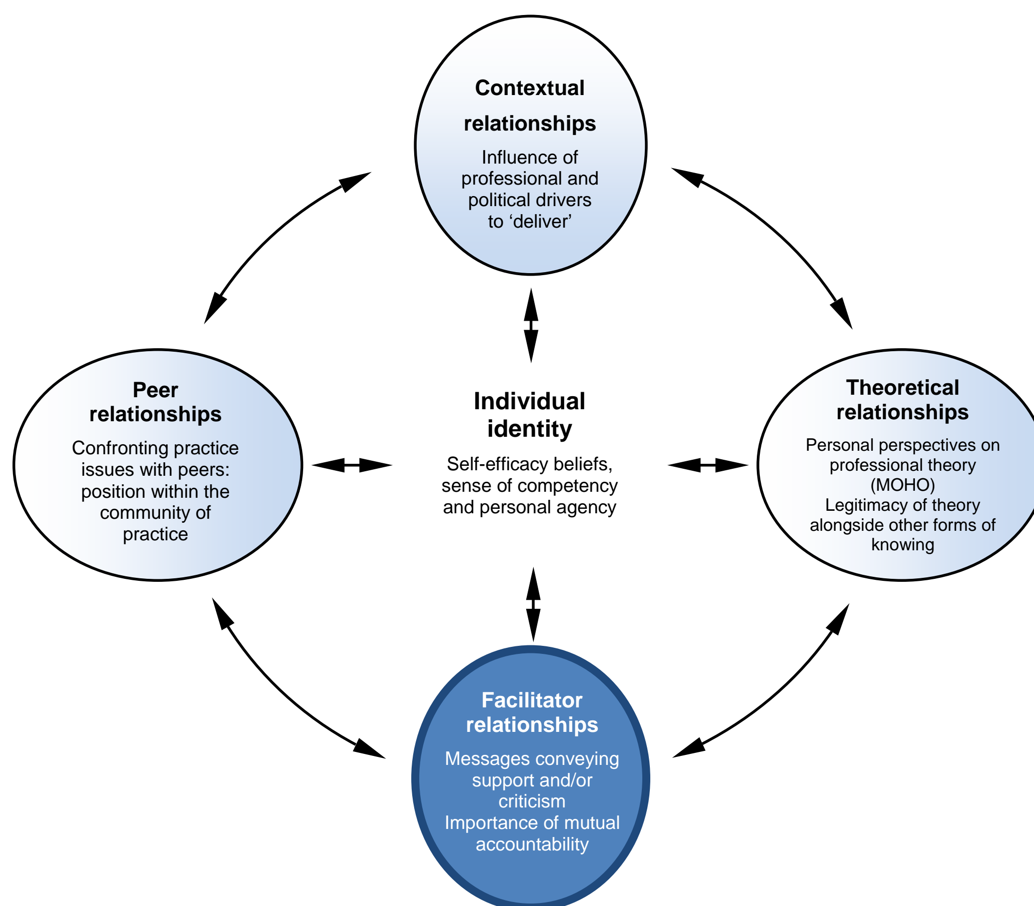
However, if the question here focuses upon whether MOHO and the associated assessment tools (or technologies for application) supported the occupational therapists to deliver occupation-focused practice and develop improved professional roles then I would have to state that MOHO did this job very well. Yet I realised that whilst individual therapist's appeared to have mutual understandings of MOHO they reproduced it differently for their own practice: MOHO was transformed through its use. I have therefore appreciated that privileging explanations and discourse from formal theory alone would restrict opportunities for the therapists and myself to learn and grow. Furthermore recognition of respect for the legitimacy of theory alongside other forms of knowing is illustrated within my participatory model of knowledge construction referred to in the previous chapter.

Whilst my own relationship with theory at the outset of the inquiry arguably reflected an 'applied science approach' (Carr 1986) towards theory and practice, in that I viewed MOHO as providing evidence which could be brought to bear on practice, I realised each therapist likewise had their own interpretation and thus 'relationship' with the theory. Nonetheless, similar to my own situation, this was not about holding a static position, but rather viewing the relationship between theory and practice as one in which attitudes could shift. As Richardson *et al.* (2004:13) state by revealing the knowledge that underpins practice we can be liberated from the confines of tradition which impose limits on practice and practice knowledge. The transition is not therefore from theory to practice but as Carr and Kemmis (1986:116) suggest from 'ignorance and habit to knowledge and reflection'.

Facilitator relationships

"The problem for the external change agent is to enter into a relationship where joint learning becomes possible. His [her] task may or perhaps should not be the actual implementation of any new system, but that of contributing to the discovery and development of appropriate starting conditions for a process which can go on its own way"
(Herbst 1976:10)

In this final section of examining my conceptual framework I wish to explore facilitator relationships through review of a number of methodological issues relating to PAR which respond to the research objective regarding the effectiveness of holding insider / outsider roles. I will examine how I believe the facilitator role has contributed to praxis amongst the occupational therapists, yet a fundamental question this section relates to is the participatory relationships between the therapists and myself.



In terms of my position I managed a trio of roles, as an occupational therapist in education, an external group facilitator and a researcher. I believe I was viewed as a challenging facilitator, I presented change and I prompted disruption and persevered despite resistance. I shifted between being viewed as a teacher by some to a mentor by others. Yet this was not all a one-way-street, for the participants too held roles and responsibilities within the process which shifted over time, roles which would be assumed by me and accepted or embraced by them. In essence, I am talking about our *mutual accountability* to one another throughout this PAR process which was required yet was fraught with challenge and complexity.

Quite early on within the process my belief in the support and guidance MOHO could offer the therapists' practice became strengthened in the practice arena. I wanted the therapists to embrace MOHO. I believed it could help and I wanted to help them. I argue such feelings reflect McNiff *et al.* (2003) suggestion that [participatory] action research is a process with both personal and social aims; the personal aim being improvement of one's own learning and the social aim an improvement of the situation. On reflection, I suggest the therapists initially considered me as a 'cultural invader,' superimposing MOHO upon those not using the model (for example

Heather and Barbara) and creating complexity for those more familiar with its concepts (Ellie). I argue they initially were 'spectators' observing my style and approach. In chapter five I shared personal reflections of early sessions where I certainly felt my every move being assessed. Yet I too was conscious of *observing* social relations and *listening* to therapists' accounts of their practice. I maintain mutual accountability was a dynamic process requiring each of us to consider our own learning experience within the group dynamic. I believe this linked to what we were prepared to share of ourselves in terms of our public / private selves. Issues of competency and pride were at stake for us all. Certainly, my personal reflections have illustrated this as documented in chapters five and six.

Part of what I perceived to be my facilitators role within the PAR approach was to encourage 'cultural synthesis' (Friere 1970). This involved not only working to improve group cohesion but to encourage participants to have ownership of the implementation of MOHO. I maintain that this was enabled through the targeting of practical issues deemed useful (Reason 1994; Stringer 2007). Friere states that in cultural synthesis, there are no observers; 'cultural action aims to supersede dominant alienating cultures' (Friere 1970:163). Whilst attractive, I argue Friere's assertion is idealist. I believe our efforts established a group dialectic, and we worked hard to address individual needs. Yet I maintain that a dominant culture was ever present, which I have referred to earlier in terms of the powerful influence of the wider professional and political context. Moreover, I argue that from the individual therapist's perspective I represented what that context stood for. I frequently found myself in politically contested scenarios as the occupational therapists identified the reality of their practice context and revealed the challenges of what was being suggested. As Senge and Scharmer (2001:245) identify, discovering and nurturing change initiatives 'for broad but latent commitment' may prove to be one of the core competencies for facilitators work within a learning community.

I have questioned what being in the facilitator role meant for me. I acknowledge that I had to accept the roles which I was offered by the community of therapists (that of an external tutor and researcher) rather than have those I would have preferred (a colleague, co-researcher, collaborator, co-participant). Whilst it has been noted how groups who engage in PAR may resist the sharing of power that is offered by the researcher (Rahman 1991, McTaggart 1997, Kidd & Kral 2005) less focus has been directed toward participants not reciprocating offers of partnership to the researcher / facilitator. Indeed, from this experience I argue that whilst PAR is advocated as a

collaborative research approach, in my experience the external facilitator needs to work hardest to assume the shared role. Attempting to be an internal player was idealistic and certainly within this research process was not feasible. Whilst perhaps it is understandable that the power differential between the participants and facilitator is likely to create tension, I suggest such findings require further research regarding the perceived satisfaction of an external facilitator's participatory role.

