Dynamic and Diverse Ways of Knowing in Mental Health Occupational Therapy

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Submitted in fulfilment of the requirements for the degree of
Doctor of Philosophy

Deakin University

April 2014
I certify that the thesis entitled

Dynamic and diverse ways of knowing: A new approach to evidence based practice for occupational therapy in mental health)

submitted for the degree of Doctor of Philosophy

is the result of my own work and that where reference is made to the work of others, due acknowledgment is given.

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This thesis tells the story of a journey through the ways of knowing which inform occupational therapy (OT) in mental health. A broad terrain was covered during this journey, and mental health occupational therapists use three different ways of knowing in their work: theory, evidence and practice. The purpose of this thesis was to integrate these ways of knowing in mental health OT, within a unified professional identity which encompassed the diverse and multidimensional nature of practice. The overall research question guiding this thesis was: How do theoretical, evidentiary and practice ways of knowing integrate and incorporate to guide evidence based practice for occupational therapists working in mental health? It was addressed through an examination of 1596 peer reviewed articles published over 13 years (2000–2012) by occupational therapists, clients and professional organisations. The intended outcome was to provide occupational therapists working in mental health with the means to integrate and incorporate theoretical, evidentiary and practice ways of knowing, in a manner that was congruent with their professional values.

Mental health occupational therapists need to use complex and diverse knowledge to answer questions, solve problems and explain the impact of occupation on mental health; however, no approach has been proposed to date which supports these complex tasks in a manner that is inclusive of diversity. To address this, a new method of data analysis and synthesis was devised to undertake the investigation described in this thesis. The Integrating Theory, Evidence and Action (ITEA) method uses multiple methods through a process of seven steps, to 1) determine or re-determine a research question, 2) select a theoretical framework, 3) identify suitable evidence, 4) deconstruct the knowledge within that evidence, 5) analyse knowledge, 6) reconstruct the knowledge by embedding it in the chosen theoretical framework, and 7) transfer and utilise the knowledge in practice. The ITEA method was repeated iteratively throughout the investigation to comprehensively explore theoretical, evidentiary and practice ways of knowing in mental health OT. Therefore, the overall approach adopted in this thesis is critical analysis, enacted through comprehensive and reflexive responses to a series of critical questions (Finlay, 2004). This series of questions was framed by the Occupational Perspective of Health (OPH) (Wilcock, 1998) which through further
analysis and critique has been modified to addresses the barriers of the original version of the OPH, and validated through analysis of the evidence base for mental health OT.

Finally, six recommendations are made to enable mental health occupational therapists to integrate and incorporate theoretical, evidentiary and practice ways of knowing to guide their practice. 1. Skills in complex thinking and reasoning must be encouraged and nurtured with therapists so that they can synthesise both the amount and diversity of information available. 2. New methods of integrating and incorporating ways of knowing needed to be developed as those currently available are unable to address such a varied knowledge base. 3. Mental health occupational therapists need to engage with personal ways of knowing of their clients, which are as valid and relevant as any other. 4. Sustainable and diverse relationships must be built and retained, and engaging with a vast and ever-evolving body of knowledge must be a collective effort. 5. Our ways of communicating our knowledge also need to modernise, to meet the demands of the information age. And finally, mental health OT must have the courage and persistence to make these fundamental and wide reaching changes—to walk the walk.

References


Journal papers


Declaration for author contributions

Paper Number: 1.


**Declaration by candidate**

In the case of paper 1, the nature and extent of my contribution to the work was the following:

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<tr>
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<td>Lavasani, N</td>
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<tr>
<td>Wrote the original draft of the manuscript, and took the lead for all subsequent drafts. Some of the manuscript used material from the second authors honours thesis, which I had supervised.</td>
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<td>Stagnitti, K</td>
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Conference Presentations


Occupational Therapy Australia 25th National Conference and Exhibition, July 24–26, Adelaide, South Australia.


Data

Research Data Australia. (2013). Database of peer-reviewed publications written by occupational therapists about mental health.

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Completing a PhD is often an individual process, with much of the doing happening in your head or while at a computer. The work you are about to read has been completed at all hours of the day and night, in short bursts and in long sessions, at home and other places. My abiding memory will be of bashing away at my keyboard in the dark, stillness of the early hours. Under the clickety clack of the keys was the purring of Amble and Neptune—silent companionship should never be underestimated.

This thesis has been professionally edited by Dr Margaret Johnson of The Book Doctor in accordance with the IPED guidelines for editing research theses.
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Evidence based practice, occupational therapy, mental health, knowledge management

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920410 Mental Health
920209 Mental Health Services
970111 Expanding Knowledge in the Medical and Health Sciences
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Stage Five – How does this evidence relate to my chosen theoretical framework?
Stage Six – How does this information answer my critical question?
Stage Seven – How will I apply this evidence to practice or further research?

Applying the ITEA method

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Stage 2
Stage 3
Stage 4
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Stage 6
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Being
Becoming
Belonging
Step 7

Ethical Considerations
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Abbreviations Used in this Thesis

ADHD Attention Deficit Hyperactivity Disorder
AOTA American Occupational Therapy Association
CMOP Canadian Model of Occupational Performance
CMOPE Canadian Model of Occupational Performance and Engagement
COPM Canadian Occupational Performance Measure
DSM Diagnostic and Statistical Manual
EBOT Evidence Based Occupational Therapy
EBP Evidence Based Practice
ICD10 International Classification of Diseases 10
ITEA Integrating Theory, Evidence and Action
KT Knowledge Translation
MOHO Model of Human Occupation
MOHOST Model of Human Occupation Screening Tool
OPH Occupational Perspective of Health
OT Occupational Therapy
PAR Participatory Action Research
POP Pan Occupational Paradigm
RF-QRA Rosalind Franklin Qualitative Research Appraisal Instrument
Chapter 1. Introduction

“True stories can be told forward, only backwards. We invent them from the vantage point of an ever-changing present, and tell ourselves how they unfolded.”

– Siri Hustvedt, The Shaking Woman or a History of my Nerves

Introduction

This thesis tells the story of a journey through the ways of knowing which inform occupational therapy (OT) in mental health. Occupational therapists use complex and diverse knowledge to answer questions, solve problems and explain the impact of occupation on mental health. A broad terrain was covered during this journey, and the varied ways that mental health occupational therapists know about their practice unfolded in three areas: theoretical, evidentiary and practice. These diverse ways of knowing provided a framework for achieving my long held aspiration of a distinctive and confident professional identity for OT and occupational therapists. In hindsight, from the ever-changing present, the outcomes of this thesis seem deceptively simple and self-evident; however, the story has many twists, turns, layers and depths. Along the way I have questioned, pressed; I have been challenged and confronted, and ultimately invigorated, by my journey. This thesis is unique in its approach, its critical analysis of evidence in a variety of forms, its focus on translating knowledge to practice and its desire to enable clinicians to use their knowledge more effectively.

Research is about deciding what to ask, and how to answer the questions that arise. For this study, my experiences and priorities, both personal and professional, drove these decisions. The overall research question guiding this thesis was: How do theoretical, evidentiary and practice ways of knowing integrate and incorporate to guide evidence based practice for occupational therapists working in mental health? The data gathered to answer this question consisted of 13 years (2000–2012) of peer-reviewed articles written by occupational therapists, clients and professional organisations of relevance to mental health. The purpose of this thesis was to integrate existing ways of knowing in OT in mental health within a unified professional identity which encompassed the diverse and multidimensional nature of practice. The intended outcome was to provide occupational therapists working in mental health with the means to integrate and incorporate theoretical, evidentiary and practice ways of knowing, in a manner that was congruent with their professional values.
INTRODUCTION

This story began with questions I posed as an experienced clinician about ways of knowing in mental health OT, and about how different forms of evidence guided practice. The new knowledge I developed challenged many existing tenets I held about the profession, particularly in the area of theory and evidence based occupational therapy (EBOT). I had assumed that theory was only for academics, with a passing (at best) relevance to “real” OT. I also believed the received wisdom that there was little evidence to support mental health OT, and that EBOT entailed utilising only high-quality quantitative studies. As I became aware of the many ways of knowing in mental health OT, my skills and perceptions changed and new rigorous methods to incorporate and integrate evidence were developed to support original paths through knowledge. By the end of the journey, a new way of knowing and understanding mental health OT was expounded. This journey of knowing has overcome many of the barriers that restricted and frustrated my practice as a clinician.

My personal stance

I was born and raised in Australia, and identify as a female, Generation X, Celtic Australian. Storytelling is central to Celtic culture, where gatherings inevitably involve endless stories told by all members of the family. Stories are a powerful way of keeping memories and transmitting information; a way of knowing that is accessible to all and quintessentially human. Drawing on my personal identity, I chose storytelling as the format of this thesis. It is the best way to support accessibility and engagement with the complexity and depth of this journey.

Despite a long period of living and practising in Europe, I feel most influenced by the professional culture and practices of Australian OT and the Australian mental health system. This context grounds the arguments advanced and innovations proposed within this thesis, although all the themes explored relate to global trends in OT and mental health. Reflective statements are included throughout the thesis, to illustrate both the influence of my personal stance and the impact of the process of inquiry on it.

This thesis is a result of a longer reflective process that originated in my career as a clinical occupational therapist. Since graduating with a Bachelor of Occupational Therapy in 1998, I have worked across a range of settings. I initially worked in vocational rehabilitation, but the majority of my career was spent with people experiencing mental health problems. Across the years I have worked in acute, community, private practice and forensic services, with people across the lifespan, in both clinical and project-based positions.
INTRODUCTION

My career has coincided with the emergence of evidence-based practice as a strong prerogative in OT. I have always been interested in research and the ways in which knowledge is gathered and applied. To this end, I completed a series of postgraduate courses to gain skills and experience. However, I felt increasingly disconnected and disconcerted when trying to engage as a clinician in EBOT. I had become accustomed to practising in a flexible manner which respected and embraced diverse and multiple perspectives. The discourse around evidence-based practice was based firmly in the medical/scientific tradition, and I was taught specific procedures and processes to critique this evidence. While I recognised the value of the scientific method, I found myself rebelling against the assumption that science is the best way of knowing about occupation.

As a clinician, I began to feel that my hard-won practice knowledge was constantly being dismissed as “non-evidence” in favour of knowledge that didn’t reflect the needs of my clients. I often left training sessions on evidence-based practice feeling irritated by the supposition that being a clinician automatically made me deficient in EBOT, in comparison to academics. I felt quite offended when someone said I could move “up” to occupational science because of my education and leave my clinical work behind, as this was the best way to engage with the evidence and gain credibility. The latter stages of my career have involved working with people who were experiencing mental illness, labelled as “hard to engage” and often contending with co-morbid conditions such as drug and alcohol abuse. It was rare to find evidence that I could easily access, and which spoke directly to my clients’ experience; the gap between the evidence I was supposed to be applying and my professional life was wide. Feelings of alienation and disenfranchisement crystallised into a single thought: “There has to be a better way.”

In my practice, theory led a shadowy existence as something I knew I “should” think about but somehow never consciously did. Through my use of the Canadian Occupational Performance Measure (COPM), I developed a passing acquaintance with the Canadian Model of Occupational Performance (CMOP) (Townsend et al., 2002) and then the Canadian Model of Occupational Performance and Engagement (CMOP-E) (Townsend & Polatjko, 2007). Unfortunately, I did not readily engage with the Model of Human Occupation (MOHO) (Kielhofner, 2008) as my view was coloured by some particularly evangelical adherents, including a manager who insisted on a “MOHO” service and would not allow any other conceptions of human occupation. I intuitively
connection with the concepts of “doing, being, becoming and belonging” (Wilcock, 1998), but once again had only a superficial understanding. At that point, I had not explored the Occupational Perspective of Health (OPH) (Wilcock, 2006), and so was largely unaware of the theory that underpinned the concepts. Overall, I felt very out of my depth with theory, but could always somehow provide a detailed description of its use in practice for the students I supervised. As a “doer,” theory in OT seemed to be at best “mildly diverting” and at worse “fluffy and self-indulgent.”

The origins of this study are therefore my experiences as an OT clinician, trying to do her best for her clients and finding EBOT inadequate as currently practised. This position has driven my desire to provide clinicians with a perspective on EBOT that is inclusive and considers more than one traditional, scientific way of knowing. This thesis has therefore sprung from my need to reconcile EBOT with my doing, being, becoming and belonging as a clinician.

My personal stance on scientific evidence is that it is one of many valid ways of knowing for occupational therapists. The scientific method is very suited to answering some questions, and has many advantages that have provided it with a privileged position as a “path to truth” in recent history. However, non scientific evidence is more appropriate to answering some questions, and also has other advantages when considered on its own merits. In the current discourse around knowledge, non-scientific evidence is often dismissed as irrational or less valid (Kinsella & Whiteford, 2009). Many of the challenges to the dominance of science have been framed as feminist (Longino, 1989) or postmodern critiques (Feyerabend 2011), but often also take an exclusive view of knowledge in advocating their (alternative) way is best.

My stance on knowledge is that all ways of knowing are equally valid; and their value is based only on their relevance to answering a given research question. I also believe that drawing on multiple ways of knowing provides a deeper understanding of an issue or topic, and that knowledge gained through multiple methods is more comprehensive than knowledge gained through a single method. This cumulative development of knowledge, drawing on published articles by a range of authors using a range of methods, also accords with my belief that knowledge grows communally. No one individual (or discipline) has all the answers, but together we can gain a fuller understanding.

Given my belief in communal knowledge generation, I find it difficult to present this thesis in the tone of “authority” that is usually expected. I hope that the readers of
this work will engage with it actively, linking it to their own beliefs and understanding. The story in this thesis could influence your personal and professional stories, and through your feedback continue to influence and be integrated with my future stories. This thesis is not intended to sit on a library shelf, but to be an active, evolving part of the profession’s ongoing discourse on EBOT. While I eschew the individualistic nature of the role of “expert” (Eraut, 2005), I can confidently present my understanding on this subject and accept that it, too, is just one of many approaches to considering the numerous ways of knowing in mental health OT.

Those who do not have power over the story that dominates their lives, the power to retell it, rethink it, deconstruct it, joke about it, and change it as times change, truly are powerless, because they cannot think new thoughts. (Rushdie, 1993, p. 17)

**Key Concepts**

This thesis is concerned with evidence for OT practice in mental health. Through my journey, the key concepts of ways of knowing, diversity, multiplicity and integration emerged repeatedly. They are the landmarks of this inquiry, and will now be defined and described.

**Ways of knowing.**

People engage in inquiry through various ways, such as empirical verification, community agreement, authority, and transcendental belief (Kuhn, 2006). Ways of knowing are therefore the methods of understanding employed to answer questions, solve problems and generally explain the world. As found through personal experience and the research undertaken as part of this thesis, there are three main ways of knowing in OT: theory, evidence and practice.

The first way of knowing in OT practice is theory. Theory refers to the formal explanations of concepts and postulates related to OT that explain the relationship between occupation and health (Kielhofner, 2009). Without grounding in theory, a therapist cannot utilise evidence—or, indeed, practise. While theory is often the first way of knowing to develop in OT students, it has a non-linear, multidimensional relationship with evidence and practice.

Evidence is the second way of knowing in OT practice, and empirical verification is currently the focus of EBOT. Evidence is information that provides grounds for conclusions which are relevant to a person’s way of knowing (Oxford English Dictionary (“evidence”, 2014), and in this thesis is specific to information
presented in peer-reviewed journals. This thesis proposes that evidence is not synonymous with research, but encompasses multiple methods that are both scientific and non-scientific. Quantitative, qualitative and mixed methods research presents scientific evidence. Non-scientific evidence acknowledged in OT literature includes literature reviews, reflections, critical analyses, economic understandings, ethical reasoning, intuition, and independent professional judgment (Bannigan & Moores, 2009; Chaffey, Unsworth, & Fossey, 2010; Lopez, Vanner, Cowan, Samuel, & Shepherd, 2008). While some of these are recognised research methods, others are not. The non-scientific evidence base for mental health OT also includes materials such as blogs, tweets, posts, client reports, websites, personal testimonies, newsletters, books and reports (Reagon, Bellin, & Boniface, 2008).

The third way of knowing in OT is practice, which is the performance of actions that are client-centred and enable health and wellbeing through occupation (World Federation of Occupational Therapists, 2012). It can include the physical “doing” of therapy with clients, along with indirect duties such as management, quality assurance, student supervision, education, and professional development. Through its combination of multiple ways of knowing, operating simultaneously in the dimensions of theory, evidence and practice, OT makes its distinctive, complex and holistic contribution to human health and wellbeing.

**Diversity.**

The principle of diversity is central to the philosophy of OT, where all clients are valued for their individual abilities and capacities and every effort is made to enable all members of the community to engage in occupations as fully as possible (Hitch, Pépin & Stagnitti, 2013a). A related concept is inclusion, a practice that ensures that all people have the ability to participate (Mannan et al., 2013). If you are accepting of diversity, there can be no reason to exclude ways of knowing solely based on difference. In this case, the rejection of evidence due only to its difference from the dominant scientific paradigm (i.e. reflective writing) is unsupportable. In this thesis, diversity is valued as an inherently positive feature, and a strong link to the core values of the profession.

**Multiplicity.**

Alongside this positive acceptance of diversity, multiplicity is embraced. Multiplicity is the quality of having a number of different features, forms or components that exist simultaneously with each other (“multiplicity”, 2014). This
thesis uses multiple methods to explore the ways of knowing related to mental health OT and answer the research question. The aspiration to use methods which are “fit for purpose,” regardless of their tradition, demands a multiple approach when the evidence base is diverse. The use of multiple methods authentically mirrors the lived experience of a clinician providing OT. The artistry and skill of the profession are the sophisticated use of a range of assessments and interventions, individually tailored to the clients’ needs. Using multiple methods will go some way to ensure that the evidence reviewed is translatable into practice.

Integration.

The ways of knowing encountered during this journey combined, complemented and influenced each other. Mental health occupational therapists are guided in practice by evidence that changes with and through each other (Shank, 2013). I maintained an integrated perspective throughout this study, where all new knowledge was linked to the identified problem and considered in regard to pre-existing knowledge. Integration involves the combining of separate elements and components into a coherent whole (“integration”, 2014).

Theoretical Framework

The theoretical framework chosen to guide this thesis is the Occupational Perspective of Health (Wilcock, 2006), which presents the concepts of health and illness in the context of occupation, health and survival. The OPH partially meets the definition of a paradigm, in that it presents broad assumptions and values rather than specific guidelines and technologies (Kielhofner, 2008). However, it is yet to be shared as a common vision across the profession, or be used to define professional practice (Kielhofner, 2009). While this second requirement of paradigms is considered essential by both Kielhofner (2009) and Kuhn (1970), occupational therapy has yet to reach a consensus or common vision around a unifying paradigm across all its domains of practice. The contemporary paradigm proposed a return to focusing on the relationship between health and occupation, in reaction to the reductionistic trends of the mid-20th century. The resulting integration of biopsychosocial knowledge with a focus on participation in occupation has been proposed as an emerging paradigm (Kielhofner, 2009). While the contemporary paradigm does articulate broad assumptions and values, it is yet to achieve broad acceptance and adoption across the profession. The term paradigm within this thesis will therefore be applied to theoretical ways of knowing which meet the first requirement of the Kielhofner’s (2008) definition only.
The human brain has “healthy survival” as its primary role, which it enacts through engagement with occupation. Health/order is achieved (for individuals, communities and populations) when all essential needs are met and capacities (physical, mental and social) are maintained, developed, exercised and in balance. Survival can only occur when people exists in a sustainable relationship with their environment, which enables its ongoing use as a resource and support. Illness/disorder therefore occur when needs are unmet, capacities are unfulfilled or environments are exploited or disrespected.

The original paradigm used the concepts of doing, being and becoming in both the health and illness domains (Wilcock, 2006), and belonging was subsequently added as a fourth dimension (Wilcock, 2007). Figure 1.1 is a modified version of the original by Wilcock, including this new dimension, as there are no visual representations of the OPH that includes all four dimensions.

![Figure 1.1 Occupational perspective of population health.](image)

The four dimension of the OPH – doing, being, becoming and belonging – were chosen as an organising structure due to their capacity to order the diverse data collected
by this thesis in a manner that retains occupation as the main focus. The dichotomous relationship was not adopted, as it was not inclusive of the concept of wellbeing, which is pervasive throughout Wilcock’s discussions on the occupational perspective of health. Some of the other aspects of the OPH (such as occupational behaviour, occupational determinants and occupational marginalisation) (Kosma, Bryant & Wilson, 2013) have been discarded as they do not have explicit places within the structure of the paradigm. Here, the OPH is applied to a body of evidence which has been collected from a population of clients, carers, therapists, students and other participants. The OPH has not been a preceding influence on any of these studies, as they were developed independent of its framework, or have indeed used other theoretical frameworks to guide their method. This inductive approach (working from the specific findings of the studies to the broader assumptions and concepts of the paradigm) has several advantages, which should serve to ensure the resulting empirical scrutiny is both robust and practically applicable. The possibility of bias in the research studies themselves is mostly eliminated, as they had not (in the vast majority of cases) been formulated with a desire to either prove or disprove the paradigm.

The large body of evidence included in this thesis also enabled this theoretical way of knowing to be tested through a variety of methodologies, traditions, geographical locations and perspectives. The use of existing applied evidence clarified how the OPH influences existing technology and knowledge that enable therapists to apply its concepts. The act of choosing it as the theoretical framework for the thesis led to an immediate recognition of its interrelationship with other ways of knowing, enhancing my grasp of the multidimensional nature of occupation.

**Approach Taken in This Thesis**

The key concepts of ways of knowing, diversity, multiplicity and integration placed a range of demands on plans for the journey ahead, and efforts to tell the story in an accessible way. The new knowledge built during the production of this thesis could not have been constructed in a linear, step-wise fashion: it evolved over time in response to new insights, new knowledge and the letting go of long-held assumptions. Having committed to remaining open to the diversity and multiplicity of the ways that mental health occupational therapists know about their practice, I needed to find a way to integrate and make sense of these ways of knowing.

The overall approach adopted in this thesis is critical analysis, the comprehensive, reflexive exploration of a topic (Finlay, 2004) mediated by the asking
and answering of a series of critical questions. Theory, evidence and practice in OT have all been critically analysed. For example, in the data included in this thesis, critical analysis has supported theory by unpacking a new OT model (Ikiugu, 2010); supported evidence by interrogating the effectiveness of a particular intervention (Schindler, 2004) and supported practice by exploring the roles of various members within multidisciplinary mental health teams (Herman, Trauer, & Warnock, 2002). Critical analysis provides a detailed understanding of a topic, and can also be applied very broadly, across a range of discipline areas. However, it has limitations: authors are not always clear about their stance on the topic; readers may not be aware of potential biases; important questions may not have been asked; or questions may not be completely answered.

To mitigate these limitations, questions guiding my critical analysis will be explicitly stated throughout the thesis. These questions were used as sub-questions to fully explore the main research question, and emerged as I expanded my knowledge and uncovered more layers within the original question. As shown in Table 1.1, there were 10 questions asked during the journey, leading me through different areas of my investigation.

*Table 1.1*

*Critical questions during this thesis*

<table>
<thead>
<tr>
<th>Phase of Journey</th>
<th>Critical question</th>
</tr>
</thead>
<tbody>
<tr>
<td>Theoretical ways of knowing</td>
<td>What theoretical ways of knowing currently underpin mental health OT?</td>
</tr>
<tr>
<td></td>
<td>How have the concepts of doing, being, becoming and belonging developed since the inception of the OPH?</td>
</tr>
<tr>
<td></td>
<td>How do doing, being, becoming and belonging interact and combine to influence occupational engagement?</td>
</tr>
<tr>
<td></td>
<td>Can the dimensions of doing, being, becoming and belonging be used in conjunction with conceptual practice models in mental health occupational therapy?</td>
</tr>
</tbody>
</table>
INTRODUCTION

| Evidentiary ways of knowing | How are evidentiary ways of knowing currently discussed in peer reviewed literature relevant to mental health OT?
|                           | What are the key findings, sources and types of evidence published in peer reviewed journals since the year 2000 which have been authored by mental health occupational therapists?
|                           | What do future citations reveal about the impact of article by occupational therapists about mental health OT in peer reviewed journals?
| Practice ways of knowing  | What is the current knowledge around how mental health occupational therapists enact practice ways of knowing in mental health OT?
|                           | How can theoretical and evidentiary ways of knowing be applied along with practice way of knowing in mental health OT?
| Pan Occupational Paradigm | What prevents the explicit use of the OPH in OT practice?

By clearly identifying these sub-questions, I hope that the journey undertaken is fully described, with the steps taken between each milestone plainly rendered. While critical analysis is the overarching approach in this thesis, alone it was not sufficient to meet the requirements of the diversity and multiplicity of the ways that mental health occupational therapists know about their practice. As will be described in Chapter 2, I supported critical analysis with a method derived from mixed methods to fully answer the original research question.

**Scope**

I took a series of decisions to bring the scope of the thesis to dimensions that were manageable within a doctoral level inquiry. The first of these was to include evidence published in peer-reviewed journals only. The main reason for excluding non-peer-reviewed evidence is not a reflection on the potential value or relevance of this information to practice, but simply a logistical consideration: the inclusion of all published evidence would have rendered the thesis unfeasibly large.

Peer-reviewed journals include a range of genres, both scientific and non-scientific. Practice descriptions, theoretical discussions, opinion pieces and reflective accounts are all commonly found, alongside the scientific evidence. A focus on these
publications provides opportunity to engage with the diversity of evidence available to occupational therapists, and explore the ways in which this integrates to form the evidence base for a specialist area of the profession.

Another reason for including only peer-reviewed evidence is its status as a source of current information, and its assumed quality. Peer-reviewed journals remain the most recommended source of evidence for occupational therapists, and evidence bases practice training often focuses on how to “read” the evidence presented in them. While the process of peer review aims to assure the quality of professional publications, it is not of itself an automatic guarantee of rigour or relevance (Brannigan, 2005). A number of criticisms have been made of the peer review process, particularly around the supposed credibility of double blinding. OT is a relatively small profession, where de facto identification of authors in small areas of specialist practice is imaginable, and where undue influence from their personal agendas is also possible. Duncan (2007) has suggested removing anonymity from reviewers as a potential solution, but currently blind review remains a standard for the dissemination of peer review evidence (Mackenzie, 2006).

Decisions were made regarding what was relevant to mental health OT, and therefore most pertinent to therapists working in this area. Based on my experience as a clinician in a broad range of settings, I began by including knowledge that was applicable to the diagnoses listed in the mental and behavioural section of the International Classification of Diseases (ICD10) (World Health Organisation, 2010). While the Diagnostic and Statistical Manual (DSM) is more common in practice, it was undergoing a major revision for much of the period of this study, so its use carried with it the risk of obsolescence. The OT role in homelessness and domestic violence was included, as these were psychosocial issues that I frequently encountered in my clinical work in mental health OT.

Knowledge relating to people with intellectual/learning disabilities (termed “mental retardation” in the ICD10) was excluded, as mental health occupational therapists generally do not work with people for whom this is a primary diagnosis; it is a separate and distinct area of OT practice in Australia. I also excluded mental health problems secondary to a physical illness or disability, as these clients work with therapists in physical rehabilitation or the disability sector.

Given the previously stated commitment to inclusivity, the decision to exclude some potentially relevant evidence may seem inconsistent. However, there was a need
to ensure the knowledge considered in this thesis was directly relevant to mental health OT practice overall and more precisely in Australia. A high percentage of people with mental health problems also experience physical health problems such as coronary heart disease, diabetes, stroke, and respiratory disease (Mental Health Fellowship of Australia, 2012). There is also an ongoing debate within OT about the separation of “physical” OT from “mental health” OT (Rigney, 2000). Evidence that cited mental health problems as secondary to physical illness or disability all originated from physical OT services, and usually described mental health problems that would not meet the threshold for referral to a mental health service in Australia.

**Overview of This Thesis**

This thesis recounts the ways of knowing which inform OT in mental health. The genre of doctoral theses belongs to an established and codified scholarly culture, structured in a manner consistent with Western scientific traditions. However, alternative thesis formats are becoming increasingly accepted as different ways of knowing are explored, to the point where this trend has been described as a movement in its own right (Four Arrows, 2008). This thesis uses an alternative format in two ways. First, it is intimately linked to published research through the 1596 peer-reviewed publications that form the basis for the analysis underpinning this thesis. A list of future publications planned from this study is also included, in Appendix A. The text of this thesis integrates existing publications as part of the story of this journey. The second feature is an alteration to the way in which the information is presented, which is displayed in Figure 1.1.
This first chapter has provided an introduction and stated the overarching research question, which is “How do theoretical, evidentiary and practice ways of knowing integrate and incorporate to guide evidence based practice for occupational therapists working in mental health?” In traditional theses, the second chapter is usually a literature review to locate the study in a research context. As the inquiry focused on the literature itself, Chapter 2 begins with a historical analysis of the methods present in peer-reviewed journals that support ways of knowing about mental health OT, and critical analysis of their strengths and shortcomings. I present the sample and methodology in full, including two publications. One of the outcomes of this thesis has been the formulation of a pioneering multiple-methods approach to understanding evidence which supports ways of knowing about mental health OT. This method retains the overall features of critical analysis, but evolved with the adoption of elements from mixed methodologies.

Chapters 3 (Theory), 4 (Evidence) and 5 (Practice) are structured around the three main ways of knowing in OT. Chapter 3 begins with an overview of theory in mental health OT to address the sub-question, “What occupational theories currently underpin OT in mental health?” My journey through theoretical ways of knowing continues with a critical analysis of the Occupational Perspective of Health. Chapter 4
begins with an overview of evidence in mental health OT to address the sub-question, “What is the current discourse around EBOT in mental health?” Results from my analysis of the evidence available around mental health OT are then presented. These findings highlight issues around finding evidence, the availability of evidence and its subsequent impact on future studies. Chapter 5 begins with an overview of current practice in mental health OT to address the sub-question, “What is the current state of practice in OT in mental health?” Building on the findings in the theory and evidence chapters, I propose two new approaches to using practice ways of knowledge, supported by two further publications.

Chapter 6 details the other outcome of this thesis: the development of the Pan Occupational Paradigm (POP). This is a new iteration of the Occupational Perspective of Health which addresses the barriers of the original paradigm, has been validated through analysis of the evidence base for mental health OT, and has been implemented as a way to frame practice. POP is described in detail with a publication, and a pilot study around its use as an organising framework with OT students.

Finally, Chapter 7 is a discussion of the thesis overall, which will bring together and integrate the key concepts of ways of knowing, diversity, multiplicity and inclusion. This chapter will conclude with an answer to the research question, a discussion of the limitations of the thesis, and recommendations for ongoing research in this area.

Summary

This first chapter of the thesis has introduced the story of my journey, and provided an overview of its context and scope. The study is a journey among the ways of knowing which inform OT in mental health, and the twists and turns which questioned, challenged, pressed, and ultimately invigorated me are acknowledged.

The specific subject, purpose and overall guiding question of this study were stated, followed by a description of the events leading to the start of the journey and my stance. Given the multidimensional nature of the journey, I provided an introduction to and description of the key uniting concepts fundamental to the approach adopted for this thesis, drawn from critical analysis and modified by elements from mixed methods. I described the scope of the study, and explored its context and underlying assumptions from the perspectives of philosophy, health, discipline and evidence. Finally, I provided an overview of the thesis as a map for the journey through these pages. Chapter 2 outlines the ways of knowing in mental health OT, and the method used in this thesis.
Chapter 2. Ways of Knowing in Mental Health Occupational Therapy

“Stay committed to your decisions, but stay flexible in your approach.” – Robbins, *Selfhelp: Find your self to help yourself.*

Introduction

Having decided that occupation has an impact on human health, OT has adopted a variety of ways of knowing and understanding about it. Peer-reviewed journals present all of these ways of knowing (and the methods used to support them), and this information that relates to mental health is the focus of this thesis. The sample of knowledge on which this thesis is based is the basis of all findings and discussion to follow, and deserves to be clearly identified.

Sampled Peer-reviewed Evidence in Mental Health OT

Only evidence published in peer-reviewed journals was included in this study, and all other forms of publication (such as newsletters, websites, blogs, books and service bulletins) excluded. Peer review is the process whereby a manuscript is reviewed by two professionals, experts in the topic of the article. The identity of both reviewers and authors is kept anonymous – a practice known as double blinding.

Duncan (2007) cites some of these difficulties while advocating the removal of anonymity from reviewers in OT. He argues that this will lead to greater transparency, accountability and credit. However, reviewers provide their services on a voluntary basis and it is unclear whether this would act as a disincentive. While peer review is an imperfect system, it remains a cornerstone for the dissemination of scientific material and a potentially supportive process for clinicians wishing to publish (Mackenzie, 2006). The subject or specialist area of the journal was not an exclusionary criterion in
this thesis, in recognition that occupational therapists often publish in non-profession-specific locations.

Articles written by people self identifying as occupational therapists, consumers of OT services, and organisations self identifying as representing the profession were included. This information was gleaned from author details provided with the article. In the case of multiple authors, the article was included if at least one of them met this criterion. In the case of authors who moved from OT positions to other roles during the time of this study, subsequent articles were also included on the basis of a presumed ongoing influence of professional training. These criteria were based on the assumption that these authors were the most knowledgeable and likely to publish articles about mental health OT.

A further set of inclusion and exclusion criteria ensured the evidence directly addressed the research aims. The evidence to be analysed needed to be considered current, as clinicians are trained to use only relatively recent sources as a basis for their practice. In this thesis, this was taken to include evidence which has been published since the year 2000, although in rapidly developing areas of practice a shorter time frame may be more appropriate. A timeframe was also relevant for logistical reasons, as calendar years are arbitrary markers of time. The majority of peer-reviewed OT and health journals have been available in electronic format from the turn of the century, minimising the need to source data from remote locations. This development in technology was an important enabling factor for a study of this magnitude; and the evidence used in this thesis all appeared in peer-reviewed publications between January 1 2000 and December 31 2012. Evidence published outside these dates, or only available in an early access format during this timeframe, were excluded. Those prior to the turn of this century are now over a decade old and did not meet the currency criterion for this thesis, while those that are only available in an early access format are yet to be formally “published” and are not as widely available as finished versions.

Articles published in English (both originally and available in translation) were included. The exclusion of articles in other languages is no indication of their value or relevance, but rather of the resources available to complete this study, and limitations posed by my being monolingual. It was initially thought this would lead to the exclusion of a small number of articles, but the articles published in languages other than English were noted throughout data collection to monitor the impact of this
decision. Table 2.1 below displays the foreign-language articles found which were likely to be relevant to the research question, and their language of publication.

Table 2.1

Articles Published in Languages Other Than English About Mental Health OT

<table>
<thead>
<tr>
<th>Language</th>
<th>Number of Articles</th>
</tr>
</thead>
<tbody>
<tr>
<td>Croatian</td>
<td>1</td>
</tr>
<tr>
<td>French</td>
<td>61</td>
</tr>
<tr>
<td>German</td>
<td>79</td>
</tr>
<tr>
<td>Hebrew</td>
<td>21</td>
</tr>
<tr>
<td>Japanese</td>
<td>4</td>
</tr>
<tr>
<td>Polish</td>
<td>2</td>
</tr>
<tr>
<td>Portuguese</td>
<td>22</td>
</tr>
<tr>
<td>Spanish</td>
<td>29</td>
</tr>
<tr>
<td>Unspecified European</td>
<td>10</td>
</tr>
<tr>
<td>(published in French/German</td>
<td></td>
</tr>
<tr>
<td>journal, but abstract did not</td>
<td></td>
</tr>
<tr>
<td>specify language)</td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>229</strong></td>
</tr>
</tbody>
</table>

At first glance, this table seems to indicate that the majority of articles published in languages other than English arise from Europe. However, there may be others (particularly in Asian languages) which regularly used databases do not index. French is an official language in numerous non-European locations, such as Canada, Africa and Oceania. Google Scholar provides listings of articles in a range of languages, but if the article has not been published in an OT journal and you do not know the language it is impossible to determine its relevance. A total of 1596 articles were located which were relevant to the research question and published in English, with a further 229 published in languages other than English.

Table 2.2 provides an overview of all inclusion and exclusion criteria for this thesis, and of the ways of knowing which were accepted.
Table 2.2

Inclusion and Exclusion Criteria

<table>
<thead>
<tr>
<th>Selection criteria</th>
<th>Inclusion Criteria</th>
<th>Exclusion Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>Way of knowing</td>
<td>Theoretical, evidentiary and practical</td>
<td>None excluded</td>
</tr>
<tr>
<td>Date of publication</td>
<td>Formally published between 01/01/2000 and 31/12/2012</td>
<td>Formally published prior or subsequent to these dates, or only available as “early access” during this time</td>
</tr>
<tr>
<td>Language of publication</td>
<td>Published in English (either originally or available in translation)</td>
<td>Only available in languages other than English</td>
</tr>
<tr>
<td>Source of publication</td>
<td>Published in peer-reviewed publications</td>
<td>Published in non-peer-reviewed publications</td>
</tr>
<tr>
<td>Type of author</td>
<td>At least one author who self identifies as an occupational therapist, consumer of OT services, or organisation representing the profession.</td>
<td>No authors who identify in the categories named</td>
</tr>
</tbody>
</table>

Having identified which ways of knowing which would be included, focused particularly on peer-reviewed information that met the criteria, I decided how to identify the data (i.e. articles) for inclusion in this thesis. Peer review evidence is collated in a range of electronic databases and search engines, which list all articles published in the journals indexed in each resource. Given the breadth of the research question, the search for evidence occurred in multiple databases (including those in non-health disciplines) – a fair greater range than would normally be encountered in an evidence based review. As will be detailed in Chapter 4 (Evidentiary Ways of Knowing), part of my journey was to include the development of an optimal search strategy using a combination of databases and search engines which retuned the greatest amount of evidence.

While the places I searched evolved over time, my search terms remained consistent throughout this journey. They were “occupational therapy” AND (“mental health” OR “mental illness” OR “psychiatry”). To enable a general awareness of any
chronological developments in knowledge of OT in mental health, this search proceeded on a year-by-year basis. For example, all articles on the topic from 2000 were located, reviewed and analysed before continuing to later years. This method of searching was facilitated by the filters on each database, which could limit results to particular years. It was also the most appropriate method when using Google Scholar, which returns high numbers of results but only displays the first 1000. If all the years had been searched simultaneously on this database, many of the sources would have been missed due to this restriction. The outcome of this step was a list of all evidence that met the criteria for inclusion in the thesis; the articles identified as meeting the search criteria for each year of the study are listed in Appendix B. A list of the articles which met the inclusion criteria, but for which a full text copy could not be located, are also included in this Appendix. These articles were not included in the analysis, and constituted 4.55% (n = 76) of the total evidence (n = 1672) available.

As stated in Chapter 1, the four dimensions of occupation – doing, being, becoming and belonging – were chosen as the features of the Occupational Perspective of Health that would provide structure to the analysis in this thesis. However, it soon became clear that four categories would be insufficient to manage the knowledge contained in 1596 peer-reviewed articles – the dimensionality of the data would still be too large for close analysis. The data needed to be broken down in to classifications which contained more manageable amounts of data. At the time of commencing this thesis, I had worked for some time on a telephone psychiatric triage service, and I adopted the format of triage as a means of breaking the evidence down into a more workable form.

In clinical settings, triage involves an assessment of a client’s mental health and wellbeing needs, and decision-making around the best treatment option (Kevin, 2002). It is a rapid intervention (frequently taking less than ten minutes), and aims to place the client in the best service to meet their needs. For this thesis, triage aimed to place the evidence (contained in each journal article) in the most appropriate category for its content to be analysed. Given the need to have categories of a manageable size while retaining the overall structure of doing, being, becoming and belonging, a system of classification with sub-categories was devised. Triage services use scales and clinical pathways to increase decision-making efficiency and improve client outcomes (Pardey, 2006), and a similar decision-making process had to be developed for this thesis to categorise evidence efficiently and effectively.
First, each article was associated with the dimension which was most evident in its content. Many articles addressed multiple dimensions of occupation, but one was always highlighted or foregrounded. The article was then classified according to its practice category, practice sub-category, type of evidence and finally level of evidence. In the initial stages of this thesis, it became clear that published evidence in mental health OT fell into one of seven broad categories: assessment, intervention, lived experience, program/service, education, professional issues and theory/philosophy. I therefore developed the practice categories to encompass the types of information that is typically presented in professional literature and the settings in which mental health OT is practiced. I then developed sub-categories for all but theoretical articles, to highlight more specific aspects of their content and settings. Table 2.3 provides an overview of the triage categories developed, with the process reading from left to right.

Table 2.3

*Categorisation Process Used to Reduce the Dimensionality of Knowledge in This Thesis*

<table>
<thead>
<tr>
<th>Dimension</th>
<th>Practice Category</th>
<th>Practice Sub-category</th>
<th>Type of Evidence</th>
<th>Level of Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doing</td>
<td>Assessment</td>
<td>Standardised</td>
<td>Quantitative</td>
<td>I</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Non-standardised</td>
<td>Qualitative</td>
<td>II</td>
</tr>
<tr>
<td>Being</td>
<td></td>
<td></td>
<td>Mixed</td>
<td>III</td>
</tr>
<tr>
<td>Becoming</td>
<td></td>
<td></td>
<td>Methods</td>
<td>IV</td>
</tr>
<tr>
<td>Belonging</td>
<td></td>
<td></td>
<td>Other</td>
<td>V</td>
</tr>
<tr>
<td>Intervention</td>
<td>Organic</td>
<td>Drug &amp; Alcohol</td>
<td>Qualitative</td>
<td>I</td>
</tr>
<tr>
<td>Lived Experience</td>
<td>Schizophrenia etc.</td>
<td></td>
<td>Mixed</td>
<td>II</td>
</tr>
<tr>
<td></td>
<td>Mood</td>
<td></td>
<td>Methods</td>
<td>III</td>
</tr>
<tr>
<td></td>
<td>Anxiety</td>
<td></td>
<td>Other</td>
<td>IV</td>
</tr>
<tr>
<td></td>
<td>Physiological</td>
<td></td>
<td>Evidence</td>
<td>V</td>
</tr>
<tr>
<td></td>
<td>Personality/Behaviour</td>
<td></td>
<td>Not applicable</td>
<td>Not applicable</td>
</tr>
<tr>
<td>Program/Service</td>
<td>Adult</td>
<td></td>
<td>Qualitative</td>
<td>I</td>
</tr>
<tr>
<td></td>
<td>Child &amp; Adolescent</td>
<td></td>
<td>Mixed</td>
<td>II</td>
</tr>
<tr>
<td></td>
<td>Forensic</td>
<td></td>
<td>Methods</td>
<td>III</td>
</tr>
<tr>
<td></td>
<td>Older Adults</td>
<td></td>
<td>Other</td>
<td>IV</td>
</tr>
<tr>
<td></td>
<td>Private</td>
<td></td>
<td>Evidence</td>
<td>V</td>
</tr>
<tr>
<td></td>
<td>Vocational</td>
<td></td>
<td>Not applicable</td>
<td>Not applicable</td>
</tr>
<tr>
<td>Education</td>
<td>Undergraduate</td>
<td></td>
<td>Qualitative</td>
<td>I</td>
</tr>
<tr>
<td></td>
<td>Post graduate</td>
<td></td>
<td>Mixed</td>
<td>II</td>
</tr>
<tr>
<td></td>
<td>Continuing professional development</td>
<td></td>
<td>Methods</td>
<td>III</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Other</td>
<td>IV</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Evidence</td>
<td>V</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Not applicable</td>
<td>Not applicable</td>
</tr>
</tbody>
</table>
Triage began with a careful reading of the entire article, using highlighting and notes to emphasise the knowledge contained within. I then determined which of the four dimensions of the OPH was foregrounded in this evidence, and assigned it to that dimension. The evidence was then considered in regard to which practice category it belonged to, and further classified according to the sub-categories in that area.

Finally, all the journal articles was subjected to two further triage steps, classifying it in regard to type and level of evidence. In the first step, evidence was grouped into one of three pre-existing classes of scientific evidence: quantitative, qualitative and mixed; or to a fourth class of other evidence. For evidence that had been classified as “other,” no further triage was required, but those which used a scientific method of inquiry were finally classified according to the level of evidence they presented. Levels of evidence exist to provide an indication of the quality of evidence, and its applicability to clinical practice (Greenhalgh, 2006). No system of standards currently exists that applies to both qualitative and quantitative data, so two different systems were required.

**Qualitative levels of evidence.**

A range of systems for determining levels of evidence were reviewed, but only two were found for qualitative research (Henderson & Rheault, 2004; Kearney, 2001). Of these, the Rosalind Franklin Qualitative Research Appraisal Instrument (RF-QRA) (Henderson & Rheault, 2004) was found to be both more extensive and user-friendly. This instrument evaluates a study’s standards of trustworthiness, measured on a five-point scale through credibility, transferability, dependability and confirmability. Each piece of qualitative evidence was subjected to key questions, and the scale provides example strategies to highlight possible evidence. If evidence exists that supports that element of trustworthiness, the study receives one point for that element. Table 2.4 presents these questions and the process for assessing the trustworthiness of each piece of evidence.
Table 2.4

Process of Appraising of Qualitative Research Using the RF-QRA

<table>
<thead>
<tr>
<th>Trustworthiness</th>
<th>Example Strategies</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Credibility (Internal Validity): can you believe the results?</td>
<td>Prolonged engagement, field journal, subjects judge results as credible, triangulation – multiple data sources, methods or investigators, Established competence of researcher</td>
<td>Yes</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td></td>
<td>No</td>
<td>0</td>
</tr>
<tr>
<td>Transferability (External Validity) – can the results be transferred to other situations?</td>
<td>Detailed description of sample and context, compare sample to larger group, representative sample</td>
<td>Yes</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td></td>
<td>No</td>
<td>0</td>
</tr>
<tr>
<td>Dependability (Reliability) – would the results be similar if the study was repeated?</td>
<td>Detailed description of methods, Two or more researchers independently judge the data, Triangulation– multiple data sources, methods or investigators, Code – recode procedure, Peer examination/external audit</td>
<td>Yes</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td></td>
<td>No</td>
<td>0</td>
</tr>
<tr>
<td>Confirmability – was there an attempt to enhance objectivity by reducing research bias?</td>
<td>Triangulation– multiple data sources, methods or investigators, External audit, Field journal</td>
<td>Yes</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td></td>
<td>No</td>
<td>0</td>
</tr>
</tbody>
</table>

Unlike the quantitative hierarchy of evidence to follow, this method is dependent on whether authors have reported their efforts to increase trustworthiness in their publication. This reporting can vary, and recommendations have been made for its adoption as a standard feature of qualitative research reports (Mortenson & Oliffe, 2009). After this process of assessment was completed, I assigned a level of evidence to the article as per the RF-QRA as shown in Table 2.5 below. These levels of evidence can also be used to extrapolate recommendations for practice, and this hierarchy is also shown in the table. The recommendations made from this process will be discussed in Chapter 5, which focuses on practice ways of knowing.
Table 2.5

**Qualitative Levels of Evidence and Grades of Recommendation for the RF-QRA**

<table>
<thead>
<tr>
<th>Level of Evidence</th>
<th>Description</th>
<th>Level of Recommendation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>Affirmative responses to all 4 aspects of trustworthiness</td>
<td>A</td>
<td>Outcomes supported by at least 1 (and preferably more than 1) Level I study</td>
</tr>
<tr>
<td>II</td>
<td>Affirmative responses to 3 aspects of trustworthiness, relevant problems noted in 1 aspect</td>
<td>B</td>
<td>Outcomes supported by at least 1 Level II study</td>
</tr>
<tr>
<td>III</td>
<td>Affirmative responses to 2 aspects of trustworthiness, relevant problems noted in 2 aspects</td>
<td>C</td>
<td>Outcomes supported by Level III, IV and V studies.</td>
</tr>
<tr>
<td>IV</td>
<td>Affirmative responses to 1 aspect of trustworthiness, relevant problems noted in 3 aspects</td>
<td></td>
<td></td>
</tr>
<tr>
<td>V</td>
<td>Relevant problems in all 4 aspects of trustworthiness</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Quantitative Levels of Evidence**

There were many more options available for assessing the levels of evidence for quantitative research. The levels of evidence defined by the National Health and Medical Research Council (NHMRC) (2000) were adapted for this thesis, due to their prevalence in its country of origin, Australia. There are five levels in the hierarchy, starting at Level V at the bottom and rising to Level I. Recent guidelines from the NHMRC have excluded Level V, given this evidence does not derive from scientific methods. This exclusion of non-scientific methods also occurs in other hierarchies of quantitative evidence, such as the Oxford Centre for Evidence-based Medicine.
guidelines (2009). I reinstated Level V in this thesis because (as previously shown) much of the data collected for this thesis fell into this category and its exclusion would have produced findings which didn’t reflect the evidence base available to mental health occupational therapists. The proportion of Level V quantitative is also relevant to assessing the overall quality of the evidence available to clinicians. Table 2.6 presents the hierarchy applied to this study, and shows how the levels of evidence can be used to determine recommendations for practice.

Table 2.6
Quantitative Levels of Evidence Defined by the National Health and Medical Research Council

<table>
<thead>
<tr>
<th>Level of Evidence</th>
<th>Description</th>
<th>Level of Recommendation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>Systematic reviews and Meta-analysis</td>
<td>A</td>
<td>Body of evidence can be trusted to guide evidence. Several Level I or II studies.</td>
</tr>
<tr>
<td>II</td>
<td>Randomised controlled trials</td>
<td>B</td>
<td>Body of evidence can be trusted to guide evidence in most instances. One or two Level II studies/several Level III studies.</td>
</tr>
<tr>
<td>III</td>
<td>Controlled trials, cohort or case control studies</td>
<td>C</td>
<td>Body of evidence gives some support for recommendations, but care must be taken in application. Level III studies, or Level I and II studies with bias</td>
</tr>
<tr>
<td>IV</td>
<td>Case series, post test only, pre test/post test</td>
<td>D</td>
<td>Body of evidence is weak and recommendations must be applied with caution. Level IV or below, or Level III and above with strong bias.</td>
</tr>
</tbody>
</table>
Further information was also gathered, but not used to organise the data. I collected information about the publication characteristics to inform the research question from a different point of view. This included the main elements of the citation for the evidence (authors, year, article title and journal), and the number of authors recorded. I assigned the affiliation of all the authors on an article to one of three categories: academic only, clinician only, or mixed. Finally, the number of days between submission and acceptance, and between acceptance and publication, were recorded where this data were given.

The analysis and findings from this process of triage will be reported in Chapter 4, but the characteristics of this sample of knowledge were crucial to the process of developing an appropriate method. Each of the ways of knowing used in mental health OT needed to be explored individually and understood comprehensively, before their interactions and relationships could be analysed to answer the original research question.

Ways of Knowing in Mental Health Occupational Therapy

Theoretical ways of knowing.

The formal explanations of concepts and postulates around the relationship between occupation and mental health are intimately linked with the philosophies and values on which OT was established (Kielhofner, 2009). This form of knowledge is constantly evolving, as our understandings of both mental health and occupation develop over time. I recognise that the findings of this inquiry are provisional. I also assert that all that can be identified as OT knowledge is grounded within profession-specific, theoretical, ways of knowing. The link between occupation and health is our defining feature, the thing that identifies knowledge and practice as OT. As such, the use of the OPH as the theoretical framework for this thesis enabled an approach which was authentic to the essential nature of OT knowledge and practice.
This thesis adopts the philosophical stance known as pragmatism. Pragmatism emerged in the United States in the last 19th century from the work of the chemist Charles Sanders Peirce, with fellow Americans William James and John Dewey developing the approach more extensively in the early to mid-20th century (Hickman, 2004). Pragmatism recognises commonality within the human experience, and emphasises the continuity and cohesion this enables. A focus on commonalities was congruent with the overall aim of this thesis to find a unified professional identity for mental health OT. If the basis of our profession is a belief in the universal impact of occupation on human health and experience, pragmatism is congruent to those values. This focus on occupation has re-emerged in recent years, although it is yet to become the unifying ideal or value which some say the profession sorely needs (Molineux, 2011). Theoretical ways of knowing provide an explanation for the relationship between occupation and health which are generalisable across a range of circumstances, methods and populations. Pragmatism also encourages an acceptance of various viewpoints and activities, with the caveat that their use must be appropriate and relevant. While any combination of theoretical approaches would be possible under other philosophies, pragmatists question the capacity between theories to work well and solve problems. It appears at present that mental health OT (and indeed OT in general) is yet to find a theoretical approach or approaches which works well and solves problems in all areas of the profession.

In pragmatism, something is true if it has an objective basis (i.e. there is evidence to support it) and the capacity to solve a problem (Hickman, 2004). Pragmatism also acknowledges there are limits to inquiry “There are areas of experience where knowing has no business” (Hickman, 2004, p. 75) – and asserts that all evidence resulting from an inquiry has equal value, but with qualification: while findings are not privileged in pragmatism, methods are, as they must be appropriate to the questions being asked and the ways of knowing being used. In other words, not all methods are equal; they must be fit for the purpose.

Given this, there are two theoretical assumptions on which this thesis is based. Theoretical, evidentiary and practice ways of knowing (and the methods that support them) have equal value. However, each way of knowing (and method) addresses particular questions and solves specific problems. Collectively they address the relationship between occupation and health, which is common to all human populations.
This philosophical position framed how theories, evidence and practices was considered in this thesis, and informed the method eventually used to complete the inquiry.

**Evidentiary ways of knowing.**

There are a number of definitions for evidence based practice (EBP), the most famous of which was proposed by the originators of the term: “the conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients” (Sackett, Rosenberg, Gray, Haynes, & Richardson, 1996, p. 71). EBP has also been described as seeking and reviewing published research to guide assessments and interventions offered to clients (Lloyd, McKenna, & King, 2004), and services that are supported by a strong scientific base, preferably accumulated through randomised controlled trials (Tsang, Siu, & Lloyd, 2011). Regardless of its definition, there is increasing pressure on clinicians to make EBP a cornerstone of their practice, despite the fact that few organisations offer a formal system of support for clinicians to complete these activities as part of their job description (Caldwell, Whitehead, Fleming & Moes, 2008).

Lloyd, Bassett and King (2004) discuss the merits of applying EBP in mental health settings, and find that clinicians should be making those interventions which have a solid evidence base a priority over traditional practices. However, Mairs (2003) notes there are very few interventions that have attracted a solid quantitative evidence base around effectiveness. She urges clinicians working in mental health to become research-active.

The source of evidence for this thesis is peer-reviewed journals. Professional journals use specific research and genre rules, which can act to suppress the diversity and multiplicity that are key concepts in this thesis. Hayes (1996) provides invited comments about solving common problems that prevent publication. Her stance includes clarity: “It is not the responsibility of the reader to work at teasing out information … It is the writer’s responsibility to make the information easily available to the reader” (p. 24). Readers do have a legitimate role in “teasing out” and “interpreting” information, and while this might be seen as an entreaty for researchers to write clearly, it also implies that consumers of that research are passively waiting to receive the information. A modernist approach to writing remains prevalent, one where the author is an authority whose opinion and work are accepted without question.

For clinicians, peer-reviewed journals are their primary source of research evidence for use in practice. Some feel peer-reviewed journals exist to promote
research (Fricke, 2004), but the idea of promoting knowledge might be more relevant to clinicians (Fossey, 2005). The accessibility of peer-reviewed journals for clinicians, in terms of communicating knowledge, is also crucial to their utility. Not only do clinicians need to know they can utilise the evidence with confidence: they also need to be able to access it in the first place. For therapists in urban Australian centres, access to libraries and universities is relatively easy to arrange; however, rural and remote therapists and those in private practice are at a distinct disadvantage, due to both the distance to libraries and the high costs of pay-per-view journals.

Several studies have found that occupational therapists generally have very positive attitudes towards engaging with evidentiary ways of knowing. However, even if mental health occupational therapists do have access to peer-reviewed evidence, barriers to EBP including lack of time, lack of confidence in understanding statistics, and unclear implications for practice dampen their motivation (Lyons, Brown, Tseng, Casey, & McDonald, 2011). These barriers can leave therapists feeling disconnected and disenfranchised, as EBOT becomes an “added extra” to cope with along with their clinical duties. Lloyd et al. (2004) discuss the merits of attempting to apply EBP in OT mental health settings and stress the importance for clinicians to use evidence based interventions. However, to do this clinicians need easy access to journals, and there needs to be research which is relevant to their clinical situation.

**Practice ways of knowing.**

The practice ways of knowing employed by mental health occupational therapists have been influenced by many external factors. I have provided an overview of the historical development of mental health in Appendix C, but will now discuss the development of the profession itself in relation to the evolution of practice ways of knowledge and the method used in this thesis.

The principles and values underlying OT have been in existence for millennia (Wilcock, 2006). These include achievement of personally meaningful goals, enablement of engagement, and the belief that occupation can influence health both positively and negatively (Hitch, Stagnitti, & Pépin, 2013a). The catalysts for the formalised organisation of the profession were the global conflicts of the 20th century. OT was established as a profession in the United States (US) towards the end of World War I, in response to the needs of returning service men and women. Romanticism and the arts and crafts movement were initially influential (Hocking, 2008), as a return to hand crafts and trades was promoted to ameliorate some of the more destructive social
changes resulting from the industrial revolution. This accorded with the Romantic philosophy which appreciated a “natural” approach and valued the subjective, irrational and personal (Hocking, 2008). The experiences and emotions provoked by the individual’s engagement with the world were valued for their authenticity and relevance to human nature, with a holistic approach adopted to work with this individually constructed engagement.