In terms of my role as an external facilitator I was not affected by in-house politics and at the outset I thought I could be (to some degree) neutral. I believed this would contribute to how the therapists' accepted me. However, whilst the Trust had not sponsored my research I am aware that the Therapy Service Manager affected me. Once involved with the teams I admit that I wanted to demonstrate positive outcomes from my involvement. I came to realise I had a vested interest in participating. Furthermore, my own epistemological stance towards MOHO as a valued professional theory influenced the situation. Through engaging in critical subjectivity (Reason 1994) I continually reflected upon how my values created challenge for me in striking the right balance between incorporating rather than imposing knowledge (Wimpenny *et al.* 2006). I admit to exercising power which became a dominant discourse at times and had potential to undermine participants' stated views. This tension was evident during decision-making procedures, for whilst PAR encourages democratic and inclusive forms of knowledge creation, the approach of using PAR for altering boundaries of knowledge is complex.

Focus on Friere's adult literacy programmes is worth noting. Friere identified the importance of regarding learners and educators as equally 'knowing' subjects (1970:31). Although he speaks of a levelling of the teacher / student relationship and the importance of examining the expertise of the 'knowers,' Friere's own style of educational practice focused on a particular method or campaign. For example, Friere used motivation sessions to engage with participants prior to the literacy training, and stages and teaching tools can be evidenced during the literacy process (the identification of generative themes selected by the participants for discussion, the practice of reading and writing skills, the use of verbal and written forms of dialogue). Friere's methods are, arguably, comparable to the MOHO utilised to shape our inquiry process, both campaigns aiming to enhance increased levels of participation for those involved in their wider social context. Whilst he acknowledges that there is no neutral education and speaks of the teacher needing to be directive at times, the overall message and sense of his theory is about a shared dialogue. Yet

realistically, were the participants of Friere's adult literacy programme free to reject the ideas of those co-ordinating the concepts used?

I too argue that fundamentally whilst I welcomed involvement, my approach was shaped by the agenda and my own values. Yet I was not acting out of a selfish desire to have things my own way, rather I maintain my values stemmed from a strong personal conviction that the therapists' situation could be improved (McNiff *et al.* 2003). In order for therapists to perceive MOHO to *be* a useful theory it needed to *become* a useful theory and I adopted strategies which I believed would make MOHO accessible and worth exploring. Yet I also came to appreciate that my keenness to impart MOHO would not be met with favourably. Shifts were more likely to occur when the individual therapists were active in the learning process, engaged in meaningful dialogue regarding their respective experience and knowledge. Indeed I argue that during the PAR process we all become 'subjects under scrutiny' (Friere 1970). Review of the therapists' practice required active questioning of all our personal motives and actions and such listening involved an acceptance that other people might be better informed. Whilst traditional research usually stops at the level of describing a situation with suggestion for how things might be changed (McNiff *et al.* 2003), PAR involved taking action prompted by asking problem-probing questions about practice concerns and what could be done *and how*. I do not believe we could have navigated a path through the complexity of the inquiry process without support from MOHO, but I also have realised that it ran deeper than this.

In chapter six I considered Vygotsky (1962, 1978) and the importance of learning taking place with others. In particular, his theory placed emphasis upon a more knowledgeable other (MKO). This notion of transmission of knowledge from one who knows to one who does not has been a focus within this inquiry. For example, Mary (chapter six) identified how she liked the mentor role. In contrast Emma was keen that I did not set the pace or agenda. It was evident I could undermine her practice by suggestion.

In considering my facilitator's relationship with the participants I have examined my own relationship with my supervisory team. Here I am aware that I sought support and was keen to meet them and glean their accepted wisdom. Yet, I was aware that my supervisors were not imposing their ideas or knowledge on me, rather our meetings offered points of negotiation from which my own ideas subsequently developed. I suggest that I related my own experiences to my involvement with the

teams. I came to realise that my role was not to 'teach' or instruct about MOHO per se and be viewed as someone who had more knowledge of problem-solving practice than the therapists. I was after all removed from practice having taken up my role within the university setting. Rather I suggest I was a person who encouraged the participants to take a more critical and informed stance. I encouraged the occupational therapists to see opportunities for improved participation within the context of their professional role with the guidance of a professional theory. Moreover, my approach would be interpreted by the therapists in their own ways and as such convey messages of criticism and / or support. However, it was not all about me for I argue the influence of one another raised the consciousness of practice for all. This then moves away from scaffold learning into terrain that promotes praxis; through dialogue, the therapists, myself included, jointly became responsible for the process through which we all grew.

In drawing this section together regarding facilitator relationships and my questioning of the participatory element of the inquiry process, I refer to McTaggart's (1997) view on authentic participation in which research means sharing the way in which knowledge construction is conceptualised, practiced and brought to bear on professional practice.

Authentic participation

McTaggart's (1997) perspective regarding the roles groups of people who engage in PAR may hold has offered an inclusive means of interpreting participation. He makes a distinction between the worker and researcher / academic roles to help illustrate that as well as distinctive tasks each group or individual takes in relation to their own institutional and cultural contexts, all parties are joined in a commitment to inform and improve a particular practice. Whilst partners across education and practice are preferred terms used here, and the practices of such partners is not narrowly conceived, I suggest McTaggart's perspective supports the experience of this inquiry in that as participants we have been involved in different ways. Academics and practitioners have joined forces to improve relationships between theory and practice, and this focus has taken place within the occupational therapists' practice context, an approach which rarely occurs within academic research (Senge and Scharmer 2001). Furthermore, considerable energy has been directed to improving the reciprocity and symmetry of relations.

I believe the therapists did view the inquiry process as bringing an increased profile for their work-based practice and this shared responsibility took place at a number of levels within the Trust. For example, the study had approval from Trust Research Ethics to which I submitted yearly progress reports. A consultative meeting was arranged in which a number of occupational therapists representing each team and myself joined to present the intentions of our collaboration to senior managers and consultants across the mental health service. Furthermore the occupational therapy service manager continued to renegotiate service provision at the organisation / managerial level (Forsyth & Summerfield Mann 2002) (In particular, regarding ways to reduce case management responsibility for the CMHT occupational therapists). At the end of my formal period of contact a service wide occupational therapy workshop was organised in which each team presented their respective experience of the participant journey including the highs and the lows and what had been learnt (reflected by the participant quotes presented in chapter seven). I argue that evidence of individual and team efforts to review practice processes reflects what I believe McTaggart was implying by authentic participation within PAR. Moreover formal shared dissemination of the groups' efforts has already begun. In addition it is intended that future papers will include new team members views.

My reference to mutual accountability at the start of this last section is also recognised in how the inquiry process would contribute towards the requirements of my own PhD award. Indeed the secondary stage of analysis was a task I predominantly completed, with support from my supervisory team and from ongoing meetings with a smaller number of the therapists. Although joint dissemination has occurred and continues to, I am aware that the occupational therapists have not read this thesis as yet, and whilst they are invited and encouraged to, I recognise that I cannot claim there is shared ownership of what has been written here. However, in writing this thesis I have felt an enormous sense of accountability. I have striven to present an honest and faithful reporting of the experience of the research process and this has been reflected within my use of the first, second and third person pathways of action / research practice (Reason & Bradbury 2001). With this I acknowledge that I write from my perspective and therefore any mistakes made are mine.

Yet as mentioned in chapter four, writing up and disseminating the findings of PAR should not detract from what is also relevant and often more difficult to account for and this relates to the ongoing impact of the inquiry on the individuals lives and

practices. For example, as well as engaging in my own reflexive practices, the occupational therapists have likewise been involved as reflexive individuals, who have disseminated their experience of the inquiry process as it occurred, with students, MDT colleagues, and other occupational therapy colleagues across other services / Trusts. What I have come to realise more fully is that the primary focus of PAR is to generate knowledge which can be effectively put to use *in a variety of ways*, through authentic participation by those involved. When applied to this study I therefore contend that the concerns experienced by a group have been embraced (Stringer 2007), furthermore knowledge has been used and generated to inform all the therapists' actions (Heron & Reason 2001), and this has provided opportunity to enhance the therapists' perception of their situation and thus served to inform their practice (McTaggart 1997; McNiff *et al.* 2003). I therefore maintain that the level of active involvement of the practitioners in this study has been sufficient to enable it to be termed participatory. I also acknowledge that the facilitator's role can be considerable in holding the PAR process together. Furthermore, whilst ideal, PAR does not require *everyone* to actively engage from the start. Indeed as Lave and Wenger (1991:36) propose 'legitimate peripheral participation suggests there are multiple, varied, more-or-less ways of being located in the field of participation'. However, through sustained time and effort in the field, and recognising contribution from a range of perspectives, new ways of conceptualising relationships with those with whom we work can be achieved.