OT did not emerge as a profession in Australia until the early years of World War II. Like the US, Australian OT practice grew through the treatment and rehabilitation of service men and women. Occupational therapists were working in mental health from the very beginning of the profession’s presence in this country. One of the first qualified therapists to work in Australia, Joyce Keam, began her career in private psychiatric facilities in the 1940s, and there are records of Western Australian occupational therapists working in mental health later in the same decade (do Rozario & Ross, 1991).

Early Australian occupational therapists were taught a wide array of crafts to use as therapeutic media, but were only able to see clients who had received a prescription for their services from a medical practitioner (Anderson & Bell, 1988). This was the beginning of a more general alignment with the medical model, which became particularly prevalent in the middle of the century (Anderson & Bell, 1988). The increasingly reductionist, modernist view of human occupation is reflected in the peer-reviewed literature across those years, as progressively smaller components of performance and less mention of the meaning of the overall occupation become evident (Hocking & Wilcock, 1997). The shift away from focusing on meaningful activity for the person, and towards pathology and cure, was at odds with the historical foundations of OT.

In recent decades there has been a conscious effort to return to holistic practice in mental health, which is more consistent with these earlier forms of the profession. A major factor in this “renaissance of occupation” has been the emergence of occupational science as a discipline (Whiteford et al., 2000; Yerxa, 2000). Occupational science is the formal study of what people do, and first emerged in the US in the late 1980s (Yerxa et al., 1989). It was initially conceptualised as a means to provide robust evidence and technical knowledge in support of OT (Clark et al., 1991), but occupational science has evolved into a separate discipline. It has not been without its critics, notably Mosey (1992), who advocated for a partition between OT and occupational science to prevent
WAYS OF KNOWING

the diversion of funding from one to the other. Another source of resistance has been
the focus of occupational science on moving the profession into new areas of practice
(Clark & Lawlor, 2009), by emphasising the universal nature of occupation.

Pierce (2014) commented on the ways of knowing unique to occupational
science, asserting that it operates across four levels of research into the relationship
between occupation and health. Each of these levels provides stability for those above,
and are designed to convey the multi-level, complex nature of occupation. First,
*descriptive* occupational science research names and explains basic concepts, and
provides occupational science with a firm basis. The second level is *relational*
occupational science research, which focuses on the relevance of other disciplines
concepts to occupation and health, and extends the concepts developed at Level 1. The
third, *predictive* occupational science research relates occupations to broach patterns in
time, development, spaces and sociocultural relationships, beginning the process of
generalising the concepts. Finally, *prescriptive* occupational science research helps
therapists to understand the theory and evidence behind practice, and provides
occupation based assessments which utilise the information gained at the previous three
levels. While this final level of research relates to the three ways of knowing presented
in this thesis (theory, evidence and practice), it presumes there is a unidirectional
influence from occupational science to occupational therapy. This thesis posits this
relationship is bi-directional, and that occupational therapy has the capacity to influence
the direction of occupational science just as equally.

Some may perceive this thesis to be an example of occupational science, due to
its use of a paradigm that formalises thinking and research into occupation and health.
However, I would contest this interpretation. Hocking and Wright-St. Clair (2011)
contend that the term “science” infers the intention to generate new, rigorous
knowledge. While embracing different ways of knowing, occupational science only
acknowledges scientific methods as a means of generating knowledge (Wright-St.
Clair, 2012). This is incompatible with the philosophical basis of this thesis, which
acknowledges and includes all ways of knowing and the methods which support them.

Alongside the return to an occupational focus supported by occupational science,
Australian mental health occupational therapists had to adapt their practice substantially
in the face of deinstitutionalisation. Mental health occupational therapists had to
reorganise, from a system dominated by large hospital-based departments, to
community-based positions which were often sole positions or within multidisciplinary
teams (Adamson, 2011). Many occupational therapists now also work in generic mental health positions, which has led to a re-examination of the profession’s role and identity (Hayes, Bull, Hargreaves, & Shakespeare, 2008; Pettican & Bryant, 2007; Reeves & Mann, 2004). While much of what is published in the peer-reviewed literature remains resistant to generic positions (Ceramidas, 2010), generic positions are common in current community practice in mental health in Australia (Lloyd, McKenna, & King, 2004).

The most recent progression in Australian mental health has been the recognition of occupational therapists as providers under the Medicare system. This change recognised OT for its important role in mental health treatment (OT Australia, 2006), and supported many people to access private OT for the first time. Some were concerned there would be a “brain drain” as experienced occupational therapists were lured from work in the public sector by the potential of greater earnings in private practice (Hitch, 2009a). In response to a proposed scaling back of this scheme, occupational therapists and their clients united in a grass roots movement to prevent the loss of the newly developed services. However, remuneration for occupational therapists remains at half the rate of psychologists, despite practitioners having similar experience and providing interventions demanding similar skill and complexity.

As a profession, OT has at times tended to develop in a passive way, driven by the influence of external factors such as changes in the health system rather than taking focused action on its own behalf (Wilcock, 2006). OT has undergone many changes in its relatively short history, and the growing understanding of the complexity of occupation is reflected in the progressively higher levels of qualification needed to begin practice. There are now entry-level masters degrees in OT in Australia, and some talk of having a doctorate as the basic qualification for practice (Griffiths & Padilla, 2006). The consequences of this could be profound, as students would need to remain at university for longer to gain a basic qualification.

Much of the historical context for Australian mental health OT remains hidden and half-remembered: outside the mainstream of evidence. It is striking how little of the profession’s history is recorded using ways of knowing which are acceptable in EBOT. The historical material on the profession has been contained in published transcripts of keynote lectures, with the only substantial record in Australia (Anderson & Bell, 1988) covering just the first twenty years of the profession’s existence. There remains a need for an updated record of OT history in Australia (Denshire, 2010). A
recent development in this area has been a doctoral study into the presence of OT in the mental health system of Victoria in Australia (Adamson, 2011). A similar study across the remaining states of Australia is needed as health in each state has developed in unique ways. The recording of the profession’s history in mental health highlights the limitations of current conceptualisations of evidence, and alternative ways of knowing come into their own.

OT has already proven to be an extraordinarily flexible, accommodating and resilient profession in the face of ongoing change, albeit reactive rather than proactive. While the overall discipline is OT, the settings within mental health where OT practice occurs range from acute/crisis services, through rehabilitation to community, and across mixed diagnoses and specialist services. Each of these settings demand a particular skill set, drawn from the overarching skills of occupational therapists. Denshire (2010) states that OT has more in common with the humanities than with the medical model, and there continues to be a tension between how occupational therapists espouse their values and how the profession actually practices. OT theory, evidence and practice sit alongside each other uneasily. OT has swung back towards the values that informed its foundation, but has acquired many modernist features along the way due to its alignment with medicine and the accommodations it has made to work within clinical health services.

The Method Used in This Thesis

The method used in this thesis therefore arises from pragmatist philosophy, the drive towards evidence based practice, and a professional history that is wondrously varied and notoriously difficult to pin down. However, the ways of knowing operate at a conceptual level, and an understanding of how they were enacted was needed to begin constructing a way of “doing” the analysis in this thesis. At this point, I decided to begin a process of critical analysis, seeking to gain a rigorous basis for my choice of method. The critical question I chose to pursue was: How have the methods used to support ways of knowing in peer-reviewed journals available to mental health occupational therapists developed over time?

Each way of knowing is supported by a range of methods, depending on the requirements of research question for that study. These methods are used to analyse the knowledge, to produce new understandings that answer questions, solve problems, and explain the impact of occupation on mental health. The methods reported in each of the peer-reviewed articles reviewed in this thesis were recorded. A total of 26 distinct
Methods for generating knowledge were noted in peer-reviewed journal articles relevant to mental health OT since the year 2000. As shown in Table 2.7, these methods can broadly be categorised into non-scientific and scientific methods.

Table 2.7

Methods that Support Ways of Knowing in Mental Health OT

<table>
<thead>
<tr>
<th>Category</th>
<th>Method</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-scientific</td>
<td>Case records</td>
</tr>
<tr>
<td></td>
<td>Reflection</td>
</tr>
<tr>
<td></td>
<td>Role statement</td>
</tr>
<tr>
<td></td>
<td>Guidelines</td>
</tr>
<tr>
<td></td>
<td>Opinion</td>
</tr>
<tr>
<td></td>
<td>Literature review</td>
</tr>
<tr>
<td></td>
<td>Theoretical discussion</td>
</tr>
<tr>
<td></td>
<td>Overview</td>
</tr>
<tr>
<td></td>
<td>Program evaluation</td>
</tr>
<tr>
<td></td>
<td>Critical analysis</td>
</tr>
<tr>
<td></td>
<td>Needs assessment</td>
</tr>
<tr>
<td></td>
<td>Consensus techniques</td>
</tr>
<tr>
<td>Instrument/Psychometric</td>
<td></td>
</tr>
<tr>
<td>Scientific</td>
<td>Descriptive</td>
</tr>
<tr>
<td></td>
<td>Phenomenology</td>
</tr>
<tr>
<td></td>
<td>Control</td>
</tr>
<tr>
<td></td>
<td>Systematic reviews</td>
</tr>
<tr>
<td></td>
<td>Pre-test/Post-test</td>
</tr>
<tr>
<td></td>
<td>Randomised controlled trials</td>
</tr>
<tr>
<td></td>
<td>Quasi-experimental</td>
</tr>
<tr>
<td></td>
<td>Participatory action research</td>
</tr>
<tr>
<td>Ethnography</td>
<td>Case studies</td>
</tr>
<tr>
<td>Grounded theory</td>
<td>Narrative</td>
</tr>
<tr>
<td>Action research</td>
<td></td>
</tr>
</tbody>
</table>

Although not the focus of this thesis, I then completed an overview of each of these methods, to understand their relative strengths and weaknesses and their place in OT. The full account of this overview is provided in Appendix D. To gain an understanding of the historical development of these methods (and the broader context of the thesis), I mapped the first appearance of each in profession-specific peer-reviewed journals, in relation to both general OT practice and specific to mental health OT. As demonstrated in Table 2.8, the appearances of these methods both generally and in relation to mental health are roughly synchronous.

Table 2.8

First Appearance of Methods in OT Literature
### Ways of Knowing

<table>
<thead>
<tr>
<th>Method</th>
<th>OT (circa)</th>
<th>Mental Health OT (circa)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Action research</td>
<td>Mattingly &amp; Gillette, 1991</td>
<td>Townsend, Birch, Langley, &amp; Langille, 2000</td>
</tr>
<tr>
<td>Case studies</td>
<td>Burton &amp; Southam, 1993</td>
<td>Cook, 2003</td>
</tr>
<tr>
<td>Delphi technique</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nominal group technique</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Control</td>
<td>Grygier &amp; Waters, 1958</td>
<td>Grygier &amp; Waters, 1958</td>
</tr>
<tr>
<td>Descriptive</td>
<td>Doniger &amp; Klopfer, 1958</td>
<td>Doniger &amp; Klopfer, 1958</td>
</tr>
<tr>
<td>Descriptive Case Study</td>
<td>Noble, 1933</td>
<td>Noble, 1933</td>
</tr>
<tr>
<td>Ethnography</td>
<td>DePoy &amp; Merrill, 1988</td>
<td>Townsend, 1992</td>
</tr>
<tr>
<td>Grounded theory</td>
<td>Kielhofner &amp; Takata, 1980</td>
<td>Corcoran, 1994</td>
</tr>
<tr>
<td>Guidelines</td>
<td>Fay &amp; Hatch, 1965</td>
<td>Norman, 1976</td>
</tr>
<tr>
<td>Instrument/Psychometric</td>
<td>Tyler &amp; Kogan, 1965</td>
<td>Watts, Brollier, Bauer, &amp; Schmidt, 1988</td>
</tr>
<tr>
<td>Literature review</td>
<td>Gaston, 1948</td>
<td>Watts, 1976</td>
</tr>
<tr>
<td>Opinion</td>
<td>Hayward, 1947</td>
<td>Deissler, 1956</td>
</tr>
<tr>
<td>Overview</td>
<td>Heyman, 1923</td>
<td>Chapman, 1924</td>
</tr>
<tr>
<td>Phenomenology</td>
<td>Vergeer &amp; MacRae, 1993</td>
<td>Heubner &amp; Tryssenaar, 1996</td>
</tr>
<tr>
<td>Pre-test Post-test</td>
<td>Rogers &amp; Hill, 1980</td>
<td>Brown &amp; Carmichael, 1992</td>
</tr>
<tr>
<td>Quasi-experimental</td>
<td>Hamilton-Dodd, Kawamoto, Clark, Burke, &amp; Fanchiang, 1989</td>
<td>Maynard, 1990</td>
</tr>
<tr>
<td>Randomised controlled trials</td>
<td>Jongbloed, Stacey, &amp; Brighton, 1989</td>
<td>Kashner et al., 2002</td>
</tr>
<tr>
<td>Reflection</td>
<td>Steiner, 1972</td>
<td>Steiner, 1972</td>
</tr>
<tr>
<td>Role statement</td>
<td>Taylor, 1945</td>
<td>Noyes, 1955</td>
</tr>
<tr>
<td>Systematic reviews</td>
<td>Fisher, Wietlisbach, &amp; Wilbarger, 1988</td>
<td>Tullis &amp; Nicol, 1999</td>
</tr>
<tr>
<td>Theoretical discussion</td>
<td>Azima &amp; Azima, 1959</td>
<td>Azima &amp; Azima, 1959</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

After completing this mapping exercise, five distinct periods in the development of methods which support ways of knowing in mental health OT emerged. As shown in Figure 2.1, each new period built on the knowledge generated in the past, although none of the methods was superseded. All remain available to current therapists.
Original ways of knowing.  
As described in an epistemological history of OT by Hooper (2006), the methods employed by OT for knowledge building in its initial years emphasised empirical knowledge, taken directly from the experiences of clients and their therapists. These original ways of knowing are accessible to all occupational therapists and do not necessarily require further training in research or scientific methodologies.
**First period of quantitative methods.**

Around the middle of the 20th century, when OT began to align more closely with the medical model, quantitative methods of knowledge generation began to appear in the professional literature. Quantitative research views reality from the positivist or realist paradigm, considering it absolute, measurable and objective (Ballinger, 2004; Eva & Paley, 2004). The hypothesis originates from existing theory and is either accepted or rejected (Losee, 1993). Numerical data is gathered via methods like surveys, direct observation, experiments, statistics and structured observations (Silverman, 2000). A range of statistical measures are applied to numerical data, which follow mathematical laws and aim for precision and reliability (Inu, 1996). To produce replicable results with minimal bias that can inform predictions, quantitative data is also expected to be valid and generalisable (Ballinger, 2004). Quantitative researchers use deductive reasoning to generalise the results from their sample to a larger population by focusing on average or group effects (Polgar & Thomas, 2000). These general principles can then be re-applied to individual cases, although their emphasis on statistically significant findings may overlook individually or socially significant results (Rudestam & Newton, 2001).

Mental health OT often operates within an often bio-medically focused sector of health care, which some would say is increasingly medicalised (Spence, 2012). It is therefore not surprising that these methods have found a place supporting ways of knowing about mental health OT. However, their introduction marked a distinct turning point, not only in regard to the adoption of scientific methods but also in the underlying philosophy of knowledge generation. Direct individual experience with all its complexity and contextual factors was replaced by controlled environments and the extrapolation of findings to entire populations. This shift to quantitative methods coincided with the development of OT as an academic discipline, and an increased presence of therapists in academic roles within the professional literature. Quantitative methods were established in OT by the end of this first period of development for quantitative methods, but were yet to be applied in their more rigorous forms.

**Qualitative method development.**

From the mid 1980s onwards (Sharrott, 1985), calls were made for alternative research approaches which would be more congruent with the re-emerging focus on occupation and the person. The introduction of qualitative methods in the 1990s was part of that shift as its methods share some values with the profession, such as client-
centeredness and resistance to reductionism (Eva & Paley, 2004; Hammell, 2002). Qualitative research assumes there are multiple and individually unique realities which reflects the naturalist or constructionist paradigm (Cresswell, 1998). A phenomenon is different from the sum of its parts, and this holistic stance is in contrast to the reductionist approach of quantitative methods (Rudestam & Newton, 2001). In the context of a dominant positivistic paradigm in health, qualitative researchers have been dismissed as “soft scientists” or “journalists” (Silverman, 2000), and qualitative approaches have been criticised for “always responding to the loudest bangs and the brightest lights” (Savin-Baden & Fisher, 2002, p. 191). These criticisms have not diminished the popularity of the approaches in allied health however, to the extent that concerns have emerged about the potential for over reliance on qualitative methods (Johnson & Waterfield, 2004).

Qualitative research tends to address knowledge at an early stage of development, when theory is in the initial stages of development or influencing variables are poorly defined. Rather than offering a fixed hypothesis, qualitative researchers propose questions that can change over time (Rudestam & Newton, 2001). Qualitative research data can take the form of both words and images (Silverman, 2000) and may produce richer and more layered knowledge (Cresswell, 1998). Qualitative researchers are themselves tools for data collection, greatly reducing the distance between researcher and researched (Conneeley, 2002). However, this brings the risk of the researcher abandoning objectivity by closely identifying with the subjects (Johnson & Waterfield, 2004).

Qualitative methods support active interpretation prior to formal analysis as a means of refining the research question and sharing knowledge, which goes some way to redressing power imbalances between the researcher and researched (Creswell, 1998; Hammell, 2002). This results in some blurring between data collection and analysis, which Crombie and Davies (1996) argue may influence the phenomena being observed. The quality of naturalistic data therefore relies heavily on the researcher’s reflective abilities, introducing the risk of negative reflexivity (McQueen & Knussen, 2002): for example, intercultural issues may challenge qualitative researchers, which then create difficulties in data collection (Butler & Smith, 2002).

Qualitative research occurs in natural settings wherever behaviour occurs without strict controls (Rudestam & Newton, 2001). The methods used to analyse qualitative data are not easily defined, and are characterised by Dickie (2003, p. 50) as
“inherently messy.” Themes are sought from recorded interactions and processes, with a balance sought between oversimplification and excessive detail while considering concepts like trustworthiness, transparency and truth during evaluation (Ballinger, 2004; Conneeley, 2002; Inu, 1996). Challenges to these concepts include the honesty of participant response, the fallibility of researcher interpretation, and difficulties in establishing rigour and validity (Johnson & Waterfield, 2004; Savin-Baden & Fisher, 2002). Mitigation of these problems can be achieved through data handling procedures, and a particular strength of subjective analysis is improved ecological validity derived from its close reflection of “real world” (Lloyd et al., 2004).

Qualitative methods gained rapid acceptance as a way of generating knowledge in mental health OT, and were adopted with little criticism or resistance in the 1990s and 2000s. However, evidence is now emerging that the non-critical embracing of these methods may have led to only superficial adoption. Borell et al. (2012) find the majority of qualitative studies recently published in OT provide only descriptive findings, with little more than 11% providing a coherent, rich understanding of their topic. Further developments in qualitative methodology are also making greater demands on occupational therapists using these techniques. Frank and Polkinghorne (2010) have made seven recommendations for the use of qualitative research in OT, urging the adoption of linguistic approaches, development of more observational data collection, and a reconnection between theories and methods. They observe that all qualitative methods are continuing to develop, and include various sub-approaches which need to be acknowledged. Many of the qualitative studies examined for this thesis did not specify an approach or theoretical underpinning, leading to the observation that “qualitative methods should be recognized as dynamic and emergent phenomena within research traditions and that alterations to methods should come from a knowledgeable and disciplined stance” (Frank & Polkinghorne, 2010, p. 56).

**Second period of quantitative methods.**

Towards the turn of the century, a second period of quantitative development brought the two most scientifically robust quantitative techniques into use: systematic reviews and randomised controlled trials. Systematic reviews were adopted early in mental health OT, but randomised controlled trials were not used for over a decade after they were first seen in general OT practice. The discrepancy in time scale between these two methods clearly shows that systematic reviews in mental health OT are
generally based on evidence originating outside the profession, as there are few that have been completed by occupational therapists.

Given the shift towards occupation- and client-centred practice, the introduction of randomised controlled trials has been something of a contentious issue in OT. While the rhetoric around evidence based practice cites randomised controlled trials as the “gold standard” in intervention evaluation, it is not always possible or appropriate to apply them in OT settings because of the complexity of the interventions and nature of service (Tse, Blackwood, & Penman, 2000). Indeed, Hyde (2004) refers to this perception as being akin to “fool’s gold,” as the real gold standard is how well the chosen techniques address the research question. Some have expressed anxiety about the implications of the lack of randomised controlled trials in OT, but as pointed out by Rappolt (2003), many other health professions also lack this kind of evidence base.

Despite these reservations, there are also positive attitudes towards the use of this technique in OT. An extensive review has been published examining the design and reporting of randomised controlled trials from an OT perspective (Deane, 2006), and the OTSeeker database has been developed to provide easier access to these types of studies (Tooth et al., 2005). Clinician participants in randomised controlled trials have also been found to transfer their new knowledge to practice as a result of participation (Finlayson, Shevil, Mathiowetz, & Matuska, 2005). The perceived importance of randomised controlled trials to OT was highlighted by a letter from a range of eminent academics (Lannin et al., 2009), expressing concern about the lack of studies using this technique being accepted for presentation at professional conferences.

**Mixed methods.**

The latest development in methods to generate knowledge and support ways of knowing in mental health OT has been the introduction of mixed methods. Despite their different philosophies, there are clearly areas of overlap between quantitative and qualitative research. Subjectivity can be found within hypothesis-driven projects, as the researcher must make subjective judgments about which variables to observe (Hyde, 2004). Both quantitative and qualitative data have a repertoire of tools for analysis, not mutually exclusive (Johnson & Waterfield, 2004): for example, numerical analysis is used in qualitative research to develop themes and verify the frequency of experiences. Such melding of practices enables some interdependency between the approaches, allowing them to combine in certain circumstances.
Mixed method research techniques are becoming increasingly prevalent and are now relatively common in OT research (Mortenson & Oliffe, 2009). Each approach is instrumental at different points in the process of acquiring knowledge. Formats for combination include sequential, parallel/simultaneous, equivalent status or more/less dominant studies (Rudestam & Newton, 2001). Potential benefits from a mixed methods technique include compensation for the relative weaknesses of quantitative and qualitative techniques, increased validity, and providing clients with choice in how they contribute to research projects (Finlay, 1997). The fundamental differences in underlying beliefs remain, such as the contrast between absolute and objective approaches versus holistic and relative perspectives, and any combination of quantitative and qualitative research must be aware of these to prevent inconsistency. Mixed method techniques present some challenges, including particular demands on sole researchers, given the necessity for familiarity and confidence in using a range of analytic techniques (Johnson & Onwuegbuzie, 2004). Its complexity makes this method time consuming, and can be resource-intensive depending on the individual techniques chosen. Mixed methods research is relatively new, and there is no consensus about the ways in which quantitative and qualitative techniques combine.

This mapping exercise and related analysis revealed that methods used to support ways of knowing in peer-reviewed journals available to mental health occupational therapists developed in five distinct periods over the past century. These periods were influenced by the historical events and trends which were affecting OT at the time (including general developments in research methods across disciplines), and there has been a general trend towards more sophisticated and resource intense methods. To determine how these methods directly supported the three ways of knowing, I completed a second mapping exercise, illustrated in Table 2.9. Examples of articles addressing each way of knowing were located, and the methods used within them recorded. I have provided further examples of articles that illustrate how each method supports different ways of knowing in the overview within Appendix D.

Table 2.9

<table>
<thead>
<tr>
<th>Methods</th>
<th>Theory</th>
<th>Evidence</th>
<th>Practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>Case records</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>Role statement</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
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<tr>
<td>------------------</td>
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<td>---</td>
</tr>
<tr>
<td>Opinion</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Theoretical discussion</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Program evaluation</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Needs assessment</td>
<td>✓</td>
<td></td>
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<tr>
<td>Instrument/Psychometric</td>
<td></td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>Reflection</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Guidelines</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Literature review</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Overview</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Critical analysis</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Consensus techniques</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
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<tr>
<td>Descriptive</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Control</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Pre-test Post-test</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Quasi-experimental</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Ethnography</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Grounded theory</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Phenomenology</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Narrative</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Systematic reviews</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Randomised controlled trials</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Participatory action research</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Action research</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Case studies</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
</tbody>
</table>

This second mapping exercise revealed that the methods that developed were capable of supporting more than one way of knowing, although not all methods supported all ways of knowing. I now knew that mental health OT was supported by 26 different methods of inquiry, some of which supported theoretical ways of knowing, some of which supported evidentiary ways of knowing and all of which supported practice ways of knowing. I had begun to understand the relationship between the ways of knowing and the methods which are used to develop them.

However, I needed to conduct further investigations into the integration and incorporation of evidence into mental health OT, to fully answer this thesis’ research question. Clinicians seeking a comprehensive and multidimensional understanding of their area of practice would consult all of the available evidence, potentially encompassing a range of methods and ways of knowing. For example, the overall
sample of this thesis contained 32 articles published in peer-reviewed journals since the year 2000, which used a range of methods and were directly relevant to forensic settings. Forensic mental health occupational therapists would need to integrate one case study, five descriptive studies, one case report, one set of guidelines, one phenomenological study, three literature reviews, four studies combining mixed methods, one opinion piece, seven practice descriptions, three pre-test post-test studies, one consensus study and four qualitative studies of unspecified theoretical background. They would in the first instance need to have the means to get access to the full versions of all of these articles. These clinicians would then need to be familiar with ways of analysing and understanding all of these different forms of evidence, and have a means to synthesise their findings in a robust yet meaningful way. Therefore, the next critical question I posed was:

**How do methods and ways of knowing support the integration and incorporation of bodies of evidence?**

The majority of methods that support the ways of knowing in mental health OT are specialised, targeted processes that mostly apply only to single studies. The past decade has seen an acceleration in knowledge published about mental health OT, in both peer-reviewed journals and other formats. In peer-reviewed journals alone, more than one hundred articles are published each year about mental health OT. The importance of methods that can integrate and synthesise ever-increasing amounts of information are recognised and acknowledged in the broader community and culture. As Wilson said,

> We are drowning in information, while starving for wisdom. The world henceforth will be run by synthesizers, people able to put together the right information at the right time, think critically about it, and make important choices wisely. (1998, p. 294)

The methods currently available to assist clinicians integrate evidence are critical analysis, literature review and systematic reviews (including meta-analyses and meta-syntheses), whereas the other methods review are designed to complete discrete, individual studies. To answer my critical question, I needed to consider the strengths and shortcomings of each, and decide which (if any) would be suitable to answer the research question for this thesis.
Critical analysis.

As stated in Chapter 1, critical analysis is the comprehensive exploration of a topic, through the practice of asking and answering a series of critical questions. It differs from overviews in the depth of its analysis, and the author can also choose to take a particular stance (for example, a feminist critique, a postmodern critique). This method provides a detailed understanding of topics, deepening on how deeply the author investigates them. Critical analysis is used across a range of setting and discipline areas, and belongs to the humanities tradition of inquiry.

Critical analysis is a particularly flexible method, but it remains dependent on the quality and relevance of the questions asked by the inquirer. Readers may therefore not be aware of potential biases. Important questions may be omitted or not completely answered. Those seeking to use scientific evidence must also critically appraise the quality of each study, to understand whether it is rigorous enough to inspire confidence in its findings and encourage its application to practice. Those seeking to use non-scientific evidence must also critically analyse the strength of the argument presented, and decide whether the opinion or interpretation is relevant and useful to clinicians’ needs. There are several layers within critical analysis where more specific, targeted methods could enhance the overall analysis and understanding of the topic. I also questioned what would occur if the evidence base included critical analyses. Applying critical analysis to a critical analysis runs the risk of circular reasoning and self-referential findings.

Literature review.

Literature reviews aim to identify themes and draw conclusions from a body of evidence, by synthesising and analysing existing research (Steward, 2004). Their purpose is to share the results of closely related studies, identifying broad themes and possible areas of conflicting evidence (Cresswell, 2006). In scientific research they are conducted as precursors to experimental studies to define the context of the finding, and also aim to situate the study in the existing evidence base. This method has several features that make it an effective and powerful way of integrating knowledge as a primary method. The advantages of conducting this form of research relate to the wealth of data available. The conclusions that can be drawn from literature reviews have a much broader scope than those from single studies, and are potentially more robust if similar conclusions arise from studies using a variety of methodologies (Baumeister & Leary, 1997). The author also provides a service to others in the
profession, by combining and presenting knowledge they would not have time to source and read themselves. Narrative allows for the linking of information in a format that is easy to follow and digest for readers (Baumeister & Leary, 1997).

**Systematic reviews.**

Systematic reviews offer an overview of primary studies, completed to an explicit and reproducible method (Greenhalgh, 2006). Systematic reviews focus on interventions and their outcomes for particular populations, including both experimental and observational studies. There are many advantages to this approach including the limiting of bias, greater reliability and the integration of large amounts of information. Systematic reviews are potentially more applicable to practice because they review a range of studies, and can draw from research conducted around the world. Like literature reviews, systematic reviews have the advantage of making a body of evidence easily accessible to clinicians, saving them time and effort. These advantages have led to this method being recognised as the strongest form of evidence available on scientific hierarchies.

However, in OT the use of this method severely reduces the body of evidence considered, due to the paucity of randomised controlled trials and systematic reviews that originate within the profession. The process of systematic review is also very complex, and in practice too time consuming for clinicians (Massy-Westropp & Masters, 2003). The necessity of regularly updating these reviews is a compounding factor. While there are several standards or guidelines available explaining how to conduct systematic reviews (e.g. PRISMA, SPIDER), none is universally accepted so there remains variability in how this method is applied.

In the past decade there have been increasing calls for more systematic reviews to be published in OT. Massy-Westropp and Masters (2003) highlighted the challenges of using this method in an OT department. They found that clinicians have difficulty understanding both the reviewed research and the process, and that a project officer needed to be appointed for successful completion of a review. The limitations of systematic reviews in addressing complex interventions (such as case management, social inclusion initiatives and family therapy) has also been raised in discussions on their suitability for the profession (Murphy, Robinson & Lin, 2009; Shepherd, 2009).

The recent literature on systematic reviews in OT has focused on how they are completed (Bannigan & Spring, 2012; Murphy et al., 2009; Palisano, 2008), including tools to support this process (Classen et al., 2008). The American Association of OT
WAYS OF KNOWING

has published a series of methodologies for systematic reviews as part of its evidence
based practice project (Arbesman & Lieberman, 2010, 2011, 2012; Arbesman,
Lieberman, & Berlanstein, 2013; Arbesman, Lieberman, & Thomas, 2011). Murphy et
al. (2009) have suggested including non-randomised studies as a means of overcoming
the paucity of randomised studies in OT. However, other sources retain the traditional
standard of randomised controlled trials only, which necessarily require the majority of
data to come from outside the profession. The variability of understanding about
systematic reviews in OT is highlighted by a discrepancy between this thesis, which has
identified twenty systematic reviews in mental health OT, and Bannigan and Spring
(2012), who identified only four. This discrepancy appears to be a function of both the
broader definition of acceptable evidence and wider search strategy used in this thesis.
During the process of selecting a method for this thesis, I wanted to trial each of the
methods to test their suitability. I had already completed literature reviews in both the
preliminary stages of this thesis and other work, and knew it would not be appropriate
for the completion of a doctoral level study. I applied two of the previously described
methods to studies, to fully understand their strengths and shortcomings – metasynthesis
and systematic review. There were insufficient randomised controlled trials to complete
a meta-analysis, but I found a body of evidence concerning participation in activities of
daily living for people experiencing schizophrenia that was suitable for meta-synthesis.
The study was published as part of a special issue of the British Journal of
Occupational Therapy on participation in occupations across the lifespan, and is
included here. Meta-synthesis has much to offer OT, particularly in generating
knowledge around the lived experience of our clients and ourselves. By synthesising
several qualitative studies, this method can overcome the limitations imposed by small
samples. However, it is a method which can only be applied to a single method –
qualitative scientific studies.

Hitch, D., Stagnitti, K. & Pépin, G. (2013). Engagement in activities and
occupations by people who have experienced psychosis: A meta-synthesis of lived
experience. British Journal of Occupational Therapy, 76(2), 77-86.
While it was impossible to conduct a systematic review that only included randomised controlled trials, I was able to complete a systematic review on the burgeoning evidence available about OT and attention deficit hyperactivity disorder by including non-randomised evidence. Its submission to a non-OT journal (Internet Journal of Allied Health Sciences and Practice) precluded the use of a discipline-specific paradigm or model as an organising structure, so I grouped the findings into practice areas to increase accessibility. For this topic, there were a good number of articles that met the inclusion criteria, providing a solid base of evidence for clinicians.


The Need for a New Method for Integrating and Incorporating Bodies of Evidence

In critiquing the existing methods for integrating and incorporating bodies of evidence, I found each had limitations that I thought made it unsuitable to answer the research question fully. Critical analysis is a particularly flexible method, but remains dependent on the quality and relevance of the questions asked by the inquirer. These questions also may or may not be relevant to practice, depending on the perspective of the inquirer. It also requires modification with additional layers of analysis to deal with different forms of evidence. Literature review shares many features with critical analyses, but without the depth of analysis I required. A literature review would have bought together the evidence base for clinicians and increased its accessibility, but it was unlikely to have generated the substantial and original contribution to knowledge required of PhD studies. The outcome will have provided an overview of the evidence available, but would not in and of itself have answered the original research question around how it is integrated with theory for practice. Finally, systematic reviews (including meta-analysis and meta-synthesis) are limited to scientific methods. Given that a large number of non-scientific methods are available and relevant to mental health occupational therapists, and that this thesis is based on principles of diversity and multiplicity, the use of this method to answer the research question necessitated the inappropriate exclusion of a large proportion of the professions knowledge.

Critical analysis was therefore the most suitable candidate from existing methods, but did not fully meet the requirements for addressing the research question. It was applicable to all three ways of knowing and could be inclusive of all forms of evidence, but was only capable of analysing the diversity of the evidence base at a general level and did not include the specialised, targeted features that would engage fully with the multiple traditions, forms and features of the evidence. I needed to use multiple methods to integrate and incorporate such a diverse evidence base, and these had to be structured in such a way that the resulting critical analysis would be rigorous, trustworthy, coherent and accessible. I therefore asked: How can the three ways of knowing in peer-reviewed journals available to mental health occupational therapists (and the methods that support them) be integrated into an evidence base that respects and sustains inclusivity and multiplicity?

Having ascertained that critical analysis by itself was not sufficient to answer the research question, I began to develop a new method. While I wanted to keep the aspect
of constant questioning, I also needed to build in specialised, targeted features that would engage fully with the multiple traditions, forms and features of the evidence. Given that mixed methods have emerged most recently to deal with the increasingly complex knowledge available in OT, I began the process of developing a new method by exploring how mixed methods combine qualitative and quantitative evidence. Mixed methods exclude non-scientific evidence, but provided a starting point for considering how to synthesise findings from different traditions and approaches. There are several proposed models for understanding combinations within mixed methods studies. Cresswell (2006), for example, proposes a model that focuses on the relative prominence and temporal placement of each form of evidence. However, the Mixed Methods Research Process Model (Johnson & Onwuegbuzie, 2004) describes a process of designing and conducting mixed methods studies which also has the flexibility to accommodate multiple approaches. The model includes eight steps, as displayed in Table 3.1, and I used these steps as the basis for designing my new method.

**Table 2.10**

*Mixed Methods Research Process Model*

<table>
<thead>
<tr>
<th>Stage</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Determine the research question</td>
</tr>
<tr>
<td>2</td>
<td>Determine whether a mixed design is appropriate</td>
</tr>
<tr>
<td>3</td>
<td>Select the mixed method or mixed model research design</td>
</tr>
<tr>
<td>4</td>
<td>Collect the data</td>
</tr>
<tr>
<td>5</td>
<td>Analyse the data</td>
</tr>
<tr>
<td>6</td>
<td>Interpret the data</td>
</tr>
<tr>
<td>7</td>
<td>Legitimate the data</td>
</tr>
<tr>
<td>8</td>
<td>Draw conclusions</td>
</tr>
</tbody>
</table>

**Stage One – What do I want to investigate?**

The Mixed Methods Research Process Model (Johnson & Onwuegbuzie, 2004) assumes a linear approach to inquiry, where you begin with a research question and end by drawing conclusions to answer it. This is consistent with the scientific methods it addresses, but the multidimensionality and ongoing development of theory, evidence and practice in mental health OT demands an iterative approach. A linear approach
would also make an answer to the original research question in this thesis obsolete very quickly, as new research and understandings are coming to light all the time. Clinicians wishing to remain at the cutting edge of evidence based practice need to engage with the ways of knowing in a continuous manner, revisiting and refining their practices in light of new understandings and developments. Therefore, the first developmental step in my method was to bend the straight line of the Mixed Methods Research Process Model into a circular process, where the conclusion of each iteration leads directly to the formulation of a new research question. The process can therefore continue as new understandings are gained, but clinicians can also opt to step away from the process for a time when they feel they know enough to inform their current practice. Step one is therefore a nominal beginning point for my method, as it is really just the beginning of a new round of inquiry.

Figure 2.2 First modification of the Mixed Methods Research Process Model.

As stated in Chapter 1, the research question guiding this thesis was, How do different ways of knowing integrate and incorporate with theory, evidence and practice to guide evidence based practice for occupational therapists in mental health? An
outcome of this first step of the new method is therefore a critical question that reflects therapists’ practice dilemmas. This question should be focused and concise to guide the synthesis of relevant information. There are a number of existing approaches for writing critical questions, with the most well known in the health field being the PICO approach (Carter, Lubinsky, & Domholdt, 2010; Lou & Durando, 2008), which refers to the identification of patient/population/problem, intervention, comparison and outcome. Depending on its focus, it is not necessary for all four aspects to be included in the question, and comparison can be omitted if there is only one intervention. Therefore, the PICO approach is just one possible way to formulate the critical question.

Stage Two – Which theory or conceptual practice model will guide my investigation?

A limitation of the Mixed Methods Research Process Model in regard to the needs of mental health occupational therapists is its focus on evidentiary ways of knowing. Theoretical and practical ways of knowing are not represented in its stages. Information related to those ways of knowing need to be included to reflect their importance and relevance to meeting the needs of clinicians. I added a step after the formulation of the research question, asking clinicians to choose a theoretical framework to frame their subsequent review of evidence. While it is possible to conduct the ITEA process without a theoretical framework, embedding one into the process increases the potential generalisability of the findings, can reflect the specific approach of a workplace and highlight the links between concepts and practice. In the case of this thesis, embedding the OPH into the process has enabled the line of enquiry to remain focused on the relationship between occupation and health. This new step is shown in Figure 2.3 below.
By placing this decision prior to data collection, theoretical ways of knowing were embedded into the review from the beginning, ensuring their presence and influence on the outcomes for clinical practice. This took the place of deciding whether mixed methods was an appropriate approach, as I had already established the limitations of mixed methods in understanding all the available ways of knowing or the methods which supported them. In this step, the clinician chooses a theoretical framework for organising evidence that may be either OT-specific or drawn from other fields and disciplines.

As stated in Chapter 1, the four dimensions of occupation – doing, being, becoming and belonging – were chosen as the features of the Occupational Perspective of Health that would provide structure to the analysis. The OPH more truly fits the characteristics of a paradigm at this point in its development, because it presents broad assumptions and perspectives and is more concerned with the relationship between occupation and health than the day-to-day work of OT (Kielhofner, 2009). However, it also remains a suitable choice for a theoretical framework, demonstrating that theories chosen as part of this new method may be at any stage of development or complexity.
Its broader focus had the capacity to include and manage the diversity inherent in this evidence base, anchoring everything in the core concepts of the profession.

By focusing on health and illness at a community and population level, Wilcock’s paradigm challenges traditional definitions of the profession as focusing on the engagement and independence of the individual in occupation (Hopkins & Smith, 1993; World Federation of Occupational Therapists, 2012). While all OT theories include knowledge from other disciplines to some extent, the OPH is unique in its public (or population) health perspective. Wilcock explicitly acknowledges the influence of the World Health Organisation to her thinking, and in particular their documentation regarding health promotion, social determinants of illness, diet, physical activity and active aging.

While it is a paradigm, some have noted that the central concepts of the OPH are directly applicable to individual health concerns and programs. Wilcock (2006) states that many readers of the first edition of her paradigm were able to identify the relevance for themselves, demonstrating that it is a theoretical structure which has continued to develop since its inception in the late 1990s. Occupation is placed at the centre of the OPH, and the fundamental underlying assumption is that occupation is essential to healthy living and wellness (Wilcock, 2007).

While doing, being, becoming and belonging have great intuitive appeal to occupational therapists, there has been no consensus on their definition to date. Some provisional definitions were required at this early stage if the OPH was to function properly as an organising structure. After a preliminary literature review, the following descriptions are amalgamated from several already proposed in the literature (Hammell, 2004; Hitch, 2009; Lyons, Orozovic, Davis, & Newman, 2002; Rebeiro, Day, Semeniuk, O’Brien, & Wilson, 2001), and used in the early stages of this study.
Table 2.11

Provisional Definitions of Doing, Being, Becoming and Belonging

<table>
<thead>
<tr>
<th>Dimension</th>
<th>Provisional definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doing</td>
<td>The active and visible performance of purposeful activity, which is necessary for health and survival.</td>
</tr>
<tr>
<td>Being</td>
<td>The personal, introspective and reflective process of ascribing meaning, motivation and purpose to occupations.</td>
</tr>
<tr>
<td>Becoming</td>
<td>The process of development and growth which leads to the individuals goals for their future selves and lives</td>
</tr>
<tr>
<td>Belonging</td>
<td>The social context of occupation, including connotations and conventions around health/illness</td>
</tr>
</tbody>
</table>

Stage Three – Which ways of knowing will be accepted?

As highlighted earlier in this chapter, theoretical, evidentiary and practical ways of knowing are supported by a range of methods, and each method may support some or all of the ways of knowing. While the next step of the Mixed Methods Research Process Model involves the selection of a method or design, clinicians first need to select which way/s of knowing best address their critical question in relation to practice. By selecting ways of knowing, they will be able to consult evidence generated through the methods that support it. The initial question and theoretical framework chosen determines the way of knowing that needs to be employed, which in turn determines the possible methods used. For example, the question, “How effective is cognitive behavioural therapy in increasing participation in activities of daily living for people with depression?” would be most directly answered through an evidentiary way of knowing, using quantitative methods. Within this process (and the broader pragmatic philosophical context of this thesis), the methods are servants of the question and theoretical framework. This is in contrast with many current discussions on EBOT, which focus on the relative merits of methods without acknowledgement of their context and purpose.

Having decided which ways of knowing will be accepted, the clinician then identifies evidence that addresses the research question and have been developed using methods that support that way of knowing. There are many potential outcomes of this step, depending on how many ways of knowing the clinician wishes to pursue and how they choose to identify relevant evidence. For example: forensic occupational therapists
may choose to only include qualitative studies (limiting their evidence base to 5 articles) for a question regarding the lived experience of consumers in that setting. As shown in Figure 2.5, this process of identification replaces the third and fourth step of the Mixed Methods Research Process Model.

![Figure 2.4 Third modification of the Mixed Methods Research Process Model.](image)

Given the breadth of the research question in this thesis, all three ways of knowing – theoretical, evidentiary and practical – and all their supporting methods were included for analysis. In practice, this process would more often focus on a particular issue, treatment or area of expertise. The method is able to accommodate inquiries on both large and small scales.

**Stage Four – How will I organise my evidence?**

At this point, the Mixed Methods Research Process Model begins to analyse the data found. Data reduction is undertaken to reduce the dimensionality of the data into more manageable units of information. For this thesis, there needed to be a further step of organising the evidence in this method to embed it within the selected theoretical framework. Without a step formally linking the evidence with the concepts in the theoretical framework, theoretical ways of knowing will not become properly embedded in the process and run the risk of being included tokenistically at a later stage. I have named this step “deconstruction,” but this term is not used in its postmodern sense of
overturning or displacing a conceptual hierarchy (Stocker, 2006). In this method, deconstruction refers to undoing and unlocking its present construction (as an article in a peer-reviewed journal) to unpack the knowledge that it contains. Figure 2.6 shows how this modification was added to the process.

Deconstruction concludes with data display, which the Mixed Methods Research Process Model defines as the display of the data collected in a summarised pictorial form. In this thesis I used a tabular format to enable the key points to be re-visited in a readily accessible and efficient manner, which will be known hereafter as “the database.”

**Stage Five – How does this evidence relate to my chosen theoretical framework?**

The Mixed Methods Research Process Model and this method cross paths again at this point, as they both analyse and interpret the data. The Mixed Methods Research Process Model calls this stage data interpretation, but it is called analysis in this method, as interpretation (particularly in regard to practice ways of knowing) will occur at a later stage. Figure 2.7 shows how I made this addition to the process.
To analyse the data collected, I correlated, consolidated and compared the data which was organised and displayed in the previous step. Correlation involved the identification of instances where a particular aspect of the OPH was supported by a range of types of evidence. Where evidence exists acquired through a range of methods, there is the possibility of triangulation when the same findings are found using multiple methods. Consolidation then occurred, where these instances was bought together and considered a discrete evidence base. The analysis concluded with comparison, where instances of correlated and consolidated evidence in support of a particular aspect of the OPH were compared to each other to highlighted incidences of consonance and dissonance. As a result, the coherence and character of the evidence around doing, being, becoming and belonging were analysed. For example: the evidence around doing for being for people with psychosis included articles which were in broad agreeance and those which were contradictory or contention. If there is only one form of research in a particular category, the process included only consolidation and comparison of the respective results. In the example just given, all of the identified evidence used phenomenological methods, so there was no need to correlate the findings with those
acquired using other methods. I will provide further description of this process in practice in the publication that concludes this chapter.

The data concerning publication was quantitative (i.e. number of authors, days to publication), and was analysed using descriptive and simple inductive methods (i.e. frequency counts, averages and correlation analysis). The Mixed Methods Research Process Model includes a phase called data transformation, where one form of data (i.e. qualitative statements) converts into another (i.e. frequency counts). This was not included in the method for this thesis, because of its overall commitment to diversity and acceptance of all ways of knowing. Each source of data is valued in its own right, and transformation carries the risk of losing its essential content. For example; converting qualitative responses into quantitative data omits much of the contextual information which makes qualitative data so rich and easily accessible.

**Stage Six – How does this information answer my critical question?**

Having deconstructed and analysed the data, the penultimate step in this method is the reconstruction of the data into an answer to the critical question. Figure 2.8 shows how I made this addition to the process.

![Figure 2.7 Sixth modification of the Mixed Methods Research Process Model.](image)

At this stage I integrated the analysed data into a coherent statement. The outcomes of the correlation, consolidation and comparison processes are presented in
prose, as a statement of the evidence. In this thesis I have produced a series of statements for doing, being, becoming and belonging, summarising the available evidence and its quality, and these will be presented throughout the thesis. I wrote these statements in the reverse order to the data analysis – beginning with statements for each sub-category that were integrated into statements for each category before being collected into an overall statement for each dimension of the OPH – doing, being, becoming and belonging.

While Johnson and Onwueguzie (2004) conduct data legitimation at this stage of the Mixed Methods Research Process Model, it is embedded within all the steps following deconstruction in the current method. Legitimation involves assessing the trustworthiness and validity of qualitative and quantitative data, and its impact on subsequent interpretations. In the ITEA method, legitimation occurs during the triage process in stage four deconstruction. An article undergoing deconstruction will be assessed as to the method used, and the level of evidence if that method is scientific.

Stage Seven – How will I apply this evidence to practice or further research?

The final step of the Mixed Methods Research Process Model was to draw conclusions from the findings; however, this was done in the previous step in my method. Theoretical and evidentiary ways of knowing had already been supported, but a step was needed to include practice ways of knowing and the crucial step of applying the new knowledge to practice. A final step of transfer and utilisation was therefore included, and this completed the construction of the new method required for this thesis. The method was named ITEA: integrating theory, evidence and action. The word action was chosen over practice to encompass the breadth of occupational therapy. Practice is defined as carrying out or exercising a profession (Oxford English Dictionary, “practice”, 2014), and the term is therefore limited to the members of the profession. This excludes the role of other stakeholders in the transfer and utilisation of ways of knowing (including clients), and also excludes action which may not be explicitly named as part of occupational therapy (such as political and social activism, or spiritual activities). The choice of action over practice for this method was therefore a conscious one, designed to maintain a broadly inclusive approach to developing and applying ways of knowing. Figure 2.9 shows the complete ITEA method.
Figure 2.8 Integrating Theory, Evidence and Action (ITEA) Method

The transfer and utilisation step is the most important for clinicians as it ensures the new knowledge they have developed through this method will have an impact on outcomes for their clients. It is also important for broader OT practice, as the application of evidence to practice has the capacity to change it by increasing effectiveness and efficiency. There are a range of methods available to achieve this (such as knowledge brokerage and guideline audit), all of which use practice ways of knowing to bridge the evidence–practice gap. To retain an appropriate degree of flexibility and enable contextual factors to be taken into account, the ITEA method does not specify how transfer and utilisation are to occur; I recommend the knowledge brokerage model as an effective way of enabling it, and this will be discussed in detail in Chapter 5.

The ITEA method adds value to the existing methods for integrating and incorporating bodies of evidence, by embedding them in a process which builds on their respective strengths and compensates for their respective weaknesses. The method shows clinicians how to use the diverse methods needed to engage with the evidence base of the profession, in a manner which is rigorous and systematic. The outcomes of this method are different to those achieved with existing methods, as they are embedded within theory, inclusive of multiple evidentiary ways of knowing and directly linked to practice and action. However, this diversity and inclusivity comes at a price, in this case...
an increased level of complexity and therefore greater time resources required for completion. Although the time that needs to be invested in using the ITEA method is likely to produce outcomes with greater relevance to the complex and multifaceted nature of modern mental health occupational therapy practice, it could be considered a limitation.

**Applying the ITEA method**

Having constructed this method, I undertook a pilot study of its application before setting off on my longer journey through the three ways of knowing. I selected an area of clinical practice in which I had experience and ongoing interest, and which I knew to have a relatively small body of evidence: OT for people experiencing alcohol misuse or abuse.

**Stage 1.**

The critical question for this pilot study was “How does occupational therapy (intervention) support recovery (outcome) for people experiencing alcohol misuse and abuse (population)?”

**Stage 2.**

The core concepts of the OPH – doing, being, becoming, and belonging – were used to organise the data.

**Stage 3.**

Peer-reviewed journals authored by at least one occupational therapist, consumer, or professional organisation were the chosen source of evidence. The occupational therapy peer-reviewed material on people recovering from alcohol abuse included both research and non-research evidence. Data were collected from articles published over an 11-year period (01/01/2000–01/01/2012 inclusive). The language of publication was English only, including available translations; the exclusion of articles in other languages is not an indication of their value or relevance, but rather the resources that were available to complete this study. This led to the exclusion of one article (n=1) (Santi, 2006).

Evidence was sourced using two electronic databases, EBSCOHOST and OTDBASE, which enabled the effective identification and cataloguing of the evidence. The search terms used were “occupational therapy” and “alcohol,” although some of the papers identified only referred to the abuse of other substances. Studies were included if at least some of the participants were recovering from alcohol abuse. The evidence base consisted of 16 peer-reviewed articles.
Stage 4.

The same system of triage described earlier in this chapter was used in the deconstruction phase of this pilot study. Data was initially classified into the four main concepts of the OPH – doing, being, becoming, and belonging. Five practice categories (and their association sub-categories) were then used: assessment, intervention/lived experience, program/service, education, and theory/philosophy.

Stage 5.

All but one of the evidence sources collected used a research method. Non-research evidence is denoted as “other evidence,” and is subjected to a general process of critical analysis with notes kept on its relevance and applicability to practice. The Rosalind Franklin Qualitative Research Appraisal Instrument (RF-QRA) (Henderson & Rheault, 2004) and the National Health and Medical Research Council (NHMRC) standards (NHMRC, 2000) were used to critique research evidence and designate a level of rigour to each piece of evidence. Table 2.12 displays the outcome of this process of analysis, and an overview of the OT evidence available concerning intervention for people recovering from alcohol abuse.

Table 2.12
Data Display for Occupational Therapy for People Recovering From Alcohol Abuse

<table>
<thead>
<tr>
<th>Phase</th>
<th>Theoretical Alignment</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Doing (n=8), Being (n=6), Becoming (n=1) or Belonging (n=1)</td>
</tr>
<tr>
<td>2</td>
<td>Assessment (n=0), Intervention/Lived Experience (n=13), Program or Service (n=1), Education (n=1), Theory, Philosophy (n=1)</td>
</tr>
<tr>
<td>3</td>
<td>Psychoactive substance use (n=13), Adult (n=1), Undergraduate (n=1)</td>
</tr>
<tr>
<td>4</td>
<td>Quantitative level of evidence III (n=1), IV (n=4), V (n=6) Qualitative level of evidence II (n=3), III (n=3), IV (n=2), Other evidence (n=1)</td>
</tr>
</tbody>
</table>

As shown above, there is a reasonable basis for knowledge around doing and being for people recovering from alcohol abuse, but evidence is sparser for becoming
WAYS OF KNOWING

and belonging (see Phase 1). Most evidence relates to either intervention or the lived experience of clients, and there has been no specific research on occupational assessment for these clients (see Phase 2). The research methodologies have generally been on the lower levels of the accepted hierarchies; although there are some relatively robust qualitative studies (see Phase 4).

Stage 6.

The following evidence statement derived from the analysis of the data shows how the method constructed a comprehensive answer to the critical question chosen in this pilot study: How does occupational therapy support recovery for people experiencing alcohol misuse and abuse?

There is a small but diverse body of evidence around the role of occupational therapy in supporting recovery for people experiencing alcohol misuse and abuse. Most of the evidence addresses doing and being for these clients, with single studies addressing becoming and belonging. The findings from this ITEA process will now be presented using the chosen theoretical framework of doing, being, becoming and belonging.

Doing.

Leisure activities featured in three of the studies, and were found to make positive contributions to the recovery process. A single case study by Stevens, Redfearn and Tse (2003) followed a young man recovering from alcohol abuse over a period of six weeks. Intervention was guided by an occupational therapy practice model, and positive improvements in occupational performance and specific behaviours were found. The client self-identified that leisure participation was an important aspect of his recovery, in terms of both participation and choosing healthy activity.

In a study reviewing a physical activity intervention (Ussher, McCusker, Morrow, & Donaghy, 2000), participation in these forms of leisure activity was found to promote independence through goal setting, integration into mainstream physical facilities, education about individual preferences for physical activity, and motivation to improve health. Participants in this study received counselling and advice, participated in discussion, and undertook supervised exercise. Participants in a study by Hodgson and Lloyd (2002) were interviewed about pre-existing participation in meaningful leisure activities. These pre-existing occupations were found to link the past with the present through the development of new meanings, and to provide opportunities for meeting new people (who potentially did not use alcohol). However, a number of
resource-related barriers to participation were identified, including mental health issues, social issues, and transport and financial restrictions.

The impact of resource restrictions was also highlighted in a study by Davies and Cameron (2010), who found that securing finances and accommodation was a priority for clients. Participants reported that taking care of themselves was important but taking care of others was more highly valued. The impact of their alcohol abuse had led to self-maintenance skills either being lost over time or never fully developing in the first place; the clients’ roles and routines focused on the requirements of maintaining their alcohol intake. The longitudinal effects of alcohol abuse on occupations were also highlighted in a study by Hoxmark, Wynn and Wynn (2012), where clients reported a significant fall in the number of activities they participated in compared to before their alcohol abuse. While a greater loss of activities might indicate higher pre-morbid function, the authors found that the number of future desired activities reported by clients did not relate to their wellbeing.

The complexity of the recovery process was commented on upon by several authors, and chaos theory was suggested as a useful framework (Haltiwanger, 2007). In a case study of a man recovering from alcohol abuse, microscopic (intention), mesoscopic (meaning), and macroscopic (perception) factors were highlighted to assist occupational therapists link brain dynamics with occupation. Stoffel and Moyers (2004) recommend that occupational therapists integrate features of brief interventions, cognitive behavioural therapy, motivational strategies, and 12-step programs into their practice. The unproven but prevalent assumption that reduction in alcohol use automatically leads to an increase in healthy occupations was also highlighted.

Only brief motivational counselling has been researched using an occupational therapy approach (McQueen, Allan, & Mains, 2006), administered to patients in medical wards who had been screened for alcohol abuse. While the therapists in the study found the screening and counselling time-consuming, it was found to be a feasible intervention for the profession to offer in that setting. More patients on these wards subsequently received motivational interviewing, but it did not result in a statistically significant decrease in their alcohol intake.

**Being.**

As a role, parenting ascribes specific meaning, motivation and purpose to occupations which are also performed (for different reasons) in other circumstances. The ‘being’ aspect of these occupations is therefore foregrounded, as the crucial
dimension in relation to any associated ‘doing’, ‘becoming’ and ‘belonging’. Two studies focused on the experience of parenting, either while continuing to use substances (Knis-Matthews, 2010) or in recovery (Martin, Bliven & Boisvert, 2008). Both used qualitative methods to explore this area, and clearly identify a role for occupational therapy in supporting people in their parenting responsibilities. Knis-Matthews (2010) found that many of her participants had had difficult childhoods themselves, and alcohol abuse had started as a means of dealing with their first families and early losses. Alcohol abuse impacted on their parenting in many ways, including reducing the time and emotional resources they had to devote to parenting tasks. Martin, Bliven and Boisvert (2008) conclude that a focus for occupational therapy exists in rebuilding occupational identity, routines, and performance capacity in alcohol-abusing parents as they engage in recovery. Participants in this study stated they preferred structure in their treatment environment. A focus on parenting skills and including families in treatment are recommended by both studies, along with finding non-abuse-based activities with which to occupy the clients.

An occupational perspective of addictive behaviour was provided by Kiepek and Magalhaes (2011). Through a literature review and synthesis of a range of addictive behaviours, they conclude that addictive behaviours (such as those used to obtain alcohol, use it, and recover from its effects) are occupations. Using the criteria of occupation (Townsend & Polatjko, 2007), the review confirms that these can give meaning, determine health, wellbeing, and justice, organise behaviour, develop and change over time, shape and be shaped by the environment, and have therapeutic potential. A clear concept of alcohol abuse behaviours as occupation foregrounds this issue as a domain of concern for the profession, as does the prevalence of alcohol use disorders in practice, highlighted by Eastabrook et al. (2003). In a survey of Canadian assertive outreach clients, around ten per cent on average were thought to be abusing alcohol; these findings were suggested to be an underestimation, and the figures rose to 23 per cent at some services.

Aspects of recovery were highlighted in the final two studies, which investigated body image (Van Deusen, 2000) and the impact of life skills training (Martin, Bliven & Boisvert, 2008), respectively. In a mixed study on body image for women recovering from alcohol abuse, Van Deusen (2000) finds that while positive body image did not appear to relate to recovery, occupational patterns were consistent during prolonged recovery. Martin et al. (2008) finds some consistency over time in the occupational
performance, self esteem, and quality of life of people who attended life skills training provided by an occupational therapist. Significant improvements and large effect sizes were found for many variables over a 4–6-month period, but there was a decline in some clients at follow-up. Unfortunately, this study provided data only for those who completed the program, and this does not necessarily represent the majority of people with alcohol problems.

**Becoming.**

A study of undergraduate occupational therapy students (Gill, Maclean, Renton, & O’May, 2011) surveyed their knowledge of alcohol issues. They were found to be unclear about national responsible drinking guidelines and current policy, but personally and professionally confident in performing occupational therapy with people recovering from alcohol abuse.

**Belonging.**

A study by MacDonald et al. (2004) compared outcome measures from those in early and late-stage recovery who attended a dual diagnosis service. Those in the later stages of recovery were more likely to perceive greater support from non-using contacts; however, the amount of contact with fellow users was the same at both points in recovery. Professional support was perceived more positively by those in the later stages of recovery, and it was this source of support which influenced their overall feelings of greater support.

**Step 7.**

This iteration of the ITEA method had demonstrated that the dimensions of doing, being, becoming and belonging are present within this relatively small area of mental health OT practice. Doing and being have been the subject of more research than becoming and belonging, but a clear relationship between each dimension and the health of people recovering from alcohol misuse and abuse has been shown by at least one study.

The evidence collected through this method has provided a comprehensive overview of the current research around occupational therapy for people recovering from alcohol abuse. While this evidence is relatively robust in parts, it is insufficient to enable the elaboration of a set of practice guidelines for clinicians at this point, although it could provide the basis for the development of such guidelines if the gaps in the available evidence were filled using consensus techniques with expert practitioners. While relatively few clinical practice guidelines that specifically address occupational
therapy intervention exist (Stergiou-Kita, Moll, Walsh, & Gewurtz, 2010), there are growing calls for their development to support excellence in practice.

The evidence statement produced using this method has highlighted some areas that require further research. These include the experiences of becoming and belonging for people recovering from alcohol abuse, the effectiveness of prescribed leisure interventions, other applications for brief motivational interviewing, and how occupational therapy can support parents who are recovering from alcohol abuse. These paths for future research are most likely to be explored by academics, but clinicians can also make valuable contributions by reporting existing practice (particularly through case studies or practice descriptions).

Finally, the completion of the ITEA process may lead to the generation of further critical questions and a further cycle of deconstruction, analysis and reconstruction. This ongoing renewal of enquiry and engagement with research is the essence of evidence based practice, as our ways of knowing about occupational therapy for people recovering from alcohol abuse develop and change in response to further development. The ITEA method could play a central role in this process by facilitating the integration of three aspects of providing good practice: strong theoretical knowledge, cutting edge research, and best practice.

This description of the application of the ITEA method has attempted to meet the recommendations stated by Mortenson and Oliffe (2009) to ensure clarity and transparency. While these recommendations were for mixed methods studies, they are also relevant to multiple methods such as this. I have provided an explicit description of the theoretical positioning and paradigmatic considerations through the embedding of these ways of knowing into the process. I have also provided a detailed rationale for using multiple methods (inclusive of all ways of knowing and methods), along with a description of how the method is appropriate to address the original research question. The potential for robust triangulation of data (particularly through the correlation, consolidation and comparison of multiple methods) has also been highlighted, which will have a positive impact on the trustworthiness of the overall findings of this thesis.

The ITEA method is used in an iterative way throughout this thesis. Each cycle produced a new critical question to be addressed, which initiated another cycle of the ITEA method, and so on. The ongoing process of question – investigation – answer – further question provided the momentum for this journey, through the three ways of
knowing. Ten cycles of the ITEA method were undertaken to address the research question, and will be described in depth in Chapters 3 to 5.

**Ethical Considerations**

For each of the cycles of ITEA undertaken during this journey, consideration was given to the ethical issues concerning the methods used, data collected and communication of results. Some of the studies were undertaken with human subjects and were approved by the Deakin University Human Research Ethics Committee (DUHREC). Exemption was obtained for others, on the grounds that they did not involve human subjects. Copies of all ethics approvals received during the course of this thesis are provided in Appendix E. Many texts on research ethics focus on human research, but I also gave consideration to ethical practice when conducting studies that did not require committee review. The authenticity, quality and credibility of peer-reviewed articles are an expression of ethical behaviour in inquiry (Cresswell, 2006), even when the method does not include human subjects. I adopted several measures during this journey to embed ethical behaviour throughout, including the avoidance of plagiarism, reusing previously published material in the body of the text, or assigning authorship inappropriately (Beins, 2012). While I took care not to misuse or misrepresent the research on which much of this project is based, there can be no guarantee that these studies were conducted ethically in the first place. I am relying on the process of peer review to ensure the quality of this research. Given the variety of ethical contexts in the cycles of ITEA method undertaken in this thesis, I will provide a statement within the discussion of each specific critical question.

**Summary**

This chapter has described the method used to explore the different ways of knowing in mental health OT. It began by introducing the sample of peer-reviewed evidence upon which this thesis is based, outlining the inclusion and exclusion criteria applied, the system of triage used to manage the data and the ways in which the evidence was critiqued. It then described the three ways of knowing proposed in this thesis in detail – theoretical, evidentiary and practice – and outlined the context within which each of them sit. This led to the first critical question of this study: How have the methods used to support ways of knowing in peer-reviewed journals available to mental health occupational therapists developed over time? An historical overview of the methods used within OT revealed that methods used to support ways of knowing in peer-reviewed journals available to mental health occupational therapists developed in
five distinct periods over the past century. Influenced by the historical events and trends which impacted on the profession throughout this time, the methods have tended to become more sophisticated and resource-intense. By mapping the methods to the three ways of knowing, I could discern that some methods support more than one way of knowing and that ways of knowing and the methods that support them interact in complex ways.

A second critical question was then posed: How do methods and ways of knowing support the integration and incorporation of bodies of evidence? I provided a critique of three current methods for synthesising bodies of evidence, exploring critical analysis, literature review and systematic analysis (including meta-analysis and meta-synthesis). Two publications were presented demonstrating the use of meta-synthesis and systematic review as methods for synthesising bodies of evidence, but each of the existing methods critiqued had limitations that made them unsuitable to answer the research question fully. This led to a third critical question: How can the three ways of knowing in peer-reviewed journals available to mental health occupational therapists (and the methods that support them) be integrated into an evidence base that respects and sustains inclusivity and multiplicity?

The answer to this question proved to be the development of a new method for integrating multiple forms of evidence. This method was called the Integrating Theory, Evidence and Action (ITEA), and its development was described in detail. I provided a worked example of the application of this method, using occupational therapy for people recovering from alcohol misuse and abuse as the topic. I then discussed the ethical considerations relevant to this thesis, and the many sub-studies of which it consists.

Having created a method for this thesis, I had a form of transportation for my journey. I had packed my bags with a range of tools (the various methods I had reviewed), and had seen there would be three main regions which I would need to explore. Before setting off, I formulated an itinerary of my stops along the way. The three main regions I was going to visit – theory, evidence and practice – each have their own features and cultures. The journey was therefore best considered three separate trips, one into each region. I wanted to fully explore one region before moving to the next, building the layers of my knowledge and ensuring that each way of knowing integrated with and informed the others.
In the face of the diversity I knew I would encounter, I had two landmarks to go exploring from. The first was the ITEA method which was used in an iterative way in each of the three regions. Every trip began with an overview of existing knowledge about theory, evidence and practice in mental health OT, before following the line of my critical questions. The ITEA method provided the momentum to continue with the journey, with each cycle generating new questions and driving me on in my inquiry.

The other anchor point was the overall research question and its focus on occupational therapists working in mental health. In each of the regions, and at each stage of my journey their needs remained uppermost in my mind. All new knowledge was critiqued with a focus on how clinicians might apply it, and what would need to happen for this translation to occur. The dimension of meaning was also fundamental to my approach, in terms of highlighting what all this knowledge actually means in practice for occupational therapy in mental health. The story of my journey has therefore been written with the explicit aim of communicating the new knowledge generated in an accessible way for that audience; it is a story for clinicians.
Chapter 3. Theoretical Ways of Knowing

“We are all agreed that your theory is crazy. The question which divides us is whether it is crazy enough to have a chance of being correct” – Bohr, *The quantum physicists and an introduction to their physics.*

**Introduction**

In the previous chapter I described the method used to explore the different ways of knowing in mental health OT. By outlining the sample of peer-reviewed evidence upon which this thesis is based, describing the three ways of knowing proposed in this thesis in detail, and giving an historical overview of the methods used within OT, I provided a context for the development of a new method for integrating the diverse evidence available to mental health occupational therapists. I then described the development of the Integrating Theory, Evidence and Action method (ITEA), which will be used throughout the rest of this thesis. Having full prepared for my journey, securing both transportation and all the equipment I would need along the way, I was ready to set off.

The first region I explored was theory, chosen as the starting point because it is fundamental to the efficient formation of new knowledge. There has been a proliferation of theories to support OT in recent decades, which Yerxa attributes to “a growing readiness for occupational therapists to leap into the unknown waters of concepts and ideas” (2000, p. 88). However, there is some trepidation and ambivalence about the growth of theory to explain the practical experience of providing OT. The need for new theories, models and frameworks has been questioned, and doubts have been raised across the years as to whether they make any meaningful contribution to the lives of working clinicians (Alexander, French, Graham, King, & Timewell, 1985; Williams, 2000).

The single study of the diverse range of theoretical ways of knowing used by mental health occupational therapists surveyed 334 Swedish occupational therapists about the approaches and models they used in practice (Haglund, Ekbladh, Thorell & Hallberg, 2000). Participants identified theories from both within and outside the profession: while the psychosocial approach was influential, the biomedical approach was given less emphasis. The Model of Human Occupation was the most frequently used conceptual practice model, possibly because supporting materials were available in
Swedish. Those working in services that adopted a particular theory were most likely to follow it, demonstrating the influence of employers. The nature of this influence (positive, negative or neutral) is dependent on many factors, and could be perceived in different ways depending on the stance of the therapist or employer. However, approximately 75% of participants did not identify any theories originating from OT, with the authors suggesting that occupational therapists need to be educated about the discipline-specific theories available to them. It was evident from this study that theories relevant to occupation include a range of concepts which mental health occupational therapists freely draw upon in their professional practice. Diversity is therefore evident within the theoretical basis of mental health OT, but in this study was deemed to be a negative factor requiring a greater focus on profession specific theories.

This chapter will explore the current state of theoretical ways of knowing within mental health OT and how they are applied to practice. It will then focus on the OPH (Wilcock, 2006), which has been chosen as the organising theoretical framework for this thesis. Through an in-depth critical analysis, I will describe how the key concepts of doing, being, becoming and belonging have evolved to the present time, in literature from all areas of practice. Finally, I will return to mental health to provide an analysis of how the OPH as a paradigm interacts with the conceptual practice models identified as currently influential. I will use the ITEA method as my vehicle for moving through this region, asking critical questions along the way to address my overall research question iteratively. Each step of this process will be depicted, to illustrate the process of inquiry and how the ITEA method supports and integrates the available evidence. Below is the first of 10 iterations of the ITEA method used throughout this thesis. This first iteration focuses on theoretical ways of knowing

**Iteration 1 of the ITEA method**

**Step 1: Re-determine the Research Question**

To gain an understanding of which theoretical ways of knowing are prevalent in mental health OT, I needed to reframe my research questions for the next iteration of the ITEA method. In this case, the critical question became: What theoretical ways of knowing currently underpin mental health OT?

**Step 2: Select the Theoretical Framework**

While the OPH had already been chosen as the theoretical framework for this thesis, it was not appropriate for this iteration of the ITEA method for two important reasons. Firstly, the OPH was likely to arise as one of the theoretical ways of knowing
in the current literature, and this would lead to it being used to analyse itself. Secondly, I was aware from my Masters studies of a more directly relevant theoretical framework about theoretical ways of knowing in occupational therapy which would answer this critical question more effectively. This framework was better suited to the critical question because it explicitly addresses the different types of theoretical knowledge on which occupational therapy draws. I also needed to find a framework which enabled an examination of the OPH itself, to prevent self reference and provide some analytical distance. I will therefore briefly step away from the OPH as a theoretical framework, but will return to it at the end of this iteration of ITEA. In terms of my journey, this is the equivalent of driving a different model car for a short distance.

The framework chosen for this iteration of ITEA was proposed by Kielhofner (2009), as an explanation of the relationships between levels and types of knowledge. He argued that there are three different kinds of knowledge that occupational therapists called upon in the theoretical underpinnings of their practice: paradigms, conceptual practice models, and related knowledge. These are not unique to OT – they exist in other professions, where they are utilised according to standing traditions and cultures. Paradigms present broad assumptions and perspectives, which in the case of OT focus on the relationship between occupation and health, and the culture of the profession as a whole. Conceptual practice models in OT are the frameworks that are unique to the profession, providing rationales, technologies and guidance for practice. Related knowledge refers to the concepts, facts and techniques that originate from other disciplines but also inform OT practice. These three kinds of knowledge are arranged by Kielhofner as layers, as shown in Figure 3.1. Conceptual practice models provide the means for applying paradigms, while related knowledge provides additional skills and concepts which augment those fundamental to OT.
Figure 3.1 Concentric layers of knowledge in the conceptual foundations.


The structure of these layers was used to provide the theoretical framework for this cycle of ITEA, because of its direct relevance to theoretical ways of knowing in OT and its neutrality in providing a framework for analysing the OPH. It also caters for the diversity of theories available to mental health occupational therapists, and is congruent with the principle of inclusivity and multiplicity that underline this thesis.

**Step 3: Identification**

To identify the evidence relevant to the critical question, I adopted many of the same inclusion criteria as the overall thesis. These included 1) evidence formally published between 01/01/2000 and 31/12/2012, 2) evidence published in English (either originally or available in translation), 3) evidence published in peer-reviewed publications, and 4) evidence with at least one author who self-identified as an occupational therapist, consumer of OT services or organisation representing the profession. To limit the search to theoretical ways of knowing, three additional search terms were added to ensure the process of identification was adapted to this particular question: theory AND/OR framework AND/OR model. This strategy identified articles classified in the “theory” category, and others that illustrated how theories support the evidentiary and the practice ways of knowing. From this early stage, it was clear that ways of knowing (and the methods that support them) are intricately related. This process resulted in the identification of 90 articles out of the original sample of 1596 directly relevant to theoretical ways of knowing.

**Step 4: Deconstruction**

Deconstruction proceeded using these three layers of knowledge identified as my theoretical framework, and further triage. Each article identified was initially
THEORETICAL WAYS OF KNOWING

categorised as describing a paradigm, conceptual practice model or related knowledge, based on Kielhofner’s definitions. As shown in Table 3.1, the evidence was then triaged in accordance to the type of evidence it reported, and (when using a scientific method) the level of that evidence.

Table 3.1
Triage Process for Evidence Related to Current Theories Underpinning Mental Health OT

<table>
<thead>
<tr>
<th>Type of Knowledge</th>
<th>Type of Evidence</th>
<th>Level of Evidencea, b</th>
</tr>
</thead>
<tbody>
<tr>
<td>Paradigm</td>
<td>Quantitative</td>
<td>I</td>
</tr>
<tr>
<td>Conceptual Practice Model</td>
<td>Qualitative</td>
<td>II</td>
</tr>
<tr>
<td>Related Knowledge</td>
<td>Mixed Methods</td>
<td>III</td>
</tr>
<tr>
<td></td>
<td>Other Evidence</td>
<td>IV, V</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Not applicable</td>
</tr>
</tbody>
</table>

a Qualitative level of evidence (National Health and Medical Research Council, 2000).
b Qualitative level of evidence (Henderson & Rheault, 2004).

In this sample, the majority of evidence (62%, n=56) was related knowledge. A smaller proportion presented conceptual practice models (35%, n=33), while only a single article addressed a paradigm. Over half of the evidence used non-scientific methods (63%, n = 59). Of the remainder, most was quantitative (25%, n = 23), with smaller numbers of qualitative (17%, n=16) and mixed methods studies (4%, n=4).

Given the focus on theoretical ways of knowing, the levels of evidence used in these articles were relatively low. For quantitative evidence, the majority was level V (83%, n = 19), with two studies each of level IV and level II evidence. However, the levels of evidence for qualitative studies were generally higher, and split evenly across all five levels. Four studies were at level V (25%), two at level IV (13%), four at level III (25%), four at level II (25%) and two at level I (13%).

The emphasis on related knowledge is reflective of its quantity in relation to conceptual practice models specific to OT, which are relatively few in number. However, none of this evidence talks about how related knowledge relates to the conceptual practice models – related knowledge appears to be used in mental health OT independently of discipline specific models. The lack of evidence around paradigms is
reflective of the ongoing debate about this level of theory in OT. As stated in Chapter 1, the profession does not appear to have found a unifying, broad theory which encompasses all of its areas of practice. Without this, the varying theoretical ways of knowing which inform practice may be applied in a fragmentary or even contraindicated manner, and a focus on occupation as a fundamental concept may be lost.

**Step 5: Analyse Data**

Detailed reading and critique occurred with every article, with notes taken to form the basis of the subsequent overall analysis. Correlation, consolidation and comparison were used to determine the character of the evidence. Correlation in this case refers to evaluating the relationship between evidence which uses different methods to address the same topic (i.e. are instances of quantitative and qualitative evidence strongly related or divergent in their findings). It is therefore distinct from correlation in quantitative statistics, related only by its overall focus on the relationship between factors. Comparison, in contrast, is a process of highlighting the similarities and differences between evidence, without necessarily analysing their relationship to each other. This assessment leads to consolidation, where all of the evidence is considered as a whole. There were very few instances of correlation or consolidation, as most of the theories found have only one or two pieces of supporting evidence for mental health OT. The exception to this is the Model of Human Occupation (MOHO), as will be evident in the following reconstructive statements.

**Step 6: Reconstruction**

The reconstructed description of the available evidence provides a synthesis of this process, and overview of theoretical ways of knowing recently published in mental health OT. There were a range of paradigms, conceptual practice models and related knowledge relevant to mental health OT reported in peer-reviewed literature since 2000, and shown in Figure 3.2. As in Kielhofner’s diagram (2009), the inner circle represents paradigms, the middle circle conceptual practice models and the outer circle related knowledge.
Paradigms

**OPH.**

I began my analysis at the centre of Figure 3.2, looking for instances of paradigms in peer-reviewed articles about mental health OT. Beginning the analysis with paradigms enabled a broad entry point, which could be honed to greater detail as the theoretical ways of knowing become more focused (i.e. conceptual practice frameworks which narrowed to particular practices, and then related knowledge that provided specific skills and knowledge to support that practice).

The only theoretical way of knowing published since 2000 that fits the characteristics of a paradigm is the OPH, which was originally proposed by Wilcock over fifteen years ago (1998b). Fieldhouse (2000) focused on vocational and social disability for clients with chronic mental health problems in the United Kingdom (UK), using the OPH as the basis for a theoretical discussion. Using the risk factors identified in the first edition of the OPH (occupational imbalance, alienation and deprivation) (Wilcock, 1998b), he proposes guidelines to enable therapists to retain mindful awareness of these broader issues: for example, he advocates the use of these factors as
Impact of paradigms on practice.

As may be expected from a paradigm, the ways in which the OPH could be translated into intervention are not clear. Fieldhouse advocates “broader work aimed at creating a more accepting community” (p. 215) without specifying how therapists could contribute to this in their workplaces. This is an inherent challenge for paradigms (which don’t provide guidelines for practice), but could have been addressed through the inclusion of a reflective case study showcasing how the OPH guided and framed his clinical thinking. However, this evidence may still have an impact on practice by guiding clinical reasoning more broadly. Fieldhouse suggests an awareness of occupational imbalance, alienation and deprivation may lead mental health occupational therapists to assess and intervene at a community level in their local area, to address the risk factors within the systems and structures that directly impact on their practice.

Conceptual practice models.

Six conceptual practice models that meet Kielhofner’s definition and have direct reference to mental health OT have been identified in peer-reviewed journals since the year 2000 – the Canadian Model of Occupational Performance and Engagement, three delineation models (the Delineation Model of Practice for Children with Attention Deficit Hyperactivity Disorder, the Model of Play-Based Intervention for Children with Attention Deficit Hyperactivity Disorder and the Model for Assessment of Assistive Technology Interventions for Persons with Dementia), the Model of Human Occupation and the Model of Sensory Processing. However, a further five were identified which met the definition partially, with the main issue being the provision of technology for implementation – the Collaborative Therapeutic Homework Model, the Kawa Model, the Lifestyle Balance model, Neuro-occupation and the Occupational Adaptation Model. Models which both fully and partially meet the criteria for being recognised as conceptual practice models will be presented here. The models which partially meet the criteria do have a presence in the literature, and are therefore part of the evidentiary ways of knowing available to mental health occupational therapists. This is congruent with the concept of diversity which underlies this thesis.
Full Conceptual Practice Models:

Canadian Model of Occupational Performance and Engagement.

Despite its general prevalence in OT, there have been surprisingly few recent references to the use of the Canadian Model of Performance (CMOP) (Polatajko, Townsend & Craik, 2007) in mental health. Both the available references are around a decade old, prior to its latest iteration as the Canadian Model of Performance and Engagement (CMOPE). The critique and findings of these articles may therefore no longer be valid, but they remain the only evidence available for mental health occupational therapists about this conceptual practice model. It could also be argued that the new iteration has not substantially altered the core concepts of the CMOP, and therefore there remains some relevance in these findings.

Both of the articles available focused on the Canadian Occupational Performance Measure (COPM) as a means of applying the model, highlighting the utility of technology. However, Warren (2002) formulated a hybrid assessment tool, combining the COPM with other assessment categories drawn from the model (such as performance components and environmental details). While the COPM has established psychometric properties, it is unclear how its integration into this assessment tool may impact on them. Clarke (2003) also highlighted some limitations to the COPM in a forensic rehabilitation hostel, noting that it may be inappropriate for clients with cognitive problems or an unstable mental state. Despite these reservations, both authors noted that clients reacted positively to working within the CMOP framework, with Warren (2002) also obtaining positive reactions from carers and clinicians. The barriers to implementation of the CMOP in mental health settings (such as those highlighted in these articles) are an important consideration, and may be a factor in the evident lack of uptake. At present, there is insufficient evidence for mental health occupational therapists to apply it to their practice with confidence.

Delineation models.

Delineation models aim to provide guidance for working with specific groups of clients (Chu & Reynolds, 2007a). There were three models which took this approach in mental health, two addressing the needs of children with attention deficit hyperactivity disorder (ADHD) and one supporting people with dementia using assistive technology. While none of these models are designed for the sole use of mental health occupational therapists, they have been developed by occupational therapists and can therefore be said to originate within the profession. OT is not the only profession with knowledge
relevant to the relationship between occupation and health, although its understandings have a depth and complexity not found elsewhere.

**Children with ADHD.**

The Delineation Model of Practice for Children with Attention Deficit Hyperactivity Disorder (Chu & Reynolds, 2007a) was designed to provide a multidimensional understanding of psychopathology and management for children with ADHD. Their model describes the interaction between six factors: child, environment, task, child/environment/task balance, family support, and successful participation in different occupations. A family-centred approach to therapy is advocated, and the authors provide examples of its use both to guide a multidimensional assessment and to plan a multidimensional intervention. The authors also developed an assessment and treatment package to support the model, which provides a clinical pathway for identifying and communicating occupational performance issues in relation to the child’s environment and the tasks demands (Chu & Reynolds, 2007b). A subsequent multicentre study offers some support for the efficacy of this package, but despite the availability of these resources it has not been the subject of further research or development to date (Chu & Reynolds, 2007b).

The Model of Play-Based Intervention for Children with Attention Deficit Hyperactivity Disorder (Cordier, Bundy, Hocking & Einfeld, 2009) is focused on play as a single type of intervention for a specific population. The model links the symptoms of ADHD with elements of playfulness, and suggests a series of play enablers (source of motivation, perception of control, suspension of reality and play cues/framing) to encourage participation and success. A pilot study using this model involved seven weekly 40-minute sessions, using both video self-modelling and graded therapist modelling (Wilkes, Cordier, Bundy, Docking & Munro, 2011). Both children with ADHD and normally developing children improved their social play following intervention using this model, providing evidence for its efficacy. At present, most occupational therapists who use play as an intervention work in paediatric settings, even though they are often targeting mental health issues. The relevance of this model to mental health OT is therefore more tenuous than the other conceptual practice models, although this may change if more clinicians move into infant and child mental health services.


**People with dementia.**

The Model for Assessment of Assistive Technology Interventions for Persons with Dementia (Alwin et al., 2007) provides a framework for occupational therapists to assess both the cost effectiveness of assistive technology interventions for people with dementia and the intervention processes that support their implementation. The model is conceptualised as an intervention over a twelve-week period, providing recommendations from baseline through intervention and at two follow-up points. This model has several unique features. It explicitly includes both client and carer perspectives, and addresses societal perspectives through cost effectiveness. Seven specific assessments are recommended in the model, some of which would already be familiar to occupational therapists working with people with dementia, such as the Mini Mental State Examination, COPM and Instrumental Activities of Daily Living scales. These are organised in a specific procedure, which is the technology provided for the implementation of this conceptual practice model. The number of assessments and requirements for re-assessment would be challenging in services with few resources or high case loads. There has been one further study (authored by one of the model’s developers) using this framework (Alwin, Persson & Krevers, 2013), which investigates carers’ views on AT interventions. Aspects of intervention which were highly important to carers are identified, with fulfillment being a particularly important factor to the success of the interventions.

**Model of Human Occupation (MOHO)**

An internationally developed overview of the MOHO’s (Kielhofner, 2008) dissemination and development in recent years provides a context for its consideration within mental health OT (Bowyer et al., 2008). While not including Australia, this overview surveys the application of MOHO in both western and eastern countries, and includes innovations from all areas of practice. Mental health is mentioned in only two of the nine countries surveyed. In Canada, the Centre de Rèfèrence sur le Modèle de l’Occupation Humaine in Quèbec was founded by mental health occupational therapists and occupational therapy academics, and has provided opportunities for consultation, networking and translation of tools into French. A passing reference to an article about the use of MOHO in mental health is also made in the review of European French developments. This suggests that the model has a limited presence in mental health OT. However, there have been 16 articles published (both prior to and after this review) which focus on the use of MOHO in mental health OT. Many of the articles describe the
impelmentation of MOHO at a service level, describing initiatives in the UK. Its applications to practice have included the design and development of an OT inpatient care pathway (Melton, Forsyth, Metherall, Robinson, Hill & Quick, 2008), embedding MOHO across settings in a mental health service (Wimpenny, Forsyth, Jones, Matheson & Colley, 2010), the structuring of an assessment and treatment pathway for women with borderline personality disorder (Lee & Harris, 2010), and its use to develop occupational profiles for patients in care package clusters (Lee et al., 2011). A survey of 262 occupational therapists found that 92.1% of respondents used MOHO as their primary treatment approach (Lee, Forsyth, Melton, Kielhofner & Taylor, 2011; Lee, Kielhofner, Morley, Heasman, Garnham, Willis et al., 2012). Participation in professional development resulted in high levels of MOHO use, which was associated with statistically significant positive client and professional outcomes. The clinicians surveyed perceived that MOHO greatly assisted their assessment, goal setting, interventions and professional identity.

The Model of Human Occupational Screening Tool (MOHOST) has also been the subject of several articles in its own right, describing and critiquing its use with people with mental health problems. Its internal constructs, validity (Forsyth et. al, 2011; Kramer, Kielhofner, Lee, Shpole & Castle, 2009; Pan et. al, 2011), discriminative properties (Forsyth et al., 2011; Kramer et al., 2009; Lee et al., 2011; Pan et al, 2011) and reliability (Kramer et al., 2009) have all been confirmed. More importantly to theoretical ways of knowing, all of these authors commented that the use of MOHOST promoted the integration of theory into practice, and promoted the unique role that occupational therapy can play in recovery. This finding was also supported by a case study of its use in acute psychiatric settings (Parkinson, Chester, Cratchley & Rowbottom, 2008). Outside the UK, MOHO has also been used on a service-wide basis in Ireland (Turner & Lydon, 2008) and Hong Kong (Liu & Bacon, 2008).

At an individual client level, there has been a series of articles describing MOHO’s implementation in daily practice. The Remotivation Process is an intervention based on MOHO and developed for clients experiencing severe volitional challenges; therapists have reported positive experiences of its use (Pèpin, Guèrette, Lefebvre & Jacques, 2008). The participation of people with depression or anxiety in physical activity was analysed using MOHO (Cole, 2010), with habituation and environmental factors found to be crucial to success. The importance of habits (and roles) was also highlighted in a case study of a women experiencing perinatal post
traumatic stress disorder (PTSD) (Pizur-Barnekow & Erickson, 2011). In this article, all levels of the model were used to analyse the presentation of the mother of a child presenting for OT and to propose a role for the profession.

While the amount of evidence which has been published about the MOHO is impressive, there remain significant gaps which impact on its applicability to practice. Much of the evidence in mental health settings has been generated in the UK, which has a distinctive cultural and service context. The MOHOST has good psychometric properties, but has only been tested in practice through the use of a single case study. Many of the articles have also focused on the benefits of using the MOHO or MOHOST for clinicians, rather than the impact on outcomes for clients. While it remains the conceptual practice model with the best evidence base in mental health OT, there are many areas for development and further investigation yet to be explored.

Model of Sensory Processing.

The originator of the Model of Sensory Processing (Dunn, 1997) used its concepts to propose a framework for understanding sensory issues for children with Aspergers Syndrome (Dunn, Saiter & Rinner, 2002). After describing the different sensory processing patterns, case studies were used to highlight what may be common characteristics for children with Aspergers Syndrome within each pattern. The evidence in this article is at a theoretical level as it proposes possible relationships without providing experimental evidence, and the author acknowledges that further research is needed to confirm the validity of what is proposed. While this article had been cited by 58 others up until December 2013 (Google Scholar, 2013), the article discussed here appears to be the only instance of applying the model to this population. Like the Model of Play-Based Intervention for Children with Attention Deficit Hyperactivity Disorder, the majority of occupational therapists using sensory interventions work within the paediatric field. However, sensory interventions are being increasingly introduced to mental health settings, particularly in acute units in Australia. People with autism spectrum disorders have very high co-morbid levels of depression and anxiety, and also often come in contact with mental health services. While the evidence to date around sensory processing in mental health is sparse, I would anticipate this area to grow over the next decade.
Partial Conceptual Practice Models:

Collaborative Therapeutic Homework Model.

The challenges of transferring therapeutic learning to everyday life provided the motivation for the development of the collaborative therapeutic homework model (Luboshitzky & Gaber, 2000). Using a case study for illustration, these authors recommend a six-step sequence first proposed by Shelton (1979). This process involves 1) careful identification of the client’s problems, 2) goal setting using behavioural terms, 3) contractual agreement between therapist and client, 4) ranking of goals to ensure the first one addressed makes the most difference to the client and is the most feasible, 5) selection of an acceptable form of skills training for the client, and 6) systemic skill and behavioural training using homework tasks. While identified as a model there is no theoretical structure presented, so in its present form it is more a list of principles for best practice. These principles, however, could be deemed as technology for application, as they provide clear guidelines for the implementation of this model into practice. It hasn’t appeared anywhere else in mental health OT literature since its publication, which indicates it has not been adopted widely in the profession. The lack of structure and technology may well be contributing factors to this lack of uptake.

The Kawa model.

The Kawa model (Iwama, 2006) differs from the other conceptual practice models in occupational therapy in its structure. Based on Japanese philosophy, it eschews a framework for the metaphor of a flowing river. While it is promoted as a culturally sensitive model, its linear conception of time may not be appropriate for some groups. A qualitative pilot study of its use in mental health (Paxson, Winston, Tobey, Johnston & Iwama, 2012) describes how two therapists applied it to practice. The therapists reported many benefits to its approach, including greater interaction with the client, increased motivation and positive challenge. The therapists also stated the model pulled them out of their usual cultural space into a “shared” space with the client where success was not defined by the health professional. The therapists felt it was particularly useful in a mental health setting, due to its open nature and capacity to encompass psychosocial issues. The Kawa model is very conceptually different to the other practice models, taking a narrative, metaphoric form. It requires a substantial shift in thinking for clinicians, which some may find difficult to make. The use of metaphor may also be difficult for some client groups to engage with; particularly if they have a
cognitive problem, acquired brain injury and/or intellectual disability. Of all the conceptual practice models, the Kawa model is the most open to interpretation and variation and so much depends on the skills and rapport building of the individual clinician.

**Lifestyle balance model**

The lifestyle balance model (Matuska & Christiansen, 2008) focuses on occupational balance, and asserts that the way in which people meet their biological and psychological needs within the environment is essential to the experience of health. It has been used in research to frame a study with Swedish women recovering from stress-related disorders (Hakansson & Matuska, 2010), and in a literature review which explores the occupational patterns of parents of children with autism spectrum disorder (Stein, Foran & Cermak, 2011). Both of these studies broadly support the validity of the model’s structure, and suggest a role for OT with both of these groups of clients. The impact of practice circumstances and populations on theoretical ways of knowing is also highlighted, both through a modification of the graphic representation of the model and the discovery that “perceived satisfaction” was a particularly important concept to understanding lifestyle balance from the participants’ perspective. However, there are no examples of its use to guide occupational therapy practice in a clinical setting. Many people with mental illness also experience chronic occupational imbalance due to a range of factors, and so it is potentially very salient to the needs of clients. Without evidence to support this assumption, clinicians who currently wish to use it must take a leap of faith.

**Neuro-occupation.**

Neuro-occupation has been proposed as a framework to understand the links between neurological structures and mechanisms, and participation in occupations (Gutman & Biel, 2001; Haltiwanger, 2007). The first mention of it is in a theoretical paper by Gutman and Biel (2001), which focuses on the links between mental health and neurological substrates of depression. They present characteristics of occupations that can be adapted to the preferences of individuals: for example, concrete, present-focused and logic based occupations can be used to promote left brain function. A related framework called non-linear dynamics theory is then introduced by Haltiwanger (2007). The main concept in this theory is that any factor that impacts on one state automatically impacts on all others, because of their interrelatedness. This article illustrates a link to theory by presenting a case study of a man experiencing alcohol
misuse, although the mechanisms by which it influenced intervention choices remain unclear. This lack of detail around application to practice in both articles is the main barrier to the adoption of neuro-occupation in mental health OT. While the theoretical framework is plausible, it is yet to be meaningfully tested in practice. Therefore, there is little current evidence available to support clinicians who adopt this approach.

**Occupational Adaptation Framework.**

Occupational Adaptation (Schkade & Schultz, 1992) has been used to frame two case studies in peer-reviewed literature relating to mental health OT. The first focuses on four homeless people (Johnson, 2006) and uses the sensorimotor, cognitive and psychosocial aspects of their lives to demonstrate the impact of homelessness on occupational engagement. It is then used in a case study describing OT within an inpatient child psychiatry service (Bouteloup & Beltran, 2007). The authors focus on the main tenants of the framework (such as process structures, occupational environment, and adaptive responses) which structure a detailed description and critical reflection on their work. The application of this framework to case studies is supportive of its use in practice, as clear examples of its role in clinical reasoning and decision making are provided. Case studies are a particularly accessible form of evidence, and show how conceptual practice models can be applied in the absence of specific technology. However, a total of two case studies over a thirteen year period suggests this model is not used widely in mental health OT, so those adopting it will most likely be practicing in isolation.

**Impact of conceptual practice models on practice.**

The six full conceptual practice models and five partial conceptual practice models reviewed have had varied impact on mental health OT. CMOP has received some support, but both studies highlight its limitations in mental health settings. This is in contrast to the large body of evidence available for MOHO, which includes many examples of the successful use of MOHOST in mental health settings. MOHO offers clinicians a range of technologies for its application, and has been the subject of a sustained and active program of research. It provides a clear example of the efficacy of integrating theoretical, evidentiary and practice approaches, with all three supporting the development of each other. The theory of MOHO is underpinned by the evidence generated by it, which in turn provides clinicians with a range of resources to support their efforts to translate it to practice.
Some of the models have remained largely restricted to the region of theory, such as the Lifestyle Balance Model and Neuro-occupation. The Model of Sensory Processing is beginning to have an impact on mental health practice (Novak, Scanlan, McCaul, MacDonald, & Clarke, 2013). There are some questions about the evidence base supporting these interventions, and their use by the profession (Rodger, Ashburner & Hinder, 2012). An exception is the Occupational Adaptation Framework, where case studies have been used to relate the theory explicitly to the practice of mental health OT. The study by Bouteloup and Beltran (2007) in particular provides an excellent example of the value of embedding evidence into theory to inform practice, and demonstrates the use of multiple methods (i.e. descriptive case study and critical reflection). Without evidence like this about the impact of these conceptual practice models on real life practice, their effectiveness remains untested.

Delineation models are particularly easy to apply to practice, given their high level of specificity and focus on therapeutic process. However, their rigidity could be experienced as stifling by some therapists, particularly if they have preferred a flexible, adaptive approach. Conversely, new graduate therapists may feel supported by the explicit instructions and processes provided. The impact of these models on practice will remain limited to the specific population for which they are designed, but within these bounds they have a clear role. In contrast to this high level of detail is the Collaborative Therapeutic Homework Model. I do not believe it has the features of a fully developed conceptual practice model, as the rationale for practice is too vague. This lack of structure and detail may why it has not been cited in any further evidence, although its influence could be invisible if it is in practical use. Principles of good practice can be useful for clinicians to consider, but their translation to practice is open to much interpretation.

On reflection, the Kawa Model’s partial status as a conceptual practice model (due to a lack of technology) exists for different reason. In its use of metaphor it provides a broad framework in which to consider occupation, and it is explicit in its address of cultural competency and awareness within occupational therapy as a profession; therefore, I believe the Kawa Model operates at the level of a paradigm. There is no reason why occupational therapy cannot have two paradigms; no one theoretical way of knowing can ever hope to embrace everyone’s beliefs and needs. While some will engage more closely with the multidimensional nature of the OPH, the narrative and strongly temporal nature of the Kawa Model will speak to others more
clearly. While occupation is a universal human experience, there is room for different world views on it.

Returning to Kielhofner’s definition of conceptual practice models, only CMOP, MOHO and the Model of Sensory Processing have developed technology to support their implementation to practice, in the form of assessments. While this seems to have helped the use of MOHO in practice in mental health, the impact of the technology supporting CMOP and the Model of Sensory Processing has not made as much of an impact. In contrast, the Kawa Model is often applied to practice in mental health occupational therapy in Australia, but has no supporting technology. This may be due to its status as a paradigm, but further research and reflection on the role of technology in the application of conceptual practice models is indicated for the future.

**Related Knowledge**

OT has a long history of incorporating knowledge from other disciplines into its understandings of occupation and health, and mental health OT is no different. This assisted the development of mental health OT in the era prior to the development of the conceptual practice models, and continues to offer a diverse range of assessment and intervention opportunities for clinicians and clients alike. However, there has also been suggestions that mental health OT should focus on discipline specific theoretical frameworks to maintain its focus on occupation As shown in the outer circle of Figure 3.2, I identify 14 types of related knowledge with direct reference to mental health OT in peer-reviewed publications since the year 2000. These types of related knowledge have been drawn from the ITEA analysis of all theoretical evidence published in this time frame, and constitute over half of that identified. While several models are included in this knowledge, they are not conceptual practice models as they do not provide a rationale or guidance specifically for occupational therapy. They have been included because they are theoretical ways of knowing that incorporate concepts, facts and techniques that are capable of informing practice in mental health OT. These forms of related knowledge can take the form of theories, frameworks and discrete concepts, as shown here.

**Action theory.**

In an overview, Davidson (2007) proposed action theory as a basis for researching and working with people with mental health problems. This theory sees people as agents of change who create their own experiences and environment, which the author believes supports the recovery approach. Action theory has been proposed as a suitable
theoretical framework in others areas of OT (Cutchin, Aldrich, Bailliard & Coppola, 2008), but has only been the subject of a single mental health article to date.

Activity analysis.

Barnes and Schwartzberg (2001) use occupational performance areas, performance components and performance contexts to base their discussion of activity analysis. Published in a psychotherapy journal, this article highlights how activity analysis can enhance the relationships between group tasks, individual participants and the dynamics of the group as a whole. Activity analysis is often mentioned as an important skill for mental health occupational therapists (for example, in Creek & Lougher, 2008; Kim, 2012), but this article is the only one to exclusively and explicitly focus upon it. It seems to be an ‘implicit’ skill, perceived to be more of a practice way of knowing than a theoretical or evidentiary one. However, if theory and evidence are not incorporated into activity analysis, there can be no way of understanding its relevance to the relationship between occupation and health, or how effective it is.

Attachment theories.

While related to the promotion of mental health, the two references to attachment theories in the peer-reviewed literature are not in mainstream mental health OT. Barnekow and Kraemer (2005) suggest Psychobiological Attachment Theory (PAT) as a useful framework for early intervention with caregivers and infants. This framework approaches the relationship as a system, and considers biological risk factors and the natural environment in its understanding of attachment. The paediatric practice focus in the discussion highlights the role paediatric occupational therapists can play in the establishment of good mental health. Attachment theory is also discussed in terms of professional issues within OT (Meredith, 2009). This article applies the theory to the mental health and wellbeing of occupational therapists themselves, making links between insecure attachment and burnout, and the role of mental health occupational therapists in assisting people increase self-understanding about attachment.

Behavioural theories.

A constructional approach using behaviour analysis and intervention training and support (BAITS) is used in a single case study focused on helping a client with challenging behaviour live more independently in the community (Redhead, Paxton, Iceton & Elliott, 2009). The BAITS program developed community living skills and provided the client with additional resources to reduce the need for outside support.
This approach is costly and intensive, but in the longer term it was considered cost-effective in terms of reducing future readmissions.

**Client-centredness.**

Client-centredness has become an abiding theme in mental health occupational therapy in recent years, synonymous with good practice and embedded in standards such as the Code of Conduct for Registered Health Practitioners (Occupational Therapy Board of Australia, 2012) and the Australian Competency Standards for Occupational Therapists in Mental Health (OT Australia, 1999). Sumison (2000) reports on the second phase of an initiative that had the ultimate aim of constructing a definition that enabled therapists to understand if they were using a client-centred approach. The key elements of the definition are respect, client involvement, partnership, environment, collaboration and empowerment. A benefit of the approach is its involvement of a wide range of therapists, but the resulting definition does not take into account some specific mental health issues (i.e. legislated compulsion) and is grounded in the particular legislative and cultural context of the UK.

Despite this initiative, the meaning of these concepts still required exploration towards the end of the decade (Kyler, 2008). A lack of clarity in terminology has been cited as a barrier, and Kyler suggests the consideration of the multiple concerns of clients in a fluid, relationship-centred approach. This would enable the understanding of clients in their context, and maximise what both clients and families can bring to therapeutic relationships and outcomes.

**Cultural competence.**

The concept of cultural competence is explored by Nayar and Tse (2006), through an analysis of the Asian population in New Zealand. Following a systematic review of literature, a ten-week education program was developed to improve the cultural competence of practitioners working with this group. The evaluation of this program was largely positive, with participants stating they felt it provided both practical and theoretical support. While it was a single program, the description provided by the authors would enable others to implement a similar educational initiative.

**Diathesis stress model.**

A diathesis stress model of wellbeing for teenage siblings of people with autism spectrum disorder was tested by Orsmond and Seltzer (2009). This model attempts to explain the relationship between the genetic vulnerability of such siblings (diathesis)
and the stress they encounter in their environment (Bauminger & Yirmiya, 2001).
While brothers reported mental health symptoms at a lower rate than the general
population, sisters reported higher levels of both depressive and anxiety symptoms;
however, their prevalence was similar to that in the general population. A family
history of autism spectrum disorder and maternal depression were both associated with
increase symptoms, but only in conjunction with a high number of stressful life events.
The authors conclude that the diathesis-stress model is partially supported as those
with more stressful life events experience more symptoms; but both genetic
vulnerability and environmental stress need to be considered in combination.

Disease models.
McGruder (2004) advocates the retention of a range of theoretical
understandings of mental illness within OT, as a point of difference between this
profession and medicine. Much of psychiatry is based on disease models of mental
illness, although the recovery movement is beginning to challenge this focus.
McGruder highlights OT’s traditional position as a distant ally of medicine by
presenting a summary of aftercare for a person with schizophrenia and comparing a
holistic model approach with a disease model approach. However, occupational
therapists remain involved in research which proceeds from a disease model, as they use
diverse ways of knowing: for example, an occupational therapist participated in a study
of the origins of auditory hallucinations in people with schizophrenia (Li, Chen, Yang,
Chen & Tsay, 2002). This study did not provide firm support for the self monitoring
model of hallucination, which was the only article reviewed that reported a negative
finding about the applicability of a theoretical way of knowing.

Empowerment.
In considering the influence of this concept in community mental health, Clark
and Krupa (2002) describe both its development and relationship to power theory.
Difficulties in finding universally accepted definitions are acknowledged, but the
authors propose that most include a participatory process (either individual or group)
that aims to increase personal control through critical thinking, action and power
sharing; that promotes dignity and equity through social change and resource
mobilisation. Despite being set in a North American service context, this overview
proposes four ongoing legacies of the emergence of empowerment that have relevance
to the Australian mental health system: 1) focus on the social determinants of health; 2)
development of conceptual models; 3) tolerance for professional self reflection; and 4)
growth of formal client-controlled organisations. Mental health OT has already taken a lead in the first two of these areas, and reflective practice is currently a prominent theme in OT in Australia. The profession has also been involved in the growth of client-controlled organisations in Australia, such as clubhouses, the employment of consumer consultants and social firms.

**Function.**

In reviewing the concept of function, Fossey and Harvey (2001) are examining one of the core concepts of OT, regardless of the area of practice. They used the context of the Australian National Mental Health Strategy to analyse how function contributes to consumer outcome measures. Their literature review revealed that function is a poorly defined concept, with functional domains often combined in conceptually inappropriate ways and assumptions made about the role of symptoms. Functional outcome measures were also often developed in the absence of meaningful consumer involvement, raising the possibility that the domains being measured may not be relevant. Function is such a core concept to OT in all practice settings, but does not appear to have been synthesised with the push for client centred practice over the past twenty years or so.

**Gender.**

The role of gender in mental health OT is the subject of a theoretical article by Pollard and Walsh (2000). They highlight that OT is gendered by nature, being a traditionally middle class, female profession. Mental health OT is also originally focused on domestic and creative activities, which are also culturally characterised as feminine. This has been challenged by the drive to align more with the masculine, scientific paradigm that is prevalent in medicine, which these authors believe has been to the profession’s detriment. In discarding the domestic, feminine aspects of occupation, the profession may be failing to address clients’ needs and passing up the chance to enhance social justice.

**Implicit and explicit continuum of interventions.**

Eklund (2002) proposes a framework for considering OT interventions in mental health, using a continuum between explicit and implicit. This framework was formulated from a reflection on mental health occupational therapy practice in Sweden, descriptions of practice from elsewhere published in journals, evidence published in textbooks, and the features of occupational therapy theories. Occupational therapists are known to use methods all along this continuum, with the explicit focused on skills
for daily living and the implicit focused on the development of capacities. However, the relative prominence of these interventions is contentious, with Eklund citing some occupational therapists believe skills performance is central to the profession while others foreground the development of capacities. She concludes that implicit methods must be acknowledged and described for the sake of clarity and transparency.

**Objects relations theory.**

Eklund (2000) explains that object relations theory is relevant to both present and past relations, and cites the work of Winnicott and Sullivan as congruent with the philosophy of OT. In particular, Winnicott’s work is linked to the concepts of being and doing, as without a sense of identity doing cannot become instrumental. Eklund suggests that object relations theory can assist occupational therapists work with clients on impairment, activity and participation levels as defined by the ICIDH-2 (World Health Organisation, 1997); however, she also acknowledges that it may have some shortcomings as a developmental theory, and that the language of some theorists (particularly Sullivan) are deficit-based.

**Predictive models.**

Predictive models look to identify factors that promote or discourage engagement in occupation, assuming these will have an impact on health. Several of these have emerged in mental health OT, all of which have focused on predicting quality of life factors for clients. In a study of 157 people using assertive outreach services in Canada, symptom distress was found to be the most influential factor, followed by psychological and physical integration (Chan, Krupa, Lawson & Eastabrook, 2005). For people with depression using inpatient services, analysis revealed that findings from particular assessments (including COPM and Occupational Self Assessment) were predictive of quality of life across a range of domains (Pan, Sarah, Chung, Chen & Hsiung, 2006). A model developed for people with schizophrenia living in Hong Kong (Chan & Yeung, 2008) found that community and social function was the most influential factor, although symptom levels also had an impact. Finally, a study with people with depression in Taiwan (Chung, Pan & Hsiung, 2009) found that symptom intensity, social support and stigma impacted on quality of life. While a range of factors were found in each of these studies, social participation, environmental support and level of symptomology featured fairly consistently. One initial difficulty with these predictive models was their development in heterogeneous
populations of people with mental health problems, but more recent studies have focused on discrete diagnostic groups.

**Radical social practice.**

A model of radical social practice is proposed in a brief opinion piece by Corrigan (2001). He argues that mental health OT has been pulled from its socialist roots, becoming less focused on self development and more on social control as it becomes more closely aligned to medicine. Corrigan highlights the role of OT in moral surveillance and social control historically, and questions whether some of our practices maintain these in the present. In regard to mental health, he advocates that occupational therapists should use social agency to describe treatment interventions, rather than clinical terminology. This model is more of an approach than a theory, and no other reference to it has been found in OT literature.

**Recovery.**

Rebeiro Gruhl (2005) reflects on the emergence of the recovery approach (or paradigm) and its potential role in mental health OT. Highlighting the striking similarities between the values and beliefs of OT and those purported in recovery, she uses a comparative table to show the areas of congruence. She acknowledges that little is known about the practical aspect of recovery: how it actually happens. Rebeiro believes this places OT in a position of leadership in the recovery movement, as drivers of research and knowledge development.

Another article to explore the concept of recovery focuses on rehabilitation in particular (Lloyd, Waghorn & Williams, 2008). These authors propose that service providers approach recovery by considering clinical, personal, social and functional domains. To look beyond a focus on symptom remission, they propose that organisations need to provide better supports for this holistic approach, effective assessments must be developed and collaborative relationships formed with families and carers. They contend that services which help practitioners address recovery systematically are more likely to improve client outcomes and reduce the overall disease burden on both individuals and the broader community.

Lal (2010), who asks if one prescription serves all people with mental health problems, takes a critical approach to recovery. She analyses the concept of recovery for its clarity, simplicity, generality, accessibility and importance. Lal questions its universal applicability, citing examples where it may not be relevant in different cultural contexts, at different points in the lifespan, or in types of services or communities.
typically underserved by mental health services. An example of the difficulties in generalising recovery is provided by ongoing efforts to develop outcome measures for recovery, which need to include as many as 18 different domains to be valid. Multiple meanings of recovery are present in different settings, suggesting a more nuanced and individualised approach to the mantra of recovery is needed.

A recent qualitative study of ten occupational therapists in New Zealand looked at how they use the recovery approach in their practice (Cone & Wilson, 2012). OT was found to facilitate recovery, as did the connection of clients with social networks. In common with Rebeiro Gruhl, the participants thought the recovery approach was very congruent with OT values and was a harmonious form of practice; recovery could therefore provide a vehicle for being more assertive about the role of OT in services. However, there were barriers to its implementation, including conflicting definitions of recovery, the influence of other professions, and limited resources. These participants also raised the cultural aspects of recovery, reflecting that it worked well with Maori clients.

**Resilience.**

Resilience theory (and the related concept of vulnerability) are explored in a study which focuses on occupational performance for people with post traumatic stress disorder (PTSD) (Lopez, 2011). Resilience is a protective factor against PTSD, and early intervention can lessen the impact of this condition substantially in the longer term. Similarly to discussions concerning recovery, Lopez states that using resilience theory promotes a strengths-based approach which is congruent with OT values. Resilience has been the subject of online discussion threads in Australian mental health OT practice, but is yet to gain prominence as a key concept for practice.

**Service models.**

Many of the articles in this category describe mental health OT within service models, generically developed to accommodate multidisciplinary teams. These models develop within particular cultural, legislative and environmental contexts, and it is notable that all originate from the US. The most notable, the international Clubhouse model, is explored in two articles (DiMasso, Avi-Itzhak & Obler, 2001; Royeen & Ramsay, 2000). It has little presence in other countries where mental health OT is practiced (such as at the national level in Australia). Mental health OT has also contributed to diagnosis specific services for young people at high risk of psychosis (Ruff, McFarlane, Downing, Cook & Woodberry, 2012), children who have
experienced trauma and/or abuse (Hyter, Atchison, Henry, Sloane & Black-Pond, 2002) and people with dementia (Schaber, 2003; Warchol 2004).

More general service models have also been addressed in the peer-reviewed literature, located in both the community and the hospital environment. The Fairweather Model of mental health programs is investigated in two articles by Haertl (2005, 2007); this model emphasises peer involvement in recovery, which encourages autonomous decision-making and problem solving.

The recovery movement is also a motivating factor in the development of a wellness and recovery model within psychiatric hospitals, described by Swarbrick (2009a). In this model, habits and routine are seen as a key to wellness, and are supported while the client is an inpatient. Finally, a study by Chapleau, Seroczynski, Meyers, Lamb and Buchin (2012) outlines the use of a consultation model, where occupational therapists in a community mental health team provide consultations to address goal attainment and homelessness with clients.

**Vocational rehabilitation models.**

While these models could be considered a sub-set of service models, their specialist nature deserves an independent analysis. The Individual Placement and Support Model (IPS) is the most commonly cited theory in this area of practice (Auerbach, 2001; Moll, Huff and Detwiler, 2003; Nygren, Markstrom, Svensson, Hansson & Sandlund, 2011). There is good evidence for the efficacy of this approach, particularly for those with severe and enduring mental health problems, although Auerbach (2001) concludes it is better suited to motivated clients seeking competitive work.

Eklund and Hansson (2001) investigate the introduction of a new vocational rehabilitation model in a rehabilitation unit. This model took a behavioural and social learning approach based on the principals of psychosocial rehabilitation developed at the Centre for Psychiatric Rehabilitation in Boston. The authors conclude that the new model had a beneficial impact on the ward’s atmosphere; however, the ward’s atmosphere had been stable over time so other measures were needed for substantial change. The Peer Employment Support (PES) model (Swarbrick, Bates & Roberts, 2009) draws on knowledge concerning self-help and peer support, and has a focus on addressing the ambivalence that is a barrier to many clients. The IPS model influences this model (through rapid placement in the workforce), but readiness is also addressed explicitly through interventions delivered by peers.
On a national level, Kirsh, Krupa, Cockburn and Gewurtz (2010) develop a framework that integrates the central constructs of work integration for Canadians with mental health problems. Constructivist grounded theory is used to review a wide range of documentary sources, and 19 key informants from various regions in Canada are interviewed. Five central perspectives emerge, focusing on competency, citizenship, workplace health, potential, growth and self-construction, and community economic development. These varied perspectives influence the ongoing discourse around work integration in Canada, and the formulation of this theory highlights how central ideas compete with, synergise, and mould the social discourse.

**Impact of related knowledge on practice**

The related knowledge found in this review has come from a range of traditions and disciplines. The vast majority of this related knowledge has only been the subject of a handful of articles; however the applicability of this evidence varies. Some of these articles (such as action theory, attachment theory, implicit/explicit continuum, objects relation theory and radical social practice) has only introduce the knowledge to mental health OT, but clinicians need to seek further information independently to apply them to practice with confidence and assess whether there is sufficient evidence for their use within mental health OT. In other cases (such as behavioural theory), their impact on practice is better illustrated through the use of case studies. For example, the case study about activity analysis enabled clinicians to envision and consider how they may use this concept in practice to make meaningful differences for their clients.

A common theme among the related knowledge reviewed is the difficulty in defining theoretical constructs. This is particularly prevalent in those articles which focus on a single concept, such as the literature review about function. However, two New Zealand studies (Cone & Wilson, 2012; Nayar & Tse, 2006) show how recovery and cultural competence can be practically applied. For example: Nayar and Tse (2006) demonstrated how an education program can be constructed and delivered to support clinicians understand a theoretical way of knowing, engage with the evidence supporting it and develop their own practice ways of knowing to apply it. Another strong theme among related knowledge is the similarity between OT values and other non OT specific concepts (particularly resilience and recovery). While these comparisons may be useful to clinicians in finding the occupational focus within the related knowledge, there is a failure to report the unique differences that OT possesses in relation to this other knowledge. There is, therefore, a danger of blurring our
professional identity and confusing other professions about our particular contribution to promoting mental health.