Conclusion and contribution towards theory, practice and PAR

The findings of this research offer a framework for unravelling some of the threads of discourse regarding knowledge implementation for professional practice. In concluding this chapter I wish to re-establish how the findings have potential to contribute towards theorising on theory, practice and PAR for occupational therapists working within mental health, including a wider audience interested in practice development.

It is important to acknowledge that the findings of this study relate to the therapists' *perception of their role* as I did not seek formal evidence to support or refute this from the therapists' respective MDT colleagues or from service users and their respective carers. Indeed such perspectives are clearly worthy of future research. Nonetheless a PAR focus has provided an opportunity to reframe and reconstruct perceptions around professional practice in light of theory. I maintain that all the participants positively shifted in their perception of their professional practice, even though their learning trajectories and thresholds of change have differed.

Theory and practice

In terms of theory and practice MOHO prompted the occupational therapists to engage in professional identity work. As Wenger (1998) implies learning involves the whole person in context and is not just a cognitive activity. Through use of MOHO the participants reflected upon their practice epistemology by examining the nature of knowledge which underpinned their practice. Key to this was how the implementation of MOHO took place within a participatory action research framework mediated by the differences of perspective amongst the occupational therapists. MOHO provided the theoretical framework from which debate took place around optimal practice. The participatory action research element supported the knowledge creating system centred on the therapists' needs. This approach to research with occupational therapists practising within mental health has not been conducted before.

MOHO itself was viewed as having practical utility. The value of using the MOHO assessment tools enabled the theory to come alive. In addition MOHO served to provide much needed boundaries for the therapists' work, which served to broaden the therapists' clinical reasoning and also reign in practice which had strayed.

In terms of facilitating partnership work to implement MOHO the challenge of negotiating change as an outsider has been examined. I also acknowledge that taking on this role as an internal team member would not be without its difficulties. I have examined the importance of mutual negotiation in removing barriers including the necessary decoding of practice in context and developing a shared dialectic with the therapists at both a team and individual level. Such practices require a considerable amount of commitment, care and persistence. As evidenced in this study, within relationships there were peaks and troughs; if left unattended with undue care or attention, relationships amongst the involved parties would not have prospered. However, despite the challenge experienced as an external facilitator in this process, I maintain that collaboration between colleagues in education and practice is vital. Furthermore I propose that *participatory* action research methods are embraced as a means of exploring theory and practice relationships to inform both educational and professional practice processes.

Addressing barriers to theory implementation has demonstrated what can be achieved through a prolonged, shared, active learning opportunity where occupational therapists from practice and education have collaborated to examine professional practice concerns. Whilst communities of practice is not a new concept in itself, working to develop a community of inquiry wherein a conceptual model of practice, like MOHO, can be regularly and openly debated provides new evidence for how professional identity issues for occupational therapists working in mental health may be addressed. Indeed I argue that within the professional practice context MOHO has offered the occupational therapists a means of renegotiating their legitimate peripheral participation (LPP) (Lave & Wenger 1991). For example, whilst LPP considers what kinds of social engagements provide the context for learning to take place (Hanks 1991:14) I have reflected upon the situation occupational therapists working within mental health experience of not being surrounded by other occupational therapists on a day-to-day basis in order to develop one another's practice. In addition, when occupational therapy practice is not representative of disciplinary domains, novice practitioners entering the field struggle to identify with a clear professional role. I therefore argue both senior and less experienced occupational therapists can strengthen their professional membership through accessing regular community of practice forums in which therapists *actively* engage with professionally orientated conceptual models of practice such as MOHO.

Moreover, if developing practitioners are encouraged to engage in critical examination of practice from the outset, justifying the rationale for their practice with others via sound clinical reasoning will be the norm rather than the exception.

The occupational therapy literature highlights the use of journal clubs and attendance at CPD courses as methods to deliver the EBP agenda. However, there is evidence to indicate that journal clubs and CPD events are ineffective in changing practice and having access to information is not enough to influence change in a practical sense (Davis, Thomson, Oxman & Haynes 1992; Eraut 1994, Usher *et al.* 1997, Smith 1999; Bannigan & Bryar 2002). What the literature does highlight is that evidence for practice needs to offer practical support, which can be easy distilled so as to be useful and useable by therapists (Hayward, Wilson & Tunis 1995; Law & Baum 1998; Cusick & McCluskey 2000). I argue that communities of practice could be considered a useful replacement to journal clubs as a meaningful and sustainable way to support occupational therapists to review both the practice epistemology which guides their practice in addition to the contribution of (professionally orientated) evidence.

The Occupational Therapy Service Manager's wish that the therapists could, through implementing MOHO, articulate an evidence base for their practice requires some attention. Implementing MOHO involved an approach which recognised the deconstruction and reconstruction of the evidence-based theoretical knowledge alongside the therapists' personal stance (worldview) and theories-in-use (or professional craft knowledge) in addition to the influence of the group collective. In essence MOHO was transformed as it was used. I suggest that occupational therapists need to consider the language they use and reflect on the assumptions and inferences suggested when stating that their practice is evidence-based. Moreover, I contend that evaluation frameworks which reflect the complexity of organisational systems require consideration when examining the relationship between measurement and context. This should include acknowledgement of the multiple realities of stakeholders and the contribution of peer review, user feedback, practice narratives and accountability issues rather than focus upon outcome evidence alone.

Contribution to PAR

In terms of a contribution to PAR, I believe that this study has demonstrated the significance of identifying with the individual participant within the inquiry process.

Within the individual meetings opportunity for the occupational therapist to be recognised as a valid and respected member of the developing community of practice was enabled. I was able to appreciate the therapists' unique circumstances and therefore gleaned much needed reference material, which proved to be invaluable when appreciating their (ongoing) response towards the learning process. Also, significantly, meeting with the participants individually provided a different platform from which relationships with team members were nurtured and dynamics altered.

Emphasis is placed on the range of learning spaces participants made use of during the PAR process. I argue the PAR literature does not adequately account for learning spaces which move from a predominant anchor point outward. For example, into the therapists' work-based settings where alternatives for practice were considered, tested out and evaluated via involvement with service users and other MDT colleagues. In addition, the therapists used their own personal learning spaces for reading and / or reflection. It became evident that the use of the combined learning spaces embraced the powerful learning opportunity PAR provided from which participants were able to use and generate knowledge for their own active efforts, for the system of which they were a part, and for wider social and cultural practices.

Finally I believe that this study highlights the additional focus required to consider the challenge of an external facilitator / primary researcher's ability to assume a participatory role within PAR.

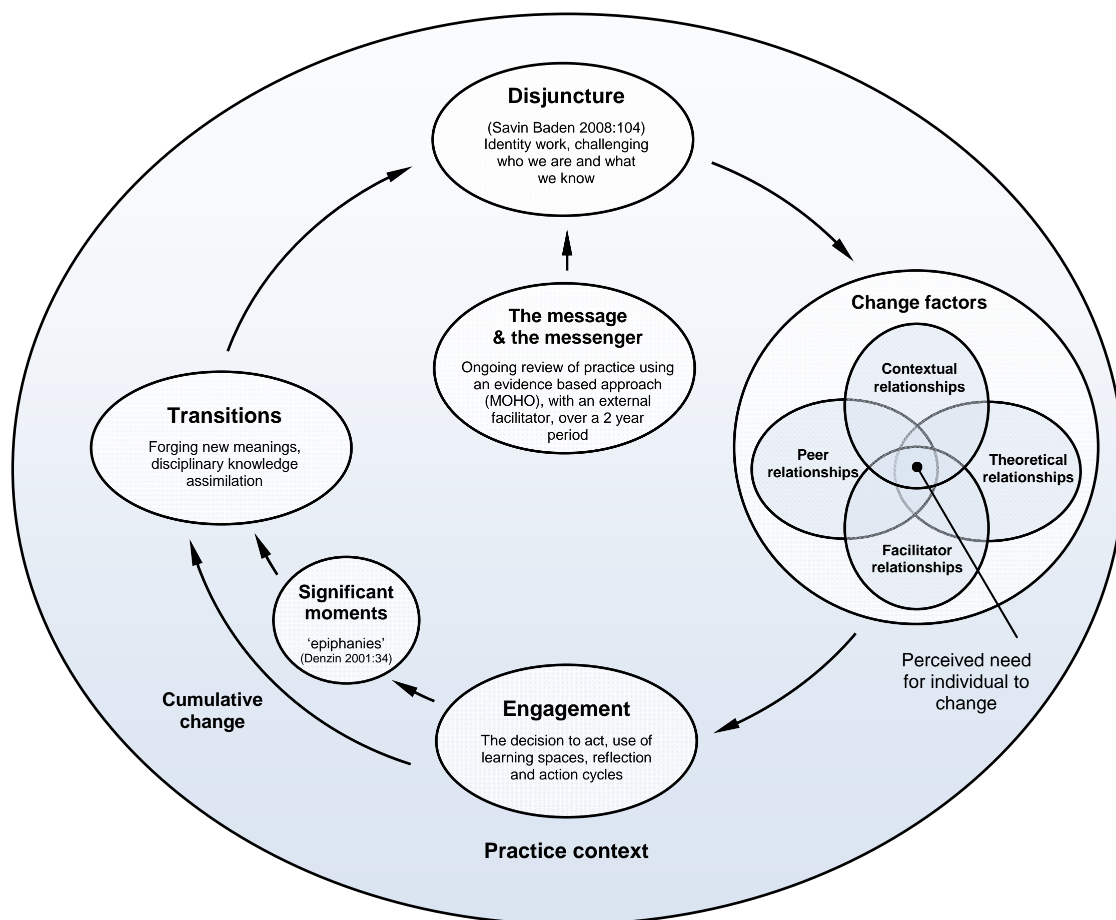
Summary: combined theoretical framework

In terms of considering how a theoretical contribution to knowledge may be proposed I acknowledge the complexity of implementing change within professional practice contexts. A range of learning and change theories have been brought together and (re)interpreted to offer new directions for theorising within the occupational therapy literature. Having engaged at this theoretical level it has felt inappropriate to suggest which, if any aspects of the inquiry process were more significant to prompt transition amongst the participants than others and two conceptual frameworks have been developed to account for the complex interplay of factors involved.

As a final contribution of the research I wish to demonstrate how the two conceptual frameworks unify the findings in a coherent manner. To achieve this I have combined

the 'participatory model of knowledge construction' with the conceptual framework of 'change factors: participatory relationships' presented in this chapter to present a 'participatory change cycle' (see figure eight). The cycle provides a map of the transitional experience of the occupational therapists adopting MOHO.

Figure eight: Participatory change cycle



I believe that this conceptualisation provides a powerful yet simple overall representation of the PAR inquiry and what was experienced as a challenging and complex process. Whilst it requires further testing I believe it has a legitimacy based upon the research findings. It potentially provides a useful means of supporting practitioners, facilitators and managers in future practice developments by helping to guide them through the complexities inherent within this work.

Ultimately the aim of this research has been to implement theory into practice and shed light on the process through which it could be achieved. I believe on both of these counts the research has been successful. A degree of substantial, sustainable

change has been evidenced across the occupational therapy service. The processes involved in this research have been experienced as complex and multidimensional and yet a clear conceptual framework representing the processes of change has emerged which I believe has use for future practice development initiatives of this type. I believe the conceptual framework has a legitimate theoretical basis as evidenced via the fusion of professional knowledge embraced within the study. I believe this research has provided a significant series of in-depth insights into the processes of change that are embodied within the conceptual framework and can be used to support its subsequent use.

The central message contained within the framework is the importance of investigating practice and examining learning as it occurs amongst people, within the contexts in which it has meaning. I have attempted to portray how disciplinary learning within this study has occurred via praxis (in light of theory), which has served to transform identities and forms of participation.

Postscript

Since my involvement with the mental health occupational therapists the therapy service manager has now moved. The acute adult team have been reconfigured out into the community mental health teams. Senior MDT colleagues within the CMHT's, whilst not rejecting opportunity to access specific contribution from the occupational therapists, continue to apply pressure for therapists to deliver on generic roles. More recently another therapy service manager has been employed covering a wider remit as the Trust merged with another mental health provision within the locality. This manager is, unlike her predecessor, not such an advocate of MOHO. This situation reflects the continual change of pace within practice settings. Whilst the previous therapy service manager was instrumental in creating opportunity for our practice development initiative, within the current system, alternative strategies would need to be adopted to apply a similar piece of focused work.

Kroeker (1996) suggests how participants are most likely to remain committed to the agenda of an inquiry when collectively developed action can be generated. Ideally the PAR process is the catalyst, which enables growth and change within a community, but thereafter this is self-sustaining when the PAR element disappears. In relation to this study, during a discrete period of time a PAR process provided a significant and sustainable learning opportunity. This is evidenced by the

occupational therapy teams who continue to meet on a monthly basis (albeit with different membership) for profession-specific group supervision with a focus upon MOHO as a guiding framework. In addition, a number of MOHO assessment tools are embedded in their practice. This, despite change in many other areas of their practice has remained a constant. I maintain this reiterates the importance of knowledge formation moving away from scaffold learning towards action learning strategies, which require those involved to become independent, conscious practitioners. Importantly, I argue that collaborative relationships between education and practice need to develop further to ensure that there is a shared reality and understanding regarding the constituent elements of professional knowledge. Such relationships need to provide opportunity for colleagues across practice and education to contribute to research and knowledge construction for the profession. This can be summed up by Mary's reflections at the end of our formal period of contact:

> I did feel the first 12 monthly sessions with you was part of research. I think for the first 12 months I was an active participant in developing the service and an evidence base. I feel it was after the 12 months that we started to kind of find out that we were linked to a wider network of what was going on in the bigger picture. I knew you were feeding things back to Kirsty. I knew you were working with other colleagues across the service, but 10 months following the initial monthly sessions it started to feel that we were part of something bigger. Previous to this piece of work I think I would have needed to go away and do a research project in order to feel like I was doing research, or go into a research post and not be involved in practice myself, whereas now I've got a perspective that I am involved in practice and involved in research, so quite a different perspective. It was not a word I associated with practice before this project.

The 'Recovering Ordinary Lives' strategy for occupational therapists working within mental health (COT 2006) has identified guidance in order to refocus occupational therapy's contribution within contemporary mental health. The document outlines how energies are to be directed towards valuing occupation, professional leadership, education and training and workforce development (2006:ix). The fieldwork from our study was completed before the 'Recovering Ordinary Lives' document emerged. That said I believe that findings from our inquiry provide much needed detail, which can inform managers, practitioners, researchers and educators about ways forward in delivering the recommendations outlined in the COT framework.

Finally, in terms of my own work, I have just been invited to engage in a two–year practice development partnership with a new mental health occupational therapy

Trust. The plan we have negotiated is to implement a similar process as used within this study across a much larger service. This will provide an opportunity to further test and refine the approaches and conceptual frameworks developed during this inquiry.

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Appendices

Appendix one

Explanation of MOHO concepts

An overview and explanation of the key concepts areas of the Model of Human Occupation (MOHO) (Kielhofner 2002)

Source: Copyright © (2002:121) A model of human occupation: theory and application. Reprinted with permission Lippincott Williams & Wilkins.

The diagram above presents the key MOHO concepts, which are briefly expanded upon below:

Volition

MOHO is concerned with understanding how a person is motivated toward and chooses to do the things they do in their lives. To explain these motives the MOHO identifies a number of concept areas, which seek to provide a means of exploring the motivation for occupation.

Volition is concerned with three fundamental issues regarding a person's thoughts and feelings towards their personal effectiveness or ability (personal causation); the importance, or worth a person attaches to what they do (values); and the enjoyment or satisfaction a person experiences in doing things (interests). These three conceptualisations are:

- Personal causation *(How effective you feel)*
- Values *(What is important to you)*
- Interests *(What you find satisfying to do)*

Habituation

The second phenomenon addressed by MOHO is the way in which people organise what they do and how they follow similar routines and patterns of doing which holds together regularity in life

The term habituation is used to reflect the temporal cues and timeframes, which make up our semi-automatic routines. Habits are seen to organise behaviour and in familiar surroundings they operate in a fairly smooth way. Consequently habits are seen as operating internalised familiar events and contexts for guiding action. In addition focus is placed upon the 'roles' we hold which shape the way in which we behave. Such roles exhibit patterns of behaviour that reflect an understanding of a socially identified status. Roles are considered in terms of role scripts, an internalised set of schemas that organise how a person perceives others, this includes the expectation and sense of obligation perceived by the person within roles.