The diathesis stress model and predictive models share a focus on identifying risk factors which can impact on occupational engagement. By highlighting particular issues which either increase or decrease quality of life, they can guide clinicians to areas that generally focus on in assessment and intervention. However, these models are based on large populations and therefore do not report findings which are directly tailored to the individual needs of particular clients. This limitation is also common to both service and vocational rehabilitation models, although the evidence for them tends to be more explicitly linked to practice. These services have been developed to meet the needs of a diverse range of people in their local areas, and their outcomes can only ever be reported in general, aggregate terms. The effectiveness of many of these models is yet to be tested, as many of the articles are descriptive or focused on staff or client experience of the services.

The theoretical ways of knowing which currently underpin mental health OT

A range of theoretical ways of knowing currently underpin mental health OT. The majority are related knowledge, drawn from other disciplines and traditions. This is hardly surprising, given the historical pattern of adapting knowledge, and there are both benefits and disadvantages to this practice of supplementing knowledge about occupation. However, evidence about this related knowledge is not consolidated. Very few (e.g. MOHO and recovery) are the subject of more than one or two articles, and in most cases there is no evidence of further impact on mental health OT. It may be that these theories are co-opted to meet specific needs or specific circumstances, and therefore will not be more broadly applied.

There are also six conceptual practice models, developed by occupational therapists and specifically relevant to occupation and health, which meet Kielhofners definition. In addition, there are a further five who partially meet the definition, in most cases having not developed technology for application. The most comprehensively developed conceptual practice model that meets the definition used in this thesis is MOHO which is regularly applied within mental health (n=17). The MOHO has been the subject of a diverse range of research using a range of methods, and of varying rigour. It is also supported by organisations in both Canada and the UK who help to formulate and sustain this program of research. I believe a key to its widespread adoption has been the availability of theoretical, evidentiary and practice information; it
has been presented in a range of ways. I was surprised at the lack of evidence published for CMOP, which, anecdotally is generally considered in Australian practice to be both prevalent and influential.

In my experience, Australian mental health occupational therapists use knowledge from all three circles – related knowledge is used to augment the professional, specific, approach outlined in conceptual practice models, and the diversity of theoretical ways of knowing used within the profession are encompassed by the values and assumptions espoused in the one existing paradigm. Clinicians therefore not only have to be competent in applying each theoretical way of knowing in itself, but also in how to integrate and combine them in coherent and valid ways to support practice. There are several theoretical ways of knowing available to mental health occupational therapists is immense, but variety can be a doubled-edged sword: it enables a truly individualised approach to therapy but can also lead to a fragmented, disjointed, theoretical basis which militates against consistent practice.

Achieving an approach to mental health OT which integrates theoretical ways of knowing with evidence and practice is deeply challenging in the face of so many choices. A paradigm has the potential to unify the field of OT by operating at the level of broad assumptions and perspectives (Kielhofner, 2009). It could therefore be said to be the most important of the three levels of conceptual knowledge – the centre of gravity around which all the other forms of knowledge orbit. The only paradigm identified in the literature is the OPH; however, there was only one piece of supporting evidence found during this iteration of the ITEA method. To achieve an integrated approach, I decided the next phase of my journey would need to explore whether the OPH was an appropriate paradigm to unify the many theoretical ways of knowing in mental health OT.

The Occupational Perspective of Health (OPH)

There has been a resurgence of interest in the OPH in recent years, as evidenced by recent studies from the UK (Kosma, Bryant & Wilson, 2013; Kramer-Roy, 2012), and the positive reception to my own conference presentations on the subject. The relevance of the OPH in particular (and Wilcock’s work more broadly) is generally recognised, and the key concepts of doing, being, becoming and belonging are commonly found within the discourse of the profession. However, as Kosma et al. (2013) emphasise, the impact of the OPH has not been comprehensively explored and the key concepts in the model are not always clearly understood.
To assess the suitability of the OPH as a unifying paradigm for theoretical, evidentiary and practice ways of knowing, I first needed to immerse myself in its concepts to fully understand it. To use the metaphor of my journey, I needed to live a while in the land of the OPH to understand its language, customs and practice. I began by reading the second edition of the model (Wilcock, 2006) several times over several months. The reflective notes I took at the time underscored two conflicting emotions within my response to this text: frustration and admiration. Frustration was my initial reaction, as I found the scholarly, dense writing style very difficult to engage with. Every chapter seemed to take at least three readings, and I felt as though the concepts that spoke most clearly to me as a clinician (doing, being, becoming and belonging) were obscured by the surrounding analysis. I was also confused by the myriad other concepts which form part of the theory, such as the occupational brain and public health focus (Wilcock, 2006; Kosma et al., 2013).

After my third reading of the text, with much use of highlighting and annotations in the margins, I began to admire the depth of analysis and breadth of vision that underlies this theory. Having immersed myself in Wilcock’s story, her knowledge infiltrated and influenced my professional story. I found myself focusing on what I considered to be the strengths of the theory, the parts that I experienced as accessible, intuitive and authentic: doing, being, becoming and belonging. Wilcock’s story influenced my personal story, as I noticed a shift in my sense of identity at this point. Having found a way to engage with her theory, I stopped thinking that it was beyond the reach of someone like me, a practical, pragmatic clinician. Making sense of all that information helped me to believe I was capable of understanding complex, scholarly works, and of formulating an intelligent response to them. At that point, I became a clinician/academic.

Having acquainted myself with the OPH, I felt more ready to examine and analyse the paradigm with a view to its ability to unify diverse ways of knowing. The previous critical question asked; What theoretical ways of knowing currently underpin mental health OT? Before setting off on my next iteration of the ITEA method, I reframed my critical question to focus on analysing the OPH.

**Iteration 2 of the ITEA method**

**Step 1 – Determine / re-determine the research question.**

How have the concepts of doing, being, becoming and belonging developed since the inception of the OPH?
I once again undertook the process of ITEA in its entirety to explore this question. This study is currently available as an early publication in *Occupational Therapy in Health Care*, where it has been published as the first of a two part article. This critical analysis was particularly timely, given the increase in interest in the paradigm in the past couple of years, and also provides an update of the professions understandings of the dimensions to date. A description of the ITEA process is included within the following article.


As alluded to in the final paragraph of the article, I felt that analysing each dimension on its own only provided a partial understanding of doing, being, becoming and belonging. In my experience, mental health occupational therapists integrate their knowledge of doing, being, becoming and belonging, dealing with all of the dimensions as they constantly interact with each other. I reframed my critical question and set off on another round of ITEA analysis to explore the dimensions at a deeper level.

**Iteration 3 of the ITEA method**

**Step 1 – Determine / re-determine the research question**

How do doing, being, becoming and belonging interact and combine to influence occupational engagement?

This study is currently available as an early publication in *Occupational Therapy in Health Care*, where it has been published as the second of a two part article. Having provided updated definitions of the dimensions in the first part, this second article focused on building an understanding of how they interact and relate to each other. A full description of the method undertaken to complete this study is included in the following article.

Having analysed the OPH in more depth, I now felt that I had a clear understanding of its four main dimensions as they are provisionally defined in current occupational therapy literature. However, this didn’t explain how mental health occupational therapists could use the OPH to integrate different ways of knowing, so the next step in my study was to explore how the dimensions were related to the many and diverse theoretical ways of knowing available to mental health occupational therapists at the level of a conceptual practice model and related knowledge. In some ways this iteration of the ITEA method highlights the “transfer/utilisation” step of the previous two iterations of the ITEA method, testing whether clinicians could use these dimensions as a unifying paradigm while also applying other forms of knowledge. I decided to focus on the relationship between the dimensions and conceptual practice models, as related knowledge is usually subsumed within them. Therefore, by understanding how the dimensions and conceptual practice models interrelate, their relationship to related knowledge can be inferred and tested at a later date. This generated a new critical question:

**Iteration 4 of the ITEA method**

**Step 1: Re-determine the research question.**
Can the dimensions of doing, being, becoming and belonging be used in conjunction with conceptual practice models in mental health occupational therapy?

**Step 2: Select theoretical framework.**
The dimensions of doing, being, becoming and belonging from the OPH which were developed in the critical analyses just reported are the identified theoretical framework.

**Step 3: Identification.**
To identify suitable evidence to answer this question, I returned to the sample of 90 peer-reviewed articles I had consulted to discover which theoretical ways of knowing currently underpin mental health OT. For two full conceptual practice models (CMOPE and MOHO), and four partial conceptual practice models (Collaborative Therapeutic Homework Model, Kawa Model, Non-linear dynamic theory and Occupational Adaptation), case studies had been conducted with clients or groups of clients. These case studies were framed by a conceptual practice model, and included discussion and analysis of how the model had been applied by clinicians in practice. I decided these articles would be appropriate sources of evidence for the use of a range of conceptual practice models in mental health occupational therapy, and any potential relationship
they might have with the OPH as a paradigm. The sources for this analysis are presented in Table 3.2.

Table 3.2
Case Studies Depicting the Use of Conceptual Practice Models in Mental Health OT

<table>
<thead>
<tr>
<th>Reference</th>
<th>Client/Condition</th>
<th>Conceptual Practice Model</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clarke (2003)</td>
<td>Clients of forensic rehab. hostel</td>
<td>CMOPE</td>
</tr>
<tr>
<td>Luboshitzsky &amp; Gaber (2000)</td>
<td>Sharon</td>
<td>Collaborative Therapeutic Homework Model</td>
</tr>
<tr>
<td>Pizur-Barnekow &amp; Erickson (2011)</td>
<td>Ms L</td>
<td>MOHO</td>
</tr>
</tbody>
</table>

**Step 4: Deconstruction.**

The process of deconstruction was based on a thematic analysis of the results and discussion sections of each of these six articles. I coded the content of each article in terms of statements relating to doing, being, becoming and belonging. As a result of this coding, I deconstructed the evidence into four datasets, one for each dimension.

**Step 5: Analyse data.**

These datasets were analysed thematically, and a matrix used to map the dimensions to the constructs of each conceptual practice model. The information in these matrices was retained within each case study to preserve the integrity of the original methods used by the authors, with no attempt being made to compare results across models or cases. These matrices can be found in full in Appendix F.

**Step 6: Reconstruction.**

The following is an example of a statement of the relationship between the OPH and Occupational Adaptation Framework drawn from one of these matrices.
Jack.

Jack is a client of an inpatient program for children aged 8 to 13 years old with severe behavioural, familial or emotional problems. He is introduced by Bouteloup and Beltran (2007) as follows:

- Jack is an 11-year-old boy. His sibling also has severe behavioural problems including a significant history of violent aggression. The family is financially and materially under-resourced. Jack has been a client of a community-based child and adolescent mental health team for several years because of ongoing emotional and behavioural problems. Jack was admitted to the inpatient program for an initial school term and made gains in reducing violent outbursts and improved emotional control. At the time of the case study he was in his second admission. (p. 229)

Person System

Doing:

Sensorimotor, cognitive and psychosocial – Jack has difficulties doing both gross and fine motor tasks, due to his existing skills and capacities. He avoids crossing the midline.

- Genetic, environmental and experiential – Jack comes from a low socio-economic background, which has reduced his access to resources which support his doing.

Being:

Sensorimotor, cognitive and psychosocial – Jack has difficulties with visual pursuit, and reports that his eyes felt sore after an eye movement screening test. He has a mixed dominance, and poor proprioception. However, he has good balance, tone and visual perceptive skills. Jack has been diagnosed as having intellectual difficulties.

Becoming:

Sensorimotor, cognitive and psychosocial – Jack tends to avoid tasks he has had difficulties with in the past, and is reluctant to persist. Over time he has been able to reduce his violent outbursts and improve his emotional control. Therapeutic goals include further improvement in this area, and working on his compliance with instructions. Nursing staff have identified academic skills, but his mother does not feel these are important.
Belonging:
Sensorimotor, cognitive and psychosocial – Jack lives with his mother and older sibling. His parents divorced some time ago, and he has no contact with his father.

Performance Components

Doing:
Work, play and self care – Jack performs chores for pocket money. He attends school, and is due to transition to high school soon. He is independent in all self care tasks.

Physical, social and cultural – Jack attends a mainstream school, where he has a history of behavioural issues. He is now using non-violent strategies to settle issues.

Being:
Work, play and self care – Jack’s role as a student involves participation in a range of occupations. He has a keen interest in Star Trek. Jack states he is confident in his self care tasks, and is beginning to experience improved motivation and confidence in writing.

Physical, social and cultural – Jack was a victim of bullying in the past. He has been encouraged to make his own choices as part of his therapy.

Becoming:
Work, play and self care – Jack wants to repeat Year 7, and has a goal to improve his writing. He has been able to build on existing skills (e.g. tying his shoe laces), and feels enthusiastic about writing when it’s about his personal interests.

Belonging:
Work, play and self care – Jack has several friends at school with whom he plays regularly. However, he has difficulties playing with his sibling due to rapid escalations to violent behaviour.

Physical, social and cultural – Jack has been a client of the child and adolescent mental health service for some years. His school friends are of the same age as he, and he is aware of the expectations his school has of his performance.
In all but one of the six conceptual practice models reviewed for this specific iteration of the ITEA, statements relating to all four dimensions of occupation were found. While no direct statements about doing, being, becoming and belonging were recorded in any of the six articles in this sample, the analysis described above identified examples of text which clearly related to the definitions of each dimensions. In addition, statements were found which related all of the major concepts in each conceptual practice model to at least one of the dimensions. The following discussion will provide details of these relationships.

**Occupational Adaptation**

The two main concepts in the Occupational Adaptation framework are the person system (sensorimotor, cognitive, psychosocial factors and genetic, environmental, experiential factors) and performance components (work, play and self care factors and physical, social and cultural factors). Analysis of the presence of doing, being, becoming and belonging was greatly assisted by the level of detail presented by Bouteloup and Beltran (2007), and statements relating to them were found across most of the concepts. However, there were no statements relating to being, becoming or belonging for genetic, environmental and experiential factors. This may be due to reporting restrictions in the peer-reviewed format, as these factors were covered quite briefly in a single paragraph. While being is relevant to all of these factors, becoming and belonging are immaterial to genetics as they cannot be changed and are a purely individual factor. There were also no statements about becoming in physical, social and cultural contexts. Jack is 11 years old, and therefore does not have much influence to change these broader contexts at this point in his life. When using the Occupational Adaptation framework, the authors identified elements that were related to the dimension of the OPH without conscious attempt or focus.

**CMOP.**

The four main concepts in CMOP are person (including spirituality), occupation and environment. Unlike the other case studies reviewed, Clarke (2003) provides an overview for an entire population of clients living in a forensic rehabilitation hostel. Occupational performance was supported by statements which my analysis related to doing, being, becoming and belonging. No statements about belonging for performance components (physical, cognitive and affective) could be identified. While the case study provided some commentary on the being of therapists and broader community members in the environment, no statements on being in the environment for these clients are
included; nor are there any statements about doing and spirituality. Clarke comments that spirituality was a somewhat contentious concept in this setting, and the therapists had replaced the term with “sense of self.” It therefore did not take a prominent place within their use of the model, but may in other settings.

**Non-linear dynamic theory.**

The three main concepts in non-linear dynamic theory are microscopic (intention), mesoscopic (meaning), and macroscopic (perception). Statements pertaining to doing, being, becoming and belonging were found across all the major concepts of this model.

**Collaborative therapeutic homework model.**

The six steps of this model were used as the organising concepts: 1) careful identification of the clients problems; 2) goal setting using behavioural terms; 3) contractual agreement between therapist and client; 4) ranking of goals to ensure the first one addressed makes the most difference to the client and is the most feasible; 5) selection of an acceptable form of skills training for the client; and 6) systemic skill and behavioural training using homework tasks. Statements about doing were present across all but one of the steps. This could be attributed to the focus of this model on a particular task. Elements of being for the case study presented for this model (Sharon) were reported in regard to the identification of her problems and her experience of the skills and behavioural training. Statements about becoming were most prominent in the goal setting step, and were revisited at the end of the article when these goals were reviewed following skills and behavioural training. Statements about becoming were also evident at the beginning and end of the process.

**Kawa Model.**

There are five main concepts within the overall metaphor used in the Kawa model: mizu (water flow), torimaki (river banks), iwa (rocks), ryoboku (driftwood) and sukima (space between obstructions) (Iwama, 2006). The single case study available to explore potential links with doing, being, becoming and belonging in this model only describes the use of the metaphor as a whole, so there was insufficient information to break the analysis down. This would be a valuable analysis to undertake in future, but there do not appear to be any single client case studies using this model published to date. Statements pertaining to doing, being, becoming and belonging were found throughout the case study presented by Paxson et al. (2012).
MOHO.

The three main concepts focus the human system in MOHO. These are performance, habituation and volition. The other components of the MOHO relate to levels of occupation, occupational identity, competence and adaptation, and the environment. Statements pertaining to doing, being, becoming and belonging were found across all concepts focusing on the human system.

The relationship of doing, being, becoming and belonging to conceptual practice models in mental health OT

In regard to the conceptual practice models as a whole, statements relating to the dimensions of doing, being, becoming and belonging could be drawn from were found in case studies across all six conceptual practice models included in the sample. The relationship between the dimensions and the conceptual practice models became more complex when considering individual concepts. Two explanations are proposed for those instances where statements about a particular dimension were not found in relation to the model’s concepts: that by relying on published case studies this iteration of ITEA is dependent on the reporting of the original authors; and that a more detailed account may or may not have provided data which demonstrated a link between the dimensions and the model.

In some instances, there was no relationship between the dimensions and a particular concept. For example; there is no relationship between becoming and genetic factors as genetics do not change, and there is no relationship between belonging and performance components because they reside within the individual. In other cases where no relationship was found, it may have not been the focus of the case study or relevant to the functioning or circumstances of the client Clinicians apply these models as a whole, as indeed they are designed to be used; and the overall finding that doing, being, becoming and belonging can be applied in every conceptual practice model recently published in mental health occupational therapy is authentic to clinical practice.

The outcome of this iteration of ITEA provided me with preliminary evidence to support the dimensions of doing, being, becoming and belonging as a paradigm which can unify the diversity and multiplicity evident in mental health OT conceptual practice models. However, further investigation would be needed in regard to related knowledge; that is, other areas of practice and other conceptual practice models. At this point, I took stock of my journey through theoretical ways of knowing. I had gained an understanding of current theoretical ways of knowing in mental health OT,
pursued a deeper understanding of the four dimensions of occupation, and gathered provisional evidence that the four dimensions could provide a paradigm for unifying theory in this area. While there were further lines of enquiry which could (and need to be) pursued, I felt at this point I had explored theoretical ways of knowing sufficiently to answer the research question for this thesis.

Summary

This chapter has reported on four iterations of the ITEA method, which have explored theoretical ways of knowing about mental health OT. The critical questions which have driven this part of the thesis are shown in Figure 3.3 below.

Figure 3.3 Iterations of ITEA method used to explore theoretical ways of knowing.

This chapter began with an introduction to the place of theoretical ways of knowing in mental health OT. The first iteration of ITEA sought to answer “what theoretical ways of knowing currently underpin mental health OT?” A total of 90 peer-reviewed articles were identified pertaining to this question, and they were deconstructed and analysed using Kielhofner’s (2009) three types of knowledge. The majority of the evidence was found to be related knowledge, and most that used scientific methods were exploratory in nature. One paradigm, eleven conceptual practice models and twelve categories of related knowledge were found during this
review. The OPH was the only paradigm identified, and MOHO was by far the most researched conceptual model in mental health OT. There is a diversity and multiplicity of ways of knowing available to mental health occupational therapists through conceptual practice models and related knowledge.

Having established the range of theoretical ways of knowing available in mental health OT, the next phase of my journey was an exploration of whether the OPH was an appropriate paradigm to unify the many theoretical ways of knowing in mental health occupational therapy. I began by engaging with the major text about the OPH (Wilcock, 2006), and decided to focus on the concepts I experienced as accessible, intuitive and authentic – doing, being, becoming and belonging. Therefore, my next critical question was, “how have the concepts of doing, being, becoming and belonging developed since the inception of the OPH?”

I completed a critical analysis of all sources citing Wilcock’s three seminal publications regarding the OPH between the years 2000 and 2012. A total of 176 sources were found, but only a small fraction of these commented on or used the OPH in any meaningful way. As a result of this analysis, the descriptions of doing, being, becoming and belonging were updated to reflect the evolving knowledge of these terms in the first part of this century. The need to perceive the dimensions holistically was a recurring theme, which recognises their impact on and interdependence with each other; but reflecting on and contemplating each dimension individually also provided valuable insights and added greater depth to my understanding.

From the findings of my critical analysis, I reformulated the critical question as “how do doing, being, becoming and belonging interact and combine to influence occupational engagement?” Using the same sample of sources, I analysed the interdependent relationships between each dyad of dimensions before combining my findings into an integrated summary of the relationships between doing, being, becoming and belonging. There were six major findings from this critical analysis: 1) The dimensions have evolved, but there remains a theory-practice gap; 2) development of the dimensions has been uneven; 3) our current outlook on the dimensions of occupation is overwhelmingly positive; 4) occupation is multidimensional and operates on many levels simultaneously; 5) the dimensions of occupation are in a constant state of flux; and 6) a holistic perspective is authentic to both the profession and lived experience of occupation.
Having critically analysed the dimensions of doing, being, becoming and belonging from the OPH, I explored how they related to the many and diverse theoretical ways of knowing available to mental health occupational therapists at the level of conceptual practice model. To achieve this, I sought to answer a reformulated critical question: “can the dimensions of doing, being, becoming and belonging be used in conjunction with conceptual practice models in mental health occupational therapy?” Returning to the sample of peer-reviewed articles I consulted for the first question, I found six peer reviewed articles of case studies which described the use of full and partial conceptual practice models. These six articles were analysed for their relationship with doing, being, becoming and belonging, with the data displayed in both matrices and evidence statements.

Statements relating to the dimensions of doing, being, becoming and belonging were found in case studies across all six conceptual practice models included in the sample. However, there were several concepts within these models for which statements relating to the four dimensions could not be found. This may have been because of limitations in the reporting of the original case studies, or because some dimensions are not relevant to some concepts described in the models (e.g. becoming and genetic factors). This analysis provided provisional evidence supporting the dimensions of doing, being, becoming and belonging as a paradigm which unifies the diversity and multiplicity evident in mental health OT conceptual practice models. Further investigation in regard to related knowledge, other areas of practice and other conceptual practice models was needed to consolidate this proposal.
Chapter 4. Evidentiary Ways of Knowing

“Power is not sufficient evidence of truth.” –Johnson, Taxation no tyranny: An answer to the resolutions and address of the American Congress.

Introduction

In the previous chapter, the diversity and multiplicity of theoretical ways of knowing in mental health OT became evident. As shown in Figure 3.3, four iterations of the ITEA method explored current theoretical ways of knowing, the development of the four dimensions of the OPH (doing, being, becoming and belonging), the interdependent nature of these dimensions, and their potential use in conjunction with conceptual practice models in mental health OT. Despite the wide range of theoretical ways of knowing available, my analysis provided provisional evidence which supported the idea of doing, being, becoming and belonging as unifying concepts which can be integrated with conceptual practice models. I felt this provided me with an answer to the original research question around the ways in which theoretical ways of knowing integrate and incorporate to guide evidence based practice for occupational therapists working in mental health, but I needed to move into the region of evidence to work on the next section of my overall research question.

As I had done when exploring theoretical ways of knowing, I wanted to begin by understanding current knowledge about evidence in mental health OT. I already understood which methods of analysis supporting evidentiary ways of knowing were available in mental health OT, from the process of developing the ITEA method. In broad terms, these methods include quantitative, qualitative and mixed methods from the scientific tradition, along with a range of other methods such as literature review, critical analysis and practice description. In this next phase of my journey, I wanted to map how much of this evidence was available for mental health occupational therapists.

Evidence maps provide an overview of the key findings in relation to a defined research area, including the sources and types of the evidence available (Arksey & O’Malley, 2005). They are constructed to identify key literature and concepts in a particular area, and to identify gaps where further research is needed (Hitch, 2012). There are several published methods for conducting evidence mapping, and one of these is compatible with the ITEA method used throughout this thesis. Arksey and O’Malley (2003) identify five broad stages in evidence mapping, and the analogous step in the
ITEA method is displayed in Table 4.1. The ITEA method has additional subsequent steps which promote the translation of evidence mapping (and other forms of evidence review) into practice, and also embeds theoretical ways of knowing into the process.

Table 4.1

<table>
<thead>
<tr>
<th>Stage in Evidence Mapping Process</th>
<th>Step in ITEA method</th>
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<tbody>
<tr>
<td>Identifying the research question</td>
<td>Determine/Re-determine the research question</td>
</tr>
<tr>
<td>Identifying the relevant studies</td>
<td>Identification</td>
</tr>
<tr>
<td>Study selection</td>
<td>Identification</td>
</tr>
<tr>
<td>Charting the data</td>
<td>Deconstruction</td>
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<td>Collating, summarising and reporting the results.</td>
<td>Analysis Re-construction</td>
</tr>
</tbody>
</table>

As during my previous journey through theoretical ways of knowing, I wanted to understand the current context for evidentiary ways of knowing in mental health before undertaking my detailed mapping. In a way, I wanted to go to a lookout and survey the general lie of the land before engaging with what I already knew was a very large and complex data set. I also wanted to retain a perspective that recognised and engaged with the mainstream, influential forms of evidence and the alternative (and considered less powerful by some) forms of evidence available to mental health occupational therapists. My first iteration of ITEA in this area looked to explore current thinking and evidence which directly related to evidentiary ways of knowing in mental health OT.

**Iteration 5 of the ITEA method**

**Step 1: Determine/Re-determine the research question**

How are evidentiary ways of knowing currently discussed in peer-reviewed literature relevant to mental health OT?

**Step 2: Select theoretical framework**

As stated previously, the OPH and its four dimensions was the chosen framework for the remaining iterations of the ITEA method in this thesis.
Step 3: Identification

To identify the evidence relevant to the critical question, I adopted the same inclusion criteria as the overall thesis, but only included articles which had been categorised into the “research” practice sub-category during the triage process for this thesis. This sub-category includes both sources that encompassed evidence based practice and those related to conducting research within mental health OT, and therefore contained the most relevant evidence for this iteration of the ITEA method.

Unlike theoretical ways of knowing, there were relatively few peer-reviewed articles about evidentiary ways of knowing in mental health OT. These articles are distinct from those using evidentiary ways of knowing through primary research (i.e. the entire sample), as they address the ways that evidence is generated and transferred into practice. I am aware of other sources about evidence in this field (e.g. Illot, 2008; Long & Cronin-Davis, 2006), but these are books or book chapters and therefore did not meet the inclusion criterion of being in a peer-reviewed publications. I acknowledge that there are additional sources available to mental health clinicians, and the influence of such sources could be pursued in future research. I identified 20 peer-reviewed articles out of the total sample of 1596 through this process, all of which could be procured and analysed.

Step 4: Deconstruction

Deconstruction proceeded using the chosen theoretical framework and further triage to identify types and levels of evidence. The same process as described in Chapter 2 was used here, with each article first classified as relating to one of the four dimensions of occupation (doing, being becoming and belonging). The content of the article was then analysed to classify its type of evidence (quantitative, qualitative, mixed methods and other evidence), and the scientific evidence was appraised and assigned a level of evidence from either the NHMRC scale (NHMRC, 2000) or RF-QRA (Henderson & Rheault, 2004).

In this sample of 20 articles, all of the evidence related to either doing or becoming, in regard to research or evidence based practice. Doing in regard to evidentiary ways of knowing relates to the activities and occupations that mental health occupational therapists participate in as part of evidence based practice and research. Becoming is demonstrated through the relationship these activities have with the therapists’ continuing development, and their professional goals and aspirations. Doing accounted for the majority of the sample (85%, n=17). Neither being nor belonging has
been explored in peer-review literature in regard to evidentiary ways of knowing in mental health OT to date. This meant that evidence based practice for mental health occupational therapists relating to occupational therapists’ sense of identity and capabilities in research were not in the literature from 2000 to 2012. Neither was belonging, in regards to how the occupation of researching influences a clinicians’ sense of connectedness, both to the profession and to other life relationships.

Over half of the articles reviewed used non-scientific methods (55%, n = 11). The remaining nine articles were split between quantitative (n=5) and qualitative (n=4) method studies. All of the quantitative evidence was exploratory in nature, and rated as level V on the hierarchy of evidence. The levels of evidence for qualitative studies were again higher, with one study at level V, two studies at level III and two studies at level II.

Step 5: Analyse the data.
Detailed reading and critique occurred with every article, with notes taken to form the basis of the subsequent overall analysis. These notes commented on how the data correlated with, consolidated and compared to each other, as I looked for instances of agreement and difference within the content of each. For example; I looked at articles that discussed the best ways to provide education to clinicians about research, and considered whether their findings were similar or contradictory.

Step 6 Reconstruct.
Reconstruction occurred when the notes from this analysis were used to formulate a prose evidence statement, structured around the four dimensions of occupation. This proceeded in a bottom-up manner, where individual studies published between 2000 and 2012 were integrated under the sub-categories of ‘research’ and ‘professional’ for both of the two identified dimensions - doing and becoming.

Doing.
Doing in relation to evidentiary ways of knowing had several different forms, which became evident as sub-themes in the body of articles during analysis. Five sub-themes were identified; generating evidentiary ways of knowing, academic–clinician partnerships, participatory action research, clients and evidentiary ways of knowing, and occupational therapists and evidentiary ways of knowing.

Generating evidentiary ways of knowing.
This sub-theme related to the conduct of research, which may or may not be translated into practice. Recent developments have focused on ways of knowing that
emphasise quantitative evidence. The American OT Association (AOTA) has supported the development of several systematic reviews relevant to mental health OT, subsequent to a broader initiative to increase the level of evidence available to the profession. A methodology for a review of OT for adults with Alzheimer’s Disease and related dementias has been published (Arbesman & Lieberman, 2011), as has a systematic review around OT for employment and education for people with serious mental illness (Arbesman & Logsdon, 2011). AOTA has also published comprehensive practice guidelines for adults with serious mental illness (Arbesman & Lieberman, 2013).

Bannigan has been an active contributor to the ongoing discourse around evidentiary ways of knowing in mental health OT, and her latest article focuses on the method of systematic reviews (Bannigan & Spring, 2012). Systematic reviews are useful for research prioritisation as they highlight gaps in knowledge around interventions and provide information about the effectiveness of the interventions themselves. Using a search which focused on systematic reviews arising only from randomised controlled trials, Bannigan and Spring located only four which were related to mental health OT: Edwards and Burnard (2003), Hunter and Nicol (2002), McGrath and Hayes (2000), and Tungpunkom and Nicol (2008). To address this lack of published evidence, the authors propose a detailed method to assist clinician’s complete systematic reviews in mental health OT, although in practice it would be too onerous for most occupational therapists. Their method includes the formation and maintenance of a steering committee, and multiple readings of the source articles (which would lead to great rigour, but is beyond the resources of most practicing mental health occupational therapists). Given the diversity of ways of knowing in mental health OT, it is interesting that the articles about generating evidentiary ways of knowing all focused on the most rigorous forms of quantitative research.

Academic–clinician partnerships.

The barriers to clinicians generating evidentiary ways of knowing are well recognised, as clinicians (and their partners) seeking to conduct research in workplaces face numerous challenges (Moll, 2012). Politically sensitive research (particular topics that could show the organisation in a poor light) is particularly susceptible to these challenges, as they are likely to encounter considerable organisational resistance. Strategic partnerships are proposed as a way of overcoming these challenges. Moll describes her experiences of conducting research on employee mental health, and
reflects that making partnerships (and clearly communicating with people on different levels throughout the organisation) was supportive.

The formation and maintenance of relationships between academics and clinicians is the focus of several studies which use case studies based in mental health to illustrate their arguments. Stern (2005) proposes a model for outcomes research which aims to overcome some of the recognised barriers such as time constraints or lack of institutional support. Students were included as part of this model as a way of socialising them into the role of researcher and consumer of research. The mentoring available to clinicians also helped to build their capacity to participate in such research, and the benefits of publishing and contributing to the evidence base was acknowledged. Other academic–clinician partnerships were highlighted in a community development program that provided individual services within the community (Swenson Miller & Johnson, 2005), and the provision of training to clubhouse members which enabled them to become competent in facilitating self report interviews as research assistants (Hancock, Bundy, Tamsett & McMahon, 2012).

A further example of academic–clinician partnerships in the UK was described by Forsyth, Duncan and Mann (2005). A partnership was formed between a high secure hospital in Scotland and the UK Centre for Outcomes Research and Education (UKCORE) at South Bank University in London. This centre was founded to integrate research and theory development, education, and practice, and multiple methods were provided to the clinicians to enhance their skills in knowledge translation. The relationship is reported to have been successful in changing practices, with clinicians beginning to generate theory and research. While this case study provides substantial detail about some aspects of the processes around this partnership, it doesn’t discuss the logistics of collaboration between two organisations which were geographically distant. The positive outcomes of the initiative are also presented descriptively, with no supporting data from either clinicians or clients.

**Participatory Action Research (PAR).**

An alternative approach to academic–clinician partnerships is offered by PAR, which engages all stakeholders in a service or situation as participant researchers. Researchers therefore become activists and advocates, as well as gatherers of knowledge. PAR has been used across several mental health settings by occupational therapists, including a community mental health service (Rempfer & Knott, 2001), vocational rehabilitation (Cockburn & Trentham, 2002) and centres for independent
living (Mirza, Gossett, Chan, Burford & Hammel, 2008). These authors highlight the congruence of PAR with the recovery approach and underlying values of mental health OT, suggesting it integrates successfully with theoretical ways of knowing. However, it can be a very resource-intensive approach, and issues of funding and political contexts can become barriers to its successful implementation. Clinicians taking on the role of activist may also face organisational challenges, and be vulnerable to role blurring and conflicts of interest.

**Clients and evidentiary ways of knowing.**

Ballinger (2012) draws attention to different ways of knowing regarding evidence in mental health OT by first highlighting existing systematic reviews (e.g. Arbesman & Lieberman, 2011) and randomised controlled methods (Cook, Chambers & Coleman, 2009; Lambert, Harvey & Poland, 2007). She then includes a contribution from a client, Dorothy Gould, who was at the time leading a project into client experiences of recovery. This focus on the contribution of clients to evidence generation highlights the need for appropriate supports to be provided to enable this. Interestingly, Dorothy makes several points about the potential lack of relevance of the sort of quantitative methods Ballinger had previously cited, but no links or critiques of this were made in the conclusion of the article. Hearing the clients’ perspective adds credibility to the argument that the research questions are the most important aspect, and that the methods selected should only be in their service. Clinicians could reflect on this when considering the tensions between client centred and evidence based practice.

An instrumental case study into client contributions to research (Restall, Cooper & Kaufert, 2011) focused on policies related to mental health and social housing in one province of Canada. Four groups of participants were interviewed (clients, service providers, advocacy organisations and governmental officials), and this qualitative data was combined with data from policy documents. Clients’ personal knowledge has been translated into these policies in a range of ways, demonstrating the relevance of the evidence on which they were based. By describing the application of personal knowledge to policy, this case study can provide guidance to clinicians looking to take an inclusive approach to local policies and procedures. However, its Canadian context potentially limits the applicability of these findings, as each organisation and nation has its own drivers and networks for policy generation and implementation.

Specific challenges associated with gathering evidence from clients in specific cases, such as people with dementia (Nygård, 2006), are also discussed in the articles
reviewed. Traditional qualitative data gathering methods such as in-depth interviews do not allow people with advanced dementia to participate fully, given their difficulties with verbal and communication skills. Informed consent can also be an issue, so a combination of techniques (including observation and adapted interview protocols) can help these clients to continue to participate actively in evidence generation. Without their engagement, the validity of the resulting data may be questionable.

The feasibility of recruiting people with schizophrenia into a randomised control trial also addresses the challenges of ensuring client participation in research (Abbott, Arthur, Walker & Doody, 2005). Several appointments were often needed to complete recruitment, because of missed attendances, difficulties in understanding study information, and ambivalence about building a relationship with the researcher. Some of the reasons for these difficulties suggested by the authors include a poor understanding of the study process and mistrust of randomisation. Clinicians seeking to work with consumers on research generation may therefore need to factor in longer time frames for data collection, or modify their data collection techniques. While randomised controlled trial are the exception in mental health OT research, these principles are equally applicable to other forms of research (i.e. some clients may find the highly interpersonal nature of qualitative interviews particularly challenging).

**Occupational therapists and evidentiary ways of knowing.**

A range of perceptions around evidentiary ways of knowing have been expressed in the literature. Mairs (2003) expresses concern that OT is under-represented in the mental health evidence base. As this article equates evidence with quantitative research only, it concludes there is little published literature to support mental health OT. Citing some poorly designed studies which produced adverse findings about mental health OT (e.g. Nicol et al., 2002), Mairs (2003) urges clinicians and academics to critique research that undermines the profession. However, Mairs’ limited view of research excludes a range of evidence which does represent OT in the mental health evidence based (as demonstrated in this thesis). The poorly designed studies highlighted show what can happen when a method is applied inappropriately, offering a pragmatist critique of this particular form of evidence.

Lloyd, Bassett and King (2004) also sought to reflect on the merits of evidence based practice, highlighting the need to engage with the dominant scientific paradigm. They contend that much clinical practice is not scrutinised for effectiveness or efficiency, but acknowledge common challenges such as difficulties in translating
An overview of evidence based practice for occupational therapists in Australia and New Zealand provides an interesting regional view (Tse, Lloyd, Penman, King & Bassett, 2004). Occupational therapists in both countries are found to have made a slow transition to evidence based practice, hampered by current health reforms emphasising increased accountability, financial constraints, increasing quality and meeting client expectations. Evidence based practice is thought to justify the need for OT and enhance the credibility of our profession, but the article describes evidence based practice as combining research with therapists’ practice knowledge, enacted through collaborations between clinicians and universities (i.e. Lloyd, Bassett & King, 2004; Lloyd, Bassett & Samra, 2000). This view of evidence based practice is closer to real life practice than many definitions, and having a regional review increases the relevance of these findings to Australian mental health occupational therapists. While evidence based practice can contribute to the credibility of OT and have benefits for clinicians, this article doesn’t address its role in improving services to clients like the previous one. An overview or critique which explored all of the reasons for (and against) evidence based practice would be useful to support clinicians to engage in the topic in a comprehensive and informed manner.

In contrast to the many partnerships described in the literature, Ammeraal and Coppers (2012) provide an account of clinicians independently implementing evidence based practice. This project occurred over an extended timeframe (six years), and aimed to develop more effective living skills training courses. In describing their process, the authors use the metaphor of a journey (including the identification of fellow travellers and a need for translators), and conclude that collaboration, context and change management strategies are important.
A further reflection on the practicalities of using evidentiary ways of knowing focuses on the facilitators and barriers to using evidence based clinical guidelines for people with dementia and their carers in the Netherlands (Van’t Leven et al, 2012). The Community OT in Dementia guideline includes a detailed timeline for treatment, provided in ten one-hour sessions over a five-week period. Occupational therapist participants reported they found it hard to engage with these guidelines, experiencing difficulties in forming treatment priorities within the framework and uncertainties about the minimal adherence criteria. However, the content of the guidelines, its supporting evidence, and the external support received were experienced as helpful. The service context in the Netherlands may also be a contributing factor in these findings, and would need to be considered if these guidelines were to be transferred to other countries.

The perceptions of Australian occupational therapists of clinical outcomes research is explored by Bowman and Llewellyn (2002). Three overarching themes were identified: knowledge and understanding of clinical outcomes research, clinicians’ experience in conducting or participating in clinical outcomes research, and the relevance of clinical outcomes research to OT clinical practice. The participants tended to focus on isolated parts of the research process; few had participated in research in their working lives. They were ambivalent about the relevance of the research to their practice, and collaborative relationships with academics were again proposed to overcome their overall lack of experience with the process and other barriers. The attitudes of clinicians to research are crucial to its implementation, as they can remain a barrier even when resourcing issues are addressed. There is often an assumption that mental health occupational therapists have a positive attitude toward evidence based practice, but as this study showed it cannot be assumed. This study was conducted over a decade ago, and new research is needed to determine whether these attitudes are still prevalent.

Finally, a new form of partnership was described in a recent article which presents the key issues in building and maintaining a long-term research collaboration between clients and clinicians (Bryant et al., 2012). Clients, a clinician and an assistant, reflected on their experiences and reported a collaborative and cyclical process of mutual learning and sharing. This mutuality had a positive impact on the potentially unequal power relationships within the group, as equity was maintained and respective knowledge respected. However, the depth of these interpersonal relationships needed
time and space for development, and were therefore best suited to longer term or ongoing relationships rather than short, project-based collaborations.

**Impact of doing evidentiary ways of knowing on practice.**

Partnerships between various stakeholders are the mode of doing evidentiary ways of knowing that is currently in ascendance. This seems to have emerged in recognition of the growing amount of evidence that clinicians are being expected to engage with, and of their need to overcome the gap between knowing about the evidence and doing something with it.

The role of clinicians in doing evidentiary ways of knowing is largely characterised as passive and receptive. None of the studies reviewed commented on the benefits of these approach to the academics – their role is seen as providers. This suggests a less than even power relationship between the parties, with the academics the people “teaching” clinicians and students how to do research and contribute to evidence based practice. The reported partnership between academics and clinicians seems at odds with the espoused values of OT, and more collaborative relationships deserves further analysis. The single study about clinician–client partnerships which demonstrated much more equity (Bryant et al., 2012), appears more coherent with OT values and could be hold the key to successful and sustainable partnerships where all stakeholders benefit from it, including clients.

Something else emerged from this analysis: the literature around doing evidentiary ways of knowing focuses more on quantitative methods than any others. In particular, systematic reviews and randomised controlled trials are highlighted as examples of best practice and good evidence. While this is true from a scientific perspective, these are the methods clinicians are least likely to adopt (either individually or as part of a team), due to the narrow range of questions they are able to answer and the resources that are required to complete them. With the entire article about mental health occupational therapists doing research as part of their evidence based practice focusing on quantitative methods, a biased impression is given of what constitutes good evidence based practice.

Current literature about clients and evidentiary ways of knowing in mental health OT is somewhat ambiguous. While there were examples of personal accounts being translated into policy (such as Restall, Cooper and Kauert, 2011), clients’ contribution to research is somehow separate from, and divorced from, what is considered high-quality quantitative evidence. Two of the articles reviewed focused on overcoming
challenges to including clients in research, but in both cases their role is confined to a participant rather than the full partnerships aspired to in participatory action research. There are several reasons for adopting a client inclusive approach to research, including ensuring the relevance of research questions, enacting client centredness across all areas of OT and building capacity across stakeholder groups.

The views of occupational therapists on evidentiary ways of knowing shows a persistent line of negativity in many of the articles about the lack of progress in implementation, the potentially disastrous consequences of non-adoption, and common barriers and challenges to implementation. Only one of the articles reviewed acknowledged the role of therapists’ practice ways of knowing in the application of evidence. Overall, evidence based practice is presented as something that is difficult and time consuming, and links between it and better outcomes for clients are rarely made. The doing of evidentiary ways of knowing in mental health OT is portrayed as being largely out of clinicians’ hands. Even when collaborations are formed, clinicians are most often the junior partners, whose lack of research experience is seen as their greatest limitation. The experience and expertise of clinicians remain under-acknowledged and undervalued in relation to (mostly quantitative) evidence. Also, very little is said about the final important step of translating evidence into practice. My perception of this body of evidence is that it currently only presents the academic’s side of this story

**Becoming.**

All of the articles related to becoming focused on OT research priorities in mental health, highlighting the profession’s aspirations for the generation of future evidence. There have been three articles about priorities for research in mental health OT published since the year 2000, two from the UK and one from Australia.

Davis and Bannigan (2000) surveyed delegates at a British Association of Occupational Therapists in Mental Health conference, and asked them to prioritise issues for research in mental health OT. The top three interventions cited as a focus for further research were activity/occupation, group work, and occupational performance skills. Feedback indicated these were identified because they were considered core skills that would increase professional status, highlight the effectiveness of OT, and assist with client-centredness. The authors made a salient point around the focus of research in mental health OT, highlighting that the emphasis should be on improving interventions for clients rather than increasing the profession’s status.
Two years later, these priorities were updated through a further survey at the next conference of this Association (Davis & Hyde, 2002). The top priority (activity/occupation) remained in position, but all other interventions were reprioritised. Occupational performance and user perspective moved up into the top three, while group work dropped to fourth.

A Delphi survey method is used in the Australian study (Bissett, Cusick & Adamson, 2002), which also draws on the opinions of professional association members. Twenty-two priorities areas were initially identified, reduced to six very broad consensus areas (i.e. research of value to clients, research of value to occupational therapists working in mental health). Within each of these areas, 27 specific topics were identified for topics such as psychosis, early intervention and consumer collaboration.

Unfortunately there have been no further studies into becoming in research and evidence based practice, and the available articles span a period of just two years. The contextual factors that influence these priorities mean these studies are most relevant to their home countries and the period of time in which they were conducted. The overall categories identified in the studies were also extremely broad, to the point where they could not practically guide a research agenda. The need for a re-examination of the priorities in this area within mental health OT is clear.

Current knowledge of evidentiary ways of knowing in mental health OT.

When considered in combination with my previous analysis of the many forms of evidence available to mental health OT to support evidentiary ways of knowing, it is clear that diversity and multiplicity remain as ongoing themes. The need for flexibility when using a range of methods of inquiry was also recognised, to ensure full participation by clients and adopt approaches (such as PAR) which can manage the generation and utilisation of various forms of evidence.

While there has been some acknowledgement of the need for therapist and client knowledge to contribute to evidence, more recent discourse around evidentiary ways of knowing in mental health OT have focused on quantitative methods at the top of the hierarchy of evidence. This relates to another underlying theme, which is the perception that research and evidence based OT are a means for the profession to gain credibility within the dominant paradigm. As noted in the introductory chapter to this thesis, there are numerous alternative fora for disseminating ways of knowing about occupation and health (i.e. blogs, tweets, posts, client reports, websites, personal testimonies, newsletters, books and reports) (Reagon, Bellin, & Boniface, 2008). The decision to
restrict this thesis to peer reviewed journal articles could be seen as contradictory to the principles of diversity and multiplicity it espouses. However, this decision was made on logistical grounds to make the volume of data to be analysed manageable. While results from implementing the ITEA analysis have also highlighted this view as undoubtedly one reason for engaging with evidentiary ways of knowing, I argue that the primary rationale for consulting the best available evidence is to improve the quality of the interventions being provided for people with mental health problems.

Initiatives to promote clinician engagement with evidentiary ways of knowing in mental health succeed within the context of partnerships or relationships, although the power relationship within them are not equitable. These partnerships may be with academics, clients or other stakeholders, and there are suggestions that they work best when power relationships within them are fairly even. While PAR was one of the research approaches used in these partnerships, the full range of potential methods for evidence generation between academics, clinicians and clients are open for the future development of evidentiary ways of knowing that reflect OT values and practice.

Our understandings of becoming for research and evidence based practice are limited to a cluster of articles which are now over a decade old. Given the many changes in mental health over that time (nationally and internally, professionally and culturally), it is likely these findings are out of date. There is a clear need to update this aspect of our understanding, which must take contextual influences (i.e. country and culture based factors) into account. There is also a need for the creation of knowledge of how evidentiary ways of knowing impact upon the being and belonging of mental health occupational therapists.

Having reviewed the methods used to support evidentiary ways of knowing in mental health OT, and the profession’s understanding of them, I felt prepared to embark on a detailed mapping of the evidence available to mental health occupational therapists. The next iteration of the ITEA method specifically focused on the key findings, sources and types of evidence found in peer-reviewed journals from between 2000 and 2012. The drawing of this map directly addresses the evidentiary ways of knowing, and captures the body of articles on which mental health occupational therapists base their practice. This led to the next iteration of ITEA in the exploration of evidentiary ways of knowing.
Iteration 6 of the ITEA method

Step 1 – Determine / re-determine research questions

What are the key findings, sources and types of evidence published in peer-reviewed journals from between 2000 and 2012 which have been authored by mental health occupational therapists?

Step 2 – Choose theoretical framework

The four dimensions of doing, being, becoming and belonging were the chosen framework for the remaining iterations of the ITEA method in this thesis.

Step 3 - Identification.

To identify the evidence relevant to the critical question, I adopted the same inclusion criteria as the overall thesis. The databases and search terms used to identify the relevant evidence have already been described in Chapter 2, but several issues arose during the process of identification during this particular iteration of the ITEA method and will be further discussed below.

Finding needles in a very large haystack.

The amount of research evidence into mental health OT has grown immensely in the past decade. As stated in Chapter 2, 1596 articles have been written about mental health by occupational therapists and published in peer-reviewed journals between 2000 and 2012. While this wealth of information is welcome, identifying topics related to human health and wellbeing in the growing mountain of evidence becomes a challenge for searching.

The usual method for locating evidence is to search in electronic databases. These services hold immense power, as they are both gatekeepers and guides to finding information relevant to our research questions (Gleick, 2011). I began the process of identifying the evidence relevant to the current critical question with pilot searches to refine my technique.

A search for all the peer-reviewed articles published by occupational therapists about mental health OT was undertaken, limited to the years 2000, 2005 and 2010. I chose these years for my pilot searches to account for any changes in database listing which might have happened over the intervening decade, as a snapshot near the beginning, midpoint and end of the timeframe of the sample for this thesis. I searched all the databases available through Deakin University in these three years, noting for each article the databases in which it appeared and the search terms under which it was listed.
A total of 336 studies were identified, from 68 databases and one search engine (Google Scholar®); a full list of these databases can be found in Appendix G. The majority of the articles were indexed to more than one database or search engine, providing a level of redundancy. Five databases were then chosen for further scrutiny, based on their prevalence as sources for the articles identified: the Allied and Complementary Medicine Database (AMED), Cumulative Index to Nursing and Allied Health (CINAHL), OTDBase, PSYCInfo, and Scopus. A further database and search engine were included due to their free availability: Scirus and Google Scholar. The coverage provided for each database or search engine was determined by identifying how many from the overall list of articles could be located using the search terms (“OT” AND (“mental health” OR “mental illness” OR “psychiatry”). As shown in Table 4.2, the level of coverage provided by each database varied significantly.

Table 4.2

Coverage of Mental Health OT Sources by Electronic Databases and Search Engines

<table>
<thead>
<tr>
<th>Database</th>
<th>Percentage of articles covered</th>
</tr>
</thead>
<tbody>
<tr>
<td>OTDBase</td>
<td>67.27%</td>
</tr>
<tr>
<td>Google Scholar®</td>
<td>35.87%</td>
</tr>
<tr>
<td>SCOPUS</td>
<td>35.32%</td>
</tr>
<tr>
<td>PSYCInfo</td>
<td>26.23%</td>
</tr>
<tr>
<td>CINAHL</td>
<td>25.45%</td>
</tr>
<tr>
<td>AMED</td>
<td>21.30%</td>
</tr>
<tr>
<td>Scirus</td>
<td>9.09%</td>
</tr>
</tbody>
</table>

To reduce the inherent redundancy from multiple listings, I analysed the patterns of databases for individual articles. OTDBase lists only OT journals, and includes several from developing countries that are not listed anywhere else. However, some of the newer titles (such as the Journal of Occupational Therapy, Schools and Intervention relating to the field of child and adolescent mental health) are not currently listed, so its coverage of professional journals is incomplete. While this database is relevant to mental health OT, using it in isolation could mean missing up to a third of the available evidence.
All the articles found in Scirus and AMED were also available in other databases, so these two databases were eliminated from the search strategy. The remaining articles were evenly spread across CINAHL, Google Scholar, PSYCInfo and SCOPUS. Thus, the comprehensive search for OT evidence in mental health necessitated a search in four different databases and a search engine. This highlights some of the barriers clinicians could face if they wanted to engage in a literature search.

Having established which databases to search, the methods used to locate evidence within each of them were analysed. Databases are indexed using predetermined search terms, which may be based on a generic taxonomy (such as Medical Subject Headings or MESH) or be specific to that database. Each of the databases uses its own system of indexation, and therefore has its own set of keywords. OTDBase is arranged around categories, but a search can also be completed via keywords in the title or abstract. Index keywords in SCOPUS may come from one of three systems (EMTREE, MeSH, or Compendex), depending on the original source of the document. Both CINAHL and PSYCInfo have developed their own classifications and codes.

It is worth highlighting that terms used by indexers can be completely different to the professional and vernacular language of OT. This is most clearly illustrated in Scopus, which publishes both keywords provided by the author and those used to index the article. The author keywords and index keywords were compared for those articles (n=84) in the list which had been listed in Scopus (n=84). There was a total of 339 author keywords (average 4 per article), of which 256 were unique terms. There was a total of 2447 index keywords (average 6 per article), of which 965 were unique terms. As demonstrated in Figure 4.1, there was very little overlap between the groups.

![Figure 4.1 Comparison of search terms in Scopus.](image)
As a search engine, Google Scholar is the exception. It indexes every word on every page it links to, allowing searches based on the language you are likely to encounter in the article. This has resulted in it being more intuitive to use, but it returns up to 1000 results per search including non peer-reviewed formats (such as books and other grey literature), and there are no current methods for efficiently transferring such large lists to bibliographic software for analysis. Searchers therefore have to check each of the references for relevance. A lack of formal indexation also causes some difficulties for users of OTDBase. Its categorisation system is somewhat idiosyncratic, with some of the classifications fairly ambiguous. Keyword searching is a more efficient method with this database, but it requires the use of synonyms to ensure access to all the articles related to a topic.

The outcomes of this analysis were presented at a conference where the focus was on providing guidance for clinicians (Hitch, Pépin & Stagnitti, 2012). For that audience, I emphasised that there were several optimal search strategies for finding research evidence supporting OT in mental health, depending on the context of the search itself. Potentially important factors included time pressures, familiarity with the databases, and financial resources, and two recommendations were provided. First, if the clinician’s context was limited in time or resources, I recommended they use OTDBase and Google Scholar® and searched with keywords they would expect to find in the article; with more time and access to the other databases (PSYChInfo, Scopus & CINAHL). Second, I recommended they supplement the initial search by using these second set of resources to fill in gaps. To do this effectively, they would need to become familiar with the appropriate indexing systems and select search teams which most closely matched those used for OTDBase and CINAHL.

I identified the peer-reviewed articles for this thesis by searching all the databases simultaneously and constructing a combined list of references. The complete list of peer-reviewed articles for this ITEA question appears in Appendix B.

**Step 4 - Deconstruction.**

The amount of data contained within the 1596 articles was considerable, and the system of triage detailed in Chapter 2 was required to deconstruct it into a manageable form. The database which I constructed to record this process of deconstruction contained information on 13 variables: author names, author designation, number of authors, year, title of article, journal, dimension of occupation, practice category, practice sub-category, evidence tradition, method of research, quantitative level of
evidence, qualitative level of evidence, submission to acceptance (days) and acceptance to publication (days).

**Step 5 – Analysis.**

The data were analysed on several levels: across the entire sample, across a sub-category, such as Intervention / Child and Adolescent (Hitch, Lavasani, Pépin & Stagnitti, 2013b) or within a sub-set of a sub-category, such as qualitative data around Lived Experience / Schizophrenia (Hitch, Pépin & Stagnitti, 2013c). For each article, descriptive statistics were used to describe the patterns and characteristics for each variable within evidentiary ways of knowing. Inductive statistics were also possible to explore the relationships between some sub-sets, and are reported within the evidence statements below.

**Step 6 - Reconstruction**

The reconstructed evidence statement that follows provides an account of the analysis of the entire sample of 1596 articles.

**Current Evidence Base for OT in Mental Health**

As stated previously, there were 1596 peer-reviewed articles written by occupational therapists about mental health OT between January 1 2000 and December 31 2012.

**Authors.**

Figure 4.2 demonstrates the overwhelming majority (88.22%, n=1408) of these were written either by authors in academic roles or by collaborative teams comprising academics and clinicians.
Across the entire sample, the average number of authors per article was 3.17 (Range 1 – 15, SD 2.15). As demonstrated in Figure 4.3, there has been a noticeable trend towards increasing numbers of authors.

There was a difference in the number of authors present in articles published in OT journals (M= 2.57, SD= 1.59) and generic journals (M=4.10, SD=2.54); t (1594) = -14.78. The number of authors in generic journals was significantly higher (p=0.00).
Publication patterns.

Across the thirteen years reviewed, there was an average of 122.77 articles (Range 88–169, SD 28.84) published each year by OT authors about mental health OT. As indicated by the range and standard deviation, the amount varied substantially from year to year. There was mostly a pattern of peaks every four years, and as shown in Figure 4.4, some years produced more articles than the following year (2001, 2003, 2007, and 2011). This trend seemed to become more pronounced with time, and one possible explanation being the occurrence of the World Federation of OT congresses in 2006 and 2010, with increases in publications the year following the congress. However, this pattern would need to be followed over an extended period of time to determine its significance.

The articles in this sample appeared in 270 separate peer-reviewed journals. These journals were classified according to whether they were specific to OT or generic, which is shown in Appendix H. The majority of articles were published in OT specific journals, as shown in Figure 4.5 below.

*Figure 4.4* Number of articles published by year.
The top 10 journals by number of articles published relating to mental health OT included 9 which were classified as OT specific (as shown in Table 4.3). None of the journals accounted for a substantial proportion of the articles, indicating a broad spread of places for publication.