- Roles (Positions in life & associated responsibilities)
- Habits (Your daily routine)

Performance capacity

The third phenomenon addressed by MOHO is that when humans do things they exhibit a range of capacity for performance. This includes not only the co-ordinated bodily movements, but also how people decide, problem-solve and make adjustments in what they do. Performance capacity thus denotes the ability for doing occupation supported by the persons underlying objective physical and mental components and their corresponding subjective experience.

- Objective components (Physical and mental abilities)
- Subjective components (The subjective experience of symptoms / illness)

The Environment

MOHO considers environmental influence on occupation emphasising that engaging in occupation always involves a relationship between the person and the environment. MOHO defines the environment as including the particular physical and social features of the specific context in which we do things. MOHO identifies two aspects to the environment, the physical and the social.

- The physical environment encompasses the spaces / places you live, work, play, relax. Also the objects, as in the tools, supplies, furniture, transport and the effects of the weather upon occupation.
- The social environment includes the social groups, the people you interact with and the cultural practices in which people carry out their occupational forms (or everyday activities).

MOHO acknowledges how the environment poses a variety of conditions, which can serve to limit or support action. In our environment we encounter expectations that

demand particular behaviours and discourage or allow others. Whilst such expectations and requirements can constrain choices, they also appear to sustain motivation. The environmental impact when engaging in occupation acknowledges the interaction between the features of the environment and the characteristics of the person.

Dimensions of doing

Dimensions of doing consider the nature of engaging in occupation, within our environment, and the consequences of such engagement over time.

Three levels of doing are identified:

- Occupational participation (Work, play, activities of daily living)
- Occupational performance (Doing an occupational form, a culturally defined way of carrying out an aspect of work, play or activity of daily living)
- Occupational skill (Discrete, purposeful actions that people use whilst performing. These types of skills are recognised as: motor, process, communication and interaction skills)

Finally the consequences of doing are represented by the areas of:

- Occupational identity (subjective meaning regarding your view of your self, your values, your self-concept, who you are and / or wish to become)
- Occupational competence (the degree to which a pattern of occupational participation reflects a sense of ability, control and satisfaction which reflects your occupational identity)
- Occupational Adaptation (the construction of a positive occupational identity and achieving occupational competence over time in the context of your environment)

Summary

In summary the MOHO concepts examined seek to explain how occupation is motivated, patterned and performed. In terms of the person three interrelated components: volition, habituation and performance capacity are identified. In addition the relationship between a person and their environments is viewed as intimate and reciprocal and illustrates how much we depend upon context for our experience and action. Finally when considering what people do in the course of their occupations, differing levels of doing can be identified, skill is embedded within performance and performance within participation. Over time, this participation results in occupational adaptation and its components, occupational identity and occupational competence.

Reference

Kielhofner G (2002) *Model of Human Occupation: Theory and Application* Third Edition, Lippincott Williams and Wilkins.

Appendix two

MOHO assessment tools used within this study

Assessment Crib Sheet
Standardised MOHO Assessment Tools being used within the service

Overarching Assessment Tools
(Tools that covers the major MOHO concepts)

MOHO Assessment Tool	Data Gathering Technique	Outcome measure	Recommended timeframe for completing assessment
MOHOST Model of Human Occupation Screening Tool (*Parkinson & Forsyth 2001)*	Combined methods – screening tool, Interview, observation, use of proxy report	Yes	A period of a few days in the acute setting Ratings and write up up to 40 mins
OCAIRS Occupational Circumstances Interview and Rating Scale *(Deshpande et al 2002)*	Interview that focuses on the persons view of their current occupational performance	Yes	Interview up to 40 mins. Ratings 5 – 20 mins.
OSA Occupational Self Assessment *(Baron et al 2002)*	Self report requiring the person to reflect upon and collaborate on therapy goals Important that the person has some level of motivation to engage	Yes	Dependent on if the client self-administers steps 1 & 2 / or if the OT works with the person Discussion of responses and writing up action plan up to 60 mins

Focused Evaluation Assessment Tools
(Tools which assess a particular skill area or environmental setting which is impacting upon performance)

MOHO Assessment Tool	Data Gathering Technique	Outcome measure	Recommended timeframe
ACIS Assessment of Communication and Interaction Skills *(Forsyth et al 1998)*	Observational evaluation	Yes	Observation 15 – 45 mins Ratings 5 – 20 mins
VQ Volitional Questionnaire (*de las Heras et al 1998*)	Observational evaluation	Yes	Observation 20 – 30 mins Ratings and write up 15 – 30 mins
Modified Interest Checklist *(Kielhofner & Neville 1983)*	Checklist evaluation	Yes	Discussion of checklist 15 – 30 mins
Role Checklist *(Oakley et al 1986)*	Checklist evaluation	Yes	Discussion of checklist 15 – 30 mins

Appendix three

Example section of a schedule used within an individual meeting

Round II Interviews - Interview schedule - 3rd Dec 2004

Welcome, thank you for meeting with me, consent to tape-record...

To understand the occupational therapist's perspectives regarding their role and contribution within the mental health service

Can you talk to me about your role and contribution as the OT within the team and what if anything has changed in terms of your practice?

How do you see your role in this team as the OT. What do you see yourself as offering?

> What do you think has contributed to this?
> Did you expect this?
> Did you expect more?
> Do you see any changes in terms of how you are working with MDT colleagues?
> Do you see any differences in terms of how you work with service users?

In what ways, if any, do you feel the Model of Human Occupation has supported or guided your day-to-day practice?

Do you feel that MOHO and use of the assessment tools has offered you any specific support in terms of developing / guiding your clinical reasoning?

To understand the transitional experience of the occupational therapists adopting the theoretical model into their practice – and to what extent this is evidenced

Has anything in particular helped / prevented you from getting to grips with the model and the assessment tools?

> Do you feel you have a good sense now of which tool to select and why?
>
> Do you feel your skills of assessment have developed / changed
>
> Which tools have you used / not used to date ?
> Any particular reasons for not using a tool?
>
> What happens following the information gathering part of the assessment now?
> - Completion of the rating scales?
> - Case formulation?
> - Sharing of assessment outcomes with service user?
> - Identifying the action plan – evidence of measurable goals?
> - Recording and reporting within MDT setting?
> - Re-assessment?

Can you tell me about the monthly group supervision sessions - how do you think they have been going? what is useful about them ? what would you change?

Thank you

Appendix four

Referral criteria reviewed in light of MOHO (older adult team)

Coventry Primary Care Trust – Older Adults Mental Health Services
Occupational Therapy Prioritisation / Referral Criteria
Adopting a MOHO framework

*Key to abbreviations overleaf

Category 1 – Code PO1
Client in need of extensive Occupational Therapy intervention to improve / support function in daily activity

Time standard: Client to receive initial Occupational Therapy assessment within 3- 7 days

Indications:
Client over/under estimates own abilities leading to inappropriate / at risk situations (V)*
Client feels hopeless about the future (V).
Client has a chaotic / empty / lethargic / inactive / over demanding routine (H)
Client is unable to take responsibility for managing basic role demands (H)
Client extremely unstable / unable to co-ordinate movements / lacks focus (M)
Client unable to complete / initiate daily occupations, disorientated, unable to concentrate (P)
Client unable to express themselves / make their basic needs known / displays disinhibited / delayed / abrupt / pressured speech (C&I)
Client lives in an inappropriate environment which prevents / restricts performance in daily activities leading to high risks (PE)
Client does not receive / requires additional support to maintain basic level of function in daily activities – currently at risk (SE)
Evidence of carer not coping with present situation (SE)

Category 2 – Code PO2

Client in need of Occupational Therapy intervention to restore / improve / maintain / support function in daily activity

Time standard: Client to receive initial Occupational Therapy assessment within 7 - 10 days

Indications:
Client requires support to sustain confidence in own abilities (V)
Client unable to identify / ambivalent about engagement in required daily activities (V)
Client finding it difficult to organise a daily routine to meet basic role demands (H)
Client experiencing difficulty recognising responsibilities / limited involvement in roles (H)
Client unsteady at times, difficulty co-ordinating movements / maintaining energy for required daily activities (M)
Client experiencing difficulty planning, problem-solving, initiating and completing basic required daily activities (P)
Client has difficulty in expressing themselves clearly in conversation / hesitant / abrupt / limited speech (C&I)
Client's home environment limits performance in daily activities leading to potential risks (PE)
Client's network of support is not adequate / not meeting / is restricting ability to achieve basic level of function – potential risk in breakdown of situation at home (SE)
Evidence of significant carer strain (SE)

Category 3 – Code PO3

Client in need of minimal / consultative Occupational Therapy intervention to support / improve / restore / prevent dysfunction in daily activity

Time standard: Client to receive initial Occupational Therapy assessment within 1 month

Indications:
Client recognises some limitations in their abilities, displays doubts, may need encouraging (V)
Client has interests that guide choices but limited opportunity to pursue such interests (V)
Client requires encouragement to work towards gaols (V)
Client generally able to maintain an organised and productive basic routine but takes more time to complete such tasks (H)
Client generally able to meet role demands (with prompts), can display hesitancy (H)
Client demonstrates questionable ability at times to maintain posture, mobility, energy for required daily activities (M)
Client demonstrates questionable ability to retain information, show understanding, make decisions when engaging in daily activities (P)
Client demonstrates questionable ability to make themselves understood / display appropriate body language engage in a conversation (C&I)
Client's home environment requires assessment to establish client's current opportunity for involvement in required / valued / safe daily activities (PE)
Client's network of support to be assessed to establish client's current opportunity for involvement in required / valued / safe daily activities (SE)
Carer strain potentially developing (SE)

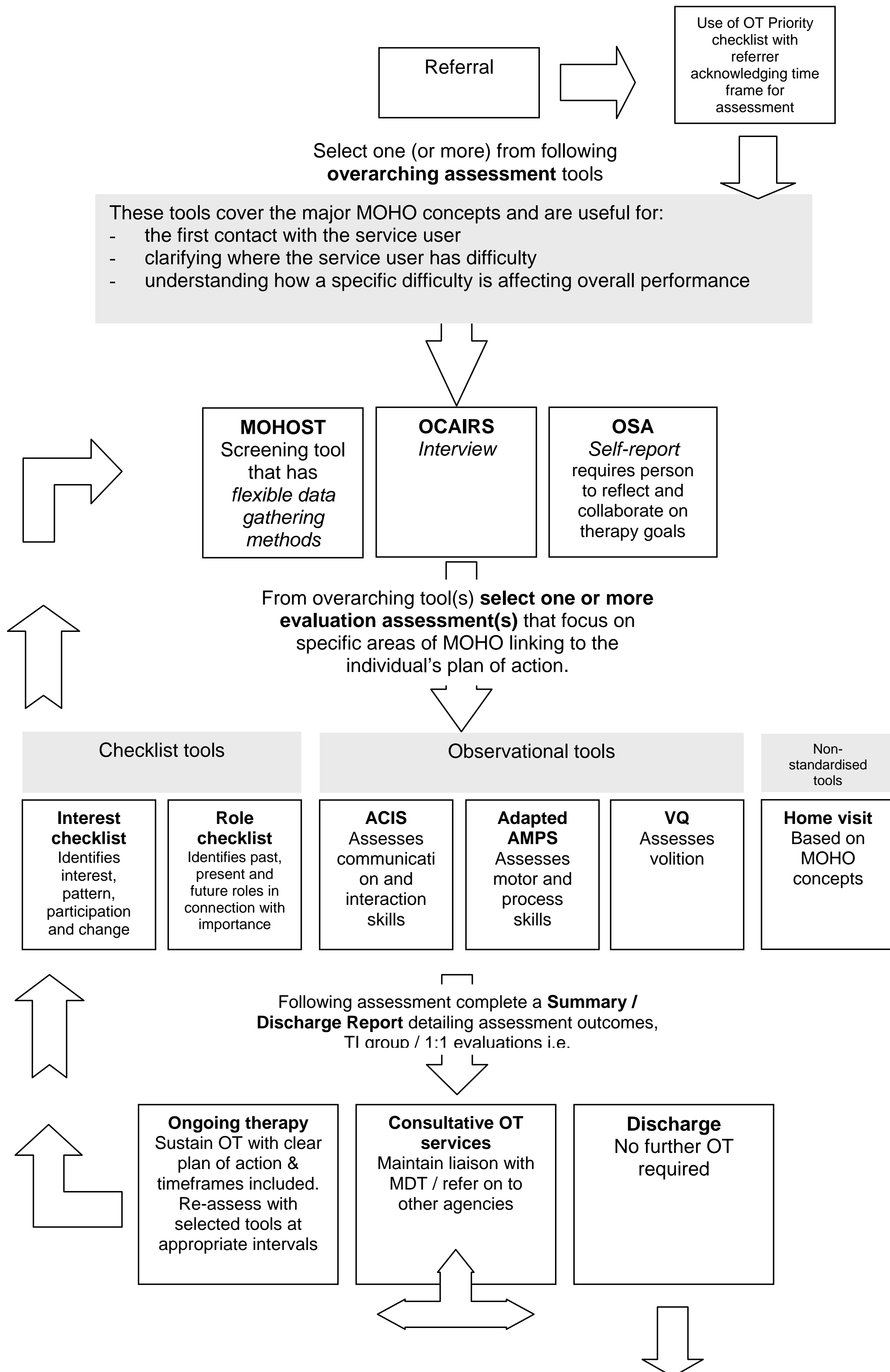
Key to use of abbreviations:

P	Personal causation
V	Values
I	Interests
H	Habits
P	Process skills
M	Motor skills
C&I	Communication and interaction skills
SE	Social environment
PE	Physical environment

Appendix five

Assessment pathway (older adult team)

Older Adult Service, Standards for Practice Protocol
Flow Chart OT Process



Appendix six

Example workbook: cognitive impairment issues

A Framework for understanding cognitive impairment:
questions / concepts to explore during therapy

Reference: Kielhofner G (2002) *Model of Human Occupation Theory and Application* Third Edition, Lippincott, Williams and Wilkins

Introduction:

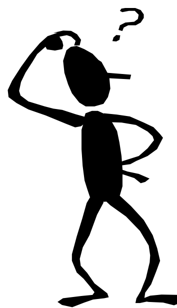
*MOHO is not diagnosis led **BUT FOCUSED ON THE OCCUATIONAL CONSEQUENCES OF THE DIAGNOSIS**.*

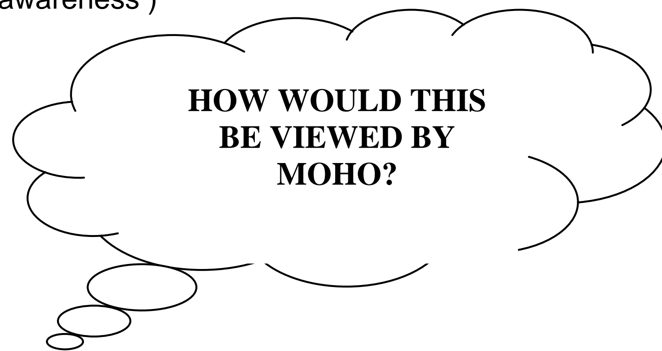
It applies to anyone experiencing disability / illness / disadvantage including those with cognitive impairments who may be unable to advocate for their own perspective, who have functional difficulties / problematic behaviours etc.

MOHO supports us to understand the 'occupational consequences' of dementia, psychosis or other diagnoses / presentations.

Examples of how individuals with cognitive impairments may present:
You are aware that the person has

- ✓ Reduced awareness of their situation or
- ✓ Reduced ability to appreciate certain risks,
- ✓ Difficulty processing information,
- ✓ Memory / recall problems etc…
- ✓ Not understand their abilities or limitations etc …. (i.e. which may denote the person has limited 'insight' / awareness)





Consider key MOHO concepts:

Volition

Personal causation:
E.g.
- ➢ Look for the persons sense of their abilities or limitations,
- ➢ Is their sense of capacity accurate?
- ➢ Do they feel effective?
- ➢ Do they feel in control of their own thoughts?
- ➢ Does the person demonstrate confidence, anxiety or other feelings when required to perform?
- ➢ Do you sense the person is in denial / unrealistic or trying to cover up for performance difficulties?

Values:
E.g.
- What things are most important for this person to do?
- What standards or other criteria does this person use to judge his / her own performance?
- Are the values this person's own, or more the influence of others?
- Do the person's values match or conflict with his or her own abilities?

Interests:
E.g.
- What does this person enjoy doing?
- What are the aspects of doing that this person likes most?
- Is anything interfering with this persons feelings of pleasure and satisfaction / performance?