Table 4.3

*Top Ten Places of Publication*

<table>
<thead>
<tr>
<th>Journal</th>
<th>Number of Articles</th>
<th>Percentage of Entire Sample</th>
</tr>
</thead>
<tbody>
<tr>
<td>British Journal of OT</td>
<td>223</td>
<td>14.00%</td>
</tr>
<tr>
<td>OT in Mental Health</td>
<td>204</td>
<td>12.80%</td>
</tr>
<tr>
<td>American Journal of OT</td>
<td>109</td>
<td>6.80%</td>
</tr>
<tr>
<td>Australian OT Journal</td>
<td>75</td>
<td>4.70%</td>
</tr>
<tr>
<td>Work</td>
<td>66</td>
<td>4.10%</td>
</tr>
<tr>
<td>Scandinavian Journal of OT</td>
<td>59</td>
<td>3.70%</td>
</tr>
<tr>
<td>OT in Health Care</td>
<td>54</td>
<td>3.40%</td>
</tr>
<tr>
<td>Canadian Journal of OT</td>
<td>42</td>
<td>2.60%</td>
</tr>
<tr>
<td>OT International</td>
<td>37</td>
<td>2.30%</td>
</tr>
<tr>
<td>OT Journal of Research</td>
<td>32</td>
<td>2.00%</td>
</tr>
</tbody>
</table>
Doing, Being, Becoming and Belonging

All the articles in this sample foregrounded one of the dimensions of occupation, either intentionally or non-intentionally. This provides substantial support for the universality of these dimensions, given the diversity and multiplicity of the sample. Being was the most frequently foregrounded dimension, as shown in Figure 4.6.

Figure 4.6 Proportion of articles foregrounding doing, being, becoming and belonging.

While the numbers of articles foregrounding becoming and belonging remained relatively steady over time, Figure 4.7 shows there has been an increase in articles foregrounding doing and being since the year 2000. This is partly due to the overall increase of articles published in later years, but also demonstrates uneven development of research around the four dimensions.

Figure 4.7 Trends in doing, being, becoming and belonging over time.
Practice categories and sub-categories.

Each category and its attendant sub-categories identified previously in Table 2.3 were analysed separately, but overall and across time. Descriptive statistics for frequency of publications were performed and the results of the analysis are presented below.

Assessment. There were 161 articles that focused on assessment, accounting for 10.10% of the total sample. The majority was about standardised assessments (n=133, 82.6%), and as shown in Figure 4.8 there have been two noticeable peaks of publication, in 2007 and 2011.

![Figure 4.8](image)

*Figure 4.8* Articles about standardised and non-standardised assessments over time.

Intervention.

There were 328 articles that focused on intervention, accounting for 20.60% of the total sample. Figure 4.9 shows the proportion of articles for each of the sub-categories in intervention.
Articles about intervention for each sub-category were also mapped by year, and are presented in Appendix I. Half of the practice sub-categories, which were Drug and Alcohol, Mood, Anxiety and Personality/Behaviour, displayed a trend towards consistently low numbers of articles. In contrast, articles about child and adolescent diagnoses (particularly autism) and organic diagnoses (particularly dementia) have steadily increased in recent years, as shown in Figure 4.10

In contrast, articles about schizophrenia and ambiguous or mixed diagnoses (i.e. those where samples included people with multiple diagnoses or participations were
only identified as having a mental health problem) demonstrated inconsistent patterns (as illustrated in Figure 4.11), with peaks at various times since the year 2000.

![Figure 4.11](image)

**Figure 4.11** Trends in articles about intervention for schizophrenia and ambiguous or mixed diagnoses.

**Lived experience.**

There were 481 articles that focused on lived experience, accounting for 30.10% of the total sample. This was the most frequently found practice category. Figure 4.12 shows the proportion of articles about each of the sub-categories, used to triage the articles.

![Figure 4.12](image)

**Figure 4.12** Proportion of articles about lived experience by sub-category.
Articles about lived experience for each sub-category were also mapped by year, and are presented in Appendix J. Drug and Alcohol, Anxiety, Personality/Behaviour and Ambiguous or Mixed Diagnoses displayed a trend towards consistent numbers of articles. However, the other four categories all showed a general trend towards increased number of articles. As illustrated in Figure 4.13, this trend, noticed in intervention articles, continued for lived experience of child and adolescent diagnoses (particularly autism) and organic diagnoses (particularly dementia). However, a decline in the number of articles on lived experience was noted in the last twelve month period (i.e. 2012).

Figure 4.13 Trends in articles about lived experience for child and adolescent, and organic diagnoses.
Articles on the lived experience of clients with mood disorders and schizophrenia were becoming more frequent by 2011, as shown in Figure 4.14.

**Figure 4.14** Trends in articles about lived experience for mood disorders and schizophrenia.

**Program/Service**

There were 445 articles that focused on programs and services, accounting for 27.90% of the total sample. Figure 4.15 shows the proportion of articles in each of the sub-categories.

**Figure 4.15** Proportion of articles about programs by sub-category.

Articles about programs in each sub-category were also mapped by year, and are presented in Appendix K. Forensic, older adults and private practice programs
displayed a trend towards consistently low numbers of articles. There was a generally increasing trend for articles about vocational programs, and as shown in Figure 4.16 articles about programs for children and adolescents, and for adults, both had peaks in the middle of the decade. The reasons for these peaks are not immediately clear, and may warrant further investigation.

![Figure 4.16 Trends in articles about vocational, adult and child and adolescent programs.](image)

**Education.**

There were 58 articles that focused on occupational therapy education that accounted for 3.60% of the total sample. The majority of these were about undergraduate courses (n=46, 79.31%), with continuing professional development the focus of most of the remainder (n=10, 17.24%). Figure 4.17 illustrates how the number of articles about undergraduate education in mental health OT has fluctuated since the year 2000, while those about postgraduate education and continuing professional development remain relatively rare. The peaks of research in 2001, 2005 and 2011 are quite striking in this evidence base, and the reasons behind these may warrant further investigation.
Figure 4.17: Articles about standardised and non-standardised assessments over time.

Theory/Philosophy. The 49 articles that focused on theory/philosophy accounted for 3.10% of the total sample. The majority of theoretical articles used related knowledge (n=35, 71.43%), and all but one of the remainder utilised conceptual practice models which either fully or partially met Kielhofner’s definition (n=13, 26.53%). This sample is smaller than the one reviewed in Chapter 3, as it includes only those articles which had theory/philosophy as their main topic and not those who applied a theoretical way of knowing to research and/or practice. Figure 4.18 shows a general increase in articles about conceptual practice models and related knowledge towards the end of the first decade of the new millennium, but this appears to have tailed off in the past two years. One again, there were peaks in publication frequency during 2007 (for conceptual practice models) and 2009 (for related knowledge), but given the number of different theoretical frameworks involved it may be difficult to attribute them to any one cause.
There were 66 articles that focused on professional issues, accounting for 4.10% of the total sample. These articles were split between the sub-categories of research and workforce, with Figure 4.19 showing the latter being more frequent.

Figure 4.19 Proportion of articles about professional issues by sub-category.

Figure 4.20 shows a generally consistent number of articles written about professional issues being published since the year 2000. These issues tend to be long running (i.e. the debate between specialist and generic roles), and hence their consistent
presence. However, there has been a noticeable increase in articles about research/evidence based practice in mental health OT in the past twelve months. Data will need to be collected for several more years to establish whether this change becomes established.

**Figure 4.20** Articles about professional issues over time.

**Types of Evidence.**

Four types of evidence were found within the 1596 articles – scientific (quantitative, qualitative and mixed methods) and other evidence. Most of the evidence found was either qualitative or other evidence, as illustrated in Figure 4.21.

**Figure 4.21:** Proportion of different types of evidence.
A total of 47 different methods were used to support the three ways of knowing in mental health OT. The top ten methods used spanned all types of evidence (as shown in Table 4.4), and a full listing of the number of articles using all 47 methods is provided in Appendix L.
Table 4.4
*Top Ten Methods Used to Support Ways of Knowing in Mental Health OT*

<table>
<thead>
<tr>
<th>Method</th>
<th>Number of Articles</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Descriptive (Quantitative)</td>
<td>429</td>
<td>26.89%</td>
</tr>
<tr>
<td>Overview (Non-scientific)</td>
<td>125</td>
<td>7.83%</td>
</tr>
<tr>
<td>Pre-post (Quantitative)</td>
<td>99</td>
<td>6.20%</td>
</tr>
<tr>
<td>Control (Quantitative)</td>
<td>97</td>
<td>6.10%</td>
</tr>
<tr>
<td>Literature Review (Non-scientific)</td>
<td>62</td>
<td>3.90%</td>
</tr>
<tr>
<td>Phenomenology (Qualitative)</td>
<td>57</td>
<td>3.57%</td>
</tr>
<tr>
<td>Program Description (Non-scientific)</td>
<td>48</td>
<td>3.01%</td>
</tr>
<tr>
<td>Psychometric (Non-scientific)</td>
<td>111</td>
<td>6.95%</td>
</tr>
<tr>
<td>Unspecified qualitative</td>
<td>108</td>
<td>6.80%</td>
</tr>
<tr>
<td>Case studies (Mixed methods)</td>
<td>91</td>
<td>5.70%</td>
</tr>
</tbody>
</table>

As descriptive methods were the most frequently encountered, the majority of the quantitative evidence available to mental health occupational therapists was rated as level V on the NMHRC hierarchy of evidence. This is the considered the least rigorous level of the hierarchy and this type of evidence cannot be applied to practice with confidence. Figure 4.22 shows the distribution of articles through the five levels of evidence.

*Figure 4.22* Quantitative levels of evidence and number of articles for each level within this sample.
The profile for level of evidence for qualitative evidence was quite different. The majority of this evidence was rated as level II or level III on the Rosalind Franklin Qualitative Research Appraisal Instrument (RF-QRA), which means it can be applied to practice with some confidence. Figure 4.23 shows the distribution of these articles through the five levels of evidence.

![Figure 4.23 Qualitative levels of evidence and number of articles for each level within this sample.](image)

A different pattern emerged in the articles where mixed methods were used. Both the quantitative and qualitative methods used tended towards the lower ends of each hierarchy, as illustrated in Figure 4.19. While mixed methods can add a layer of rigour (by allowing for triangulation of data), this effect is lessened considerably when both forms of evidence are at the lower ends of the hierarchy. This may occur because it is easier to consolidate data which is essentially descriptive, than combine data which is more dissimilar in form. It’s also unlikely that the research questions being posed in mixed methods studies could be satisfactorily answered by a randomised controlled trial and a robust qualitative study. Using these two methods would necessitate two quite different research questions.
Publication Process.

Some of the journals publish information about the publication process with their articles, usually in the form of dates for submission, acceptance or publication. The data for these variables is inconsistent, as not all journals publish it and some have changed their policy in this regard during the time of this thesis. Sometimes the data are given only by month, and in this case it has been assumed the date was the first of that month. This introduces some potential inaccuracy into the following results, but they are the most accurate possible in the circumstances and readers should regard them as estimates rather than final values.

Around one third of articles (n = 526, 32.96%) included information about the time taken between submission and acceptance. The values ranged between 1 day and 939 days, indicating a wide range of procedural speed. The mean number of days between submission and acceptance was 207.83 (SD 145.30). A higher proportion of articles (n=661, 41.42%) included information about the time taken between acceptance and publication. Again, there was a wide range of values (1-994) and the mean number of days was 231.57 (SD 166.69). Therefore, the average article written by occupational therapists about mental health OT takes approximately seven months to be accepted for publication, and a further seven or so months to appear in its final version in print.

Many journals now have an early online facility, but the dates between acceptance and publication in this format are rarely recorded. As shown in Figure 4.20, the times
between submission and acceptance (SA) and acceptance and publication (AP) have tended to decrease, although they have increased in the past twelve months.

![Figure 4.25 Trends between submission to acceptance, and acceptance to publication, over time.](image)

There was a difference in the average time between submission and acceptance between OT journals ($M=241.87$, $SD=156.41$) and generic journals ($M=173.28$, $SD=124.14$); $t(524)=5.56$. Articles progressed from submission to acceptance significantly more quickly in generic journals ($p=0.00$). There was also a difference in the average time between acceptance and publication between OT journals ($M=237.96$, $SD=174.77$) and generic journals ($M=224.76$, $SD=157.62$), but this did not reach statistical significance.

**The current evidence base for OT in mental health**

The analysis above has provided a detailed picture of the evidence available to occupational therapists in mental health. As per the ITEA method, I reconstructed it using the dimensions of occupation. The following evidence statement therefore integrates and incorporates theoretical (as embedded in the method) and evidentiary ways of knowing, as a step to synthesising all three ways of knowing for practice.

**Doing.**

An important aspect of doing in the evidence base for mental health is the initial location and identification of relevant evidence. Currently, mental health occupational therapists need to consult up to four databases and a search engine to gain access to all available evidence relevant to their practice. A large degree of redundancy exists within
these resources, as most articles are listed in more than one place. The cost of subscription fees and available time may limit the ability to find this evidence.

Another important factor is the use of search terms. This analysis showed terms used by indexers are often completely different from the professional and vernacular language of OT. Authors tended to nominate fewer terms, and of all used in the sample only 3.03% were used by both authors and indexers. While this has little impact on Google Scholar searches (which are based on everyday language), it can significantly affect the results received from a database search.

There has been an increase in articles foregrounding doing since the year 2000, many focused on the interventions which occupational therapists provide in mental health. Interventions for people with organic diagnoses are prominent, as are studies which include a sample with ambiguous or mixed diagnoses. Interventions for children and adolescents, and those for people with schizophrenia, also form significant parts of the evidence base. Some trends were found for increased articles about specific diagnoses, showing how external forces that shape an evidence base can have an influence. Other articles which foregrounded doing focused on the programs which occupational therapists provide their interventions. Much of this evidence around programs focuses on services for adults and vocational services.

Most of the evidence available to mental health occupational therapists was either produced using quantitative or non-scientific (other) evidence. A broad range of analytical methods supported the three ways of knowing. Generally, the quantitative evidence was ranked in the bottom two levels of the hierarchy of evidence, while qualitative evidence tended to be ranked in the second and third tiers. Articles using mixed methods tended to combine less rigorous methods from the bottom two levels of the hierarchies. As noted previously, rigorous quantitative studies require much resourcing and don’t always answer the research questions that are relevant to mental health OT. Qualitative studies are particularly relevant to a client centred approach, and can be conducted in a rigorous manner with fewer resources. The use of descriptive methods in mixed studies highlights their congruence for answering single research questions. The use of more robust methods in a mixed manner would present greater challenges to formulating a coherent research question and meaningfully consolidating the different forms of data.
Being.

This evidence base directly influences the being of mental health occupational therapists by providing information that they incorporate into their professional abilities and capacities. The vast majority of the 1596 articles in this sample were written either by authors in academic roles or collaborative teams comprising academics and clinicians. There was an average of 3.17 authors for each article, with significantly more recorded in generic journals than OT journals. The aforementioned diversity is also evident in the fact the articles were found in 270 separate peer-reviewed journals. The evidence is therefore usually constructed in collaborative teams, and those teams are usually larger for studies published in generic journals. This could potentially be quite supportive of clinicians, who can participate in the evidence generating process to a level that respects their many other duties and demands.

Being in relation to clients lived experiences is the most frequently foregrounded dimension, and there has been an increase in articles focusing on it since the year 2000. Occupational therapists initially engage with a client’s being through assessment, and the majority of evidence in this area related to standardised measures. Evidence about the lived experience of clients was the most frequently found, and again articles which included a sample with ambiguous or mixed diagnoses were prominent. In these studies, the specific diagnosis was not considered to be relevant to the being of the clients, despite the fact there are clear differences between the symptoms, medications and stigma associated with various diagnostic categories. The lived experience of a person with a mood disorder may be quite different to a person with psychosis, due to the impact of their condition on their skills, abilities and sense of self. The prevalence of ambiguous and mixed diagnoses samples in mental health OT research is also incongruent with a client centred approach, as all who participate are put in the broad grouping of ‘people with a mental health problem’. There were also substantial evidence bases around the lived experience of child and adolescent clients, people with schizophrenia, and people with organic diagnoses. Conversely, the lived experience of people with personality/behavioural disorders, and drug and alcohol issues are relatively underdeveloped, which may be related to potential difficulties in engaging people experiencing these issues in the research process.

Being in relation to the identity of the profession as a whole accounted for less of the evidence base. Much of the available evidence about the theory/philosophy of mental health OT used related knowledge, as discussed in detail in Chapter 3.
about professional issues included evidence about research and workforce issues, with the former becoming more prominent in the past twelve months. While workforce issues have a consistent presence in the literature, the increase of articles about research supports the idea this issue is gaining prominence in mental health OT. However, as shown in the review at the beginning of this chapter, there remain many gaps in our understanding of how research and workforce issues impact on the identity of OT in mental health.

**Becoming.**

Becoming is seldom foregrounded in evidence, and this situation has remained steady over time. The only area of consolidation is in regard to education, where evidence focuses mostly on undergraduate courses with students becoming therapists. The lack of evidence around the continuing professional development of occupational therapists in mental health is concerning, given that there are requirements in many countries for clinicians to keep their training updated. In Australia, these requirements are explicitly linked to professional registration, and therefore the ability to continue practising. A greater understanding of the continuing professional development (and indeed postgraduate education) needs of mental health occupational therapists is needed, particularly around the impact this education has on their subsequent practice.

**Belonging.**

Belonging is the dimension least foregrounded in evidence, which may be attributable to its relatively recent emergence in professional discourse. However, it is worth noticing that the majority of the evidence available on mental health OT is published in journals that belong to the profession. While this ensures the evidence is accessible to the profession, it also potentially diminishes opportunities to share our knowledge with other disciplines to mutual benefit.

There is evidence to support all areas of mental health OT in greater and lesser amounts. Our knowledge in some areas is relatively comprehensive, or rapidly developing. In others there is a distinct lack of evidence, and the reasons for this are not clear. The most prominent example is the relative lack of evidence about mood and anxiety disorders, which are the mental health problems with the highest prevalence. Accepting the inclusive perspective of this thesis has enabled a comprehensive understanding of what is available to mental health occupational therapists, and challenges the perception that “there’s so little evidence.”
I began at this point to wonder what became of evidence once it had been published in a peer-reviewed journal. From the pragmatic perspective, the ultimate value of evidence lies not in the methods used to complete it, but in its capacity to solve problems and influence future practice. Having gained an understanding of the various methods (both scientific and non-scientific) used to generate evidence to support the ways of knowing, the profession’s overall understanding of evidence and the characteristics of the evidence base itself, I wanted to explore the final part of the cycle of evidence generation – its translation into use.

One (by no means perfect) measure of this influence in regard to evidentiary ways of knowing is to analyse the number of times an article is cited. I decided to explore this in my next iteration of the ITEA method.

**Iteration 7 of the ITEA method**

**Step 1 – Determine / re-determine research question.**

What do future citations reveal about the impact on future research of articles by occupational therapists about mental health OT in peer-reviewed journals?

**Step 2 – Choose theoretical framework.**

The four dimensions of doing, being, becoming and belonging were the chosen framework for the remaining iterations of the ITEA method in this thesis.

**Step 3 - Identification.**

To identify the evidence relevant to the critical question, I adopted the same inclusion criteria as in the overall thesis. The databases and search terms used to identify the relevant evidence have already been described in Chapter 2. However, I limited my search to articles published in the first three years of this project (2000, 2001 and 2002) to enable enough time to elapse since publication for a comprehensive analysis of impact on future research. If there were going to be any citations as a result of a publication, you could reasonably expect them to come within the first decade. This led to the identification of 289 articles, a subset of the overall sample analysed previously.

**Step 4 - Deconstruction.**

Deconstruction proceeded by each article being entered into Google Scholar®, and the number of citations recorded. Citations from all sources (i.e. peer-reviewed journal articles, books, grey literature) were included in the count. In common with the overall thesis, citations in languages other than English were excluded. Citations were
recorded on a year-by-year basis, broken up into OT and generic sources. To qualify as an OT source, the citation needed to be in an OT journal or have OT in the title.

**Step 5 – Analysis.**

The analysis undertaken for this question used descriptive and inductive statistics.

**Step 6 - Reconstruction.**

The following reconstructed evidence statement provides one view of the impact of articles by occupational therapists about mental health OT in peer-reviewed journals.

**Future citations of articles by occupational therapists about mental health OT in peer-reviewed journals.**

A total of 7218 citations were recorded for the 289 articles in this sample, giving an overall average of 24.97 per article. However, 947 citations were rejected because they were in languages other than English or no year for the citation could be found. The final sample was 6271 citations of the 289 articles. The following reconstruction is therefore based on 86.88% of the total citations, which is sufficient to provide some confidence in the findings.

The number of citations per article ranged from 0 to 465. Relatively few articles had never been cited (4.15%, n=12), and a possible factor appears to have been publication in difficult-to-access journals. The Irish Journal of Occupational Therapy, South African Journal of Occupational Therapy and World Federation of Occupational Therapists Bulletin accounted for half of the articles that have never been cited, and I had difficulty getting access to electronic or copied versions of their articles. Of the six other articles that had never been cited, three described interventions (Gregg, McRobert & Pillar, 2002; Lee & Dawe, 2002; Lloyd & Samra, 2000), two were overviews (Babiss, 2002; Gutman & Haynes, 2002) and one addressed a workforce issue (Wigham & Supyk, 2001).

The majority of articles were cited between once and twenty times (n=183, 65.40%). Ten articles were cited more than one hundred times in the subsequent decade. As shown in Table 4.5, the most cited article (Fossey, Epstein, Findlay, Plant & Harvey 2002) garnered the majority of these citations. Five of the articles that were cited more than one hundred times in the subsequent decade were about children or adolescents (four of which referred to sensory processing), two were about involving clients in the research process, and two concerned working with people with dementia. This is complementary to the previous finding that working with children and
adolescents, and with people with organic diagnoses is a growth area in the evidence base for mental health OT. The two about inclusive research practices with clients highlights the importance of this topic to the profession, even if it isn’t regularly practices at the moment.

Table 4.5

Top Ten Most Cited Articles Published in 2000, 2001 and 2002

<table>
<thead>
<tr>
<th>Article</th>
<th>Study Type</th>
<th>Citations</th>
</tr>
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Many more citations were recorded in generic sources than in OT sources. As shown in Figure 4.26, almost three quarters of the citations for these articles were located outside profession-specific publications.

Excluding the years 2000 and 2001, which did not include citations from all of the articles reviewed, there is an overall trend for increasing citation of articles written by occupational therapists about mental health OT. While this trend is relatively mild within the professional literature, it is marked in generic sources where the rate of citation continues to accelerate (as shown in Figure 4.27).
There was a significant difference \((p=0.00)\) in the total number of citations between articles published in OT journals \((M= 16.92, SD= 22.30)\) and generic journals \((M=42.87, SD=68.04)\); \(t\) \((285) =-4.82\), with articles in generic journals cited more frequently. Of articles published in OT journals, there was a significant difference \((p=0.002)\) in the number of citations to them in OT journals \((M=7.55, SD=9.15)\) and generic journals \((M=4.20, SD=7.50)\); \(t\) \((285) =3.05\), with articles in OT journals being more often cited in OT journals. Of articles published in generic journals, there was also a significant difference \((p=0.00)\) in the number of citations in generic journals \((M=32.44, SD=57.61)\) and citations in OT journals \((M=7.43, SD=15.17)\); \(t\) \((285) =4.03\), with articles in generic journals significantly more often cited in generic journals.

The average time between publication and first citation was 2.83 years in OT journals and 3.05 years in generic journals. As shown in Figure 5.23, this average time was higher for generic journal citations of articles published in 2000, but similar times were recorded for both types of citation in subsequent years. Extending this analysis for several more years would confirm whether the trend for reduced time to first citation shown below was continued.

*Figure 4.27* Number of future citations by location.
In regard to the time to first citation in a generic journal, there was a significant difference \( (p=0.00) \) between articles initially published in OT journals \( (M=3.97, SD=2.87) \) and generic journals \( (M=1.80, SD=1.87); t (285) =6.31 \), with articles in generic journals cited in generic journals more quickly.

**The impact of future citations.**

Very few of the articles written by occupational therapists about mental health OT go uncited, and those that are uncited tend to be in journals that are difficult to access. The articles that were most cited included a large proportion addressing autism (particularly sensory processing), which is in practice more often dealt with by paediatric occupational therapists. This and dementia have been areas of increased publication in recent years (see Figures 4.10 and 4.13). Meaningful client involvement in services and research has also gain prominence as a general theme in psychiatry in the early 21st century, so the high numbers of citations may be reflective of current trends.

Citations for these articles were far more likely to be found in generic journals, and there is a strong trend for ongoing acceleration in citation rates in these journals. Articles which were originally published in generic journals were cited significantly more often than those in OT journals, both overall and in the sub-group of generic journals. However, those originally published in OT journals were significantly more
often cited in OT journals. The degree of impact on research is therefore somewhat dependent on the place where the original article was published.

While the impact an article makes on academics or clinicians occurs contemporaneously with their accessing it, evidence of this impact takes approximately three years to appear in future citations. The outcome of this iteration of ITEA provides preliminary evidence concerning the impact of articles written by occupational therapists about mental health OT, but citation counts are a relatively blunt instrument. Future research that follows the influence of the content of the evidence, by tracing the development of ideas through a line of articles on a particular subject, would be illuminating.

Once again, I paused to take stock of my journey to date, and particularly what I now knew about evidentiary ways of knowing. I had gained an understanding of current understandings about evidentiary ways of knowing in mental health OT, analysed the characteristics of the overall body of evidence relating to mental health OT, and investigated the impact of this evidence through an analysis of future citations. This had provided me with sufficient information to address the evidentiary aspects of the research question for this thesis, and so I decided to move on to my final area of inquiry: practice.

**Summary**

This chapter has reported on three iterations of the ITEA method which have explored theoretical ways of knowing about mental health OT. The critical questions which have driven this part of the thesis are shown in Figure 4.29 below.
After introducing evidentiary ways of knowing, I sought to gain an understanding of current knowledge about them. A critical review of current sources regarding research and evidence based practice in mental health OT identified a relatively small body of articles on this topic. All of the evidence related to either doing or becoming, meaning that being and belonging with regard to evidence in mental health OT are yet to be addressed in the professional literature.

A need for flexibility when applying methods has been recognised, both in ensuring full participation by clients and by adopting approaches such as PAR which can manage the generation and utilisation of various forms of evidence. Quantitative methods remain a focus in the peer-reviewed literature, as does an underlying theme that research and evidence based practice are a means for building OT’s credibility. Partnerships were another prominent theme in the literature about evidentiary ways of knowing in mental health OT. Regardless of the stakeholders in these partnerships, it seems that evidence generation cannot occur effectively in isolation. A need for
updated priorities for research in mental health OT was also highlighted, as all evidence concerning this is now over a decade old.

The current evidence base for OT in mental health was then mapped and analysed. In the initial stages of this iteration of ITEA, it became clear that finding evidence on this topic can be a challenge. Currently, academics and clinicians need to search in four databases and a search engine to ensure they are identifying evidence on mental health OT in a comprehensive manner. The search terms used by occupational therapists were found to be significantly different to those used by the indexers of the databases, which may also act as a barrier to identification. I made recommendations regarding the optimal search technique for clinicians, who are less likely to have access to the databases.

As a result of my identification process, a total of 1596 peer-reviewed articles written by occupational therapists about mental health OT were found. The majority of these were written either by authors in academic roles or by collaborative teams of academics and clinicians. On average, each article acknowledged 3.17 authors and there was a trend towards increasing numbers of authors per article. Articles published in generic journals had significantly higher numbers of authors per article.

Each year an average of 122.77 articles were published about mental health OT, but the total amount varied substantially from year to year. There appears to be a pattern of increased numbers of article every four years, perhaps an after-effect of the World Federation of OT congresses. The articles reviewed appeared in 270 separate peer-reviewed journals, the majority of which were specific to OT. None of the top ten most frequently found journals accounted for a substantial proportion of the articles, indicating a broad spread of places for publication.

All of the articles foregrounded one of the dimensions of occupation, and being was the most prominent throughout the body of literature. Both being and doing have been the focus of an increasing number of articles in recent years, but becoming and belong remain under-represented in literature about mental health OT.

Four types of evidence were found within these articles, with quantitative and other evidence being the most frequently adopted approaches. A total of 47 different methods were used to support the three ways of knowing in mental health OT, and the ten most frequently used included methods from all traditions of research and inquiry. The quantitative studies were mostly at the lower ends of the hierarchy of evidence, while qualitative studies tended to be in the middle ranges of the hierarchy. Studies
using mixed methods tended to combine methods which were on the lower reaches of the hierarchies of evidence.

The average article written by occupational therapists about mental health OT takes approximately seven months to be accepted for publication, and a similar time to appear in its final version in print. These times have tended to decrease, although they have increased again in the past twelve months. Articles progressed from submission to acceptance significantly more quickly in generic journals.

Finally, I explored the impact of these articles by analysing the future citations of those published in the years 2000–2002. Each article was cited an average of 24.97 times, with the majority being cited 1–20 times in the following decade. A small proportion had never been cited, and ten had been cited more than 100 times. Many more citations were recorded in generic than in OT sources, with almost three quarters of the citations for these articles located outside profession specific publications. There is an overall trend for increasing citation of articles written by occupational therapists about mental health OT, particularly in generic sources.

Articles in generic journals were cited far more frequently overall, but articles in OT journals were significantly more often cited in OT journals. Similarly, articles in generic journals were significantly more often cited in generic journals, so there appears to be some demarcation between these two categories of publication. The average time between publication and first citation was similar for article published in OT journals and generic journals. However, articles in generic journals were cited in generic journals significantly more quickly.
Chapter 5. Practice Ways of Knowing

“Weaving the warp and weft of occupational therapy refers to the art and science of clinical practice. The metaphor of weaving a tapestry depicts the improvisational aspect of treatment in which practitioners draw upon, modify, and ultimately apply a scientific body of knowledge to enhance the life opportunities of those they serve.”

–Wood, *Weaving the warp and weft of occupational therapy: An art and science for all times.*

Introduction

The previous chapter highlighted the diversity and multiplicity of evidentiary ways of knowing in mental health OT. A wide array of methods is being used to explore occupation in mental health, embracing a range of philosophical standpoints and the diverse settings in which the profession practises. The amount of evidence available to mental health occupational therapists is steadily accelerating, presenting many challenges to clinicians who wish to integrate evidence with theory for better practice. Having reviewed current understandings about evidentiary ways of knowing in mental health OT, and investigated the characteristics of the body of evidence available to clinicians, I decided to carry my learning about both theory and evidence into the next region: practice.

While I would substitute “evidence” for “a scientific body of knowledge” in the quote above, Wood’s analogy of weaving provides a sound metaphor for understanding mental health OT practice. Occupational therapists need to draw on knowledge and skills developed across multiple domains to be successful in supporting their clients. Their knowledge is framed by paradigms, conceptual practice models and related knowledge, and includes an understanding of quantitative, qualitative, mixed and other evidence. This necessitates an ability to interweave theory and evidence in a coherent manner. However, mental health occupational therapists also draw upon knowing which has developed experientially, through their lived experience of providing mental health OT services. This in turn, interacts with the knowledge of people who have personal lived experience of mental health and illness, and who have developed their own expertise with regard to their illness. While these personal ways of knowing are beyond the scope of this thesis, they influence ways of knowing for mental health occupational therapists that are committed to reflective, client-centred practice.
To set the scene for my journey through this way of knowing, I wanted to explore the current understandings of practice in mental health OT in a new iteration of the ITEA method.

**Iteration 8 of the ITEA method**

**Step 1: Determine/re-determine the research question**

What is the current knowledge on how mental health occupational therapists enact practice ways of knowing in mental health OT?

**Step 2: Theoretical framework**

The four dimensions of doing, being, becoming and belonging were the chosen framework for this iteration of the ITEA method.

**Step 3: Identification**

To identify the evidence relevant to the critical question, I first adopted the same inclusion criteria as in the overall thesis. However, additional criteria were then applied to ensure the sample focused on current practice in mental health occupational therapy, and the ways in which practice ways of knowing are manifested. Only those pieces of evidence which were identified as using a practice evaluation or role statement methods during triage were included.

A total of 70 peer-reviewed articles that met the inclusion criteria about practice ways of knowing in mental health OT were located during this process of identification, all of which could be procured.

**Step 4: Deconstruction**

Deconstruction proceeded using the chosen theoretical framework and further triage to identify types and levels of evidence. The same process as described in Chapter 2 was used here, with each article first classified as relating to one of the four dimensions of occupation (doing, being becoming and belonging), as defined from the critical analysis in Chapter 3. The content of the article was then analysed to classify its type of evidence (quantitative, qualitative, mixed methods and other evidence), and the scientific evidence appraised and assigned a level of evidence from either the NHMRC scale (NHMRC, 2000) or RF-QRA (Henderson & Rheault, 2004)

In this sample, all the dimensions of occupation were represented. The practice focus, doing, accounted for the majority of the sample (75.71%, n=53). The other articles foregrounded being (4.28%, n=3), becoming (12.86%, n=9) and belonging (5.71%, n=4) in practice. Practice ways of knowing was mostly supported by non-scientific evidence, however three studies used scientific methods as part of their
practice evaluations; one quantitative (level V), one qualitative (level V) and one mixed study (level V).

To analyse the body of evidence related to this specific iteration of the ITEA, a further process of deconstruction was undertaken, focusing on the country in which each study originated because practice contexts vary considerably around the world, as a result of cultural, organisational, legislative and other factors. As stated in Chapter 1, this thesis is written from an Australian stance, and it was important to maintain awareness of the potential interaction between this stance and the knowledge within the articles. This feature was also important to my understanding of how well current knowledge can be applied to the Australian context. Overall, the majority of knowledge originated from Western, English speaking countries, as shown in Figure 5.1.

![Country of origin for articles about practice ways of knowing](image)

Figure 5.1 Country of origin for articles about practice ways of knowing

As the figure illustrates, the majority of knowledge about practice ways of knowing originates from either the UK or US. An overall critique and reflection on where the practice knowledge has originated from will be presented in the concluding remarks for this iteration of the ITEA method. However, it is striking how few of the sample originated from Australia. Mental health is a well developed and enduring specialist area of practice in this country, operating (as noted in Chapter 2) within a nation specific context. Therefore, Australian mental health occupational therapists must always analyse the cultural context of all evidence before deciding whether it is relevant to their own practice. The origin of the majority of the evidence in Western European influenced cultures is no guarantee it will be applicable to the Australian context.
Step 5: Analysis

Detailed reading occurred with every article, with notes taken to form the basis of the subsequent overall analysis. I consolidated and compared the data organised and identified in the previous step. First, when a particular aspect of the OPH was supported by different types of evidence, I consolidated those articles into a discrete evidence base (i.e. all the articles related to ‘doing’). The analysis then continued with correlation and comparison, where I evaluated the findings from each article with each other, highlighting incidences of consonance and dissonance. For example: I analysed articles about interventions in acute settings for areas of agreement around best practice. If there was only one form of research on a particular category, the process involved only consolidation and comparison of the respective results. From this critique and analysis, I observed that practice ways of knowing are usually communicated in descriptive ways which focus on processes and defining the scope of practice.

Step 6: Reconstruction

The following reconstructed evidence statement provides an overview of current knowledge into practice ways of knowing published from 2000 to 2012 in peer reviewed journal articles by mental health occupational therapists. The overview describes how mental health occupational therapists enact practice ways of knowing, experience these ways of knowing as occupational beings, develop these practice ways of knowing over time, and find a sense of belonging through them.

Doing.

The American Occupational Therapy Association has published a series of 14 articles about practice in the profession, in various areas including our knowledge and skills in mental health promotion, prevention and intervention (Burson et al., 2010). The mental health promotion, prevention and intervention statement is arranged around four areas: 1) foundations, 2) evaluation and intervention, 3) professional role and service outcomes and, 4) mental health systems, with knowledge and skills from each domain being integrated and applied by occupational therapists to support clients. This statement defines the scope of practice as including those with or at risk of psychiatric, substance abuse or behavioural disorders. It also highlights the professions areas of knowledge as 1) competency enhancement and skill development, 2) risk reduction (e.g., establishing habits and routines) and (3) intervention strategies to minimise symptoms. As a general statement of role, this article could form the basis of job descriptions and service development initiative where mental health occupational
therapists are employed. While it does generally provide an overview of what OT does in this field, the focus on health promotion in this statement is more aspirational and the applicability of this aspect is less clear. This (and the other statements discussed below) also originates from the American perspective, which is very different to the practice context in Australia. In particular, the section on mental health systems is irrelevant outside of America, and would need to be reformulated in relation to the other areas to ensure the applicability of the information. Therefore, these articles can only serve as templates for similar documents in other countries, which would need to be developed within their own contexts.

A further role statement from this series addressed mental health OT in the promotion of psychological and social aspects of mental health (Rand, Eng, Kannenberg, Amini & Hartmann, 2010). This statement highlights the profession’s understanding that function is supported by the interrelationship of a range of factors, all of which need to be addressed for successful outcomes. Three main forms of intervention to promote psychological and social aspects of mental health are described: 1) provision of activities and occupations which support goal setting; 2) occupational engagement that enables clients to demonstrate abilities, recognise strengths and understand their ongoing needs; and 3) adaptations to the physical and social environment. Therapeutic use of self, mastery experiences and role modelling are considered key components of OT intervention, along with consultancy and advocacy. Care is taken throughout this statement to emphasise that this is not confined only to mental health OT, but that all occupational therapists have skills and abilities which support good mental health. However, the statement does not address the specialised experience of mental health occupational therapists, which develops as a result of long-term experience in engaging with practice ways of knowing. There is a qualitative difference between the therapeutic use of self practiced by a mental health occupational therapist and by those who are specialised in areas of practice with a different focus. Mental health occupational therapists have undergone further training in techniques which emphasise psychodynamic and interpersonal skills, given the centrality of these to their work with clients. Their understanding of therapeutic use of self has greater depth due to its use as a fundamental intervention in this practice setting, and is practiced in the context of this related knowledge.

Finally, the American Occupational Therapy Association has published a single page statement on stress and stress disorders (Stallings-Sahler, 2007). This provides a
précis of the magnitude of stress-related issues in the US, and briefly states the role of OT in establishing healthy patterns, routines and occupational engagement. While published in the American Journal of Occupational Therapy, this statement is clearly intended for an audience outside the profession and therefore would be most likely accessed via the Association’s website. It’s publication in a peer reviewed professional journal is therefore somewhat puzzling, as it does not appear to be written for that publications target audience. For clinicians, its main application would be in communicating their role to others, rather than directly to practice itself.

Apart from these role statements from the American Occupational Therapy Association, practice has been described and evaluated in five particular situations and contexts presented below: abuse and trauma, child and adolescent services, community settings, inpatient facilities and vocational rehabilitation.

**Abuse and trauma.**

Ten articles met the criteria for this practice sample about practice ways of knowing when working with people who have experienced abuse or trauma. This is dominated by studies from the US, with only a single example from Canada. This is not a separate practice area, but rather a feature of practice that may be present in any service setting. A special issue of *Occupational Therapy in Mental Health* published in 2001 highlighted the emerging role of OT with people exposed to domestic violence. While the role of the OT in these situations varies with the setting, Helfrich and Aviles (2001) provide some guidelines for the profession’s focus for assessment and intervention. These guidelines use MOHO as a framework, and suggest a range of assessment tools from this theoretical standpoint for application. In recognition of the range of settings in which OT may intervene, the authors also delineate five levels of involvement for the profession in domestic violence issues: 1) legal requirements to report abuse, 2) referrals to other services, 3) direct treatment, 4) indirect services, and 5) program consultation. Example of existing work performed by mental health occupational therapists focusing on domestic violence include an outpatient day hospital program for women in Canada and the US (Giles et al., 2007; Parker, Fourt, Langmuir, Dalton, & Classen, 2007) and a vocational intervention for people residing in a shelter in the US (Helfrich & Rivera, 2006).

The traumatic events of September 11 2001 provided a catalyst for the development of a program for fire fighters in New York (Cordero & Zimbelmann, 2005) and for the development of an employment placement program in New York
While these services were not specifically for people with diagnosed mental illness, many of the participants did experience mental health problems like depression and anxiety in the aftermath of the event, and the occupational therapists involved had backgrounds in mental health. There has been a wider recognition of the potential role for OT in disaster management and response in recent years in more general literature outside of this practice sample, originating from the US (Scaffa, Gerardi, Herzberg & McColl, 2006; Oakley, Caswell & Parkes, 2008; Taylor, Jacobs & Marsh, 2011) and in response to the Black Saturday Bushfire disaster in Australia (McDonald, 2009). These are, however, the only two pieces of evidence which specifically address what mental health occupational therapy does in such circumstances.

**Impact of evidence regarding abuse and trauma on practice.**

The current evidence about the work of mental health OT in response to abuse and trauma is focused on the immediate aftermath of these terrible events. There is also a focus on responses to large-scale disastrous events which are likely to impact on a relatively small number of clients across their lifetimes. There is a well established link between abuse, trauma and mental illness in the longer term (Breckenridge, Salter & Shaw, 2012), and the clients of mental health OT may be dealing with events from years or even decades ago. The majority of clients seen by mental health occupational therapists who have a history of abuse and/or trauma will be living with the longer term consequences, but at present there is little in OT for clinicians to draw upon for practice in this common situation. Without further research in this area, mental health occupational therapist must rely on their professional experience and artistry to enable occupational engagement for people with a longer term history of abuse and/or trauma, and this may not necessary lead to effective or efficient assessment or intervention.

**Child and adolescent services.**

Much of the evidence supporting practice ways of knowing in services for young people with mental health problems is focused on promoting the potential contribution of mental health OT with clients in their teens and early adulthood. This area of practice has been addressed by mental health occupational therapists from six different countries, including two international collaborations. A critical literature review of international evidence around the role of mental health OT in adolescent health (Hardaker, Halcomb, Griffiths, Bolzan, & Arblaster, 2007) finds that this role is not clearly defined. Five studies outlining OT interventions in this practice setting were
located (2 from the US, 2 from New Zealand and 1 from Canada), but the authors expressed concerns that practice may be inconsistent and based on the preferences of individual clinicians.

A systems approach to working in child and adolescent psychiatry is described by Estes, Fette and Scaffa (2005) in response to a shift towards recovery-oriented services in the US. While saying that mental health OT can contribute through the roles of case manager, multidisciplinary team member and consultant, the authors also outline a discipline-specific role for the profession. They emphasise that mental health occupational therapists have specialist skills and knowledge in facilitating the participation of young people in their community and can support this client group to develop new skills through coaching and providing opportunities to gain mastery.

Mental health OT appears to have had a low profile in the US at the time of this article (include reference here again), and strategies were suggested to cement the role of the profession with this client group.

The more established place of mental health OT in some countries is reflected in the content of an article about practice with people experiencing early psychosis from a collaboration between Australian and UK authors (Lloyd, Waghorn, Williams, Harris & Capra, 2008). Using the clinical guidelines developed by the International Early Psychosis Association Writing Group (2005) as a context, the authors discuss six key areas of intervention in early psychosis services: psychosocial treatment, specific treatment programs, social functioning, weight control, substance misuse and vocational rehabilitation. The authors conclude that mental health OT must be a part of these services for clients to reach their recovery aspirations, and to prevent longer term decline in function.

In terms of specific programs and practices, practice is supported for the role of mental health OT in child and adolescent eating disorder services (Gardiner & Brown, 2010), the promotion of recreation for children with autism (Potvin, Prelock & Snider, 2008), with children involved in foster care (Precin, Timque & Walsh, 2010), and with child survivors of war (Simo-Algado, Mehta, Kronenberg, Cockburn, & Kirsh, 2002).

Two articles focused on the actual doing of mental health OT in child and adolescent services. In her descriptive review of the occupational performance of adolescents in an inpatient unit setting, Schnell (2008) describes a group program that consists of both activity and discussion based groups, including recreational, physical and craft activities. This study used a revised Occupational Therapy Task
Observational scale (OTTOSTM) and formalised review at the end of each group, and concludes that group programs are developmentally appropriate to this age group. Young (2007) recounts her experience of working within a specialised service for children with attention deficit hyperactivity disorder. Four intervention strategies are described in depth: sensory integration, the Alert program, problem-solving approaches and behavioural modification. The author comments that the role of OT with these clients has become better known with time, and that working with parents is a key aspect of her role.

**Impact of evidence about child and adolescent services on practice.**

There is currently little evidence available about working with pre-school or school-aged children, although some may be offered indirectly in the literature about paediatric OT. Clinicians have a range of articles about the role of OT in various areas of child and adolescent practice to draw upon, and some of this information may be generalised to other settings; however, the articles about intervention strategies are more limited and specialised in their focus. As working with children and adolescents in mental health is a relatively small area of practice, multi-site studies would be required to generate the larger samples needed for rigorous studies. Given the funding and logistical requirements of such studies, these clinicians may not have a comprehensive body of evidence in the foreseeable future. However, there is evidence of the growth of this area of practice across several countries, and collaborative research has already occurred in this area. A coordinated effort to continue these partnerships is likely to be the most effective approach for this area of mental health OT practice.

**Community.**

Much of the evidence around practice ways of knowing was set in community services, which mirrors the current profile of the profession in the post de-institutionalisation era. Over 70% of the articles on community practice originated from Australia and the US, with contributions from Canada, Ireland and the UK. While many of the perspectives on mental health OT practice come from experienced therapists, Wollenberg (2001) offers a unique account from the perspective of a new graduate in the US. He commenced as the first occupational therapist in his position and took the opportunity to develop a program based on the principles of recovery. The influence of theoretical ways of knowing on practice ways of knowing is acknowledged in this article, as the author found it strengthened both his and his clients’ understanding of the relationship between OT, recovery and wellness. Recovery is also a strong theme
in a literature review about its integration into practice (Casey, 2007). In contrast to Wollenberg’s focus from a single perspective, Casey presents three separate models and a framework, with the relative merits of each discussed and the process of implementation reflected on in depth. In providing this explicit link between theoretical ways of knowing and practice ways of knowing, this article helps clinicians to understand the processes of integrating their various forms of knowledge into practice. While the current discussion is focused on practice ways of knowing, the presence of theory in these articles is relevant to links this analysis is ultimately trying to construct.

The overall evidence base for practice in community mental health OT is very diverse, with no areas of consolidation. Within the sample meeting the inclusion criteria for this thesis, I wrote the only article which highlights the role of assessment in community mental health OT practice, providing an overview of the process of selecting OT outcome measures in a continuing care unit in Australia (Hitch, Hevern, Cole & Ferry, 2007). Once again, a theoretical way of knowing (the strengths model) was used to frame the process described, and a range of outcome measures with which we were familiar were analysed in regard to their worth in the community setting. Further papers about the use of assessments and outcome measures in this setting would be valuable to clinicians, as they both frame interventions and act as means of assessing their effectiveness.

Six descriptions of specific interventions are available to clinicians working in community mental health. An Australian program for parents with mental illness called Living with Under Fives (Bassett, Lampe & Lloyd, 2001; Bassett & Lloyd, 2005) uses a range of intervention strategies to strengthen relationships within families and assist parents with mental health issues to develop better parenting skills. A fitness and lifestyle program, also from Australia (Lloyd, Sullivan, Lucas, & King, 2003), uses structured fitness and education sessions to address a range of physical education topics and change skills such as goal setting and monitoring outcomes. The authors highlight how this is a great example of combining physical health and mental health OT, and stress the need for greater integration of the two (currently largely separate) areas of practice. Clients in this program were reported to have reduced either weight or body fat or waist measurement, or to have ceased to gain weight.

An example of the use of a specific intervention is provided by Orchard (2003), who explores motivational interviewing with clients experiencing anorexia nervosa in the UK. By focusing on the difficulties and fears of the clients, the author believes
motivational interviewing provides a comprehensive approach to treatment and provides
greater depth than strengths-based interventions alone. An initiative to augment adult
day centres for people with dementia in the US by adding care management for their
family caregivers is described by Reever, Mathieu, Dennis, and Gitlin (2004). When
the person with dementia enters the service, the family caregivers are offered an
assessment of strengths and weaknesses of their caregiving and provided with a care
plan of their own. The interventions offered to caregivers include counselling,
education, referral and supportive contact, and each package of care is adapted to the
needs of the particular family. This form of practice is found to be feasible, and to
produce significant benefits such as reduced burden, increased confidence and increased
wellbeing. Finally, the role of a single clinician in inaugurating a dual-diagnosis
anonymous meeting is reported as an example of meeting the needs of a particular
group of clients (Roush, 2008). In this case, mental health OT was able to consult with
an existing program about the formation of an adapted group, which was then able to
operate in a sustainable, peer-led manner with graded support from the clinician.

One overview of an entire area of community practice is provided, focusing on
practice with people experiencing homelessness in America (Griner, 2006). She
contends that an occupational therapists existing mental health skills are very relevant to
a population where many experience ongoing psychiatric problems, and that offering
OT students fieldwork in services which support these clients can cement the
profession’s role and offer additional services to this population. However, the national
context of this article limits the applicability of her discussion to other countries, as the
US health system is unlike any other in the world.

The impact of systems or organisational issues was highlighted in five on doing
mental health OT in the community. The impact of information technology on practice
in community mental health OT is highlighted in a study by Cremin and Hederman
(2002), which took place in a child and adolescent service. While located in a specialist
service, the article addressed a practice issue which is common across all services. Two
prototype systems were developed under this initiative, a clinical records system and a
tool to support the recommendation of activities, advice and ideas for their clients.
Given the age of this article, it is likely that other mental health OT practices have
followed with innovations in information technology, but no other studies on this topic
are available.
One of the examples of partnerships between clinicians and academics provided in the literature overtly focuses on the improvement of practice (Lloyd, King & Bassett, 2005). An Australian mental health service decided to use its partnership with local academics to focus on under-researched practice areas such as the development of psychosocial rehabilitation systems and recovery models. The resulting program of research was explicitly designed to meet their particular clients’ needs, but while clients were noted to have a role in this study, it was not fully participatory. In another example of academic–clinician collaboration, the practice of mental health OT in a rehabilitation section of the health service in Queensland is explored through a quality project (Munro et al., 2007). Occupational therapists working in these services were found to face a range of challenges, including a changing client population, pressures concerning discharge planning, and a lack of community services to refer clients on to. Personal stories of clients and carers experiences in the services are included, and generally these services are found to provide positive opportunities to both occupational therapists and their clients.

Integrated care pathways have also been trialled in mental health OT community settings, as a study from the UK describes (Rigby, Hannah, Haworth, Molloy & Scutts, 2007). Mental health OT is found to provide discipline specific services to crisis resolution/home treatment teams, despite their short time frames and the generic nature of the team positions. Clients received on average six sessions during their time with this team, and the pathway was felt to operationalise and focus the service in a fast paced environment. Another article from the US outlines the services delivered by the Collaborative Support Programs of New Jersey, designed and delivered by clients (Swarbrick, 2009b). These programs include self-help centres, wellness and recovery programs and peer employment support. In this situation, mental health OT is one of many collaborators coordinated by the peer-led service itself.

**Impact of evidence about community services on practice.**

While all of the articles about community practice report encouraging initial results of practice on client outcomes, a common issue among them is the lack of follow-up studies which confirm the effectiveness of these interventions. While some clients only engage with community services on a short term basis, many with chronic mental health problems continue to receive mental health OT over a period of years. The longer term implementation and impact of these interventions is important to both these groups, in regards to longevity of impact and engagement. Several areas of
community mental health OT were not represented in this body of evidence, including case management and private practice. In Australia, case management remains a dominant form of service provision in public mental health services (Ceramidas, 2010), and private practice has become increasingly prevalent due to the impact of government initiatives (Hitch, 2009). However, the current evidence base does not support practice ways of knowing for either of these areas, leaving mental health occupational therapists without a firm base on which to base their work. This gap in knowledge may be due to ongoing controversies around whether case management and private practice are ‘core’ OT modalities, but does not reflected the lived experience of many working in the field.

Inpatients.

Inpatient settings are the focus of five articles about practice ways of knowing. All but two of these studies originate from the UK, with the remainder from the US. An example of an intervention developed for a specific client group is a group skills-based program aimed at people with dual diagnosis (mental health problems and substance use) in the US (White, 2007). The program was targeted at clients who had difficulty managing daily routines, and interventions included a range of learning strategies including individualised folders, diaries, work sheets, group discussion and homework. Pre- and post-test outcome measures highlighted significant improvement in time management after participation, while clinical observations included improved punctuality and ongoing use of diaries after the group.

Another focused initiative sought to integrate theoretical ways of knowing into practice, using MOHO to create a specific assessment and treatment pathway for women in the UK with borderline personality disorder (Lee & Harris, 2010). The clinicians comment on the length of time needed to successfully integrate a conceptual practice model into their setting, but conclude that the benefits outweigh the resources intensity of this approach. Structure and grading are found to be important, and dialectical behavioural therapy is a prominent intervention strategy used to support the clients’ occupational goals. The relationship between evidentiary ways of knowing and practice for a well-planned acute ward program is highlighted by Barnes, Parslow, Bheeroo and Woodham in the UK (2008). Using a collaborative approach between staff and clients, one weekly group session was devoted to the development and maintenance of an allotment garden. The therapists explicitly cite three sources of evidence (Fieldhouse, 2003; Fieldhouse & Sempik, 2007; Griffiths & Core, 2007), seeking to use an evidence based approach.
In practice, there were further articles that linked practice with evidentiary ways of knowing, with two articles about the development of clinical guidelines in a forensic inpatient setting in Scotland (Duncan, Thomson & Short, 2000; Duncan & Moody, 2003). In the context of a series of government white papers, this service formulated a guideline implementation group, which met monthly to discuss how to translate the contents of the white papers into their setting. The focus of the group was the appraisal of guidelines using the Appraisal Instrument for Clinical Guidelines (Cluzeau et al, 2003), and the provision of recommendations about their appropriateness. A pathway developed subsequently is based on MOHO, and has the potential for promoting consistent practice while allowing for individualised assessments and interventions.

Another practice article which focuses on the development of systems describes the planning behind the implementation of a consultation service to a general hospital in the US (Merryman & Richert, 2001). This service developed in response to changes to the health care system, including shorter lengths of stay, interdepartmental lines of service, and managed Medicaid for people with severe and enduring mental health problems. The authors developed case-based consultation services through functional safety evaluations and the provision of an in-service. SWOT analysis was used to identify the needs for mental health OT in this setting, but the authors acknowledge that it was difficult at times to remain client-focused among the many other pressures in this environment. Its setting in the American health system also limits the applicability of this article to clinicians from other countries, given its origin in response to changes in that system. Articles which occur within these contexts can also be time limited in their relevance, as the changes that provoked the development of new practices may only be in force for a short period of time. In this case, the article is over a decade old, and subsequent modifications to the American health system (such as Obamacare) may have rendered the findings obsolete.

**Impact of evidence about inpatient services on practice.**

Inpatient services were the subject of a relatively small number of articles in the sample, and tended to focus on processes rather than assessments or interventions. In many cases, clients appeared to remain in the acute setting for long enough to complete programs over several weeks. With the mean length of stay in Australian inpatient wards being approximately 15 days (Zhang, Harvey & Andrew, 2011), clinicians may find it challenging to find sufficient time to apply such programs. While clinicians could apply some of the evidence currently available, there is nothing that directly
addresses the most common situation in the Australian mental health system: a new graduate providing services (both individual and group) to a mixed and constantly changing client group. This poses a particular challenge to novice clinicians, as they are unable to base their practice on directly relevant evidence and must rely more on their still developing clinical reasoning skills. However, this could be overcome with good quality supervision, and assistance in locating and synthesising the broad range of evidence which could be relevant to this particularly diverse cohort of clients.

Vocational rehabilitation.

Practice in this area seems to be well established, and the majority is focused on enabling people with mental health problems to gain or regain employment. This knowledge originated from six different countries, and included contributions from Hong Kong and South Africa. While a sheltered workshop program was the subject of one article (Stelter & Whisner, 2007), supported employment was the more popular model, discussed in several articles from around the world. Quantitative outcomes indicate high levels of program completion in Hong Kong, with up to 60% of clients subsequently finding either supported or independent employment (Wong & Wan, 2000). However, supported employment does not overcome all the barriers experienced by clients, such as economic downturns, inadequate support systems and stigma (Chiu, 2000). The economic contexts of Hong Kong and South Africa are also very different from each other and from other countries where mental health OT is practiced. The types of jobs available to clients, and the working conditions in which they are placed depend on local industrial legislation and practices. For example, the industrial relations system in Australia places many demands and standards onto both employers and employees which may not be present elsewhere.

There are many challenges to the provision of OT practice in supported employment in mental health OT, and the formation of partnerships with non-government agencies has been recommended in Australia to increase its sustainability (Waghorn, Collister, Killackey & Sherring, 2007). Mental health occupational therapists are rarely employed to only focus on vocational issues, and usually play a consultant role in these partnerships while the non-government agencies engage in more of the practical and procedural tasks involved. These partnerships can take advantage of knowledge of local job markets, but depend on the skills of each respective partner and the quality of the partnership itself.
The link with evidentiary ways of knowing for the practice of vocational rehabilitation is highlighted by Davis and Rinaldi (2004), who explore the implementation of evidence-based principles to vocational rehabilitation in a service in the UK. Partnerships (between the client, OT and case manager) are again identified as crucial; these were facilitated by leaders from both the OT department and the general service, and needed to include firm understandings of respective roles. Successful outcomes are found to depend on a client-centred approach, and the OT’s role is one of facilitation, guidance, and enabling.

A range of other models for vocational rehabilitation are present in the literature, however all are described in only one article and are therefore not supported or consolidated by multiple pieces of evidence. These include a job clinic (Devlin, Burnside & Akroyd, 2006), a system of delegating job placements to professionals with appropriate levels of skill and experience (Graham, 2007), an outpatient program (Morin, 2008) using a play approach, and a program that focuses on keeping people with mental health problems in their current jobs or returning them to previously held positions (Robdale, 2004). The success of this final scheme led to it securing ongoing funding and being recognised as an example of good practice by a UK Social Exclusion Unit, demonstrating that models other than supported employment can have substantial positive impact.

Some practice ways of knowing for vocational rehabilitation are closely related to particular client groups. These include a day service for people with personality disorder in the UK (Hirons, Rose & Burke, 2010), a project targeted at getting people in the US experiencing homelessness back into employment (Munoz, Reichenbach & Hansen, 2005; Munoz, Dix & Reichenbach, 2006) and, in New Zealand, employment services for young people with psychosis (Porteous & Waghorn, 2007). While the profession as a whole resists categorising clients according to diagnosis, these authors assert that tailoring their services to the specific needs of each group of clients is an example of client-centred practice.

One of the few existing practice guidelines in mental health OT was produced in New Zealand (Tse, 2002), and focuses on a single diagnosis. The guidelines were developed from a literature review, and address interventions which support people with bipolar disorder to achieve their vocational goals. Tse embeds his eleven guidelines in the “Choose–Get–Keep” model of supported employment, partly because it can be modified and adapted to the needs of individual clients. The guidelines are therefore
presented in each of the phases of this model, and all are supported by a brief discussion
of the supporting evidence. A graphic representation of the guidelines is also provided,
and could easily be displayed in a workplace and potentially promote their application.
Tse acknowledges that further research is needed to evaluate the guidelines and
contribute to their further development; and while they have been cited twelve times (as
of 02/01/2014, Google Scholar) they do not appear to have been evaluated to date.

Mental health within the general workplace emerged as another theme in the
sample of papers on practice. As highlighted by Quirke (2001), stress is a common
feature in this environment and can impact on both people with a disability and the
general community. She demonstrates the need for health promotion and preventative
interventions by highlighting the benefits to the community of such an approach.
Quirke contends that all occupational therapists can contribute to these initiatives in
their workplaces by ensuring good communication, defining what their services cover,
and practising effective time management and early recognition of potentially stressful
factors. Rai (2002) focuses on aggression in the workplace, and suggests a role for
mental health OT in its prevention. She contends that mental health occupational
therapists could provide training to employees and employers about managing
aggression, problem solving support regarding specific workplace problems, and
modifications to the work environment and job demands to reduce risks. However, this
type of practice is more likely to be adopted in the vocational rehabilitation area of
practice than by mental health occupational therapists in Australia. While creating
mentally health workplace has become a focus for some mental health services (Sane
Australia, 2014), mental health occupational therapists seeking to apply this evidence to
their practice would most likely be operating in an extended scope of practice.

Impact of evidence about vocational rehabilitation on practice.

The evidence concerning practice in this area mostly comprises descriptions of
different models and configurations of services. Supported employment has been the
dominant model in recent years, and most mental health occupational therapists work
within such services in Australia. Much of this evidence will therefore be transferable,
and that regarding alternative models offers insights into “add on” features which could
be offered by supported employment services. Diagnosis-specific evidence is also
readily applicable by clinicians, and provides the possibility of offering tailored
solutions to sub-groups of clients within a general service. That is not to say there are
no mental health occupational therapists applying them to practice; but without
publication these efforts remain invisible. Finally, the evidence around mental health OT in a health promotion role around workplace stress and aggression remain speculative at this point, but could give clinicians some guidance on an emerging area of practice.

Being.

Being has been the subject of much less research than doing in practice ways of knowing for mental health OT, and the three identified studies have each approached the topic in a different way. The being of occupational therapy within a community mental health team was evaluated by clients in a study from New Zealand (van der Haas & Horwood, 2006). As part of a program evaluation, a qualitative self reporting survey was sent to clients who had received mental health from the team. In this case and setting, the profession was characterised as client-centred and occupationally focused, both of which contributed to clients reporting positive outcomes and empowerment.

A Canadian overview by Krupa, Radloff-Gabriel, Whippey and Kirsh (2002) was undertaken of practice within assertive outreach teams, including the generalist and specialist functions of occupational therapists within these teams. They conclude that occupational therapists in these teams operated at an individual, program and community level, and that the assertive outreach approach was consistent with the professions focus on increasing social inclusion and quality of life. However, these teams were often led by professionals from a biomedical background, meaning that in some cases OT was the only profession using a rehabilitative approach. This review resonates with my own experiences of working in assertive outreach teams over a period of five years. However, in my experience, tensions around safeguarding community safety and risk management were also constraints that affected OT in these settings. Despite the service model being adopted, the being of the profession is therefore largely influenced by factors within individual workplaces.

Occupational therapy students from the US completed a study into the being of dementia caregivers, using their findings to discuss mental health OT interventions with this group (Ziff, Schaffner & Perkinson, 2000). This is an example of practice ways of knowing of mental health occupational therapists being influenced by personal ways of knowing of people with lived experience of mental health and illness (in this case, carers). They suggest that carers have traditionally been seen to inhibit treatment goals, leading to feelings of exclusion and misinformation. By giving caregivers an identity as service recipients in their own right, the authors recommend the provision of supports to
them to enable their role, and in turn enable better performance by the client. The value of the being of the carers was therefore presented as a function of their value to the primary relationship between OT and the person with dementia.

**Impact of evidence about being on practice.**

Despite the position of being as one of the two most researched dimensions of occupation, it is under-represented in the evidence supporting practice in mental health OT. There is no current evidence about the being of clients in mental health OT, their identity within that context, and how their skills and abilities are represented. While the studies which have been completed could be used by clinicians to reflect on how their own profession is perceived, much meaning is lost without evidence about being for clients or carers, and the influence that this exerts on practice ways of knowing. The absence of evidence about the ‘being’ of clients in regards to the way mental health OT is enacted in practice is alarming, given the prevalence and general acceptance of client centredness as a key concept in practice. Without an understanding of the being of clients, mental health OT practice becomes something that we do ‘to’ them, rather than ‘with’ them. A similar critique was provided for the focus of the profession around evidentiary ways of knowing – occupational therapy is not done for the benefit of the profession, but rather for the benefit of our clients and the broader community.

**Becoming.**

Becoming is a prevalent area of evidence about practice in mental health OT, but not around the explicit focus of therapy on the enablement and promotion of a client’s goals and aspirations. The majority of this evidence has been about the becoming of student occupational therapists as they progress towards graduation, and all of these studies have originated in the US.

The participation of OT students in several initiatives shows how becoming relates both to their personal development as novice practitioners and to the development of the profession as a whole. Examples include the development of OT programs in homeless shelters (Herzberg & Finlayson, 2001; Shordike & Howell, 2001), community mental health services (Walens, Helfrich, Aviles & Horita, 2001), the prison system (Tayar, 2004; Provident & Joyce-Gaguzis, 2005) and a free clinic (Martin, Pilon-Kacir & Wheeler, 2005). Students were reported to have experienced positive transformative learning in all of these articles, although considerable anxiety was associated with fieldwork in settings where no OT was on-site for support. These articles also make the assertion that such placements lead to further opportunities for the
expansion of the profession into emerging areas of practice. None of the authors addresses a critical consideration of this approach to the becoming of occupational therapy students – should we be placing the responsibility of expanding the profession on our least experienced members?

The only article which addresses the becoming of a group of mental health occupational therapists explores this theme through the process of group supervision in the UK (Wimpenny, Forsyth, Jones, Evans & Colley, 2006). The mental health OT participants reported that group supervision provided a space for reflection they did not otherwise have, and enabled them to increase their self-awareness and understanding of how skills linked with theory and practice. A number of specific practice outcomes were identified and implemented as a result of these supervision sessions, clearly showing the direct impact they had on practice.

Finally, two articles focused on the becoming of clients. A program to address employment for people recovering from mental health issues in Switzerland describes the development of a kiosk (Wenger & Wermelinger, 2012). In this case, becoming was enhanced by providing clients with training opportunities in the kiosk, in a safe and supported environment that provided real work experience. The OT role provided both therapy (for those yet to commence training) and support (for those who were working in the kiosk). As illustrated by a case study, there were positive outcomes from this program and there are plans to continue it in the longer term.

While this initiative was OT led, a client controlled decision-making council in a treatment mall at a state hospital in the US provides an example of how clients can have a direct impact on practice ways of knowing (Webster & Harmon, 2006). Clients maintained their participation in the council even at times of relapse, indicating it was a motivating occupation in its own right. Increased productivity and satisfaction were noted as a result of this initiative, and the author also speculates on its impact on the becoming of the broader institutional programs and culture.

**Impact of evidence about becoming on practice.**

The current evidence concerning becoming on practice mainly relates to the role of clinical supervisor to students. It is questionable whether this evidence is applicable in an Australian context, where role emerging placements occur in very different service and cultural contexts. The evidence about becoming for mental health occupational therapists is limited to one article, while that about becoming for clients is also sparse. However, the articles that do address the becoming of clients both provide good case
studies in the active inclusion of client in their therapy, and some general principles around this can be gleaned from the contents (i.e. ensuring activities are directly relevant to goals). A clinician wishing to apply this knowledge would need to do so at the level of individual studies, and the level of description provided in each case would enable some generalisations to be made.

**Belonging.**

One of the ways practice ways of knowing can address belonging is by focusing on the social inclusion issues faced by many people with mental health problems. Four articles describe practice which addresses social inclusion, with street children in the US (Densley & Joss, 2000), clients of a community mental health service in the UK and Australia (Heasman & Atwal, 2004; Russell & Lloyd, 2004), and people with mental health problems in the European Union (Kantartzis et al, 2012). Noting the principles of occupational justice issues, Densley and Joss (2000) recommend that mental health OT become involved in working with street children at individual, group and population levels, suggesting a role in the prevention and rehabilitation of the sequelae of abuse, poverty, lack of education, and health services. A population approach was also practiced by a European partnership called ELSiTO (Kantartzis et al, 2012). This partnership focused on the nature and processes of social inclusion for people with mental health problems, and included equal contributions from clients, occupational therapists and other disciplines. The article focuses on the personal narratives of several clients, particularly addressing factors which support voluntary work participation. The authors comment on the prevailing view that voluntary work is not “real work,” and the difficulties clients face when they don’t fit into the prevailing view of who is a “worker.” However, concepts of what constitutes ‘real’ work vary significantly across cultures, and in some countries voluntary work is generally valued as being meaningful in and of itself. This attitude is therefore less likely to be encountered in Australia, where it is a long established practice and approximately one third of the adult population engage in some form of voluntary work (Australian Bureau of Statistics, 2008).

Two articles describe interventions that focus on physical activity and wellbeing as a means to social inclusion. The development of a lifestyle course for clients of a community mental health service in Australia (Russell & Lloyd, 2004) led to the development of a relationship with a local TAFE provider, embedding the program within the local community. Clients attended for three hours a week, for eleven weeks,
and topics ranged from personal development (i.e. self image, motivation) and health (i.e. nutrition, aerobics) to ongoing education (i.e. opportunities to continue at the TAFE college). In contrast, the Active Advice Project (Heasman & Atwal, 2004) focuses on leisure by having clients identify interests, facilitating participation, and helping to form networks of people with similar interests. While this personalised, scaffolded approach was successful in engaging 47% of the sample, more than half did not continue with their personal plans for leisure in the longer term. The long-term impact of both these programs is yet to be evaluated.

**Impact of evidence about belonging on practice.**

The current evidence concerning belonging could be used by clinicians to assert a role for mental health OT in social inclusion, particularly on a population basis. The findings of the two programs concerning physical activity and wellbeing are reported as (at least initially) encouraging, and provide some justification for pursuing this form of occupational engagement as a means to social inclusion. However, these two groups were fairly resource- and time-intensive for the therapists, and may not be easily instituted in non-urban areas.

**Current Knowledge of How Mental Health Occupational Therapists Enact Practice Ways of Knowing in Mental Health OT**

This review gives an overview of current practice in mental health OT, but it is not fully objective. The practices and initiatives described above are only those that have been published in peer-reviewed journals, and anecdotally there are many more, particularly those which are clinician led, which are not published. The main outlets for theory and evidence are peer-reviewed journals, and so these bodies of evidence can be considered representative; but practice ways of knowing are often communicated in less formal forums such as blogs, newsletters and magazines, so the representativeness of this body of knowledge is less certain. Access to this ‘hidden’ information is often dependent on membership of particular groups (such as professional associations or online discussion forums), and so its distribution can be limited. For clinicians to keep abreast of this information about practice ways of knowing in mental health OT, a centralised resource or clearinghouse would need to be established, where the various sources of information could be curated and accessed. On reflection, the critical question should have read, “what is the current knowledge about practice ways of knowing in mental health OT as represented in peer-reviewed journal articles?”
As noted at the beginning of this chapter, the majority of the articles about practice ways of knowing originate in either the UK or US. The strong representation of the US in the evidence is quite surprising, given that only 2% of the profession works in mental health in that country (Norris, Bunger, Courchesne, Smith & Willoughby, 2007). While it could be argued that the UK and US are culturally similar to Australia, practice contexts vary substantially. For example, the National Health Service in the UK and the Medicare system in Australia differ markedly in access and reimbursement. There are also subtle cultural differences, of which I became aware when conducting my own analysis. An example of this was the US study by Stelter and Whisner (2007), which I found to present a particular moralistic perspective not found in Australian practice. Mental health occupational therapists must therefore read evidence about practice ways of knowing critically, assessing how much of it is directly transferable and how much needs to be tailored to local conditions.

Knowledge about practice ways of knowing also tend to have been published in the early half of the first decade of the century. In fact, the average age of articles addressing mental health OT practice is 7.75 years, indicating a slowing in the number of articles addressing this way of knowing in recent years. This is somewhat concerning given the essential nature of practice to mental health OT, and may be related to the increasing emphasis on the evidence which practice is ostensibly based upon.

There is some integration of the three ways of knowing (theory, evidence and practice), but none of the articles reported practice ways of knowing which are explicitly influenced by both theory and evidence. The skills which mental health OT contributes to mental health care have been broadly defined, but there is considerable variation around the doing practiced in a range of settings. The profession has moved into several new areas of practice in the past decade, such as working with people who have experienced domestic violence, survived terrorist attacks, or have become homeless. In each of these new areas, long-established skills and techniques are being applied to a new population.

Generally speaking, current knowledge about practice ways of knowing in mental health OT tend to focus on working within systems more than working with individual clients. Practice information is therefore presented at the level of service, rather than the level of individual clients (which tends to be presented through evidentiary ways of knowing). The doing of mental health OT is currently defined
largely by the systems and organisational factors within which it operates, while the hands on doing of therapists (and the non-theoretical and evidentiary ways of knowing that underpin it) are reported in practice descriptions or overviews. To date there appear to have been no efforts to consolidate and compare these non-scientific overviews of practice, which diminishes their potential to influence the profession. However, it is possible this has appeared outside the peer-reviewed realm of this thesis, or that the search conducted as part of this thesis missed some published evidence (as acknowledged in Chapter 2).

The being of mental health OT was rarely addressed through practice ways of knowing. The views of two groups of clients provided an interesting insight into how we are perceived by others, while a review of mental health OT practice in assertive outreach confirmed the many similarities that exist between these two approaches. Comparisons of mental health OT with other professional and research cultures are prevalent throughout the evidence base, including theory (i.e. recovery) and evidence (i.e. participatory action research). They may be an indication of an ongoing process of defining our identity within mental health.

Many of the articles addressing becoming though practice ways of knowing recount student placements in emerging areas of practice. While there are many good reasons for developing this sort of placement, the ways of knowing developed in these emerging areas are necessarily limited by the novice knowledge of the students. It is expecting a lot of students to work in such unstructured settings, as noted in several of the articles where careful screening of candidate students was advocated. Only one article provided an insight into the becoming of mental health occupational therapists, and this is clearly an area in need of further development.

Finally, an obvious relationship exists between belonging and practice ways of knowing that address social inclusion. While some initiatives are addressing this relationship on a population scale, it is interesting to note that two articles focused on leisure activities as a route to promoting social inclusion. As found throughout this thesis, the place and impact of belonging (and indeed becoming) on practice ways of knowing is an underdeveloped topic in this profession.

With this understanding of practice ways of knowing, I reflected on how I wanted to continue my exploration of practice ways of knowing. While I wanted to know more about how mental health OT is actually practice, I realised that my primary source (peer-reviewed journals) was unlikely to give me the information and experience
I wanted. A comprehensive review of practice ways of knowing in mental health OT would require visits to many workplaces, interviews with many mental health occupational therapists, and extended observation of their practice. All of this was well beyond the scope of this thesis, but is an area of future inquiry I would like to explore. I therefore decided my journey through practice ways of knowing would focus on how I could apply and integrate the knowledge I brought with me about theory and evidence into practice.

**Iteration 9 of the ITEA method**

**Step 1: Determine/re-determine the research question.**

How can theoretical and evidentiary ways of knowing be applied along with practice ways of knowing in mental health OT?

**Step 2: Theoretical framework.**

The four dimensions of doing, being, becoming and belonging were the chosen framework for this iteration of the ITEA method.

**Step 3: Identification.**

To identify the evidence relevant to the critical question, I adopted some new inclusion criteria. Limiting my search to the same inclusion criteria as the thesis would have disregarded a range of information I knew existed outside OT. However, I included the same databases as they are also relevant to the broader field of allied health. To capture the ways in which theory and evidence are applied to practice, I used the search terms “knowledge brokerage” AND “knowledge translation” AND (“health” OR “allied health”). The first two terms were chosen as they most directly relate to applying knowledge to practice, and are the terms most commonly in use at present to describe this. A process of screening was then undertaken where the abstracts, and at times the full texts of each article, were reviewed for relevance to the critical question, leading to a final sample of 13 articles.

**Step 4: Deconstruction.**

Deconstruction was not undertaken in this iteration of the ITEA method, as the sample of knowledge was already manageable in size.

**Step 5: Analysis**

The analysis of these sources proceeded using the same method described throughout this thesis. Each source was read, and notes made of its content to inform the analysis. The knowledge contained in each was correlated, and consolidated, which in this case took place within a single evidence base. Examples of consonance and
dissonance were sought, and the content of each article compared and analysed in relation to others.

**Step 6: Reconstruction.**

The reconstruction of these sources is introduced in the following brief discussion and expanded upon in the peer-reviewed journal article to follow. The four dimensions of occupation have not been used to organise this statement, given the small amount of evidence available. While elements of doing, being, becoming and belonging are evident throughout the following section, they are not explicitly signposted so the discussion and peer-reviewed journal article flow together and are more accessible to the reader.

Knowledge translation (KT) is “a dynamic and iterative process that includes the synthesis, dissemination, exchange and ethically sound application of knowledge to improve health, provide more effective health services and products, and strengthen the health care system” (Straus, Tetroe & Graham, 2009, p. 165). KT is becoming an increasingly influential concept in health care, but the proliferation of alternative terms (such as implementation science, research utilisation and knowledge exchange) points to its formative stage of development (Ward, Smith, House & Hamer, 2012). At present, KT is used almost exclusively in reference to the application and translation of evidentiary knowledge to practice, but occupational therapy has begun to develop a different vision.

Throughout the timeframe of this thesis, occupational therapists have been advocating for diverse ways of knowing to be translated into their practice. There have been regular calls to accept professional expertise (i.e. practice ways of knowing) into evidence based practice, in recognition of the multidimensional nature of clinical reasoning. Rappolt (2003) acknowledges this approach will not increase the amount of scientific evidence available to occupational therapists, but argues that it will nevertheless improve practice through greater reflection. This practice could then go on to be subjected to scientific methods as part of the constant, ongoing feedback between ways of knowing.

Reflection is also advocated as a suitable partner for evidence based practice by Bannigan and Moores (2009), who developed a model to illustrate the relationship between this practice way of knowing and evidentiary ways of knowing. The Knowledge to Action Process (Graham et al., 2006) was adapted in an article by Metzler and Metz (2010) about KT in OT. This process was chosen because of its
explicit acknowledgement of diverse ways of knowing, including experiential knowledge, and also for its compatibility with a systems approach. Economics, ethics, professional judgment and intuition have also been the subject of recent studies which have highlighted the impact they can have on practice as part of an evidence based approach (Lopez, Vanner, Cowan, Samuel & Shepherd, 2008; Chaffey, Unsworth & Fossey, 2010). However, this move to embrace diverse ways of knowing has not been universal across the profession. Evidence based practice is often defined only as translation of scientific knowledge into practice (Tsang, Siu & Lloyd, 2011) and, where explicitly addressed, evidence based behaviours relate only to how to apply scientific knowledge to practice (Thomas, Saroyan & Snider, 2012).

A range of KT methods are available to occupational therapists in mental health, but their efficacy varies considerably. A systematic review of KT strategies available to allied health professionals (Scott et. al., 2011) concludes there is insufficient evidence to recommend any of the strategies so far proposed in the peer-reviewed literature. Despite this, a range of outcome tools have been developed to measure the efficacy of KT initiatives (Van Eerd et al., 2011), and while many have acceptable validity, reliability and responsiveness, all are focused on scientific evidence. A recent systematic review (Novak, Russell & Ketelaar, 2013) finds there are some KT strategies for which there is supporting evidence. Interventions are graded according to the Evidence Alert Traffic Light Grading System (Novak & McIntyre, 2010); Table 5.1 displays those which were found to work, those which don’t, and those for which findings were equivocal.
Table 5.1

Effectiveness of KT Strategies

| Go (Green)                                                                 | Audit with feedback of clinical performance, clinical practice guidelines for simple behavioural changes, continuous quality improvement, financial incentives, mass media, multi-faceted interventions, outreach visits, peer comparison feedback, reminders at point of decision-making, research active role models, tailored interventions |
| Measure (Yellow)                                                          | Collaborations, communities of practice, consensus building, continuing professional development about evidence based practice, journal clubs, knowledge brokers, librarian assistance, opinion leaders as educators, small group work, task substitution between team members |
| Stop (Red)                                                                | Clinical practice guidelines for complex behavioural changes, continuing professional education that is didactic, passively disseminated educational materials |

I needed to find a strategy or strategies which would enable the transfer and utilisation of theory and both scientific and non-scientific ways of knowing into practice. The ITEA method went some way to achieving this goal, but the final step (transfer and utilisation) did not provide sufficient detail about how to proceed. To add information about all the potentially effective strategies would make the method extremely complex, and more than likely prevent it from being adopted and implemented. I therefore decided to focus on two strategies which I thought were most relevant to mental health OT: knowledge brokerage and practice guidelines.

As explained in the following article (which has been accepted for publication in the *Journal of the Australian and New Zealand Association of Mental Health*), knowledge brokerage is an emerging model of KT. The following description outlines the process of investigation I undertook while exploring the potential for knowledge brokerage in mental health OT. This manuscript is not available in PDF format, as it remains in press.

**Current Development of the Super Moth Project**

Since the time this article was written, there have been several further developments in the Super Moth project and in my understanding of knowledge brokerage in mental health OT. Funding was received from the OT Australia (Victoria) Research and Quality Assurance Grant program, which enabled three occupational therapists who had presented at the 2012 state conference to join the project and work on publishing their findings. Along with ongoing work with the original, the following outcomes have been achieved: one manuscript provisionally accepted to a peer-reviewed journal, six occupational therapist (four in mental health) working on four manuscripts in the final stages of preparation, and one project which will now be undertaken as part of a research masters degree.

It has become evident to me that a knowledge brokerage model can encompass a range of strategies previously identified as being effective for KT, such as supporting audits and quality improvement, enabling multi-faceted intervention, outreach visits, providing a research active role model, tailoring information, collaborating, continuing profession development around evidence based practice, access to librarian assistance and small group work. Through building a relationship with a particular workplace, the KT strategy can be adapted to its particular needs and embedded within its organisational structures. In an ideal world this would take the form of a dedicated position (possibly shared with a university), which would enable the time to develop the necessary relationships over time and a sense of continuity.

However, there also needs to be provision for the less than ideal world that many mental health occupational therapists operate within. Variations and hybrid models of knowledge brokerage such as the consultancy model (as adopted in the Super Moth project), project specific work, and multidisciplinary knowledge brokerage, would enable at least some of the benefits of this approach to reach some services. Modified versions of the knowledge brokerage may be particularly relevant to rural, remote and voluntary services lacking the resources to implement the full version.
Further work is required to realise what these modified versions might look like, and this should be supported by evaluation of how effective different forms of knowledge brokerage are. While the individual contexts of workplaces and organisations will always require a flexible approach, there may be features which have more general effectiveness such as short- versus long-term engagement, or the degree of clinician involvement. The nature of the relationship between the knowledge broker and the clinicians is also likely to have more general significance. As highlighted in Chapter 4, the power differentials in these relationships tend to be skewed currently towards the academic, with the clinician being a passive receiver of guidance and training. In knowledge brokerage, the broker is usually located within the clinical environment, and this sort of imbalance would not be sustainable.

Dissemination of the results of knowledge brokerage is another way of spreading the potential benefits of this approach. One of the roles of a knowledge broker could be to facilitate dissemination, and there are a range of methods and genres available to achieve that such as role statements, practice evaluations, and literature reviews.

**Clinical Practice Guidelines.**

Clinical practice guidelines are a form of dissemination, specifically aimed to support clinician decision-making on a day to day basis (Kumar & Worley, 2010). An overview by Stergiou-Kita (2010) examines the factors which influence the implementation of clinical practice guidelines in occupational therapy practice. Clinical practice guidelines are relatively rare in mental health OT, with only five found in the review of evidentiary ways of knowing (Heasman & Atwal, 2004; Hogan et al., 2008; Moniz-Cook et al., 2008; Tse, 2002; Wong & Wan, 2000). These guidelines tend to adopt methods which only account for high-quality quantitative evidence, and are therefore relatively brief. Stergiou-Kita finds that characteristics related to the guidelines, clinicians, patients and organisational context all have an impact on whether they are implemented. Her recommendations focus on the implementation of such guidelines, and she concludes that no one strategy can be recommended above others. This accords with the findings of Novak, Russell and Ketelaar (2013) that KT strategies generally need to be multidimensional.

While clinical practice guidelines have been found to be effective in influencing simple practice behaviours such as hand washing, there is evidence they are ineffective in influencing more complex forms of interventions, such as those which occur regularly in mental health OT. However, the main advantage of clinical guidelines has
been their wide dissemination in peer-reviewed journals, making the knowledge which underpins them widely available. As described in the following article (Hitch, Taylor, Pépin & Stagnitti, 2013) published in the *International Journal of Psychosocial Rehabilitation*, I developed a process for formulating evidence based guidelines as a means to address some of the barriers to implementation, taking advantage of the strength of this form of KT.


I had gained an overview of current understandings about practice ways of knowing in mental health OT, and explored two potential strategies for implementing diverse ways of knowing into practice: knowledge brokerage and evidence based practice guidelines. I realised that this provided me with sufficient information to address the practice aspects of the research question for this thesis, as I now understood how they integrated and incorporated with theory and evidence. The theoretical structure afforded by the dimensions of occupation provided a context for considering all the different manifestations of mental health OT, although, as I noted above, the current evidentiary ways of knowing were not entirely supportive of the dissemination of practice. I therefore concluded that I had reached a destination in my journey that marked the end of my doctoral studies. There were further journeys possible and more places to explore; the iterations of ITEA could continue evolving into the future; but as keen as I was to get going on these new adventures, I needed to unpack my suitcases, take stock and regroup.
Summary
This chapter has reported on two iterations of the ITEA method, which explore theoretical ways of knowing about mental health OT. The critical questions which have driven this part of the thesis are shown in Figure 5.2.

Figure 5.2 Iterations of ITEA method used to explore theoretical ways of knowing.

After introducing practical ways of knowing, I explored current understandings of these ways of knowing in mental health OT. I acknowledged that my review is based only on what has been published in peer-reviewed journals, and therefore represents only a partial picture of current knowledge. Evidence about practice ways of knowing tend to originate either in the UK or US, and there seems to have been less of this evidence published in recent years.

Broad role statements are available concerning the role of occupational therapy in mental health from the American Occupational Therapy Association, and these statements reveal considerable variation in the “doing” practiced across a range of settings. Mental health OT is developing a presence in several new areas and with new populations, using the skills developed over many decades as a basis for this growth. Overall, evidence about practice ways of knowing focuses more on working within systems than working with individual clients, meaning that the practice ways of
knowing in day-to-day mental health OT remain reported individually as practice
descriptions or overviews.

Understanding of the being of mental health OT also remains under-developed,
and several pieces of evidence attempted to clarify its identity in comparison with other
professional and research cultures. Becoming in mental health OT practice was mostly
expressed through evidence about the role of student placements in emerging areas of
practice. The evidence about belonging through mental health OT practice consists of
practice evaluations and role descriptions about initiative which explicitly address social
inclusion.

I reflected that my primary source (peer-reviewed journals) was unlikely to give
me the sort of information and experience I wanted to draw a comprehensive review of
practice ways of knowing in mental health OT. Therefore, I decided to focus my
ongoing journey on ways of applying and integrating into practice the knowledge I
already had about theoretical and evidentiary ways of knowing. This directly related to
the process of knowledge translation (KT), which has had a growing profile in health in
the past decade. Some OT authors advocate a more inclusive model of KT within the
profession, while others maintain a tradition quantitative focus. I reviewed the efficacy
of a range of KT methods, and decided to investigate which of them enabled the
inclusion and integration of theory, and a range of non-scientific ways of knowing, into
practice.

Two strategies were presented in depth: knowledge brokerage and evidence
based practice guidelines. Knowledge brokerage for mental health OT was developed
through the initiation of the Super Moth project, described in detail in a published
article. The development of evidence based practice guidelines (in response to some of
the challenges presented by current clinical practice guidelines) was also described in
detail, supported by a copy of a published article. I concluded the chapter by reflecting
that I had now reached a destination in my journey, and was ready to take stock of my
experience.
Chapter 6. The Pan Occupational Paradigm

“Harmony exists in difference, no less than in likeness, if only the same key-note govern both parts.” –Ossoli, *Women in the nineteenth century*

**Introduction**

In the previous chapter, the relationship between and influence of theoretical and evidentiary ways of knowing into practice were explored. The evidence analysed to explore practice ways of knowing was from peer-reviewed journals, and provided a partial view of what is happening in mental health OT; this medium is not one where the main proponents of this way of knowing (clinicians) have a large presence. Knowledge translation (KT) was identified as a process through which EBOT happens, although there remains some ambivalence about which of the many strategies available for the transfer and utilisation of knowledge to practice to mental health occupational therapists is most effective. Two KT methods that emerged in the literature reviewed were explored in relation to mental health OT – knowledge brokerage and evidence based practice guidelines – and found to have potential for integrating ways of knowing for best practice.

As I stopped to take stock of my journey through the ways of knowing, I was first struck by the diversity of information available to help mental health occupational therapists support their clients. A system or method needed to be developed which considered the breadth of evidence, embracing all methods and traditions. The ITEA method provides a means to integrate this information, by embedding theory, evidence and practice into the process of managing information, and being inclusive of diverse ways of knowing. These ways of knowing capture all aspects of mental health OT, from the types of information available to clinicians to the full range of human engagement in the myriad of occupations which are available. Diverse ways of knowing have led to a profession practising across an ever-growing range of settings, with increasingly varied groups and populations. The challenge is to maintain a coherent sense of occupational therapy while remaining responsive to the full gamut of human occupation. Occupation remains the heart and soul of occupational therapy: the one thing that unites all of the professions many manifestations and ongoing developments. To remain true to our heart and soul (and therefore ourselves), mental
health occupational therapists need a structure within which to consider, process and apply many different ways of knowing about occupation in mental health.

Having submerged myself in the work of Anne Wilcock, I had developed a deep appreciation for her vision of the role of occupation in health. From my journey through theoretical, evidentiary and practice ways of knowing, the dimensions of doing, being, becoming and belonging had provided a consistent framework. All of the dimensions were evident within the ways of knowing, regardless of the form of knowledge collected or the way in which it was analysed. All 1596 articles foregrounded one or more of the dimensions, with no examples found of evidence written by mental health occupational therapists which was not directly related to doing or being or becoming or belonging. Given that the sample includes the majority of mental health evidence for the past 12 years (excepting non-English article and those which didn’t meet the inclusion criteria), it is reasonable to say that the dimensions of occupation highlighted by Wilcock in the OPH provide a unifying framework within this specialist area of knowledge. However, they are not explicitly present within the evidence base – my journey has enabled me to see the largely implicit influence of doing, being, becoming and belonging.

So, why has the OPH had so little demonstrable impact on mental health OT practice? While I was aware of a handful of direct references (e.g. Fieldhouse, 2000), the findings of this thesis support the implicit presence of doing, being, becoming and belonging in every part of the knowledge base for mental health OT. Given my contention that a unifying framework is essential to enable mental health occupational therapists to practise in a manner which is coherent and authentic, and considering the presence of the dimensions of the OPH, its hidden influence is problematic. If mental health occupational therapists are not familiar with the paradigm, it cannot be used in a conscious and mindful way to guide practice. The problem does not lie in the structure of the four dimensions – their validity has been proven in this thesis – and so I set out on my next iteration of the ITEA method to explore the reasons why the OPH remains a shadowy influence.

From my journey I knew there was relatively little knowledge available which directly related the work of Wilcock to mental health OT, so I decided to broaden the scope of this final iteration of ITEA to gain an understanding of the impact of the OPH on occupational therapy in general. I therefore re-determined my critical question as follows:
Iteration 10 of the ITEA method

**Step 1: Re-determine the research question**

What prevents the explicit use of the OPH in occupational therapy practice?

**Step 2: Select theoretical framework**

Once again the four dimensions of doing, being, becoming and belonging were the chosen framework for this iteration of the ITEA method.

**Step 3: Identification**

To identify the evidence relevant to this question, I used four complementary strategies - personal reflexivity, discussions with a range of interested parties (including academics, clinicians, students and clients), critique of primary sources and critique of published evidence in peer-reviewed journals. These strategies will now been defined and explained.

**Personal reflexivity.**

Reflection refers to the subjective observation and reporting of actions taken, including the rationale for them and associated emotions. Reflexivity is where reflection takes the context of both the reflectee and their knowledge base into account (Bolton, 2010). Through my journey, I kept field notes outlining my reflections on both the discoveries I was making and the process through which I was making them. I practiced reflexivity by integrating these insights with my understanding of the overall context of mental health OT from previous practice, and the knowledge of peer reviewed evidence which I built up during the course of the thesis. These field notes were not kept in a separate file or diary, but were interspersed throughout my many versions of this thesis, peer-reviewed articles and general notes. This recording strategy was a deliberate attempt to embed reflexivity within the overall process, rather than have it as a separate process to be added at a later date. For this iteration of ITEA, I reviewed all my files and notes for instances relating to the research question and placed that material into a single Word document.

**Discussions with interested parties.**

Through my journey I also sought opportunities to talk about the OPH with a broad range of professional contacts. These discussions took place face to face, informally and formally, in workplaces and at conferences, and online through emails. Just as the insights and observations gained from my personal reflexivity were recorded at various places throughout my records, data from these discussions were held in a range of places. For example, comments I had collected about the utility of using
doing, being, becoming and belonging for the evidence based practice guidelines were held in the files related to that article, while comments about the dimensions in research evidence were written in field notes related to the journey through evidentiary ways of knowing. I also reviewed all my files and field notes for instances from discussions with interested parties relating to the research question, and placed that material into the same Word document as my personal reflexivity.

Primary Sources.

The OPH developed over several years spanning the turn of the current century. The first edition of *An Occupational Perspective of Health* was published in the late 1990s (Wilcock, 1998a), and the concepts of doing, being and becoming were highlighted in a presentation at the 12th World Federation of Occupational Therapy Conference in Montreal, Canada. These concepts were subsequently expanded upon and rapidly gained publication in both the *Canadian Journal of Occupational Therapy* (Wilcock, 1998b) and the *Australian Occupational Therapy Journal* (Wilcock, 1999). An updated presentation of the concepts and structure of the OPH was contained in a second edition of *An Occupational Perspective of Health* (Wilcock, 2006). In this later version Wilcock acknowledges that many readers of the original edition had been able to identify the relevance of the theory to individual health concerns and programs, indicating the beginnings of its application to practice. Finally, Wilcock adds a brief discussion of the emerging concept of belonging in an article (2007) published just before her retirement from the profession. These articles and books are the primary sources for the OPH, as they are the body of literature which outline its structure, concepts and potential areas for application. I had recorded my understanding of them, and my reaction to their contents, in my field notes on personal reflexivity.

Published evidence in peer-reviewed journals.

A different inclusion and exclusion criterion was used for this iteration of ITEA than that adopted for the rest of the thesis. This was to ensure the evidence identified was directly relevant to the research question. Three seminal publications about the OPH were identified (Wilcock, 1998b; Wilcock, 2006; Wilcock, 2007) and all sources citing the four core concepts were located using the citation count feature on Google Scholar®. The overall sample was therefore the sources (journal articles, books and grey literature) which had cited one of the seminal publications in the years since their publication. While citation analysis is an imperfect way to determine influence, it allowed an overall estimate of the OPH’s influence on authors writing about
occupation. As of December 1st 2012, 507 individual citations including some sources citing more than one of the three seminal publications.

Inclusion and exclusion criteria were applied to this sample of citations. The sole inclusion criterion was that the cited source either used or commented on the application of the OPH. Exclusion criteria included duplicates (n=53), articles not written in English (n=65), and articles with no accessible full text copy (n=16). When screened for use or commentary on the application of the OPH, a further 199 articles were excluded.

Of the final sample of 176 sources, very few articles included comments beyond an acknowledgement that Wilcock identified a link between occupation and health. Those which either used or commented on the application of the OPH beyond acknowledging the link were read more closely, and the relevant content added to the Word documents which held the notes from personal reflexivity and discussions with interested parties.

**Step 4: Deconstruction**

Deconstruction occurred through a process of categorising the data collected, according to the four dimensions of occupation. The notes from all of my 176 sources were provisionally grouped into those addressing doing, being, becoming and belonging in relation to the use of the OPH in occupational therapy practice. I say provisionally because (as discussed in Chapter 4) all the dimensions are interrelated and some of the data in the sources was potentially relevant to more than one of the dimensions.

Knowledge related to doing included that which addressed aspects of the OPH with a direct impact on its application – how its terms are defined and the way in which it is presented. Knowledge related to being included that which addressed the form of the OPH: its “being as entity”, defined in Chapter 3 as the sense of who someone is as an occupational and human being. Knowledge related to becoming included that which addressed how it is integrated into practice and its development over time. Finally, knowledge related to belonging included that which addressed the inclusivity of the OPH, and how it relates to all aspects of OT.

**Step 5: Analyse Data**

The notes taken from my sample of sources were then read several times from a critical perspective, with notes taken about factors which emerged. These notes were analysed using constant comparison, by categorising, coding, identifying categories
and connecting them progressively as the data was collected (Boeije, 2002). While constant comparison is an explicitly qualitative method, it has many similarities with the correlation, comparison and consolidation process undertaken during the ITEA method. An understanding of the data is constructed progressively by a critical engagement with everything collected, leading to the development of new meanings. As the qualitative data was analysed, seven consistently identified barriers to the explicit use of the OPH in occupational therapy practice emerged. The existence of each barrier was supported by data from more than one source article, and in some cases was identified in sources using various methods (i.e. scientific and non-scientific), although I acknowledge that they were also framed by my own perceptions, knowledge, context and experience. I had some basic familiarity with the OPH as a clinician, and have developed my personal opinion of it during the course of this thesis. This analysis occurred towards the end of the process of analysis for this thesis, and these previous experiences had already flagged some of the barriers in my perception. Other clinicians and academics may see other barriers to the use of the OPH, and I hope this thesis will stimulate such debate in the future.

**Step 6: Reconstruction**

The following reconstruction begins with being rather than doing, as the analyses of the other dimensions are founded on my analysis of the form of the OPH. While I have stuck with the common usage in mental health OT up to this point (putting doing first), the process of analysis in this iteration of ITEA did not begin with the doing of applying the OPH to practice. Seven barriers are identified within this reconstruction, relating to all of the dimensions:

- the validity of concepts other than doing, being, becoming and belonging in the OPH has not been established;
- there is a dichotomous focus on health and illness;
- terms are poorly or inconsistently defined;
- detailed information is not always readily accessible;
- presentation is static and fragmented;
- there is a lack of organised support for implementation;
- there is a lack of cultural diversity.
Barriers to the explicit use of the OPH in occupational therapy practice

**Being.**

The being of the OPH relates to the capacities and characteristics of the paradigm, and is an expression of the paradigm’s ‘being as entity’. The data about the being of the OPH relate to its manifestations and what gives it a distinct identity. Two of the barriers were found to relate directly to the ‘being as entity’ of the OPH – the validity of the dimensions and the dichotomous focus on health and illness.

*The validity of concepts other than doing, being, becoming and belonging in the OPH has not been established.*

While the validity of the four dimensions, doing, being, becoming and belonging, as a unifying framework has been demonstrated within the sample in this thesis, the OPH is far more than just these. Wilcock discusses a range of concepts in her two books (1998b, 2006), providing the complex background to the development of paradigm. Occupation is placed at the centre of the OPH, and the fundamental assumption is that occupation is essential to healthy living and wellness (Wilcock, 2007). The OPH presents the concepts of health and illness in the context of occupation, health and survival (Wilcock, 2006). Wilcock argues that the human brain has “healthy survival” as its primary role, which it enacts through engagement with occupation (2006). Health/order is achieved (for individuals, communities and populations) when all essential needs are met and capacities (physical, mental and social) are maintained, developed, exercised and in balance. Survival can only occur when the person exists in a sustainable relationship with the environment, which enables access to ongoing resources and support. Illness/disorder occur when needs are unmet, capacities are unfulfilled or environments are exploited or disrespected (2006). If these concepts are support the applicability of the OPH, they need to be more clearly defined and their relationships to practice explicitly stated.

*Dichotomous focus on health and illness.*

While all occupational therapy theories include knowledge from other disciplines to some extent, the OPH is unique in its public (or population) health perspective. Wilcock (2006) explicitly acknowledges the influence of the World Health Organisation on her thinking, and in particular their policies concerning health promotion, social determinants of illness, diet, physical activity and active aging. She attempts to “link occupational terminology with that of public health, so that interdisciplinary speak...
becomes easier” (p. xiv). The OPH communicates broad assumptions and perspectives on the values and focus of occupational therapy. By focusing on health and illness at a community and population level, Wilcock’s OPH also challenges traditional definitions and assumptions of occupational therapy, which usually focus on the engagement and independence of individuals in occupation (Hopkins & Smith, 1993).

The OPH uses the terms “health” and “illness” dichotomously to describe its domain; this conceptualisation is shown in Figure 6.2. This figure is a modified version of an original graphic representation by Wilcock, as there are none currently available that include all four dimensions. Belonging has been added as context surrounding the original three dimensions, although it is possible that Wilcock would have included it as a smaller, discrete dimension alongside them.

![Figure 6.1 Modified version of the occupational perspective of population health.](image)

The WHO definition of health used in the OPH has been criticised for the relatively static quality implied by “a state of complete physical, mental and social wellbeing, not merely the absence of disease or infirmity” (Blair, Hume & Creek, 2008; WHO, 1946). Illness is not defined as such, so its meaning remains open to interpretation, as does its relationship to health in the OPH. The OPH also uses the term
wellbeing, and this is in fact the concept cited most frequently throughout the detailed description of the theory. Wilcock (2006) acknowledges that there are many different definitions of wellbeing, and quotes several to provide an idea of the concept’s breadth and complexity. Many different perspectives on what constitutes health and the possible causes of illness are canvassed in the OPH, but wellbeing is the concept used to categorise them into three determinants of health: physical wellbeing, mental wellbeing and social wellbeing.

Wilcock (2006) states that physical wellbeing has long been the focus in medically dominated post-industrial cultures, and is therefore the easiest for most people to grasp. Mental and social wellbeing are also discussed by Wilcock, with the latter acknowledged as the most complex and challenging to understand. Wilcock adds that wellbeing is enhanced if people are allowed to develop their spiritual capacities, “to experience timelessness and higher order meaning” (2006, p. 139), although she does not explicitly locate spirituality in her paradigm.

Therefore, while named as a perspective on health, I believe the OPH is in reality a perspective on the occupational nature of humans and their wellbeing. Given the centrality of health, illness and disability to the theory, the inconsistent use of terms can introduce confusion and encourage assumptions which may not be relevant. For example, illness may be assumed to pertain only to biologically based ill health, while wellbeing may be limited to psychological factors. Confusion about the dichotomous use of health and illness (and indeed what is meant by these terms) obscures the being of the OPH, and is a clear barrier to its explicit use by mental health occupational therapists.

Doing.

The doing of the OPH relates to how it is applied to practice, both explicitly (through practice) and implicitly (through clinical reasoning and reflection). The data about the doing of the OPH relate to the tools which exist for its application, and resources available to clinicians to support its use. Three of the barriers were found to relate directly to the doing of the OPH – poorly or inconsistently defined terms, accessibility of detailed information and the nature of its presentation.

Poorly or inconsistently defined terms.

Health, illness and wellbeing are not the only terms in the OPH which are potentially confusing. Wilcock provides a specific definition for only one of the four dimensions (becoming), as she takes an inclusive approach by canvassing and
discussing several different perspectives on each of the other dimensions. I recognise it would perhaps be futile to attempt to operationalise these terms too specifically: for example, there are many different types of doing, as denoted by terms such as acting, behaving, participating and performing (Crabtree, 2003); but a lack of description of these terms as they relate to the OPH can lead to uncertainty about their use and meanings in the occupational context.

Wilcock (2006) acknowledges that being is perhaps the most difficult term for people to understand in the context of modern health systems. She focuses on the emotional, lived experience aspects of engaging in occupations in her description of being, stating that it encompasses “how people feel about what they do” (p. 113). This is supported by extensive discussion of the capacities of consciousness and creativity as vehicles for people to find meaning in what they do. However, by only considering the incorporeal aspects of being, Wilcock effectively separates it from the bodily, physical aspects of being. This has led others to describe the OPH as overly existential (Cutchin, Aldrich, Bailliarid, & Coppola, 2008).

Wilcock discusses personal capacities in some detail, stating they are critical to complex, self initiated being through doing that appears to go beyond meeting the pre-requisites of health. She defines capacity as “the innate and perhaps undeveloped potential, aptitude, ability, talent, trait or power with which each individual is endowed” (2008, p. 117). These capacities are the foundations of being, and it therefore seems to be an omission to disregard capacities which are physical, cognitive or mental.

**Accessibility of detailed information.**

Along with the barriers caused by poorly defined terms, the applicability of the OPH is also hampered by the manner in which the theory is presented, particularly in its more detailed form. The two journal articles which first expanded on doing, being and becoming (Wilcock, 1998b; Wilcock, 1999), followed by belonging (Wilcock, 2007) are relatively accessible, written in a style which enables the reader to generally grasp the four dimensions. They were published for occupational therapists, in occupational therapy journals. However, I found the main text which expands on the theory (Wilcock, 2006) a very scholarly work, dense in detail and quite demanding of the reader. In the preface to the second edition, Wilcock states that it was “written principally to inform those interested in improving the health of populations about the potential place of occupation-based initiatives in public health” (2006, xiii). It is not written for occupational therapists per se, but for those who aspire to take their
professional skills in a public health direction. This appears to be based on an assumption that the profession as a whole should be moving towards a more public health focus, but this way of practising occupational therapy has remained just one of the many forms the profession takes. The proportion of the readership that can easily access the extended form of the theory is therefore limited, as readers must be willing to engage both with Wilcock’s view of occupational therapy’s scope of practice and her individual writing style.

Despite the overtly public health focus of the OPH, not one of the hundreds of sources which have cited this paradigm originate from public health. I acknowledge that writing across disciplines is extremely challenging, as each area has its own language which accumulates through professional socialisation (Carter, Ferzli, & Wiebe, 2007). Despite postgraduate qualifications in public health, Wilcock retained a strong connection to occupational therapy in describing her paradigm, and this does not appear to have connected with public health practitioners. Writing within a discipline is based on an intimate relationship between writing and knowing (Carter et al., 2007), and I suggest that the OPH speaks more clearly to occupational therapists.

**Static and fragmented presentation.**

A uni-dimensional or linear approach to the theory has been adopted in some research influenced by the OPH to date, and is considered by some to be a valid approach in inquiry (Duncan, 2009). This is evidenced by studies that have focused on one dimension exclusively (e.g. Sutton, 2010), and by debate about what comes first – doing or being (Iwama, 2003; Wada, 2011). However, Wilcock repeatedly reminds her readers that all dimensions of the OPH interact in constant and dynamic ways.

There are also studies that demonstrate that the dimensions do not have equal value or a linear relationship. Nunn (2007) finds that occupational therapists do not experience all four dimensions to an equal degree during the experience of professional mentorship, and there is a small body of evidence that suggests being is particularly foregrounded for those at the end of their lives (Lyons et al., 2002; Pickens, O’Reilly & Sharp, 2010). A study of Pakistani families in the UK with children who have disabilities (Kramer-Roy, 2012) finds that belonging was the most important dimension to their carer role, and that being as a carer was strongly influenced by their faith. The full depiction of a relationship as complex as that between occupation and health in a two-dimensional diagram is likely to be impossible, although this is the usual method for transmitting this sort of knowledge, and the problems this causes are not unique to
the OPH. Theoretical ways of knowing are often easier to grasp and retain if they are presented in a visual format, but this always involves a level of simplification. In the case of the OPH, its current representations misrepresent a fundamental aspect of the paradigm – its multidimensional, interrelated nature – and are therefore a barrier, rather than an aide to understanding.

**Becoming.**

The becoming of the OPH relates to factors which impact on the hopes and aspirations of those who seek for it to be implemented. This relates to its ongoing development over time, assuming an evolution towards increased acceptance and explicit use.

**Lack of organised support for implementation.**

The OPH is at a disadvantage in relation to other theoretical frameworks in occupational therapy because it lacks organised support for implementation. The highest-profile conceptual practice models are those which are supported by some infrastructure and organisations dedicated to their dissemination: for example, MOHO is supported by the Model of Human Occupation Clearinghouse, the Centre de Référence sur le Modèle de l’Occupation Humaine, and the UK Centre for Outcomes Research & Evaluation. The CMOPE is supported by the resources of the Canadian Association of Occupational Therapists. In contrast, the OPH lost its main proponent when Anne Wilcock retired from occupational therapy in 2004. Since her retirement the OPH has not evolved further, and the most current version is now eight years old. While the universal applicability of paradigms usually result in their achieving enduring relevance, much has changed in OT in the past decade. In particular, the OPH does not provide occupational therapists with any online or digital tools for application, which are becoming increasingly prevalent throughout healthcare.

**Belonging.**

The belonging of the OPH relates to how it relates to the overall culture of mental health OT and the population which the profession serves.

**Lack of cultural diversity.**

The OPH aims to encompass all human doing, being, becoming and belonging. However, I noted it was explicitly developed from a Western perspective, and is strongly influenced by a scientific approach. While analysing underpinnings as a theory of human nature, Wilcock uses evolutionary and biological theories to outline the
evidence for the impact of occupation on humans as a species, which requires the reader to accept an evolutionary perspective on the origins of diversity.

A major influence on the OPH was Wilcock’s ongoing work on the history of ideas about occupation and health (2001a, 2001b). The paradigm is interspersed with examples of both the ancient and modern rules for health, all of which are Western European and most of which are from an Abrahamic, monotheistic tradition. It could be argued that the profession of occupational therapy is historically and in current practice mostly Westernised, although the global human experience of occupation is not.

Wilcock repeatedly highlights the need to value and accept the different ways in which individuals experience occupation. However, given the paradigm’s aim to assimilate the theory and practices of occupational therapy and public health, the OPH as a whole appears to take the position of epistemological humility (Goldingay et al., 2012). Equity is at one end of the epistemological continuum (Goldingay et al. 2011), which ranges from assimilation, through unawareness and humility, to a position of equity. Different ways of knowing about occupation are recognised, but the dominant view (in this case occupational therapy) remains privileged. In the absence of full epistemological equity, the OPH cannot be applied in a culturally inclusive manner.

The cultural stance of the OPH has been critiqued from an Eastern cultural perspective (Iwama, 2003; Wada, 2011), particularly regarding the temporal presentation of the four dimensions – doing, then being, before becoming and belonging. Both Iwama and Wada note that in Japanese culture, people may begin with becoming before progressing to being and doing. For indigenous Australians, belonging to their community and country is a crucial factor in health and wellbeing (Stedman & Thomas, 2011). In its current form, particularly in the ways it is currently presented, the OPH is not inclusive of all cultural contexts and this is a barrier to its use in an increasingly diversified global community.

There is a broader debate within occupational therapy about its cultural stance, and the OPH is not unique in drawing from a limited range of cultural perspectives (Hammell, 2009; Hammell, 2011). However, in recent years it has been successfully applied within non-Western cultural contexts (Duncan, 2009; Ekelman, Bazyk, & Dal Bello-Haas, 2003; Heigl, Kinébanian, & Josephsson, 2011). The dimensions of occupation may therefore transcend cultural contexts, even if their conception was grounded within one particular perspective. Much more research and exploration is
required to confirm the cultural relevance of the OPH to all mental health OT clients, and will be critical to the assessment of its efficacy as a paradigm.

**Step 7: Transfer and Utilisation**

In other iterations of the ITEA method in this thesis, Step 7 has often been beyond the scope of my journey. The translation of each set of findings into practice will be a project of many years, and the research required to fully evaluate ten instances of knowledge transfer and utilisation was well beyond the scope of this thesis. However, given the focus on application to practice in this case, it was imperative to address the ways in which the OPH could be transferred and utilised in mental health OT, and this entailed proposing potential solutions to the problems posed by the seven barriers.

As I stated in Chapter 1, I was motivated to undertake this thesis by the thought that “there has to be a better way” to enact EBOT. Having identified the four dimensions of occupation from the OPH as a potentially unifying framework for mental health OT, and recognised a series of barriers to their explicit use to manage diversity and guide practice, it was time to propose changes to overcome the identified problem. It was time to use the knowledge and experience I had gained through this doctoral study to propose that better way, and provide a theoretical framework which would enable clinicians to integrate their theoretical, evidentiary and practice ways of knowing in a manner that always had occupation at its heart. By developing a new iteration of the OPH, which overcome the limitations of its existing iteration, I was aiming to answer the original research question and let clinicians know ‘how to’ practice in an integrated and authentic manner.

**A New Iteration of the OPH: The Pan Occupational Paradigm (POP)**

The Pan Occupational Paradigm is a new iteration of the OPH which addresses the identified barriers to its explicit application to OT practice. The OPH is a paradigm about occupation, developed by an occupational therapist for occupational therapists. However, it hasn’t been widely adopted by the profession, and remains underutilised and under researched. Its latest iteration (POP) is an expression of the occupational therapy way of knowing about occupational engagement and health. The prefix “pan” (“pan~”, 2014) is used in the sense of universality or relevance to all occupations, while it is identified as a paradigm due to its focus on broad assumptions and values.

POP has a different structure to the existing OPH. POP is not a conceptual practice model as it does not fully or partially meet the definition provided by
Kiellhofner (2008). POP neither provides guidelines for practice, or suggests assessment and intervention techniques and technologies (Clarke, 2003). Unlike the OPH, POP is a uni-disciplinary paradigm. It aims to act as a statement of the ways of knowing about occupation that is unique to the practice of occupational therapists. In this aspect, it differs considerably from the OPH, which was designed to span at least two disciplines (occupational therapy and public health).

POP consists of six main elements; the four dimension of occupation, the wellbeing / ill being continuum and OT. The four dimensions of occupation – doing, being, becoming and belonging – are considered to comprise an occupational being. This occupational being may be an individual, group or population. The occupational being moves along a continuum of wellbeing / ill being during its lifespan. OT (both through individual therapists and collectively as a profession) brings it theoretical, evidentiary and practice ways of knowing to its interactions with the occupational being, and within these interactions they combine with the personal ways of knowing inherent within that person, group or population. OT is conceived as entering an interaction with the occupational being, and leaving when its work has been completed.

POP is based upon two assumptions. The first is from the original OPH, confirming that humans are occupational beings and their wellbeing is directly influenced by their occupational engagement (Wilcock, 2006). The second is an acceptance of epistemological equity – that the occupational therapy way of knowing about occupation is one perspective among many, and that all forms of knowledge generated by occupational therapists are of equal value to our understanding.

The four dimensions.

Throughout the on-going construction of the answer to my original research question, I realised that doing, being, becoming and belonging interact with each other constantly, but do not have an equal influence at all times. All four dimensions were present at all times, but different dimensions are foregrounded according to personal meaning, occupational characteristics and environmental factors. The decision to use the OPH as a theoretical framework to organise this thesis enabled an in depth exploration and critique of the OPH and its components. This led to the reformulation of the definitions of the four dimensions which are found in POP, the new iteration of the OPH. These definitions are based on Wilcock’s initial work and informed by the subsequent analysis of the dimensions use across this thesis. They provide the most
detailed and current representations of doing, being, becoming and belonging that are available.

**Doing**

Doing is the medium through which people engage in occupations, and the skills and abilities needed for doing accumulate across time. It involves engaging in occupations which are personally meaningful, but not necessarily purposeful, healthy or organised. Doing involves being actively engaged, either overtly (i.e. observable, physical) or tacitly (i.e. mental, spiritual). Doing follows broadly similar patterns across the population, and humans are able to adapt their doing to greater and lesser degrees according to circumstance.

**Being**

Being is the sense of who someone is as an occupational and human being. It encompasses the meanings they invest in life, and their unique physical, mental and social capacities and abilities. Occupation may provide a focus for being, but being also exists independently of occupation during reflection and self discovery. Being is expressed through consciousness, creativity and the roles people assume in life. Ideally, individuals are able to exercise agency and choice in their expression of being, but this is not always possible or even desirable.

**Becoming**

Becoming is the perpetual process of growth, development and change which resides within a person throughout life. It is directed by goals and aspirations, which can arise through choice or necessity, from the individual or from groups. Regular modifications and revisions of goals and aspirations help to maintain momentum in becoming, as does the opportunity to experience new or novel situations and challenges.