Look at the persons' past occupational life for clues regarding the above. Gather this information via a variety of means i.e. from observation, from relatives, friends or other staff etc.
Focus on the importance of establishing individual desires, preferences and the value of the person having something meaningful to do

Habituation
Roles:
E.g.
- What is the overall pattern of role involvement for this person?
- What roles are still intact?
- Are they under or over involved in roles?
- How important are these roles for this person?
- Can they meet the role obligations of each role?

Habits:
E.g.
- Does this person have well established habits?
- Look at their routine, what is this persons style of performance and is it effective?
- what behaviours do they routinely display ?,
- what quality of life is offered by the habitual habits of this person ?

Performance capacity – mind and body unity (the ability of doing, the capacity to perform)

Objective viewpoint:
Are there underlying impairments? E.g. Look at the persons' capacity for performance in their:
- Sensory ability
- Neurological ability
- Musculo-skeletal ability
- Cognitive ability

Objective & subjective viewpoint:

- Look at how the person organises him / herself?
- How do they make sense of what is happening around them (objects/people)?
- What happens when situations get too complex or are unfamiliar? (observed behaviour)

E.g.

- Do experiences of confusion, altered bodily perceptions, pain, fatigue etc. influence this persons performance ?
- What are the consequences of impairment for this person and how they perform activities? (the persons view, your view and that of the MDT)

Moreover re: the persons subjective view - What is their experience of the impairment? How do they talk about their situation and what they are going through / how they are dealing with it? Are they able to report on the 'lived experience' (*i.e. how we experience ourselves as bodies and how our bodies are part of the self (Kielhofner 2002 : 25*) Or, what can you infer from your observations and check this out via therapy goals ?

MOHO places significance upon the persons ***subjective viewpoint*** of their illness and it's impact on shaping how they perform.

Other models address performance capacity, and therapists should use these models as a means of addressing specific problems in this area in order to help provide further explanation of the persons mental, cognitive, physical abilities. E.g. cognitive perceptual, sensory integration, cognitive behavioural, biomechanical; theories regarding procedural memory etc. assessment tools - e.g. CAPE.

The use of borrowed knowledge, other theories and assessment tools, discussions re: symptomotology etc. often denotes common ground with other members of the MDT. Such detail accessed does not generally specify the reasons for the persons disengagement in their occupations, nor the occupational consequences of the identified impairment. Therefore, such theories should be used in combination with MOHO, which provides the occupation-focused perspective.

Environment

Look at their current **physical** and **social** environment:

E.g.

- Does this person have adequate resources (space & objects) for doing things?
- Is the environment sufficiently familiar / culturally relevant?
- What opportunities are available to support preferences, desires and interests?
- Do interactions with others support or inhibit the person's performance?
- What demands are preventing, restricting, and putting pressure on achieving preferences, desires, and interests?
- Does the environment provide appropriate occupational forms which this person can and wishes to engage with?

In essence via assessment formulate the person's occupational status i.e.

- Which occupations provide some measure of **independence** and safety?
  Connect to ADL / leisure / productivity pursuits
- How is **motivation** expressed and in what environmental circumstances?
  Past volitional traits can influence motivation
- What in a person's **routine** provides them with a sense of control and/or pleasure? *Personal causation may be severely affected when feeling out of control, lost abilities can impact on the person's sense of efficacy.*
  Withdrawal and anxiety may result – this may lead to uncooperative behaviour, aggression etc. such behaviour may be explained as a coping strategy by the person to gain some sense of control in order to feel safe.
- What is a person doing that makes him/her feel **valued**?
  Compare with knowledge of the persons previous value system via occupational life history with relatives etc.

WHAT CAN THIS PERSON DO?

Assess the persons' levels of doing

Occupational participation = in terms of what ADL, leisure, productivity does the person engage or desire to engage ?

Performance = consider the persons abilities / difficulties experienced which achieve / restrict performance in occupational forms

Skills = what motor, process, communication and interaction skills are required to match / achieve the above levels of performance **In what environmental contexts –** this can be of key significance

Generate an understanding of the persons occupational life, this includes : ***identifying their strengths and limitations*.**

This view of function not only considers the persons' underlying capacity or skill,

BUT ALSO includes the volitional, habituation and environmental factors that impact upon that persons success in participating in occupations over time

WHICH ASSESSMENTS CAN I USE TO GET THIS INFORMATION?

Process of assessment – e.g. communication with the person via verbal, non-verbal means, use of MOHO assessment tools, observation during occupation performance tasks, and during other identified periods during the day, speak with staff and/or relatives, friends etc..

Consider use of MOHO observation assessment tools e.g. Volitional Questionnaire (VQ), AMPS, ACIS,

Can the person engage with an interview? IF YES Carry out interview using OPHI –II / OCAIRS with relatives if not with the person IF NO Carry out a MOHOST

Once strengths and challenges have been identified, consider what changes you are considering with that person and significant others as appropriate.

Consider the individuals' level of engagement with therapy and meaningful ways to engage that person in therapy

Examples of what therapy can look to address areas of strength and difficulties identified :

- Develop a structure, a daily schedule with the person – a routine, which is safe, orientates them, decreases confusion
- Encourage consistency of a daily schedule with staff / carers / family in terms of other environmental contexts using similar prompts / cues etc..
- Work to engage in occupations which build on the persons values, previous interests, roles etc.. – encourage the person to assist / help with everyday tasks whenever possible
- Ultimately work to engage person in meaningful occupations they have responded to
- Look at their environment (physical and social) does it support / provide opportunities for the person to achieve individual desires, preferences and something meaningful to do ? Is it sufficiently familiar i.e. hospital OT kitchen versus kitchen in own home ?
- Validate the person's ongoing attempts, observed feelings / reactions, setbacks, interests directed towards particular activities etc..
- Work to establish a means of communication and trust, follow this through to other environments and social networks
- Look at ***occupational characteristics*** not simply the cognitive impairment

(Refer to master table pp 347 –355 for further examples of the process of therapy)

Summary

For individuals with cognitive impairments e.g. the progression of dementia / the experience of psychosis etc.. there is a constant assault on a persons' occupational self image. Therapy aims to gain an understanding of the persons' ongoing roles and routine (what keeps them functional), their volition (in particular their perception of their performance capacity i.e. personal causation) their performance capacity(i.e. their underlying skills and abilities). MOHO encourages the therapist to put in the time and effort to learn about the persons' volition, habituation, performance capacity and environmental contexts in order to establish a meaningful therapy plan with links to other complimentary models of practice as appropriate.

Appendix seven: publications

Group reflective supervision: thinking with theory to develop practice

Exploring and implementing participatory action research

Appendix eight: academic posters

Exploring participatory action research (PAR)

Transitions, forging new meanings, identity shifts: a participatory model

Exploring Participatory Action Research (PAR)

Progress report focusing on methodological issues

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Context and Rationale

The aim of the study is to explore, via a programme of supervision, training and support, the impact of implementing the Model of Human Occupation (MOHO) (Kielhofner 2002), a conceptual practice model, across a specific service.

Setting

This research presents a 'scholarship of practice' development, i.e. an academic/practice partnership designed to deliver and generate evidence based practice (Forsyth et al 2005). Three teams of mental health Occupational Therapists (OT) within a local Primary Care Trust (PCT) worked in collaboration with the primary researcher.

Methodology

PAR involves *participation* and *action*. It asserts that knowledge should be developed in collaboration with local experts who 'share experiences through a dynamic process of action, reflection and collective investigation' (Gaventa and Cornwall, 2001: 74). Participants were encouraged to consider themselves as co-researchers, with shared objectives and decision making powers. Strategies involved engaging with the OT's in a series of group self-reflective cycles over a 12 month period (*see Figure 1*).

PAR is both challenging and rewarding to implement. Some of the problems/opportunities encountered are highlighted below.