**Belonging**

Belonging is a sense of connectedness to other people, places, cultures, communities and times. It is the context within which occupations occur, which Lala and Kinsella (2011) characterise as a “situatedness” within an ongoing life. A person may experience multiple belongings at the same time. Relationships are essential to belonging, whether they be with a person, place, group or other factor. A sense of reciprocity, mutuality and sharing characterise belonging relationships, whether they are positive or negative.
Figure 6.3 is the representation of POP where the dimensions of doing, being and becoming are superimposed on belonging to denote that they are all contextualised by this last dimension. They are depicted as shapes within shapes, to highlight the lack of linear relationships between them and the overall holistic approach required. An animated version, in which the dimensions pulse larger and smaller to show how different dimensions are foregrounded at different times and for different occupations, can be accessed at http://www.deakin.edu.au/~stacieb/.

![Diagram of POP](image)

**Figure 6.2 Diagram of POP.**

**The wellbeing continuum.**

In Figure 6.3, the column to the left denotes a continuum from ill being to wellbeing. It does not denote time, but rather the person’s current state of wellbeing. At one end of the continuum are the negative consequences of occupation for a person, population or community: illness, deprivation, alienation, injustice and death. At the top of the continuum are the benefits of engagement in occupation for a person, population or community: wellbeing, health, happiness, inclusivity and justice. These
factors may remain general or could be customised for a client to reflect the particular goals (derived from becoming) for that client. The arrowhead at the other end denotes the aspiration to move towards the benefits of engagement in meaningful occupation, by addressing doing, being, becoming and belonging.

**Occupational therapy.**

Occupational therapy usually plays a small part in the overall occupational life of a person. The smaller yellow arrow represents an occupational therapist, who may enter the occupational life of a person at any point and initially engage with any dimension. For the purpose of illustration only, the arrow enters at the lower right corner in the animated version of POP, and exits as shown in Figure 6.3 when therapy concludes. In reality, the path of the arrow would be unique to each case, as would the sequence in which it moved through the dimensions. During therapy, occupational therapy moves between and is present in all the dimensions. Once occupational therapy is concluded, the client continues towards the benefits of engagement in meaningful occupation but may also experience setbacks or changes which move them in the opposite direction.

**Significance of colour.**

The use of colour in the animated version of the figure refers to an important but often forgotten aspect of the OPH. The continuum and dimensions are green to highlight the need for healthy occupations to be environmentally sustainable for the ultimate health of all. Wilcock (2006) discussed sustainability at length while outlining the OPH, but it wasn’t discussed in any of the mental health literature which formed the sample for this thesis. Sustainability has however been recognised in a position statement by the World Federation of Occupational Therapists (2012), who highlight it as an opportunity to align the profession with global issues. Adoption of the POP therefore brings with it an opportunity to become more aware of the sustainability of occupational therapy intervention and developments, although this is an area that requires far more research.

**Contribution to occupational therapy knowledge and practice.**

While deeply embedded in the work of Wilcock, POP offers several new contributions to occupational therapy knowledge and practice in mental health. It addresses the barriers already identified which have prevented the implementation of the current form of the OPH in several ways. A new, animated visual representation of the paradigm has been provided which overcomes the previously static and fragmented style of presentation. The new expanded definitions of doing, being, becoming and
belonging have been explicitly designed to increase the accessibility of these concepts, and will facilitate their application to and recognition in practice. While paradigms are not designed to provide guidelines for treatment, these definitions will inform ongoing development and provide a stronger framework for theoretical, evidentiary and practice ways of knowing to work within. The publication articles associated with this thesis have endeavoured to communicate the detailed and complex underpinning of this paradigm clearly within the domain of mental health. The dichotomous focus on health and illness has been removed, replaced with multiple concepts of both the positive and negative outcomes of occupation. The existing cultural critiques of the temporal order of the dimensions have been addressed in the structure of POP, where all the dimensions are acknowledged as asserting simultaneous influence and an order in which they are foregrounded is not specified.

POP contributes to the knowledge of mental health occupational therapy by providing a clear and coherent paradigm within which to consider all forms of practice. POP provides a contemporary theoretical structure for considering the relationship between occupation and health, originated by Wilcock but subsequently developed through the work of many other occupational therapists. POP contributes to the practice of mental health occupational therapy through its unification of all practices under a common set of values and understandings. POP is related to all of the conceptual practice models, and they can be used to apply its concepts.

The definition of paradigms as professional culture highlight that mental health occupational therapy is primarily focused on the four core concepts identified by Wilcock in the OPH. Occupational therapists enable people to do what they want, be who they wish, become what they hope and belong as an equal through occupation. This makes sense of and guides their professional actions, regardless of the mental health practice setting or health care context in which they find themselves.

POP presents the concepts of doing, being, becoming, and belonging (both individually and interdependently) within a conceptual continuum of ill-being and wellbeing as a way to show how occupational therapists promote wellbeing in individuals and communities. As such, it articulates the heritage, culture and expertise of a profession that is wonderfully varied and notoriously difficult to pin down. Adoption of POP as a guiding paradigm in mental health occupational therapy will not diminish this diversity and flexibility, but rather provide occupational therapy with a
unique way of explaining engagement in meaningful occupation on a continuum of wellbeing.

The Future of POP in Occupational Therapy

POP is a distillation of occupational therapy’s unique way of knowing about occupation. In reference to Kielhofner’s layers of professional knowledge (2009), POP (like the OPH) partially meets the requirements for designation as a paradigm. With its articulation of the broad assumptions and values which underlay occupational therapy, POP provides a framework for a consensus or common vision across all its domains of practice. However, this is yet to be fully realised and is likely to depend on its application to other areas of practice (aside from mental health) in the future. There are several specific potential lines for its further development, some of which are currently being pursued. As a paradigm, POP makes no direct recommendations about application to practice. A more detailed description of the relationships between the paradigm, conceptual practice models and related knowledge, and the ways in which existing technology and techniques can be utilised within POP, would be extremely useful to clinicians. The ability of POP to account for cultural diversity also requires further investigation, and could be explored using case studies into its relevance to occupations within various cultural groups. These case studies can highlight how POP enables a focus on occupation rather than on personal characteristics or disability. While these factors form part of the being and belonging of the occupational being, the concept of occupation transcends them.

Finally, the development of a body or organisation would go some way to enhance the profile of POP in occupational therapy and consolidate resources. This could take the form of a special interest group, an online community of practice or something more formal like the Centre de Référence sur le Modèle de l’Occupation Humaine. A certain level of interest and engagement would be required from the profession before such a group could be formed, and POP is still very much in its infancy. The next step in its overall development will be the publication of a book based on this thesis, including a range of case studies which demonstrate how POP can be applied to practice. Should this be successful, the formation of a supporting organisation could be undertaken.

Adoption of POP in Occupational Therapy Practice

Each of the articles reviewed for this thesis were found to foreground at least one of the four dimensions, and when considered as a whole they provide strong support for
it being a unifying theory for mental health OT. The structure has also been successfully applied to the analysis of conceptual practice models and evidence mapping in this thesis, and the formulation of evidence base practice guidelines (Hitch, Taylor, Pépin & Stagnitti, 2013). However, I was yet to introduce POP to its intended audience: practitioners of occupational therapy.

Given the testing of POP and analysis of its application to practice will be a long term project, a full evaluation of the responses of mental health occupational therapists to POP was beyond the scope of this thesis. However, I wanted to conduct a pilot study before concluding my journey to 1) provide a basis for future research and 2) gain an indication of how future occupational therapy practitioners perceived its worth. The research question I sought to answer was ‘Does POP assist occupational therapy students to understand how the concept of occupation for health unifies occupational therapy?’

Method

As the ITEA method is a method for synthesising diverse bodies of evidence, ITEA was not used for this study as it was generating new knowledge. Also, POP is a new paradigm and there is no evidence yet on which to base an iteration of the ITEA method. For this study, I conducted a single group pre-post study, using two mixed methods surveys. Ethical approval for this study was received from the Deakin University Human Ethics Committee for Health, and this certification is included in Appendix E.

Sample.

I identified a cohort of final year OT students as an appropriate sample to answer my question. These students had considerable practice experience, having already completed 1000 hours of fieldwork placements by this point in their undergraduate degree. They were also completing a capstone unit called “Critical Analysis of Occupational Issues,” which has an explicit focus on integrating the learning opportunities they have participated in across the course. The unit encourages students to apply their research and analytical skills to occupation and OT practice in broader contexts (i.e. socio-political perspectives, community development and global perspectives). Topics addressed in the unit include identifying trends in OT practice, critiquing professional directions, developing critical reflection and analysis, considering current issues related to occupation and health, and promoting occupational health and change management (Deakin University, 2013). Therefore, this unit was
also an appropriate setting for introducing POP, considering its potential for unifying and integrating their understandings.

Twenty-four fourth year students out of a potential fifty-eight (41.38%) consented to participate in the pilot study by attending the lecture and completing both the pre- and post-lecture survey. A further two students completed only the first survey, and returned blank copies of the second survey; their responses were excluded from the analysis. No demographic details were collected from this sample.

**Measures**

The surveys included closed answer questions using numerical scales and open answer questions seeking comments, and a copy of both are provided in Appendix M. As no suitable tool existed, these surveys were designed specifically for this pilot study. They were not pre-tested before administration with the target sample, but were reviewed by both thesis supervisors and the ethics committee of the hosting university. While the lecture introduced POP, the terminology in these surveys related only to the OPH. This was designed to reduce confusion, and also to reiterate that POP is the latest iteration of the OPH and therefore builds on the students’ knowledge of Wilcock’s work.

Survey One consisted of five questions, addressing both general understanding of theoretical models and the OPH in particular. The first two questions asked students to list the theoretical models they were familiar with, and then rate them out of 10 in regard to their understanding of them and confidence in applying them to practice. They were prompted to include only theoretical models in occupational therapy, but no other guidance was given. Students were then asked about the OPH specifically, and provided ratings out of 10 for their understanding and confidence relating to seven specific features of this paradigm. Finally, students were asked to briefly describe why they attended this lecture and what they were hoping to get out of it.

The second survey had six questions, the first two asking students to re-rate their understanding and confidence of the OPH immediately after the lecture. They were then asked to rate the relevance of the OPH as a whole to practice on a scale out of ten. Finally, they were asked to comment on which terms of the model they most liked or connected with, which they least liked or connected with and to make any other comments they wished to provide.

**Procedure**
Students were invited to participate in this study by a staff member unrelated to POP or any other units being taught in their fourth year. This invitation occurred in person, via a brief presentation prior to the commencement of the lecture. A plain language statement was read out to the class during this presentation, and copies made available in paper form for students wishing to keep one. Students were encouraged to ask questions, and discuss their participation with both the staff member and each other before making a decision. Their consent was confirmed in writing with a signed form that was returned with the first survey.

Students were asked to place an individual identifier on their survey (to enable matching of pre and post data). The first survey was distributed and time allowed for its completion (approximately 5–10 minutes). Students who didn’t wish to participate were advised the lecture would begin after the surveys of those participating had been completed, and were invited to take a short coffee break.

POP was introduced in a 45-minute lecture entitled “The professional identity of occupational therapy: Who are we and what do we stand for?” delivered on September 11, 2012. The lecture was presented by the author of this thesis, and its accompanying slides are provided in Appendix N. Within the OT degree course, the students had received teaching about Wilcock’s work in general and the OPH in particular in their first year, third year and earlier in the fourth year of their degree. At the conclusion of the lecture, the staff member returned and reminded students that their participation was voluntary. The second survey was then distributed, and time allowed for its completion (approximately 5–10 minutes).

**Analysis**

The quantitative data was analysed using both descriptive statistics (such as frequencies and means), and inductively (with the Wilcoxon signed ranks test). Qualitative data were analysed using content analysis as described by Vaismoradi, Turunen and Bondas (2013) where themes were derived directly from the comments provided by the students. Using this method, the frequency of comments were noted, grouped into similar responses and categorised under a theme. I have chosen to report the findings below using the four dimensions of occupation as an organising framework. The contention of this thesis is that doing, being, becoming and belonging are unifying concepts which are ubiquitous throughout mental health OT. Therefore, this format of reporting highlights how this manifests at the micro level of a single, small study.

**Findings.**
Data relating to three of the dimensions of occupation were identified through this pilot study. As it focused on whether POP assisted occupational therapy students to understand the concept of occupation for health in occupational therapy, no questions were asked about how the students would engage in applying POP to their practice. Therefore, none of the data collected foregrounded doing in relation to the POP, and this aspect will be explored in future research.

**Being.**

Most of the questions in these surveys assessed the occupational therapy students’ being in terms of their self-perceived capacities and abilities in relation to theoretical frameworks in occupational therapy. More specifically, the pre and post surveys assessed the students’ self-perceived capacity to identify, understand and feel confident about theoretical ways of knowing in mental health OT. Students initially identified the top five models they felt they had been exposed to during the undergraduate course. No distinction was made between conceptual practice models and related knowledge, because the aim of this question was to discover what their perception of relevant theoretical ways of knowing. They then rated their understanding of each model (1 = “no understanding” and 10 = “excellent understanding”), and confidence (1 = “no confidence” and 10 = “excellent confidence”) in using them. Of 116 separate responses, Table 6.1 shows that nine different models were identified.

Table 6.1

*Theoretical Ways of Knowing Identified by Fourth Year OT Students*

<table>
<thead>
<tr>
<th>Model</th>
<th>No</th>
<th>Mean Understanding</th>
<th>Mean Confidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Model of Human Occupation (MOHO)</td>
<td>24</td>
<td>6.67</td>
<td>6.54</td>
</tr>
<tr>
<td>Person Environment Occupation Performance (PEOP)</td>
<td>24</td>
<td>9.02</td>
<td>9.15</td>
</tr>
<tr>
<td>Canadian Model of Occupational Performance and Engagement (CMOPE)</td>
<td>20</td>
<td>5.45</td>
<td>5.43</td>
</tr>
<tr>
<td>Kawa River</td>
<td>19</td>
<td>6.76</td>
<td>5.76</td>
</tr>
<tr>
<td>Intentional Relationship Model (IRM)</td>
<td>11</td>
<td>6.72</td>
<td>6.56</td>
</tr>
<tr>
<td>International Classification of Function (ICF)</td>
<td>10</td>
<td>7.33</td>
<td>7.00</td>
</tr>
<tr>
<td>Human Activity Assistive Technology (HAAT)</td>
<td>6</td>
<td>4.83</td>
<td>5.33</td>
</tr>
<tr>
<td>Occupational Performance Model (Australia)</td>
<td>1</td>
<td>6</td>
<td>6</td>
</tr>
</tbody>
</table>
In the final stage of the second survey, the students were asked to comment on the three aspects of the lecture which they most liked or connected with, and the three they least liked or connected with. Table 6.3 displays the themes which were evident in more than one response, and there were clear preferences expressed in regard to both positive and negative aspects.

**Table 6.2**

*Aspects of this Lecture that Students Most and Least Connected With*

| Most liked or connected with                                      | n  | Least liked or connected with                        | n  |
|-----------------------------------------------------------------|----|-----------------------------------------------------|--|--|
| Definitions for doing, being, becoming and belonging            | 18 | Review of Wilcock’s work, and development of both OPH and POP | 8  |
| Animated POP model                                              | 12 | Static OPH diagram                                  | 3  |
| Emphasis on interconnectedness                                  | 5  | Description of OPH/POP as a paradigm                | 4  |
| Review of Wilcock’s work, and development of both OPH and POP   | 5  | Few examples and case studies                       | 3  |
| Static OPH diagram                                              | 4  | Too much information in one lecture                 | 3  |
| Relevance to OT                                                 | 3  | Accessing information on the OPH                    | 2  |
| Provision of examples                                           | 3  | Concept of being                                   | 2  |
| The foregrounding of dimension over time                       | 2  | How it relates to practice                          | 2  |
| Room for interpretation and individualisation                   | 2  |                                                      |    |
| Highlights we are only in people’s life for a short time        | 2  |                                                      |    |
| The idea that not all occupations are healthy or purposeful     | 2  |                                                      |    |
At the conclusion of the survey, the students were asked for any further comments they wished to make about the OPH and POP. Thirteen participants offered opinions, many generally positive comments about their learning about the OPH. Of those who offered specific feedback, much was related to the animated model of the POP: “The diagram was really useful POP shows all the dimensions interacting and creating/influencing health and wellbeing.” “I thought the moving model was great.” “It was really well represented and diagram was exceptionally interesting and creative.” Other participants disagreed with how OT was represented in the animated model, perceiving the placement of the yellow arrow as indicating the profession only deals with illness: “I didn’t like how the arrows in the POP model entered/exited where they did.” “That the role of OT came from the bottom (illness).”

Comments relating to specific features were that more information on its relationship to other models should be presented, that the link between being and roles was illuminating, and that occupational imbalance should be added to the bottom of the continuum. Participants also commented positively on the professional identify aspect of the lecture, stating they found it helpful to hear a personal, critical perspective and that it helped them consider their own professional identities. Two participants added the comment that they wished they’d heard more about the OPH and POP earlier in their undergraduate training, as it would have provided them with a framework for all their learning. They suggested that it be integrated into the two introductory first-year OT subjects in future.

Therefore, the students had pre-existing skills and abilities with ten theoretical ways of knowing. However, their understanding of these theories and confidence around applying them to practice was individually diverse. Prior to the lecture, their understanding of the OPH was less well developed than for many other models (e.g. PEO, MOHO, Kawa, IRM & ICF), and it was the model about which they had the least confidence. It was also not identified on the surveys of the students. Those who added comments indicated the lecture had been a positive experience for them, and had provoked in some participants a desire to learn about the paradigm in more detail.

**Becoming.** As this lecture was provided as part of an undergraduate course, some of the questions addressed the students’ sense of becoming a qualified occupational therapist. Students were asked why they attended this particular lecture, to gauge general interest in the topic. Some stated they attended all lectures as a policy, and were not necessarily aware of the topic before arriving (20.83%, n= 5). Of those
who specified a reason for attendance, many wanted to know more about the OPH specifically (37.5%, n= 9) and particularly how it applied to practice. As one participant commented, “I am hoping to gain information to benefit future practice and not just more useless model info.” Other students stated they generally wished to improve their knowledge by attending the lecture.

Students also rated their understanding of the OPH as a whole, each occupational dimension, how the dimensions interacted, the relationship of the OPH to practice, and their confidence in apply this to practice, both before and immediately after the lecture. All of these items were rated on a scale out of 10, where 1 was “no understanding” and 10 was “excellent understanding.” Wilcoxon signed-ranks tests were undertaken to compare the students understanding and confidence in relation to the concepts discussed in the lecture. As shown in Table 6.3, there were significant improvements for each of these items following the lecture.

Table 6.3
Student’s Rating of Their Understanding and Confidence with the OPH

<table>
<thead>
<tr>
<th>Item</th>
<th>Mean Pre</th>
<th>SD Pre</th>
<th>Mean Post</th>
<th>SD Pre</th>
<th>Z</th>
<th>p value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Understanding the OPH as a whole</td>
<td>6.04</td>
<td>2.56</td>
<td>7.83</td>
<td>1.15</td>
<td>-3.343</td>
<td>.001</td>
</tr>
<tr>
<td>Understanding doing</td>
<td>6.33</td>
<td>2.22</td>
<td>8.37</td>
<td>1.13</td>
<td>-3.854</td>
<td>.000</td>
</tr>
<tr>
<td>Understanding being</td>
<td>6.17</td>
<td>2.14</td>
<td>7.79</td>
<td>1.32</td>
<td>-3.879</td>
<td>.000</td>
</tr>
<tr>
<td>Understanding becoming</td>
<td>6.04</td>
<td>2.33</td>
<td>8.29</td>
<td>1.20</td>
<td>-3.849</td>
<td>.000</td>
</tr>
<tr>
<td>Understanding belonging</td>
<td>6.37</td>
<td>2.39</td>
<td>8.37</td>
<td>1.10</td>
<td>-3.804</td>
<td>.000</td>
</tr>
<tr>
<td>Understanding how these dimensions interact and influence each other</td>
<td>6.21</td>
<td>2.25</td>
<td>8.25</td>
<td>1.07</td>
<td>-3.987</td>
<td>.000</td>
</tr>
<tr>
<td>Understanding how the OPH relates to practice</td>
<td>6.04</td>
<td>2.58</td>
<td>8.04</td>
<td>1.27</td>
<td>-3.707</td>
<td>.000</td>
</tr>
<tr>
<td>Confidence in applying the OPH as a whole to practice</td>
<td>4.15</td>
<td>2.44</td>
<td>7.27</td>
<td>1.42</td>
<td>-4.311</td>
<td>.000</td>
</tr>
</tbody>
</table>

Following the lecture, the students rated their understanding of the latest iteration of the OPH, and confidence in applying it as better than all models except for the PEO. This suggests the students successfully engaged with the content of the lecture, and
were able to derive some meaning in relation to how the OPH could be applied to their practice in future.

**Belonging.**

Some of the students attending this lecture stated they were attracted by the opportunity to learn about the professional identity of OT (29.17%, n = 7). In the second survey, students were asked to rank their belief of the relevance of the OPH to the identity of OT as a profession, where 1 was “not at all relevant” and 10 was “completely relevant.” Following the lecture, the mean ranking provided by this group of students was 8.52 (SD = 1.28, Range 6-10). This finding indicates the students perceive the OPH to be relevant to the identity of the profession, although additional qualitative data would need to be collected to understand how they perceive that relevance.

**POP as a means of promoting a unified professional identity in OT.**

The results of this pilot study provide some preliminary indications that POP does assist OT students to understand the dimensions of occupation, interactions between them and the relevance of these concepts to the identity of OT as a profession. These findings do not confirm whether the new iteration of this paradigm helps OT students to understand the concept of occupation for health as a whole, but these pilot findings are encouraging. The students identified nine different theoretical ways of knowing with which they were familiar, and none initially chose the OPH. In this sample, MOHO and PEOP were identified by all participants, and the CMOPE and Kawa River models were also prevalent. The students felt they understood PEOP and ICF the best, and were most confident in their abilities to apply these to practice. Despite their popularity, the MOHO, CMOPE and Kawa River models attracted only moderate levels of self-rated understanding and confidence.

The students demonstrated some initial interest in learning about the OPH, and were attracted to attend by the opportunity to learn about the professional identity of OT. There is therefore some evidence that this topic is of interest to this sample. The quantitative elements of the survey demonstrate significant improvements in the students’ understanding of and confidence in the OPH and POP following the lecture, and post-lecture ratings of the relevance of the paradigm to practice were also high. These findings indicate that this small group of students came away from this single, introductory lecture on the OPH and POP with a sense that it was broadly relevant and useful to their practice in occupational therapy. However, there are other potential
explanations for these findings, including the provision of socially desirable answers or a generally positive reaction to the lecture being over. The longevity of this effect was not measured, and it is also possible that the content may have been quickly forgotten once the students left the lecture theatre.

The definitions of doing, being, becoming and belonging, developed through the critical analysis outlined in Chapter 3, was the feature of this lecture with which many students most connected. The animated POP model was also generally found to be helpful, although it was interesting some students cited the modified visual representation of the OPH (presented earlier in page 300 of chapter 6) shown as a slide in the lecture as a positive aspect of the lecture. This suggested that a dichotomous representation of health and illness resonates with some OT students, despite its incongruence with concepts such as wellbeing and recovery. Visual representations of the paradigm were appreciated regardless of the iteration (either OPH or POP), which is important to future planning for its ongoing development, as they seem to facilitate a grasp of the interrelationships between various concepts in the model. The advantage of the POP diagram and animation is its representation of the latest iteration of the paradigm, and it should therefore be used in preference to the OPH diagram that it supersedes. Students also indicated the emphasis in the lecture on the interconnectedness of the dimensions helped them to engage with the paradigm, and this is most clearly represented in the POP diagram.

The inclusion of an overview of Wilcock’s work, and the process of development for the OPH and POP in the lecture, was received somewhat ambivalently. Many students identified the overview of her work as an aspect they engaged with, but a larger group stated they didn’t connect as successfully with this contextual information. In the context of a discussion on professional identity, such historical and contextual information is important to enable occupational therapists to understand the depth of development that supports the paradigm. The challenge may be to present this in an engaging manner that highlights its relevance to practice and is accessible to all occupational therapy practitioners (including students, therapists and allied health assistants) when POP is more widely disseminated. Some students also highlighted the concept of “paradigm” as difficult to understand, so this is another area which may need to be covered in more depth or in a more engaging manner for future lectures.

Overall, these findings suggest that these students found POP an accessible theoretical way of knowing, in which they could see potential for application to
practice. The most frequent suggestion for development was the provision of more case studies and practice examples to assist its application and translation. The provision of such supporting information would also continue the process of testing the unifying and universal claims of the paradigm, and will be an important direction for ongoing research. If POP is found to have relevance and utility in a range of practice settings, and in working with a diversity of clients and their occupational needs, its claims as a unifying paradigm will be strengthened.

There are many limitations to this pilot study, which greatly limit the generalisability of these findings. The sample size is small, and OT students may engage with POP in very different ways to OT clinicians. The time frame was also limited, but this method was appropriate to the pilot nature of this study. The provision of a single lecture is also a limited way of introducing POP, as full understanding will require much more information and many more opportunities for reflection. I gave the lecture, and it is unclear whether the same results would be achieved if it was delivered by someone with a less intimate knowledge of the paradigm. Other limitations around the interpretation of these findings (i.e. other explanations for the generally positive response) have been highlighted previously. Replication of this study with several different lecturers would be required before the effect of this factor is fully understood. However, these preliminary findings (particularly the quantitative outcomes) do suggest that further research on the impact of POP would be worthwhile, utilising larger samples of students and including members of the practicing profession.
Summary

This chapter has reported on a single iteration of the ITEA method and a pilot study, which have explored theoretical ways of knowing about mental health OT. The critical question which has driven this part of the thesis are shown in Figure 6.4 below.

![Figure 6.3 Iterations of ITEA method used to explore theoretical ways of knowing.](image)

Having unpacked my suitcase, I reflected on all I had acquired on this journey and began to process and make sense of it. While the ITEA method contributed to integrating theoretical, evidentiary and practice ways of knowing in mental health OT, the theoretical frameworks chosen to embed within it could not always account for the diversity of practice within the profession. ITEA is a means for integrating knowledge, but does not in itself provide a means to structure that knowledge in a manner that encapsulates the “occupational being” of OT – its identity, values and remit.

Regardless of the setting or population receiving services, OT has a distinct and consistent character: a sustained focus on occupation. This was found to be true across the full range of information available about mental health OT in this thesis, and I began to consider the OPH as a potential candidate for expressing this evident unity and consistency due to the ubiquitous nature of the four dimensions of occupation. Drawing on the critical analyses around doing, being, becoming and belonging described in Chapter 3, I reflected on the current uses of the OPH and developed POP to address the identified barriers which were preventing its successful translation into regular mental health OT practice.

POP is the culmination of several forms of testing. The updated definitions of the four dimensions emerged from a comprehensive critical analysis drawing on...
evidence from across the profession, both within and outside of mental health. This indicates a strength and consistency to these concepts, regardless of the practice setting. The review and analysis of evidentiary ways of knowing through the ITEA method revealed that all of the articles foregrounded at least one of the four dimensions, and I have already found the dimensions are applicable across a number of case studies which use various conceptual practice models. To this preliminary evidence, I added a pilot study where the OPH and POP were introduced to fourth year OT students in a single lecture. None of the students identified the OPH when asked which models they had encountered in their undergraduate course, which suggests it is not as firmly entrenched in their being as the other models they had been exposed to. The findings of this pilot study indicate that information about POP significantly improved the students’ understanding and confidence, and led them to rate its relevance to the profession reasonably highly in the immediate aftermath of the lecture. However, this is a very small study based on a single lecture with very short term data collection, so the results must be interpreted with caution and considered as a potential indication only. From my work on the OPH and POP to date, I feel confident to propose that it is worthy of further investigation as a unifying paradigm for OT in general.
Chapter 7 Discussion and Conclusion

“The use of travelling is to regulate imagination by reality, and instead of thinking how things may be, to see them as they are.” –Johnson, *The letters of Samuel Johnson: Volume II: 1773-1776.*

Introduction

Having completed my journey and told the story of what I saw, I reflected on and critiqued the experience and what I have learnt from it. The discussion that follows will present the summary of the findings of this thesis, along with a critique of and reflection on their meaning. I will then state the contributions of these findings to practice, along with the limitations inherent in this thesis. Finally, I will outline potential future developments in this field of inquiry before concluding.

There were ten iterations of the ITEA method and a pilot study in this thesis and they were all directed towards building the answer the overall research question: How do theoretical, evidentiary and practice ways of knowing integrate and incorporate to guide evidence based practice for occupational therapists working in mental health? The extensive analysis of mental health literature for evidence based practice conducted for this thesis led to six recommendations to enable integration and application of diverse ways of knowing to practice. Given that the overall research question focused on “how,” these recommendations provide an answer in the form of a series of ways to promote the integration and incorporation of theory, evidence and practice to guide evidence based practice for occupational therapists working in mental health.

1. Let the question dictate the methodology, rather than privileging particular approaches.

As stated in Chapter 1, this thesis is framed by a pragmatic philosophy which encourages an acceptance of various viewpoints and activities, with the caveat that their use must be appropriate and relevant. This is congruent with the philosophy (and indeed practice) of the profession, which is founded on a respect for inclusivity and diversity. The range of human occupation has been reflected on throughout this thesis, and my understanding of it has been advanced through the posing of questions in all the iterations of ITEA reported here. This process of gaining knowledge reflects that
undertaken by the profession, which has engaged in almost a century of sustained inquiry, questioning and exploration (as summarised in Chapter 2).

After reviewing 1596 articles, I found that the most widely used type of evidence is quantitative (MacDermid & Law, 2008), although there is growing recognition and acceptance of the role qualitative evidence can play in evidence based practice (Del Mar & Hoffman, 2010). However, scientific evidence (particularly quantitative evidence) remains dominant in terms of perceived credibility in occupational therapy, to the point where some have stated that those not basing their practice on high-level quantitative studies should be “named and shamed” (Walker, 2013).

This thesis has asserted that quantitative evidence is just one of a range of approaches to generating knowledge. It is certainly a powerful tool for answering particular questions, but is inappropriate for addressing others. Advocating the acceptance and valuing of other forms of evidence (particularly non-scientific forms of evidence) does not in any way diminish the utility of or place for rigorous quantitative research in mental health occupational therapy. This position simply puts it in perspective, and opens up greater possibilities for mental health OT to build on its current knowledge in innovative, creative and client-centred ways.

Rather than asking for more studies to be completed using a particular method (Lannin et al., 2009; Bannigan & Spring, 2012), I propose we amend our understanding of rigour to a focus on using the best method to answer the question posed. As Brannigan (2005) declares, peer review by itself is no guarantee of rigour, nor is the privileging of quantitative methods that are suitable to answer only a certain sub-set of questions. More importantly, quantitative methods will not always answer the questions that mental health occupational therapists are posing, or produce evidence which is readily translatable into practice. Hence the importance of considering other types of evidence, based on rigorous but different methods of inquiry.

2. Develop new methods of integrating and incorporating ways of knowing.

Our current ways of integrating and incorporating ways of knowing have not kept track with the new demands of increasing complex methods of inquiry and bodies of evidence. The methods of synthesis currently available to mental health OTs include systematic review, literature review, meta analysis, meta synthesis and critical analysis, but these are limited by both the range of evidence they include and/or the depth to which they synthesise the information. These limitations can place restrictions on their application to practice, particularly in response to questions which are complex and
multifaceted. A need to develop a new method of integrating multiple ways of knowing emerged from the recognition that clinicians now have access to a rapidly growing and diversifying body of evidence. There is an expectation that they keep up to date, and make sense of all this information, alongside the completion of their usual clinical duties. The ITEA method enables mental health occupational therapists to embed theory and evidence into their inquiries, and then apply this knowledge as part of their practice ways of knowing. The method therefore goes some way to bridging the gap between traditional evidence based processes and clinical practice, integrating a range of knowledge in a manner which is more relevant, accessible and applicable to the usual way in which mental health occupational therapists work. Its implementation in the thesis has lead to the development of a comprehensive, multidimensional answer to the original research question.

While it is iterative, the ITEA method retains a consistent structure with a series of clearly defined steps which is followed sequentially. This is appropriate to the conduct of inquiries in a systematic manner, but does not fully reflect the authentic experience of clinical reasoning. Therefore, the ITEA method is different to mental health clinical practice, where clinicians move back and forth between the various ways of knowing in organic ways in practice, particularly when working with people experiencing complex circumstances and challenges. This is an advantage, as the ITEA method may be used across disciplines, and for the related knowledge that the profession so often calls upon. For example, a mental health occupational therapist could use ITEA to investigate the experience of working in a multidisciplinary team, including the perspectives of all the different disciplines and multiple sources of evidence (i.e. scientific studies, personal reflections, practice descriptions etc.).

In choosing the OPH, I took a paradigm for this thesis which operated at the level of broad assumptions and values about the relationship between occupation and health. This perspective enabled me to identify the steady presence of occupation within a very large data set, and through this I found the omnipresence and consistency of the four dimensions to be most striking. It has almost become part of the landscape: a context for every piece of evidence I considered, regardless of method or practice setting. Adopting the OPH as my paradigm has provided a new level of focus and clarity about the relationship between occupation and health to my understanding of occupational therapy, which enables me to practice in an authentic, holistic and coherent
way. Rather than feeling overwhelmed by the amount of evidence available, I feel able to use it to address specific questions about promoting occupation for mental health.

In working with both the ITEA method and POP, I found that adoption of the ITEA method on its own would address the problem of working with diversity in evidence based practice, but not how this would then be translated into practice in a coherent, authentic and occupationally focused way. For the knowledge gained through the ITEA method to be meaningful to mental health OT, it needs to be supported by a framework which expresses the being of the profession. The Pan Occupational Paradigm (POP) is therefore a method for integrating and incorporating ways of knowing in a uniquely OT way. Together, ITEA and POP could provide the tools for other mental health occupational therapists to integrate theory, evidence and practice ways of knowing to guide high-quality and client-centred practice.

3. Engage meaningfully with a fourth way of knowing.

When we leave an occupational being at the end of our professional relationship with them, we take something of their personal way of knowing with us. Personal ways of knowing are the individual’s (or group’s) way of understanding and making meaning as an occupational being; their understanding of how the relationship between occupation and health works for them. Personal ways of knowing can only be acquired through lived experience, as illustrated by personal testimonies published in the peer-reviewed literature in recent years (e.g. Mack, 2002). Personal ways of knowing are transformed into practice ways of knowing by occupational therapists adopting them as part of their professional experience. If client-centred practice is adopted, the client’s personal way of knowing provides crucial information around their sense of being, what and how they do, what they want to become and the ways in which they belong. They become part of evidentiary ways of knowing through many different methods, such as the aforementioned personal testimonies, qualitative research and surveys of client experience. Finally, they are incorporated into theoretical ways of knowing through a client-centred focus, although the role of clients in the formative stages of theory construction remains underdeveloped. While there are examples of clients directly contributing to the development of small-scale grounded theories, conceptual practice models and paradigms have tended to be developed only by occupational therapists or other health professionals and academics.

The need to engage meaningfully with personal ways of knowing also relates to the need to address the being of mental health OT. This relates to the identity of the
specialty, and the abilities and capacities that mental health occupational therapists use which are unique to their setting. Client-centeredness is believed to be an important tenet of practice (Sumsion & Lencucha, 2007), but in OT, clients remain largely excluded from the processes of developing new theory, evidence and practice. When they are consulted, it is often at a late stage when the major decisions have already been made and their contribution can only result in modifications or improvements on the existing developments. Just as there need to be new ways of integrating and incorporating ways of knowing, there also need to be new approaches that ensure that all ways of knowing, including personal ways of knowing, are represented in mental health OT.

The recently published *Quality Framework for Inclusive Research* (2012) provides inclusive research principles that give a theoretical framework for including personal ways of knowing. The relevance of begin inclusive and including clients to OT is explored in depth by Layton (2013), who concludes that a move to inclusive research would be an extension of the profession’s existing realisation of client-centeredness. If inclusivity were extended to theory and practice, a real adoption of epistemological equity could be possible, and the resulting evidence based practice would be truly relevant and meaningful. As one client said, “if my experience doesn’t fit with your paradigm, your paradigm is wrong and needs to be changed” (Layton, 2013).

4. **Build sustainable and diverse relationships.**

A major factor in engaging with different ways of knowing is the development of relationships with a range of stakeholders. Knowledge transfer, utilisation and translation always occur within a social environment, whether on a small scale (i.e. therapist and client) or large scale (i.e. within a health service). The evidence underpinning evidence based practice in mental health OT is now so extensive that it is virtually impossible for an individual to remain up to date and engaged with it while also practicing clinically. Relationships are therefore the medium through which knowledge translation can be enacted, both from a logistic and change management points of view.

Including clients in the development of theory, evidence and practice would necessitate the development and long-term management of positive working relationships with people who have lived experience with mental health issues. Mental health occupational therapists have often been expected to implement evidence based
practice as individuals, receiving training on how to critique approved forms of evidence and being exhorted to somehow apply these to their daily practice. However, the proliferation of partnerships between clinicians and academics in the past decade highlights the benefit of forming working relationships between these groups. Clinicians and academics have their own ways of knowing, and the use of each other’s respective expertise leads to better outcomes.

Careful attention needs to be paid to the power differentials in such relationships, as a hierarchy of power is evident within the peer-reviewed literature. All the articles outlining partnerships between academics and clinicians speak of the benefit to the second group, but none reflect a consideration of the benefits to the first (aside from the possibility of finding more places for fieldwork). These relationships are currently depicted as uni-directional, with the clinicians learning from the wisdom of the academics. The ultimate aim of evidence based practice has also been obscured in many cases, with the benefits to the profession (i.e. increased credibility and access to funding) highlighted instead. The benefits for clients often get lost in the current discourse (Davis & Bannigan, 2000), indicating they are at the bottom of the hierarchy despite the profession’s good intentions.

The growing formation and maintenance of social networks around ways of knowing in mental health OT require particular abilities which should be more valued. The translation of knowledge is not likely to succeed if the people doing the translation, and the social and organisational networks in which they operate, are not part of the process. The ability to read a journal article, critique it and then think about how to implement it in practice is a relatively minor individual skill when it comes to integrating and incorporating ways of knowing. I believe the ability to form relationships and partnerships (which are based on inclusivity and equity) with all key stakeholders is far more important to successful knowledge translation and innovation, recognition that no one person or source holds all the answers. The mantra for academics in particular must shift from ‘publish or perish’ to ‘partner or perish’ (Garrett, 2014).

5. Modernise our ways of communicating.

Currently, the main source of information about ways of knowing on which to base practice are peer-reviewed journals. The way in which we communicate about mental health OT has a profound impact on the subsequent relevance and application of the diverse knowledge (whether in peer reviewed journals or other arenas) we are
accumulating as a profession. The example of the poor uptake of the OPH to date highlights what we lose when knowledge is not communicated effectively. In the fifteen years since the second edition of Wilcock’s work was published, it has made little impact on practice despite its inherent quality and impressive scholarship. This is also despite the fact that the OPH is explicitly taught in several Australian OT schools, so education or training appears to be insufficient on its own. The POP was developed in response to clarifying how Wilcock’s work may be communicated, and the applicability of her work to practice.

Throughout the writing of this thesis, I have struggled with conforming to the accepted norms of the genre of peer-reviewed journals (and indeed thesis writing). To succeed in peer-reviewed publication, mental health occupational therapists must adopt specified formats, write to a particular style, and submit under specific genre categories. This provides some consistency to the way in which information is presented, and makes information easier to identify and locate. They must also undergo peer review, which is mostly a subjective process usually conducted by more senior members of the profession. In this environment, the format or mode of expression, not content, may take precedence, regardless of whether it is the best way to communicate that particular type of evidence. This is similar to the privilege sometimes given to methods of inquiry over the needs of the research question. For example: a pre-post survey design with a large sample about client experiences of a mental health service may be more likely to achieve publication over a smaller sampled qualitative study, even though the smaller study could provide a greater depth of data and specific examples of good and bad practice.

However, change is slowly beginning to occur. Peer-reviewed journals are undergoing a radical transformation as the information age changes expectations of the availability and dissemination of professional knowledge. Innovations such as open access, portable peer-reviewed and electronic-only journals have developed in response to calls for faster dissemination of results and greater access to information which can improve practice. While these do not necessarily guarantee the publication of articles reflecting diverse ways of knowing, they do contribute to faster distribution of evidence. As shown in Chapter 4, knowledge about mental health OT in peer-reviewed journals takes on average approximately seven months to be accepted for publication. Even if they are available at that time through early online facilities, this delay is unacceptable in an age where other evidence (such as professional newsletters, blogs and online
which has not been through peer review is available instantly via the Internet. If articles are rejected by one journal, which may be the case for more controversial or specialised knowledge, the time to publication may stretch to years.

It also became clear that practice ways of knowing may not be fully represented in peer-reviewed journals. Only 11% of the knowledge about mental health OT comes from clinician authors, and articles that focus on practice, as opposed to theoretical or evidentiary ways of knowing, appear to be in decline. It seems that the focus on evidence based practice has boosted one way of knowing at the expense of another. It may be that peer-reviewed journals are not the best place for the dissemination of practice ways of knowing, and that alternative forms of communication like practice magazines, web based publications or blogs may ensure greater access and promote the sharing of great ideas. There is a risk that such a move would see practice ways of knowing relegated to a less prestigious category, but this will occur only if epistemological equity is abandoned.

To modernise our ways of communicating would therefore entail changes in both the formats in which information is available, and the way in which it is peer-reviewed. There have been calls for changes to peer review in occupational therapy in the past (Duncan, 2007), but to date the double blind model remains the norm. Occupational therapists are not specifically trained in the skills of peer review from a writerly or literary perspective, where the process is deemed to be one of “critical friendship.” Peer review can be perceived as a form of “gate keeping” with the aim of preserving the standards and prestige of the profession (Brown, 2011), and (depending on the perspective on what those standards are) this leaves the process susceptible to exclusionary practices. Could it be time to remove the anonymity of peer reviewers, as is currently practiced by many open access journals? Should there be a review of the timeliness of peer review, and the adoption of practices which have enabled journals in other disciplines to complete the review and publication process in under a month?

This is a topic for broader discussion, and goes to the heart of what we as a profession consider “quality” evidence. It will also involve discussion of the broader place of occupational therapy as a “small” profession within a biomedically dominated health system. To gain the credibility and recognition that is valued within this system, occupational therapists have needed to engage with the systems and processes just described. Breaking away from this carries risks, but we may be able to take advantage of the changes afoot in peer-reviewed publishing to forge a new way of doing things.
6. **Walk the walk.**

A recurring theme through the evidence relating to mental health OT is the presence of good intentions. Clinicians are reported to want to perform evidence based practice (Novak, 2013), researchers indicate they want to include clients at every stage of their work, and the acceptance of multiple ways of knowing is proposed as a progressive and philosophically authentic approach (Layton, 2013). However, in that time-honoured phrase, the road to hell is paved with good intentions. The framing of the research question in this thesis as a “how” was a deliberate attempt to get to strategies that could be used: outcomes which would *transform* practice, rather than *inform* it.

To implement the measures listed here will be deeply challenging. Integrating and incorporating theoretical, evidentiary and practice (and personal) ways of knowing in mental health OT in a meaningful way demands a radical approach, which is superficially at odds with the way things are now. While I have found the better way I was originally searching for, my journey from this point is likely to be more difficult, more complex, and darker. To achieve these six actions, I will be testing a way of doing which is well entrenched and carries much credibility and prestige. Throughout my journey, I have met with resistance to my ideas, some of which has been very strong. However, these recommendations can be achieved if I form positive, strategic partnerships and take everyone along with me.

**Contribution of This Thesis to Practice**

This thesis was explicitly intended to apply directly to practice from its inception. At every stage I have been mindful of making the outcomes accessible to clinicians and relevant to modern mental health OT. Far from a weighty, academic tome, I wanted this thesis to be a practical document, providing tools for solving problems and making positive changes in the positivist tradition. I sought for the finished product to be immediately accessible to mental health clinicians – for them to be able to pick up the ideas in this thesis and its attendant publications and run with them.

To that end, this thesis has synthesised a body of evidence for an entire specialty area of occupational therapy. The meta-synthesis and reviews which have arisen from it provide mental health occupational therapists with knowledge ready to digest and apply, which they would be unlikely to have time to collate themselves. These publications, and several others from other sections of this thesis, have and will directly contribute to
the evidentiary ways of knowing in mental health OT. The database on which the overall analysis of evidence was based has been made freely available to other researchers (http://researchdata.ands.org.au/database-of-peer-review-publications-written-by-occupational-therapists-about-mental-health), and will be updated on a yearly basis. Providing information on which areas are well and poorly researched, where knowledge about mental health OT is published and how long it takes to become available, has also contributed to practice, by highlighting areas for further development and challenges associated with accessing evidence for EBOT from current sources.

The ITEA method will also impact on the practice of individual clinicians and their workplaces, if they choose to apply it as part of their personal and professional development. For this method to be successful, they need to be given sufficient time and resources within the workplace, ideally supported by a recognition of this work in their job description. Given that the majority of situations are not fully resourced, however, it would likely be more fruitful and manageable when used by multi-stakeholder partnerships. These partnerships (which could be uni or multidisciplinary) may overcome the logistical and relationship building issues which can be an impediment to knowledge translation, particularly for larger topics which are informed by multiple ways of knowing.

The impact of the ITEA method on practice also depends on the application of the final step: transfer and utilisation. The exploration of knowledge brokerage and evidence based practice guidelines in this thesis contributes to the understanding of these recent innovations in knowledge translation. No one method will meet all the knowledge translation needs of mental health occupational therapists, but this thesis proposes strategies which have the potential to be successful at both workplace and profession levels. In the case of the Super Moth project (see Chapter 5), this has resulted in six projects being prepared for publication in peer-reviewed journals, while three evidence based guidelines have also been developed and are in the process of being prepared for publication.

However, the theoretical ways of knowing which have been explored and developed in this thesis have the widest potential for impact on practice. In critiquing the four dimensions of doing, being, becoming and belonging, and in formulating the POP, I am proposing a paradigm that can be applied to any area of practice. The new definitions of the four dimension of occupation and other modifications made in POP will overcome the identified barriers to the implementation of the OPH, and highlight
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its suitability as a unifying paradigm for OT in mental health and other settings. The clarification of our unifying professional identity may have many impacts on practice, including accessible language for communicating OT to clients and other professionals, a clear consolidation of the base from which the profession spreads its diverse practices, and an opportunity to enact a very powerful understanding of occupation and health. Occupation is at the heart of both the OPH and POP, and this is congruent with the shift in occupational therapy over the past few decades back towards the founding philosophies and values. This thesis is intended to provoke a shift in mental health OT towards greater inclusivity, diversity and multiplicity in practice.

As stated in Chapter 1, a motivator for my completion of this thesis was the thought, “there has to be a better way.” I believe I have found a better way, but acknowledge that it is quite different from the prevailing ways that knowledge is valued and used to inform evidence based practice. In line with the values which underlie this thesis, I acknowledge these different perspectives and understand they have much to offer for our understanding of mental health occupational therapy. However, I am committed to pursuing the changes I have recommended above, from my personal belief and based on the evidence analysed in this thesis that they will advance mental health occupational therapy. Adopting a position of mutual respect and collaboration, I am committed to changing these systems from within by promoting consensus and building positive relationships.

My Own Doing, Being, Becoming and Belonging

My journey through the ways of knowing in mental health OT has had a deep and lasting impact on my own doing, being, becoming and belonging as an occupational being. It has both challenged and illuminated occupation in every dimension, in ways that have been informed by my past and will inform my future. The reflection to follow is based on my occupational being, both personal and professional.

I entered my work on this thesis with an idea of “how” evidence based practice was done, despite misgivings about the efficacy of those methods. Rather than discarding these ways of doing, I have come to see them as parts of a broader repertoire of methods I have developed. Many doctoral projects use established methods of inquiry, but part of my doctoral journal was to formulate my own methods as no suitable processes already existed. The benefit of this approach has been the opportunity to tailor the doing of this project to its specific requirements, much as an occupational therapist tailors interventions to each individual client. This has been very
satisfying, although building methods from the ground up requires much time and intellectual resource.

I have come to understand the notion of “rigour” very differently as a result of my development of new ways of doing evidence based practice. In traditional methods, rigour is deemed to be a function of the robustness of method used in a study. In science, rigour is “an attitude that contrasts with the weakness of human nature, does not allow laziness, the lack of attention, the acceptance of inexact methods, the adoption of groundless conclusions, accepting the predominant opinion despite the lack of data which sustains it” (Allende, 2004, para. 7). Rigour is often therefore equated with methods high in the quantitative hierarchy, such as systematic reviews and randomised controlled trials. The development of the RF-QRA (Henderson & Rheult, 2004) demonstrates the strength of this association, as it has spread to the assessment of qualitative research.

However, I saw rigour manifested in a range of other forms of evidence which support mental health OT: researchers who eschew the human tendency to stereotype, to focus on the lived experience of clients, precisely recounting their knowledge in verbatim quotes; clinicians who have clearly laboured for years to develop a new program or service, which is then reported with sufficient attention to detail to enable others to benefit from their practice wisdom; teams who have formulated their research strategy in a participatory way, honing the focus of their method to ensure they met their communal, contextually based goals. I have also read sources which used “rigorous” methods, but contained methodological errors or biases that were not acknowledged. I no longer believe that rigour is a function of scientific ways of doing – it lies in the quality of approach taken, with any method.

The completion of this doctoral study has also provoked a profound shift in the way I do more generally. When I commenced at the end of 2008, I was working part time at Deakin University and part time in my private practice. The following five years have seen me move house, have three children, experience bereavement, fight ill health and support my partner through a complete career change. In the beginning I used to work in long bursts, setting aside entire days to write many thousands of words. I fell into the mistaken idea that I could only “do” when I had enough time and space, and if I didn’t feel I had the right conditions, I waited until they came along. The early years of this doctoral study were therefore marked by long periods of relative inactivity.
From this “peaks and troughs” way of doing, I transitioned to a “little and often” method. My computer would go on in the morning and I would work in short bursts throughout the day, as and when I could. Much of this thesis was written sentence by sentence, during naps, quiet moments and single episodes of Peppa Pig. Much of it was also “written” in the quiet midnight hours when I had settled my children, and in other periods of mental “free time” when I could turn ideas over and over in my head, rehearse the opening paragraphs of articles and beat arguments into better shape. I’m left with a way of doing work that moulds itself to the needs of my family, and relies far less on sitting at a computer screen. The independently driven nature of doctoral studies enabled me to make this transition, and it is one that will continue to serve me and my family well in the next phase of my academic career. My journey through the ways of knowing in mental health OT has also been a journey from the clinical world to the academic one.

My occupational being has also evolved during this thesis to include the role of academic as part of my identity. This has partially been facilitated by my simultaneous work as a lecturer and fieldwork supervisor, but I wish to take the role in a different direction. I would like to be a knowledge broker, which I believe is an academic role which will emerge in the coming decade. The most meaningful use of my new skills and abilities will be in enabling clinicians, clients and other stakeholders to translate multiple ways of knowing into practice. This includes skills more usually associated with the role of academics, including research generation and teaching, along with knowledge translation-specific skills such as building and maintaining relationships and working with stakeholders to implement changes.

I have also identified a potential role which I don’t think forms part of my occupational being. The formulation of POP could be seen as an exercise in occupational science, contributing to the study of humans as occupational beings and the nature of occupational engagement. However, my contact with occupational science during the writing of this thesis emphasised how separately that discipline sees itself from occupational therapy. This doesn’t accord with my goal to find ways of applying knowledge to make positive changes and, in my opinion, discounts the decades of occupational therapy knowledge upon which occupational science is based. By aligning itself with science, this discipline privileges a particular way of knowing, a position which I am unable to support following my study. While being a knowledge broker is an authentic part of my being, the role of occupational scientist is not.
Towards the end of the writing of this thesis, I became aware of a challenge to my sense of professional being. I had always considered myself a client-centred mental health occupational therapist, and still think I was able to walk the walk in this regard when dealing with patients. However, my focus on what are essentially OT ways of knowing (theory, evidence and action) didn’t fully take client (personal) ways of knowing into account. Personal ways of knowing were present in some parts of my study, such as the meta-synthesis into experiences of engagement in activities of daily living for people with psychosis. However, they were only addressed after they had been transformed into an OT way of knowing, usually through evidentiary processes. I have come to believe this fourth way of knowing is fundamental to POP, and indeed to the meaningful generation of further knowledge generation in mental health OT. I experienced some shame upon realising how clinician-centred I had initially been, and am committed to being more inclusive from this point forward.

My focus on theoretical, evidentiary and practice ways of knowing may have been influenced by the predominantly individualistic culture of OT in general. The profession’s belonging is aligned to the Western cultures from which it sprang, which in recent centuries has emphasised the rights of the individual. This stands in contrast to the collectivist and interdependent cultures found in other parts of the world, which the profession is increasingly coming into contact with as it develops in new countries. The rise of social inclusion as a theme in mental health over the past decade has also challenged the emphasis on “independence” which was previously held in mental health OT. Our evidentiary ways of knowing are increasingly being used to explore how mental health OT enables people to become more included in their communities, and practice ways of knowing have contributed to understanding how this can be facilitated.

However, many conceptual practice models continue to focus on the individual, with visual representations showing concepts located both within and around the client. Belonging is usually addressed through the concept of environment, which surrounds the client and is acknowledged to have an impact on their occupational engagement. Rather than being something that surrounds an occupational being (whether an individual, group or population), POP conceptualises it as a context in which they are embedded, something that exists both internally and externally. I put forward that understandings of belonging in mental health OT in the coming decade will come to acknowledge this embeddedness and interdependence, further increasing the complexity of our understandings of occupation for health as a social phenomenon.
While I have at times felt out of step with the predominant discourse centred on evidence based practice in OT, the completion of this thesis has ultimately consolidated my sense of belonging to the profession. I see occupation everywhere, both professionally and personally, and feel it closely matches my beliefs, values and understandings of life. The strength of our underlying philosophy, and its consistency across incredibly diverse settings, populations and practice, hints that it may be applicable across cultures. However, I know that I am a long way off proving that the OT way of understanding health is common to all humans.

And so finally, this thesis led me to re-appraise my goals and aspirations for the future: my becoming. I now know that I want to continue working in academia, carving out the role of knowledge broker. I want to involve personal ways of knowing in all my further knowledge generating activities, and develop my skills in working with diverse networks that mirror the complexity of the understandings being traded. Most of all, I want to use my new-found sense of doing, being and belonging to focus on knowledge brokerage that has a direct impact on the health and wellbeing of people with mental health problems, and the occupational therapists who serve them.

My aspirations for the profession are related to these personal goals, but will take the united efforts of thousands of people globally to come to life. I want OT and mental health OT in particular to commit itself to the meaningful recognition and inclusion of multiple ways of knowing, from both within and without the profession. I want it to recognise that it stands on an incredibly firm base, whose values and philosophies are grounded in lived human experience. I want OT to stop judging itself by other people’s standards and start holding itself to its own. I want occupational therapists to stop saying “there’s just no evidence” and “we aren’t very powerful,” because both those statements are patently untrue when considered from an occupational perspective. I want OT to become comfortable with treading the innovative, progressive path, taking advantage of the many opportunities offered by modern communication, technology and knowledge generation. I want OT to become a catalyst in working partnerships, making the most of everyone’s respective knowledge and experience in tackling the increasing complexity we face. In short, I want OT to become the profession it’s always had the potential to be.

**Limitations**

As with any study or inquiry, this thesis has its limitations. The most striking is that all of the findings have been based on evidence and knowledge in a single area of
OT practice – mental health. While mental health accounts for between 8% and 17% of the profession in Australia (Ceramidas, 2010), it is a much smaller proportion in other countries such as the US. The findings around evidentiary and practice ways of knowing are therefore limited only to mental health OT, and expansion to general practice would require much further research. However, the critical analysis undertaken of the OPH and the resulting formulation of POP drew on evidence from all areas of practice, and therefore the applicability of those developments is more general. This is also true for the ITEA method, which, was developed from other methods available to all professions.

The need to develop new methods and iterations of theory mean that those presented in this thesis are at a very early stage of development. While much can be proposed about their potential uses and applicability, further examples of their application to practice are needed to test whether they do meet these proposed qualities. The scope of the research question for this thesis was necessarily broad, and this limited the depth to which I could explore some of the critical questions which drove this inquiry. I experienced my journey through theoretical, evidentiary and practice ways of knowing as quite speedy, as I had a lot of ground to cover. Given that this thesis has been the result of five years of work, it is clear that gaining the detailed level of familiarity with mental health OT to which I aspire will be the work of an entire career.

The choice of peer-reviewed journals as the primary source of data for this thesis also produced some limitations. The confines of this format include the potential for censorship inherent in peer review, the long delays between submission and publication and then publication and citation, and the fact that few clinicians writing independently are represented in this form of literature. As stated previously, I am also doubtful of the format’s suitability for communicating practice ways of knowing, meaning my findings from this part of the journey may not have been comprehensive. Occupational therapists are becoming increasingly adept at using alternative formats of communication to talk about their profession, such as Twitter and other online communities. While excluding them from this thesis made the data set more manageable, it also means it focuses on an older form of communication, one which is likely to change substantially by the end of this decade.

Another limitation highlighted during my journey through evidentiary ways of knowing was the disparate places in which evidence about mental health OT is located. While the search strategy I formulated is based on a robust process of formulation, I
cannot guarantee that my sample includes all peer-reviewed journal articles written by occupational therapists, clients or professional associations. There was a substantial number of articles which might have been relevant to this thesis, had full copies of them been found (see Appendix B). The difficulties I have had in finding all available evidence about mental health OT, despite the resources available to me as a university employee, highlights the limitations of current systems of indexing professional knowledge.