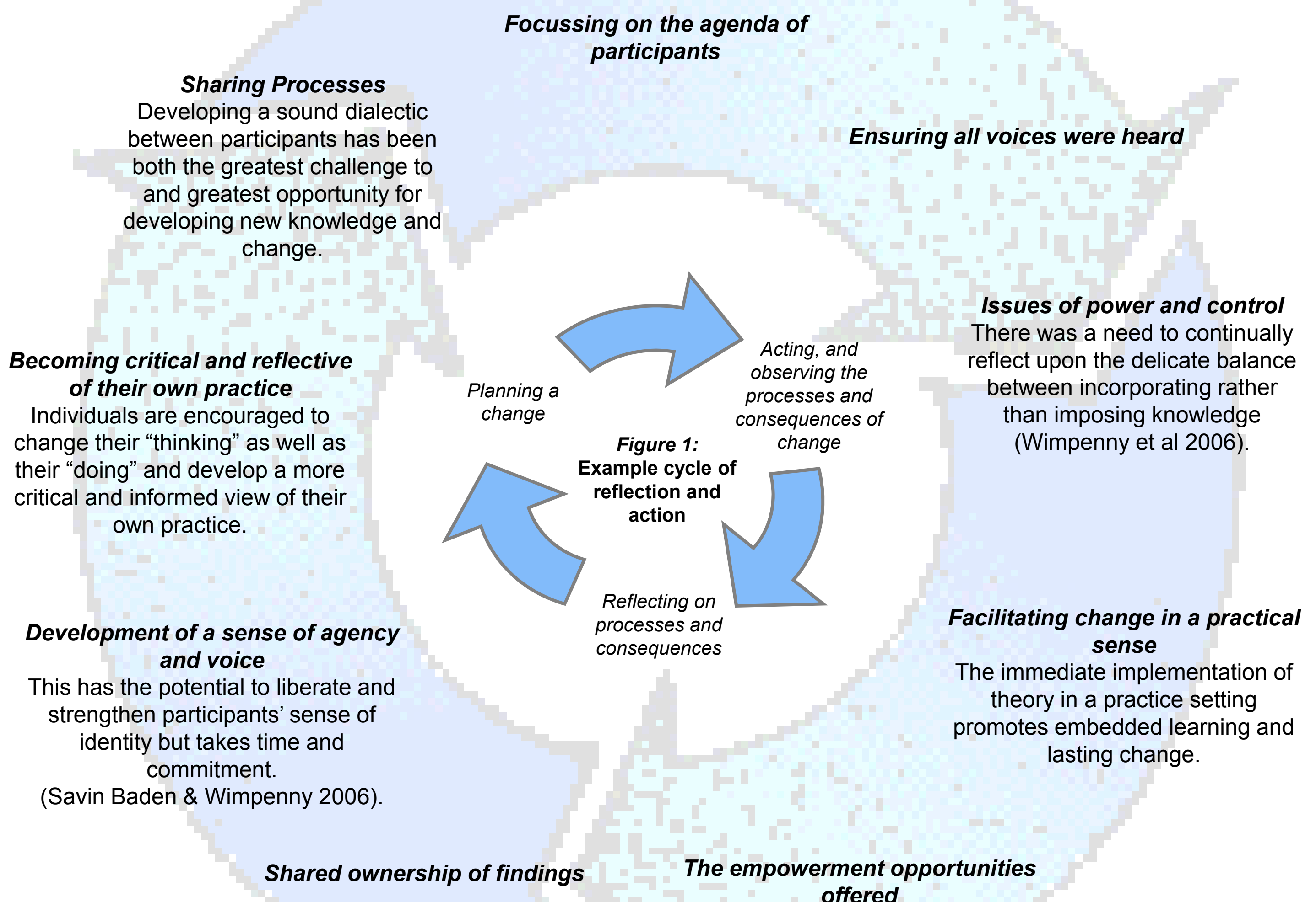

***Figure 1:* Example cycle of reflection and action**

Conclusion

PAR provides a framework to explore research aims whilst offering the potential for individual expression and participation. The OT's have had opportunity to reflect upon the efficacy of their practice, and have taken practical steps to make changes in order to improve services.

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Forsyth K,Summerfield Mann L, Kielhofner G (2005) Scholarship of Practice: Making Occupation-Focused, Theory-Driven and Evidence-Based practice a reality. *British Journal of Occupational therapy* Vol 68(6) pp.260 – 268.

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Kielhofner G (2002) *A Model of Human Occupation: theory and application* 3rd Edition. Baltimore MD: Lippincott Williams and Wilkins

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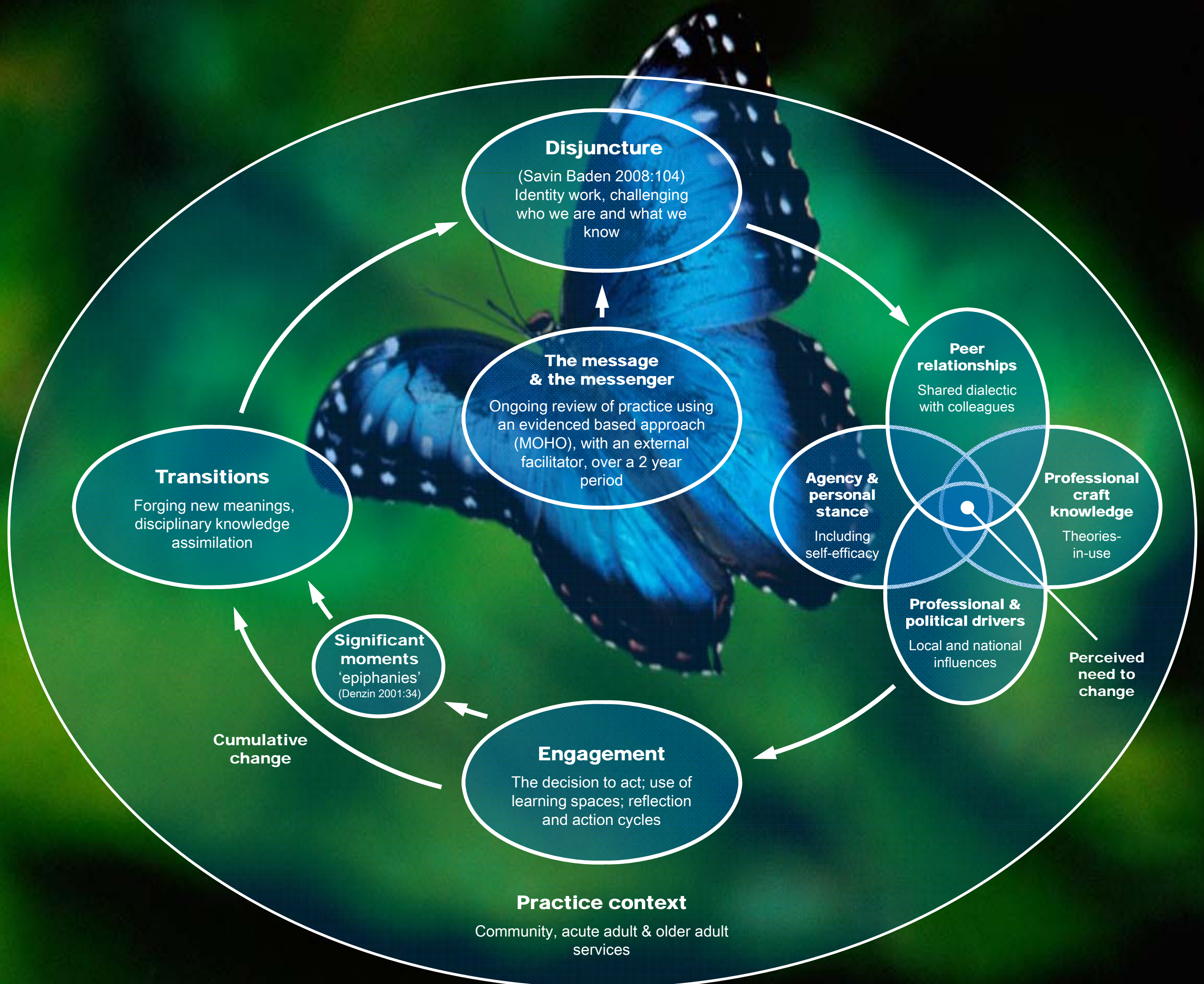
Introduction

This conceptual framework illustrates the processes by which an evidence based conceptual model of practice (the Model of Human Occupation, MOHO, Kielhofner 2002) supported the advancement of the occupational therapy participant's practice during a participatory action research inquiry process (Reason 1994). The framework portrays the interplay of personal and contextual influences involved in negotiating integration of propositional forms of knowledge.



Conclusion

This practice development initiative has examined learning as it occurs amongst people, within the contexts in which it has meaning. It acknowledges disciplinary learning has occurred via praxis (in light of theory), which has served to transform identities and ways of knowing and participating.

Transitions, forging new meanings, identity shifts: a participatory model

Implementing an evidence-based approach within a mental health occupational therapy service

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