Finally, the personal ways of knowing which I came to understand as crucial to mental health OT were not comprehensively explored as part of this journey. The independent nature of doctoral studies somewhat militates against a participatory action research approach with true equity between stakeholders, and it is perhaps a reflection of the limitations of this form of study that it could not be meaningfully included as part of my journey. Without a detailed understanding of personal ways of knowing, the translation of knowledge in mental health OT is missing a crucial piece and is unlikely to be truly client-centred.

**Future developments from this thesis**

There have been a range of outcomes from this thesis, all of which have scope for further development. POP will need to be tested in a range of settings, particularly outside mental health. Case studies could be an ideal methodology for these developments in the immediate future, enabling the full context and circumstances of its place in OT to be described. As a paradigm, no assessment tools or intervention strategies need to be constructed specifically for use with POP; however, the detailed mapping of the tools and strategies professionals already possess (of which there are many) against the domains would greatly assist clinicians in understanding how to make the leap from knowing to doing. To comply with my commitment to inclusive practices, I would like to pursue first-hand reflections and accounts from all stakeholders, particularly clients, to understand how the POP operates “in the wild.” I would also like, every five years, to revisit the critique of how doing, being, becoming and belonging are represented in the professional literature, to chart the ongoing evolution of these terms across time.

While the ITEA method in its current form provides a systematic structure for integrating ways of knowing, the final step of transfer and utilisation is the one with the least development in OT. There are many studies which describe searching for, critiquing and synthesising literature, but we are yet to close the loop and really get to
grips with the processes of knowledge translation. It was applied only to peer-reviewed evidence in this thesis, and it would be instructive to use ITEA with other forms of evidence to see if it remains useful.

The development of a strategy for formulating evidence based practice guidelines leaves open the possibility of developing these documents for the full range of diagnoses in mental health and beyond; however, before this proliferation occurs, it would be worthy to spend time assessing the effectiveness of the evidence based practice guidelines for depression which are already in existence. Studies which investigate the clinician’s experience of implementing the guidelines, and any resulting impact on client outcomes, will be crucial to determining the efficacy of this strategy. Developing more guidelines before providing evidence that they make a positive impact on clients will only add to the tendency to miss out the transfer and utilisation stage, as mental health occupational therapist will not have robust tools to assist them.

To address some of the limitations of current forms of communicating evidence in OT, innovative ways of disseminating knowledge need to be explored. There will always be a place for peer-reviewed journals, but other ways of communicating which are quicker and more inclusive (particularly of practice ways of knowing) could also be developed. The open access movement has much to offer in allowing easy accessibility to rapidly published knowledge, but often requires authors to pay high publication fees which will exclude all but well-funded researchers. Social networks (particularly those which collate and curate, such as Scoop It) are potential mediums, but would have to overcome long-standing and well entrenched attitudes and philosophies about what constitutes “real evidence.”

As foreshadowed in the previous section, further inquiry into personal ways of knowing and inclusive research practices is needed. This will necessitate the formation of partnerships with multiple stakeholders, ideally of long-term relationships and programs of inquiry which feed back into practice at multiple points. Such inquiry is very complex and does not fit many current research funding models or preferences. Knowledge brokerage offers models which may overcome these barriers, marrying an inclusive approach with individual projects which are more traditional and therefore more likely to be funded.

The area of research I would most like to pursue from this thesis is the development of knowledge brokerage as a model of EBOT and a potential career option. In the knowledge brokerage role, there is the potential to incorporate all the
measures listed in this chapter; to truly integrate and incorporate multiple ways of knowing and promote inclusive research practices. I feel that this particular role, with one foot in academia and one in practice, could provide a viable career path for those who do not want to have to leave one realm to work in the other. Most importantly, however, my preliminary research suggests that knowledge brokerage is an effective means of promoting knowledge transfer which will ultimately be to the benefit of both clinicians and clients.

**Conclusion**

Integrating and incorporating theoretical, evidentiary and practice ways of knowing in mental health OT demands skills and a coherent framework in which to practice them. Occupational therapists must deploy the complex thinking and reasoning skills they already possess in creative and inclusive ways to make the most of the steadily increasing amount of knowledge available to guide their practice. As shown in this thesis, new methods and processes are needed to enable this to be fully enacted; for the diverse ways of knowing to be truly integrated and incorporated. These new ways must include a willingness to engage with the personal ways of knowing of our clients, and (just as we do in therapy) accept them as active partners in the generation of new knowledge about occupation and health.

The formation of relationships with many different stakeholders is a crucial skill, as it is these partnerships which will support engagement with complex evidence and its translation to the complex situations that exist in real life. Such modernised practices need to match with modernised ways of communicating knowledge about occupation and health. Ultimately, they must be backed by a willingness to transform good intentions into real action – to take all these diverse ways of knowing and weave them into the art and science of enabling clients to engage in meaningful occupation.


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REFERENCES


Appendix A

List of future publications planned from this thesis


APPENDIX B: ARTICLES MEETING INCLUSION CRITERIA

Appendix B

Articles meeting the inclusion criteria which were available in full text by year

2000


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APPENDIX B: ARTICLES MEETING INCLUSION CRITERIA


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APPENDIX B: ARTICLES MEETING INCLUSION CRITERIA


2007


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2005


**2006**


**2007**


2008


2009


**2010**


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APPENDIX B: ARTICLES MEETING INCLUSION CRITERIA


**2011**


Appendix C

Historical overview of the development of mental health

Mental health enables people to engage in occupations to their full potential, cope with day-to-day stresses, engage in their community, and live a free and satisfying life (Headspace: National Youth Mental Health Foundation, 2012). Mental health includes emotional, psychological and social wellbeing, where wellbeing is a subjective state of satisfaction and comfort with life (Thomas, Gray, & McGinty, 2012). Mental health problems and mental illness occur in all human cultures around the world, and can result in occupational dysfunction in all areas of life. In Australia, mental illness is the leading cause of disability burden, accounting for an estimated 24% of total years lost due to disability (Begg et al., 2007). The prevalence rate in Australia estimated to be 20% of the population aged between 16 and 85 in any given year (Australian Institute of Health and Welfare, 2012).

The history of societies’ responses to mental health and wellbeing issues has ranged from acceptance and even valuing symptoms, to complete social exclusion. Throughout the 18th and 19th centuries, people in Western societies with mental health problems (and others who were on the margins of the community) were sent to asylums. The initial purpose of these asylums was to separate these people from society, ostensibly to provide rest and sanctuary in line with the tenants of moral treatment, but they soon acquired a stigma (Peters, 2011). Asylums in colonial and federation Australia were not always as closed and threatening as often imagined (Coleborne, 2009). There is evidence that families were familiar with these services, and used them to protect and provide welfare for family members who were struggling with mental illness (Coleborne, 2009). There were also private mental health services available from early in Australia’s history, which provided a similar range of treatments to the statutory services (Duke, 2008). While occupation in these setting was initially in the form of forced labour, it gradually became more therapeutic and the first positions dedicated to promoting the use of occupation for health emerged in the 1930s (Adamson, 2011).

Psychiatry has developed dramatically in the past century, particularly in the field of pharmaceutical support. Towards the middle of last century, effective pharmaceutical treatments such as lithium and early anti-psychotics became available for the first time in Western societies. Allied health workers also began to add
psychological treatments to their repertoire, starting with the work of Freud in the early
decades of the 20th century. The psychological and pharmaceutical approaches are seen
as mutually exclusive by some (Unger, 1987), but many patients have benefited from
both modes of treatment. There remains ongoing ambiguity towards these forms of
treatment however, for example, many who are prescribed psychiatric medication chose
not to take it (Roe, Goldblatt, Baloush-Klienman, Swarbrick, & Davidson, 2009).

The asylum model of care had predominated well into the middle of the 20th
century. However, lengthening periods of admission had by then resulted in serious
overcrowding, causing strain on the supports provided (Peters, 2011). An ideological
shift occurred in response to these mounting problems, leading to the
deinstitutionalisation movement. Deinstitutionalisation began as early as the 1950s in
some states of Australia, and proceeded in phases, often commencing with increased
discharges of existing patients followed by efforts to decrease new admissions (Doessel,
2009). This movement really gained momentum in Australia in the 1960s, when
asylums began to close and supports started to evolve into a more community based
system.

Virtually all people in Australia with mental health problems now live in the
community, returning to institutional care only when they become acutely unwell.
Despite some initial difficulties in implementing this new model of care, recent research
indicates deinstitutionalisation has been effective in instances where careful planning
and proper resourcing occurred (Newton, Rosen, Tennant, Hobbs, & Lapsley, 2000).
Another consequence of deinstitutionalisation has been a refocusing from reactive
assessment and treatment to promotion, prevention and recovery. In Australia, a series
of National Mental Health Plans have acted as a driver, by changing public policy at a
federal level. The first of these were formulated in 1992 by the Keating government,
and they are revised and updated every five years (Whiteford, Buckingham, &
Manderscheid, 2002)

Until the first National Mental Health Plan, Australia’s mental health polices
echoed those of the United Kingdom (Adamson, 2011). However, since 1992 the
country has forged its own path focusing on a developing array of priority areas to
support the transformations required by deinstitutionalisation. Three areas have
remained ongoing priorities for the past twenty years – promotion of mental health,
prevention of mental illness, and quality and effectiveness of services (Australian
Health Ministers, 1998, 2003; Commonwealth of Australia, 1998; Department of Health
and Ageing, 1992). However, each new plan has also included time specific priorities, as shown in Table 1.1. While the 1992 plan identified multiple priorities to address the many service issues identified at the time, each successive plan has been more focused, and increasingly taken a long term, population based perspective.

Table C1

*Australian National Mental Health Plans*

<table>
<thead>
<tr>
<th>National Mental Health Plan</th>
<th>Time Specific Priority Areas</th>
</tr>
</thead>
<tbody>
<tr>
<td>1992 – 1998</td>
<td>Consumer rights, relationship between mental health services and the general health sector, linking mental health services with other sectors, service mix, primary care services, carers and non-government organizations, mental health workforce, legislation, research and evaluation, monitoring and accountability</td>
</tr>
<tr>
<td>1998 - 2003</td>
<td>The development of partnerships in service reform</td>
</tr>
<tr>
<td>2003- 2008</td>
<td>Increasing service responsiveness, fostering research, innovation and sustainability</td>
</tr>
<tr>
<td>2009 – 2014</td>
<td>Social inclusion and recovery, early intervention, service access, coordination and continuity of care, accountability - measuring and reporting progress</td>
</tr>
</tbody>
</table>

The recovery approach is the most recent to gain wide acceptance in mental health. There are many definitions available for recovery in mental health. However, a general sense has developed of recovery as the finding of meaning and purpose in life, independent of the presence or absence of symptoms (Meddings & Perkins, 2002). Self-determination is an important part of recovery, as clients learn how to manage and maintain their mental health themselves (Clayton & Tse, 2003). The adoption of the recovery approach in the past fifteen years has been a challenge to the existing power structures in mental health. Recovery “is not something that mental health services do” (Repper & Perkins, 2012, p. 76), so their role has transformed to one of assistance or enablement.
Several recent studies have confirmed that occupational therapists have adopted the recovery approach, and it is commonly found in modern OT practice (Cone & Wilson, 2012; Gardner, Dong-Olson, Castronovo, Hess, & Lawless, 2012; Gibson, D'Amico, Jaffe, & Arbesman, 2011). There are many similarities between the recovery approach and the values espoused by OT, including the adoption of an individualised approach, meaningful participation of clients and carers in treatment planning, client-centred practice and strengths based health promotion (Lloyd, Tse, & Bassett, 2004). However, Lal (2010) cautioned against the uncritical adoption of this approach, and urged the profession to question the definitions and practices used to support people under this approach.

As highlighted by Peters (2011), any history of mental health cannot present a whole or objective truth. There are so many competing subjective perspectives; a simple chronology cannot tell more than the barest of stories. It is a history that encompasses social factors, particularly political ones around how to ‘deal’ with the mentally ill. The research in this thesis sits within a controversial area of health, which has traditionally been fragmentary and riven by unequal power relationships. As a mental health profession, OT has been buffeted by and reacting to social and political turbulence throughout its history.

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Appendix D

Overview of methods that support ways of knowing in mental health OT

**Original Methods to Support Ways of Knowing (1923 – 1997)**

As described in an epistemological history of occupational therapy by Hooper (2006), the methods employed by occupational therapy for knowledge building in its initial years emphasised empirical knowledge, taken directly from the experiences of clients and their therapists. These are methods which are accessible to all occupational therapists, and do not necessarily require further training in research or scientific methodologies. It is not therefore surprising that these methods remain the ones most often used by clinicians publishing in mental health occupational therapy since the year 2000. Table D1 lists all of the methods that emerged in this period.

<table>
<thead>
<tr>
<th>Method</th>
<th>Occupational Therapy (circa)</th>
<th>Mental Health Occupational Therapy (circa)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overview</td>
<td>(Heyman, 1923)</td>
<td>(Chapman, 1924)</td>
</tr>
<tr>
<td>Descriptive Case Study</td>
<td>(Noble, 1933)</td>
<td>(Noble, 1933)</td>
</tr>
<tr>
<td>Role statement</td>
<td>(M. Taylor, 1945)</td>
<td>(Noyes, 1955)</td>
</tr>
<tr>
<td>Opinion</td>
<td>(Hayward, 1947)</td>
<td>(Deissler, 1956)</td>
</tr>
<tr>
<td>Theoretical discussion</td>
<td>(Azima &amp; Azima, 1959)</td>
<td>(Azima &amp; Azima, 1959)</td>
</tr>
<tr>
<td>Needs assessment</td>
<td>(Hely, 1971)</td>
<td>(Hely, 1971)</td>
</tr>
<tr>
<td>Reflection</td>
<td>(Steiner, 1972)</td>
<td>(Steiner, 1972)</td>
</tr>
<tr>
<td>Guidelines</td>
<td>(Fay &amp; Hatch, 1965)</td>
<td>(Norman, 1976)</td>
</tr>
<tr>
<td>Literature review</td>
<td>(Gaston, 1948)</td>
<td>(Watts, 1976)</td>
</tr>
<tr>
<td>Instrument / Psychometric</td>
<td>(Tyler &amp; Kogan, 1965)</td>
<td>(Watts, Brollier, Bauer, Schmidt, 1988)</td>
</tr>
<tr>
<td>Critical analysis</td>
<td>(Neistadt, 1990)</td>
<td>(Townsend, 1997)</td>
</tr>
</tbody>
</table>

While these methods fall outside the realm of scientific evidence, they are not without reliability and validity. One of the criticisms often aimed at these original ways
of knowing are their lack of rigour. However, many of the methods used to ensure rigour within science are also used in the area broadly known as the humanities, to which most of the following methods belong. The most obvious example is in literature review, which has been adopted as a crucial early stage in scientific studies. However, identification of themes, comparisons of positive and negative instances, descriptions of process and even statistical analysis can all be found in the following methods. And, of course, all of the methods accessible through professional journals have been subjected to peer review. This criticism is therefore based on stereotypical views of these methods from a scientific perspective, and has been highlighted as an example of scientism (Kitcher, 2012), the belief that natural science uses the best method for developing truth and understanding the world (Ginev, 2013).

**Overview.** An overview provides a comprehensive summary or synopsis of a particular issue, intervention or topic of interest to the profession. This method uses the communication skills of selecting relevant information, relating it to the needs and interests of occupational therapy, using evidence to support assertions and presenting a range of sources in a concise and focused manner. For example; an overview can be used to support a theoretical way of knowing, by providing a synopsis of how a theory can be used in a particular practice setting (e.g. Warchol, 2004). An overview could support an evidentiary way of knowing by discussing the characteristics of a type of service, to ensure consistent use of terminology (e.g. Corbiere & Lecomte, 2009). An overview could support a practice way of knowing by providing clinicians with a synopsis of important legislation (e.g. Cottrell, 2005).

The main advantage of the overview for mental health occupational therapy is that it provides a handy compendium of information to clinicians on a particular topic. This broad perspective on a topic may be sufficient to guide practice in a general way, or serve as a starting point for a more detailed exploration of the evidence base in a particular area. However, readers of overviews are entirely subject to the choices and skill of the author of that article. In deciding what to include (and what to omit) the author of an overview shapes a particular view of the issue, intervention or topic that is subjective. Consideration of the provenance of an overview is therefore advisable.

**Case Records.** Case records provide an account of interventions or highlight a particular aspect of an evaluation (Fisher & Ziviani, 2004). They differ from the case studies that will be identified in the final section of this review, as they do not employ scientific methods. This method can also be known as program description or practice
analysis (College of Occupational Therapists, 2013). This method often communicates its content by way of a story, and is often an account of a new, creative or innovative practice. For example; a case record can be used to support a theoretical way of knowing by descriptive the application of a particular framework in a specific practice setting (e.g. Bouteloup & Beltran, 2007). A case record could support an evidentiary way of knowing by providing a description of the implementation of a particular intervention (e.g. Fitzgerald, Kirk, & Bristow, 2011). A case record could support a practice way of knowing by outlining a particular type of service model which is appropriate to occupational therapy (e.g. Prodinger et al., 2012).

An advantage of case records is their ability to provide a detailed account of an individual intervention or service. By telling the story of how this intervention or service developed and operates, the readers can take an example that may be applicable to their own practice. Such case records are often derided as being exploratory and lacking in rigour (Fisher & Ziviani, 2004), they can capture issues and experiences which are authentic to the changeable, complication contexts of clinical practice. However, these case records can be presented in a journalistic manner, comprising of only information with little critical analysis. They can make them less engaging to read, and don’t assist the reader to see beyond the specific situation being covered.

**Role Statement.** A role statement is an article that focuses on defining the role of mental health occupational therapy in a particular setting. They can be considered a sub-type of overview, but have a particular significance in a profession that has ongoing issues with role blurring (Hughes, 2001). This method uses similar skills to overviews, but also requires the ability to link the information with the occupational therapy profession. Roles statements are most often found supporting evidentiary and practice ways of knowing, and no examples of their use to support theory were found in this study. For example; a role statement can be used to support an evidentiary way of knowing by outlining the place of the profession in providing a particular intervention (e.g. Rai, 2002). A role statement could also support a practice way of knowing by outlining how occupational therapy can contribute to a specified type of mental health practice (e.g. Krupa, Radloff-Gabriel, Whippey, & Kirsh, 2002).

Role statements are often seen as being particularly useful in areas of practice where occupational therapy is newly developing, to guide the expansion of the profession. In mental health, opportunities for this expansion have proliferated since de-institutionalisation, as new models of care and services have rapidly evolved as the
sector changed comprehensively (e.g. early intervention, assertive outreach). An often cited reason for clarifying the role of occupational therapy in any setting is the need to prove its worth and defend against genericism (Taylor & Rubin, 1999). However, much of the evidence using this method is located in occupational therapy specific journals that indicates the profession itself needs convincing at times that it has a role in these newer services. A disadvantage of this method is that the role of occupational therapy in any service is heavily influenced by organizational, legislative and cultural factors. These articles can therefore be difficult to generalize for occupational therapists working in other countries, in other health systems.

Opinion. An opinion piece (also known as a viewpoint) is generally a shorter article that puts forward a particular stance on a topic relevant to occupational therapy. An editorial is also a type of opinion piece, but has not been included in this study as they are not subjected to peer review. While based on subjective opinion, this method also involves the use of some evidence to support the arguments being made and a willingness to address topical and sometimes controversial subjects. For example: an opinion piece can be used to support a theoretical way of knowing by discussing the philosophical underpinnings of occupational therapy, and how these influence its place in mental health practice (Corrigan, 2001). An opinion piece can be used to support an evidentiary way of knowing by raising concerns about the evidence base for mental health occupational therapy (Mairs, 2003). An opinion piece could also support a practice way of knowing by highlighting potential moral and ethical concerns around the adoption of a particular intervention (Plastow, 2006).

Opinion pieces can be wonderful stimulus for debate on contentious issues in occupational therapy, and are often the subject of ongoing discussion through responding letters to the editor. In their shorter format, they are also easier to digest if time is limited and don’t require any specific skills in understanding a particular genre or type of evidence. However, peer review journals are not a free press – each opinion piece goes through the process of peer review, and reviewers can request modifications to the manuscript. It is also possible that opinion pieces that are deemed too controversial or radical may not get through this process, deemed to be unfit for publication by reviewers who hold more traditional views. Peer review brings with it the risk that only ‘acceptable’ opinions will make it to publication, and more radical elements of the profession have already began to seek out online forums for expression.
**Theoretical Discussion.** A theoretical discussion provides an overview of a theoretical concept or model in relation to occupational therapy. This method requires strong abstract and metacognitive skills, as the subjects are often intangible and highly complex ideas. This method may be used to present an entirely new theory, analyse an existing theory or compare competing theories in a particular field. Unsurprisingly, this method is most often used to support theoretical ways of knowing, for example by refining concepts currently used to underpin occupational therapy (Kyler, 2008). However, it can support evidentiary ways of knowing by, for example exploring the development and dissemination of a particular model over time (Bowyer et al., 2008). Theoretical discussions can also support practical ways of knowing, by providing frameworks which translate concepts into everyday therapy (e.g. Alwin et al., 2007).

An advantage of theoretical discussions is that their findings are potentially transferable across a wide range of settings and specialties. They provide the reader with the opportunity to reflect on the first way of knowing to develop during training, which underpins both evidentiary and practice ways of knowing. However, much depends on the quality of the discussion in the article. A well-written theoretical discussion is accessible, and succeeds in making complex concepts understandable. However, this method is used almost exclusively by academics and may therefore take a scholarly tone that is less accessible for readers from other groups (especially clinicians). Many clinicians don’t engage with this type of evidence and have negative ‘ivory tower’ perception of it, which can potentially lead to paradigm free practice (Molineux, 2011).

**Needs Assessment.** Needs assessment is a process which focuses on gathering and analysing information to highlight gaps between what is available to clients and what should be ideally (Finlayson, Baker, Rodman, & Herzberg, 2002). While scientific methods may be used as part of the assessment, the process itself is not recognized as a formal category of research in accepted hierarchies. This method is often deployed in areas within which occupational therapy is establishing a presence, and can form part of the process towards developing a role statement. While a distinctive method, only three examples of its use in mental health occupational therapy since 2000 have been found. It has been used to identify the occupational needs of runaway women in Iran (Malekpour, 2008), to guide the development of an occupational therapy program in a homeless shelter (Finlayson, Baker, Rodman & Herzberg, 2002) and to identify the needs of survivors and emergency service workers at Ground Zero in New York (Precin, 2003). In each of these cases, it has informed a practice way of knowing.
The value of needs assessment is their illumination of an important, and often implicit process. As occupational therapy services develop over time (even in well established areas), recurrent needs assessments are required to ensure their relevance. It is also an important method for establishing cost effectiveness, and maintaining sustainable funding. However, published needs assessments are firmly grounded in their own unique situations and circumstances which can make their generalization limited. They also don’t always include the participation of clients / recipients of the service which brings their validity into question.

**Reflection.** Reflection is a method where people provide a subject account of an experience, thinking over it, considering its aspects and evaluating its impact on themselves and those around them (Creek, 2007). Reflective evidence often takes the form of a personal testimony around a critical incident, but can also be a meditative deliberation of a particular topic. For example: a reflection can be used to support a theoretical way of knowing by providing an in-depth consideration of a particular concept (Clark & Krupa, 2002). A reflection can be used to support an evidentiary way of knowing by providing an ‘insiders’ account of living with a mental illness (Mack, 2002). A reflection could also support a practice way of knowing by considering the response of services to a particular event (Diamond & Precin, 2003).

Reflections are often written in the first person, and can be very powerful in conveying the lived experience of personally transformative events and ideas. When the insights from the reflective process are clearly communicated, the deep learning from those experienced can be transmitted to the reader. It is difficult to discern the quality of the processes supporting that reflection in many of these articles however. Without a structure or another person to ‘bounce off’, the reflective process may be insular and not provide links to the broader context in which it sits.

**Guidelines.** Guidelines are statements formulated based on research and/or expert consensus and opinion, which are intended to promote best practice and improve the quality of occupational therapy (Blain & Townsend, 1993). Clinical practice guidelines are the best known form of this method, not all guidelines are formulated based on robust quantitative evidence and panels of experts. This method is often carried out over two steps – the collection of evidence, and its transformation into recommendations. For example: guidelines can be used to support a theoretical way of knowing by suggesting ways in which a model can inform occupational therapy (Luboshitzky & Gaber, 2000). Guidelines could also support an evidentiary way of
knowing by outlining how up to date research can guide role development with people experiencing schizophrenia (Schindler, 2004). Guidelines can be used to support a practice way of knowing by providing recommendations on which to base practice (Hitch et al., 2013).

Guidelines have great appeal to clinicians, as they are readily applied and are considered to be evidence based. They are often the end product of a long and complex development process, which clinicians wouldn’t be able to conduct without considerable resourcing. Their resource intensiveness also leads to this method only being used for practice issues and areas which are likely to be generally applicable across the profession. Therefore, guidelines are often not available in more specialized areas or for those people experiencing multiple co-existing difficulties. The level of reporting of the method of their development is crucial in guidelines, as it provides the key information needed to critique their quality.

**Literature Review.** Literature reviews aim to identify themes and draw conclusions from a body of evidence, by synthesizing and critiquing existing research (Steward, 2004). Their purpose is to share the results of closely related studies, identifying broad themes and possibly areas of conflicting evidence (Cresswell, 2006). In scientific research, they are conducted as a pre-cursor to experimental studies to define the context of the finding and in this case they also aim to situate the study in the existing evidence base. For example: literature reviews can be used to support a theoretical way of knowing by providing a conceptual review of a particular theory (Fossey & Harvey, 2001). Literature reviews could also support an evidentiary way of knowing by providing a synthesis of factors which influence sustainable return to employment for clients (Tsang, Lam, Ng, & Leung, 2000). Literature reviews can be used to support a practice way of knowing by providing an overview of occupational therapy interventions which address a particular issue (Moro, 2007)

This method has several features that make it an effective and powerful way of integrating knowledge as a primary method. The advantages of conducting this form of research are largely related to the wealth of data available. The conclusions which that can be drawn from literature reviews have a much broader scope than those from single studies, and are potentially more robust if similar conclusions arise from studies using a variety of methodologies. The author also provides a service to others in the profession, by combining and presenting knowledge they wouldn’t have time to source and read
themselves. Narrative allows for the linking of information in a format that is easy to follow and digest for readers.

Instrument / Psychometric. The development of assessments may lead to them becoming standardised or non-standardised. The development of non-standardised assessments are often outlined in overviews or descriptive case studies. However, the development of standardized assessments involves the use of psychometric methods, which are statistical methods for measuring abstract constructs that are expressed through human behaviour (Raykov & Marcoulides, 2011). This method is only used to support practice ways of knowing through the formulation of assessment tools.

The use of assessments that have been proven to have good reliability and validity enables outcome measurement over time, or comparison to population norms during the assessment phase. These benefits are widely recognized, and yet there remains lower than expected uptake of standardized outcome measures in allied health professions (Duncan & Murray, 2012). To use this type of evidence, a clinician needs to feel comfortable in their knowledge of psychometric principles like reliability and validity, and also the benefits the tool may have for both themselves and their clients in daily practice. Much of this evidence focuses on statistical outcomes and does not go on to elaborate on what they mean in practice.

First Wave of Quantitative Methods to Support Ways of Knowing (c1985 – c1990)

Quantitative research views reality from the positivist or realist paradigm, considering it absolute, measurable and objective (Ballinger, 2004; Eva & Paley, 2004). This attitude emerged from physical sciences during the 18th century Enlightenment, and assumes the universe acts in a consistent and predictable way through phenomena influenced by discoverable causes (Seale & Barnard, 1998). The causes are discrete, conform to universal laws and are considered to be under the researcher’s control (Inu, 1996; Johnson & Waterfield, 2004).

Quantitative research tests a particular hypotheses or question proposed by the researcher, with the aim of establishing relationships between variables controlled for extraneous effects (Finlay, 1997; Inu, 1996). The hypothesis originates from existing theory and is either accepted or rejected (Losee, 1993). Numerical data is gathered via methods like surveys, direct observation, experiments, statistics and structured observations (Silverman, 2000). Quantitative researchers consciously remain detached external observers of the phenomenon being studied, and this research is often
conducted in controlled environments such as institutions or service settings (Finlay, 1997).

A range of statistical measures are applied to numerical data, which follow mathematical laws and aim for precision and reliability (Inu, 1996). To produce replicable results with minimal bias that can inform predictions, quantitative data is also expected to be valid and generalisable (Ballinger, 2004). The rigours of these analyses appear self evident, and difficult to criticise in and of themselves, although extreme numbers and cases tend to be excluded. Quantitative researchers use deductive reasoning to generalise the results from their sample to a larger population by focusing on average or group effects (Polgar & Thomas, 2000). These general principles can then be re-applied to individual cases, although their emphasis on statistically significant findings may overlook individually or socially significant results (Rudestam & Newton, 2001).

By the early 1990s, evidence based practice had become an important concept in health care with its attendant drive for greater accountability. Mental health occupational therapy operates within a sector of health care which is often biomedically focused, and some would say increasingly medicalised (Spence, 2012). Quantitative scientific methods are the predominant methods used to support biomedical ways of knowing, and they began to be regularly used by mental health occupational therapy in the mid to late 1990s, as shown in Table Four.
Table D2

*First Wave of Quantitative Methods to Support Ways of Knowing (c1985 – c1990)*

<table>
<thead>
<tr>
<th>Methods</th>
<th>Occupational Therapy (circa)</th>
<th>Mental Health Occupational Therapy (circa)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Descriptive</td>
<td>(Doniger &amp; Klopfer, 1958)</td>
<td>(Doniger &amp; Klopfer, 1958)</td>
</tr>
<tr>
<td>Control</td>
<td>(Grygier &amp; Waters, 1958)</td>
<td>(Grygier &amp; Waters, 1958)</td>
</tr>
<tr>
<td>Pre-test Post-test</td>
<td>(Rogers &amp; Hill, 1980)</td>
<td>(Brown &amp; Carmichael, 1992)</td>
</tr>
<tr>
<td>Quasi-experimental</td>
<td>(Hamilton-Dodd, Kawamoto, Clark, Burke, &amp; Fanchiang, 1989)</td>
<td>(Maynard, 1990)</td>
</tr>
</tbody>
</table>

**Descriptive.** Descriptive methods aim to capture the trends, attitudes or opinions of a population, through the study of a representative sample of that group (Cresswell, 2006; Mehl & Conner, 2012). While often dismissed as ‘low grade’, descriptive research is crucial in the early stages of understanding a topic or phenomenon, to provide the basis on which further more rigorous studies can be based (Mehl & Conner, 2012). Surveys or questionnaires are usually employed to collect this data, and this is the most often used quantitative method in mental health occupational therapy. No examples of descriptive methods supporting a theoretical way of knowing in mental health occupational therapy were found in this study, despite its relevance to theory development. Descriptive methods could support an evidentiary way of knowing by exploring consumer and caregiver views on their rehabilitation needs (Tsang et al., 2011). Descriptive methods can be used to support a practice way of knowing by survey attitudes towards the use of client-held medical records (Stafford, Laugherne, & Gannon, 2002)

Descriptive methods can provide preliminary information about potential trends and tentative causes or relationships between factors for clinicians (Grimes & Schulz, 2002). Those that report on opinions can also provide readers with an insight into the perspective and attitudes of clients, carers and the profession itself. In a profession as
diverse (and varied) as occupational therapy, descriptive methods also enable some of the more specialized areas of practice to be represented in professional literature. Descriptive studies are also relatively low in cost and time commitment, which enhances their sustainability. One problem with this method occurs when unwarranted conclusions are drawn about causality, leading clinicians to over-estimate the strength of the findings. Unrepresentative samples can also skew the results of these methods, and this can be difficult to assess when sample data is poorly reported.

**Control.** A non randomized control study may compare outcomes between a group that has received an intervention, and another comparable group which has not (National Health and Medical Research Council, 1999). These methods may also compare the predisposing factors which may influenced the outcomes of groups, for example contrasting the outcomes for people with and without autistic spectrum disorders (Mann, 2003). They are also known as quasi-experimental methods (Cresswell, 2006). These methods can highlight relationships between interventions and subsequent outcomes, but cannot rule out confounding factors in the absence of randomization (Sibbald & Roland, 1998). For example: control methods can support a theoretical way of knowing in mental health occupational therapy, by clarifying the outcomes associated with particular factors within a model (Cordier, Bundy, Hocking, & Einfeld, 2009). Control methods could support an evidentiary way of knowing by, for example comparing the impact of untreated psychosis on quality of life (Law et al., 2005). Control methods can also be used to support a practice way of knowing by assessing the effectiveness of a specific return to work program delivered by occupational therapists (Eklund, 2011).

The main advantage of control or quasi experimental methods is their relevance to real life. While randomization enhances the rigour of quantitative methods, it is not always possible, desirable or ethical to assign people in this manner (Cresswell, 2006). They can also provide significant information from relatively small samples, which is particularly useful for if the topic is highly specialized or uncommon (Mann, 2003). However, given that much research is conducted with volunteer subjects, there is always a risk of bias within the samples chosen for each group. They are also most costly and time consuming then other methods, although still less than a randomized controlled trial.
Pre-test / Post-test. A pre-test/post test methods administer a measure to a single group prior to an intervention and following its conclusion (Cresswell, 2006). This design is also known as pre-experimental, although it can be incorporated into quasi-experimental and experimental designs, where the measure is administered to both groups. No examples of pre test/post test methods supporting a theoretical way of knowing in mental health occupational therapy were found in this study. Pre test/post test methods could support an evidentiary way of knowing by following the changing roles of clients in a service (Eklund, 2001). Pre test/post test methods can also be used to support a practice way of knowing by assessing the effectiveness of a specific program, to a preliminary degree (Fitzgerald, 2011).

Pre-test/post-test designs mirror the usual process of providing occupational therapy, with a baseline assessment and final evaluation. However, the risk of bias or validity issues is high with this method, especially when all measures are performed by the same clinician. The presence of studies without blind assessors in an evidence base indicates that it remains in a earlier stage of development, and may therefore not be attracting funding to support this level of rigour.

Qualitative Methods to Support Ways of Knowing (c1989 – c1996)

Qualitative research assumes there are multiple and individually unique realities, which reflects the naturalist or constructionist paradigm (Cresswell, 1998). A phenomenon is considered to be different from the sum of its parts, and this holistic stance is in contrast to the reductionist approach of quantitative methods (Rudestam & Newton, 2001). The positivistic model has dominated health for many years, and in this environment qualitative researcher have been dismissed as ‘soft scientists’ or ‘journalists’ (Silverman, 2000). It has also been criticized for “always responding to the loudest bangs and the brightest lights” (Savin-Baden & Fisher, 2002, p191). However qualitative approaches are increasingly popular, to the extent that concerns have emerged about over reliance on them (Johnson & Waterfield, 2004). Growing acceptance may reflect naturalism’s congruence with core values and trends in health care like challenging reductionism and client centred practice (Eva & Paley, 2004; Hammell, 2002).

Qualitative research tends to address knowledge at an earlier stage of development, when theory is in the early stages of development on influencing variables is poorly defined. This is not to say it is always original, as tentative frameworks and literature reviews are still required to frame data gathering (Seale & Barnard, 1998).
Rather than a fixed hypothesis, qualitative researchers propose questions that can change over time (Rudestam & Newton, 2001). Qualitative research data can take the form of both words and images (Silverman, 2000) and is believed to produce richer and more layered knowledge (Cresswell, 1998). Qualitative researchers are themselves tools for data collection, greatly reducing the distance between researcher and researched (Conneeley, 2002). However, this brings the risk of the researcher abandoning objectivity by closely identifying with the subjects (Johnson & Waterfield, 2004).

Qualitative methods support active interpretation prior to formal analysis as a means of refining the research question and sharing knowledge, which goes some way to redressing power imbalances between the researcher and researched (Creswell, 1998; Hammell, 2002). This results in some blurring between data collection and analysis, which Crombie and Davies (1996) argue may influence the phenomena being observed. The quality of naturalistic data therefore relies heavily on the researchers reflective abilities, introducing the risk of negative reflexivity (McQueen & Knussen, 2002). For example - Qualitative researchers may be challenged by intercultural issues, which then create difficulties in data collection (Butler & Smith, 2002).

Qualitative research occurs in the natural settings wherever behaviour occurs without strict controls (Rudestam & Newton, 2001). The methods used to analyse qualitative data are not so easily defined, characterised by Dickie (2003, p. 50) as ‘inherently messy’. Themes are sought from recorded interactions and processes, treading a line between oversimplification and excessive detail while considering issues like ‘trustworthiness’, ‘transparency’ and ‘truth’ during evaluation (Ballinger, 2004; Conneeley, 2002; Inu, 1996). These concepts have been challenged on the grounds of the honesty of participant response, fallibility of researcher interpretation and the difficulties in establishing rigour and validity (Johnson & Waterfield, 2004; Savin-Baden & Fisher, 2002). Such problems can be mitigated somewhat by data handling procedures, and a particular strength of subjective analysis is improved ecological validity due to its close reflection of ‘real world’ (Lloyd, et al., 2004).

In a relatively short period in the early to mid 1990s, qualitative research was introduced to occupational therapy, although there had been calls for its greater use for almost a decade prior (Sharrott, 1985). Its emergence provoked a great deal of commentary at the time, with many highlighting the congruence between its naturalistic philosophy and underlying tenants of occupational therapy. It was readily embraced by occupational therapy, with little criticism or resistance.
However, this may have lead to a superficial adoption of these methods. Borell et al. (2012) found the majority of qualitative studies recently published in occupational therapy provided only descriptive findings, with only around 11% providing a coherent and rich understanding of their topic. Further developments in qualitative methodology are also making greater demands on occupational therapists using these methods. Frank and Polkinghorne (2010) have made seven recommendations for the use of qualitative research in occupational therapy, which urge the adoption of linguistic approaches, development of more observational data collection and a reconnection between the theories and methods being used. They also observe that all of the qualitative methods are continuing to develop, and include various sub-approaches which need to be clarified. In this thesis, many of the qualitative studies did not specify any approach or theoretical underpinnings, providing support to their observation that “qualitative methods should be recognized as dynamic and emergent phenomena within research traditions and that alterations to methods should come from a knowledgeable and disciplined stance” (Frank & Polkinghorne, 2010, p56). Table D3 shows the five main qualitative methods currently in use in mental health occupational therapy, and their date of introduction.

Table D3

<table>
<thead>
<tr>
<th>Methods</th>
<th>Occupational Therapy (circa)</th>
<th>Mental Health Occupational Therapy (circa)</th>
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<tbody>
<tr>
<td>Ethnography</td>
<td>(DePoy &amp; Merrill, 1988)</td>
<td>(Townsend, 1992)</td>
</tr>
<tr>
<td>Grounded theory</td>
<td>(Kielhofner &amp; Takata, 1980)</td>
<td>(Corcoran, 1994)</td>
</tr>
<tr>
<td>Phenomenology</td>
<td>(Vergeer &amp; MacRae, 1993)</td>
<td>(Heubner &amp; Tryssenaar, 1996)</td>
</tr>
<tr>
<td>Narrative</td>
<td>(Haskell &amp; Dickie, 1994)</td>
<td>(Bailey, 2001)</td>
</tr>
</tbody>
</table>
Ethnography. Ethnography involves the researcher studying a cultural group within its natural setting for a prolonged period of time, to gain familiarity with its cultural norms, practice and traditions (Cresswell, 2006). Many different forms of ethnography have been used within occupational therapy, including disability ethnography (Krefting, 1989), auto-ethnography (Denshire, 2011; Warne & Hoppes, 2009), performance ethnography (Carless & Douglas, 2010) and institutional ethnography (Prodinger, Shaw, Laliberte Rudman, & Townsend, 2012). No examples of ethnography supporting a theoretical way of knowing in mental health occupational therapy were found in this study. Ethnography could support an evidentiary way of knowing by exploring the culture of caregiving, and how that impacts of an occupational therapists work with a client (Salmon, 2006). Ethnography can also be used to support a practice way of knowing by investigating the culture around the use of technology by people with disabilities (Nygård & Starkhammar, 2007).

Ethnography can produce extensive and in-depth findings, which provide a comprehensive understanding of the culture being investigated. This method also allows for these understandings to evolve over time, as research questions are not predetermined and can be reframed in the light of new evidence. Ethnography is also considered to produce high levels of validity, because the data is collected first hand through observation and prolonged engagement. However, this detail comes at a price as this method is very resource and time intensive. It can also be susceptible to observer bias, particularly if there is a cultural difference between the researcher and the group being observed. Constant reflexivity is recommended when conducting ethnographic studies to reduce this risk.

Grounded Theory. Grounded theory involves the researcher deriving a general theory of a process, action or interaction, which is based on the views and observations of a group of participants (Cresswell, 2006). These theories may be either substantive (derived from a single setting) or formal (derived from multiple settings) (Nayar, 2012). This method is clearly most aligned with the theoretical way of knowing, as it produces theory as an outcome. However, it can also support the evidentiary and practice ways of knowing. For example: it can support the evidentiary ways of knowing by providing a framework for setting up new services in collaboration with clients (Ásmundsdóttir, 2009). It could also support the practice way of knowing by explaining the rehabilitation process for people with stress related disorders (Eriksson, Karlstrom, Jonsson, & Tham, 2010).
Grounded theory involves a deep level of data immersion, and allows for analysis to begin early and influence the ongoing data collection. It is particularly useful for investigating activities or circumstances that happen fairly regularly, allowing for multiple data collection opportunities and some stability in the conceptual framework. The constant comparison method has also been cited as being rigorous, and is seen by some as the most effective outcome of the development of grounded theory. While researchers are asked to put aside all preconceived ideas about their topic of study before beginning, in practice this is almost impossible and so there is a possibility of data being made to fit theory. Like ethnography, grounded theory is very time and resource intensive. It also produces only localized theories, which require further development before they can be generalized or use to generate clinical tools.

Grounded theory has been identified as a suitable method for occupational therapy research by two authors. Stanley and Cheek (2003) highlighted it utility in supporting theory development, but acknowledged it can only be a preliminary step. They also raised some concerns that it wasn’t used very often within the profession, which could be related to its resource demands. Nayar (2012) focused on its applicability to occupational science and found it particularly relevant to understanding the social processes relevant to that discipline.

Phenomenology. Phenomenology involves the researchers identifying the essential aspects of a human experience in relation to a particular phenomenon, as identified the research participants (Cresswell, 2006). Broadly, there are two different types of phenomenology evident in occupational therapy literature. In traditional phenomenology, personal reflection forms the basis of ‘epoche’, which is a process of putting aside prejudgements, biases and preconceptions (Moustakas, 1994). However, in the Interpretative Phenomenological Approach (IPA), the researchers perspective is embraced and considered to be the context for all subsequent analysis and interpretation (Clarke, 2009; Hitch, 2009). For example: phenomenology can support a theoretical way of knowing in mental health occupational therapy, by validating a model through the clients lived experience (Håkansson & Matuska, 2010). Phenomenology could support an evidentiary way of knowing by researching the lived body experience of people with eating disorders (Gogarty & Brangan, 2004). Phenomenology can also be used to support a practice way of knowing by investigating the meaning and form of engaging with occupational therapy for clients (Ivarsson, Söderback, & Ternestedt, 2002).
Like grounded theory, phenomenology demands in-depth engagement with the phenomenon being studied, and produces rich data full of meaning and detail. With its focus on and valuing of individual experience, it is congruent with the professions values around client centredness. It can also be a transformative experience for both researchers and participants, as their understanding of the phenomenon and its relationship to their own lives becomes deeper. The main disadvantages to using phenomenology centre on its intense subjectivity and individual basis. The data generated can be messy and ambiguous, if the researcher is not experienced in prompting for clarification or data collection has not continued on to saturation (where no new themes or understandings emerge). The detailed data produced by this method, and the need to directly quote from it for credibility can also present difficulties when attempting to fit within most journal word limits.

While highlighting its suitability to occupational therapy research, Wilding and Whiteford (2005) acknowledge that phenomenology is both philosophically and theoretically complex. However, they assert it strength lies in its ability to engage with multi-dimensional, situated phenomena that is common in occupational therapy practice. These authors also link the use of phenomenology with the concept of ‘being’, a common inherent quality in all humans which is expressed through occupational engagement. The Karolinska Institute in particular has adopted phenomenology (particularly interpretative) as a method for understanding the construct of occupation (Frank & Polkinghorne, 2010), and it continues to have a regular presence in occupational therapy literature.

**Narrative.** Narrative research involves both researcher and participant/s telling their stories about a particular aspects of their lives, which is then combined into a collaborative narrative (Cresswell, 2006). This form of research includes life histories, narrative data and thematic analysis (Bonsall, 2012). For example: narrative research can support a theoretical way of knowing in mental health occupational therapy, by recounting therapists experiences of implementing a particular theoretical approach (Pépin, Guérette, Lefebvre, & Jacques, 2008). Narrative research could support an evidentiary way of knowing by providing an account of everyday life following long term psychiatric hospitalization (Hocking, Phare, & Wilson, 2005). Narrative research can also be used to support a practice way of knowing by developing standards for trauma informed peer support (MacNeil & Mead, 2005).
Narrative research provides detailed data about the quality of the participants and researchers' experiences, and their inter-relationship with each other. Storytelling is also a natural way to collect data, which enables participants to engage in a method of communication which is neither contrived nor constrained by data collection demands. However, these studies are highly individual, and for that reason are considered to be unreliable sources of evidence. They cannot be used to predict future actions or behaviours, and therefore a number of narratives which provide similar data would be needed before general trends could be applied to practice.

Narrative research was the focus of two articles in a special qualitative issue of the American Journal of Occupational Therapy in 1996, but provided two very different perspectives. Larson and Fanchiang (1996) were supporting of its use in occupational therapy, citing its support for the profession's humanistic practices and potential role in developing an interpersonal relational ethic which reduces distance. However, Duchek and Thessing (1996) raised concerns about its place as a research method, stating “As long as the positivistic view of science reigns in the larger academic and scientific community, occupational therapy will have a difficult time selling storytelling as science” (p395).

Despite this negative assessment, narrative research has continued to be utilized in mental health occupational therapy, albeit at a lower frequency than the other qualitative methods. In a recent review of narrative in occupational science, Bonsall (2012) proposed a typology which was intended to strengthen and support its development in the discipline. Narrative is found in everyday life, clinical reasoning and research methods, and in the final category a distinction is made between data and inquiry. Bonsall highlights narrative can be integrated into other research approaches, and also used in multiple ways in the same study (i.e. life histories and thematic analysis). Its role as an inquiry method in its own right may be somewhat obscured by its versatility in other areas of the profession.

Second Wave of Quantitative Methods to Support Ways of Knowing (c1990 – c2002)

Following the introduction of qualitative methods to mental health occupational therapy, a second wave brought the two most scientifically robust quantitative methods into use. Mental health occupational therapy began to use randomized controlled trials over a decade after they were first seen in the profession, however it was an early adopter of systematic reviews. The discrepancy in time scale between these two methods clearly shows that systematic reviews in
mental health occupational therapy are based on evidence originating from outside of the profession. The implications of this will be explored later in the thesis.

Table D4
*Second Wave of Quantitative Methods to Support Ways of Knowing (c1988 – c2002)*

<table>
<thead>
<tr>
<th>Method</th>
<th>Occupational Therapy (circa)</th>
<th>Mental Health Occupational Therapy (circa)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Systematic reviews</td>
<td>(Fisher, Wietlisbach, &amp; Wilbarger, 1988)</td>
<td>(Tullis &amp; Nicol, 1999)</td>
</tr>
<tr>
<td>Randomised controlled trials</td>
<td>(Jongbloed, Stacey, &amp; Brighton, 1989)</td>
<td>(Kashner et al., 2002)</td>
</tr>
</tbody>
</table>

**Systematic reviews.** Systematic reviews offer an overview of primary studies, completed to an explicit and reproducible method (Greenhalgh, 2006). Systematic reviews focus on interventions and their outcomes for particular populations, including both experimental and observational studies. In some systematic reviews, a specific method to integrate the studies is used. Meta analysis is the statistical integration of several quantitative studies which all address the same research question (Greenhalgh, 2006). A related method (called meta synthesis) has also been developed for qualitative studies, and found to be appropriate to the needs of occupational therapy (Gewurtz, Stergiou-Kita, Shaw, Kirsh, & Rappolt, 2008). No examples of systematic reviews supporting a theoretical way of knowing in mental health occupational therapy were found in this thesis. However, systematic reviews could support an evidentiary way of knowing by providing an evaluation of education and strategies used to support carers of people with Alzheimer’s Disease (Thinnes & Padilla, 2011). Systematic reviews can also be used to support a practice way of knowing by evaluating strategies used to promote recruitment and retention for occupational therapists in mental health (Hunter & Nicol, 2002).

There are many advantages to this approach including the limiting of bias, greater reliability and the integration of large amounts of information. Systematic reviews are potentially more applicable to practice because they review a range of
studies, and can draw from research conducted around the world. Like literature reviews, systematic reviews also have the advantage of making a body of evidence easily accessible to clinicians, saving time and effort on their behalf. These advantages have led to this method being recognized as the strongest form of evidence available on scientific hierarchies.

However, in occupational therapy the use of this method severely reduces the body of evidence considered, due to the paucity of randomized controlled trials. The process of systematic review is also very complex, and in practice too time consuming for clinicians. This is compounded by the necessity of regularly updating these reviews. While there are several standards or guidelines available around how to conduct systematic reviews (e.g. PRISMA, SPIDER), none of these are universally accepted so there remains variability in how this method is applied.

In the past decade, there have been increasing calls for more systematic reviews to be published in occupational therapy. Massy-Westropp and Masters (2003) highlighted the challenges of using this method in an occupational therapy department. They found clinicians found it difficult to understand both the research being reviewed and the process, and that a project officer needed to be appointed for successful completion of the review. The limitations of systematic reviews in addressing complex interventions (which include the majority of mental health occupational therapy) has also been raised in discussions on their suitability for the profession (Shepherd, 2009; Murphy, Robinson, & Lin, 2009).

The recent literature on systematic reviews in occupational therapy has focused on how they are completed (Bannigan & Spring, 2012; Murphy et al., 2009; Palisano, 2008), including tools to support this process (Classen et al., 2008). The American Association of Occupational Therapy has also published a series of methodologies for systematic reviews, as part of its evidence based practice project (Arbesman & Lieberman, 2010, 2011, 2012; Arbesman, Lieberman, & Berlanstein, 2013; Arbesman, Lieberman, & Thomas, 2011). Murphy et al. (2009) have suggested including non-randomised studies as a means of overcoming the paucity of randomized studies in occupational therapy. However, other sources retain the traditional standard of randomized controlled trials only, which necessarily requires the majority of data to come from outside of the profession. The variability in understanding about systematic reviews in occupational therapy is highlighted by a discrepancy between this thesis
(which has identified twenty systematic reviews in mental health occupational therapy) and Bannigan and Spring (2012) (who have identified only four).

**Randomised Controlled Trials.** Randomised controlled trials (also known as experimental studies) examine the influence of specific interventions on outcomes by providing it to one randomly assigned group while withholding it from another randomly assigned group (Creswell, 1998). No examples of randomized controlled trials supporting a theoretical way of knowing in mental health occupational therapy were found for the period of time examined in this thesis. However, randomised controlled trials could support an evidentiary way of knowing by investigating the occupational engagement and adaptation of people with dementia (Lee et al., 2006). Randomised controlled trials can also be used to support a practice way of knowing by investigating a decision training aid used for referral prioritization (Harries, Tomlinson, Notley, Davies, & Gilhooly, 2012).

**Mixed Methods to Support Ways of Knowing (c1992 – c2003)**

Despite their different philosophies, there are clearly areas of overlap between quantitative and qualitative research. Subjectivity can be found within hypothesis driven projects, as the researcher must make subjective judgments about which variables to observe (Hyde, 2004). Both quantitative and qualitative data have their own repertoire of tools for analysis, but these are not mutually exclusive (Johnson & Waterfield, 2004). For example - numerical analysis is used in qualitative research to develop themes and verify the frequency of experiences. Such melding of practices enables some interdependency between the approaches, allowing them to be combined in certain circumstances.

‘Mixed method’ research methods are becoming increasingly prevalent, with Mortenson and Oliffe (2009) finding they are now relatively common in occupational therapy research. Each approach is said to be instrumental at different points in the process of acquiring knowledge. Formats for combination include sequential, parallel/simultaneous, equivalent status or more/less dominant studies (Rudestam & Newton, 2001). Potential benefits from a mixed methods method include compensation for the relative weaknesses of quantitative and qualitative methods, increased validity and providing clients with choice in how they contribute to research projects (Finlay, 1997). However, the fundamental differences in underlying beliefs remain and so any combination of quantitative and qualitative research must be aware of these to prevent inconsistency. Mixed method methods present some challenges, including particular
demands on sole researchers, given the necessity for familiarity and confidence in using a range of analytic methods (Johnson & Onwuegbuzie, 2004). Due to its complexity, this method is also very time consuming, and can be resource intensive depending on the individual methods chosen. Mixed methods are relatively new, and there is no consensus around the ways in which methods can be mixed.

The methods displayed in Table D5 have been classified as mixed methods due to their capacity to be conducted in this way. The consensus methods (nominal group technique and Delphi technique) always use mixed methods, while action research and case studies may be conducted using either or both quantitative and qualitative methods. It is interesting to note that these last two methods are the newcomers to occupational therapy, despite their ability to be conducted using single methods.

Table D5

*Mixed Methods to Support Ways of Knowing (c1983 – c2003)*

<table>
<thead>
<tr>
<th>Method</th>
<th>Occupational Therapy (circa)</th>
<th>Mental Health Occupational Therapy (circa)</th>
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</thead>
<tbody>
<tr>
<td>Consensus techniques</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Delphi technique</td>
<td>(Dulcy, 1983)</td>
<td>(Emery &amp; Huebner, 1996)</td>
</tr>
<tr>
<td>Nominal group technique</td>
<td>(Twible, 1992)</td>
<td>(Jensen, 1997)</td>
</tr>
<tr>
<td>Action research</td>
<td>(Mattingly &amp; Gillette, 1991)</td>
<td>(E. Townsend, Birch, Langley, &amp; Langille, 2000)</td>
</tr>
<tr>
<td>Case studies</td>
<td>(Burton &amp; Southam, 1993)</td>
<td>(Cook, 2003)</td>
</tr>
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</table>

**Consensus techniques.** Consensus techniques are those that are used to gain agreement amongst a group of experts, be they clinicians or academics. The two consensus techniques used in occupational therapy literature are nominal group technique and Delphi technique. Nominal group technique allows for both individual idea generation and group discussion, usually conducted through a face to face meeting (Steward, 2001). Delphi technique is also a panel research technique, which occurs remotely and does not allow for discussion of responses amongst participants (Beukes,
Both techniques combine collection of qualitative data with quantitative data derived from voting or prioritization. For example: consensus techniques can support a theoretical way of knowing in mental health occupational therapy, by providing an updated definition of a concept (Sumson, 2000). Consensus techniques could support an evidentiary way of knowing by delineating occupational therapy research priorities in mental health (Bissett, Cusick, & Adamson, 2001). Consensus techniques can also be used to support a practice way of knowing by identify quality process indicators in services for people with dementia (Kroger et al., 2007).

Nominal group technique allows for clarification of questions and responses through discussion within the group, however Delphi technique allows the participation of people from a broader geographical area. Apart from these factors, the relative advantages and disadvantages of these techniques are much the same. Both techniques provide opportunities for non-threatening, depersonalize contributions to the process, which enables all members of the group to contribute. They are also relatively low cost, although using Delphi technique remotely may take a longer time. Participants in both groups also get the opportunity to reflect on an issue which is relevant to their practice, which they may find beneficial in itself.

The main drawback to consensus techniques is their reduced ability to get data on poorly defined problems. Unless the facilitator is skilled in seeking clarification and testing that clarification against the views of the group, the results may be unfocused and therefore not applicable to practice. The results of these techniques also do not allow for feedback on why people voted the way they did, which could reveal important insights into the topic at hand. The boundary between these two techniques can also be blurred in hybrid approaches, so that some studies speak of adopting an approach or process rather than a specific technique (Sumson, 1998). As such, a clear description of the method used in each study is required for its quality and rigour to be assessed.

**Action research.** Action research is an approach which aims to achieve change through practically relevant research (Townsend, 2013). Action research follows a generally cyclical process of reflection, planning, action and observation (REF). This can include a wide range of approaches, although a particularly prevalent method in mental health is participatory action research, which is particularly focused on power relations and equality for people in marginalized communities (Cockburn & Trentham, 2002). For example: action research can support a theoretical way of knowing in mental health occupational therapy by investigation the implementation of a particular
theoretical framework from the perspective of clinicians (Wimpenny, Forsyth, Jones, Matheson, & Colley, 2010). Action research could support an evidentiary way of knowing by exploring social networks in the context of the modernization of mental health services (Bryant, Vacher, Beresford, & McKay, 2010). Consensus techniques can also be used to support a practice way of knowing by exploring the social inclusion and community development aspects of a particular service (Fieldhouse, 2012).

Action research focuses on problems that have been identified by the participants, which increases its relevance to lived experience. It also encourages problem solving, and can be instituted as part of regular practice reflection and evaluation activities that are already occurring. Action research can promote ‘reflection in action’ (Schon, 1987), and can contribute to the development of practice theories (Koshy, 2005). However, action research entails the researcher taking on some responsibility for change in addition to their research activities, and this can be derailed if adequate handover plans are not made at the end of the project. There is also the potential for negative role blurring, giving the dual role of research and participant held by all members of the group. Action research also involves a heavy commitment of both time and resources, to both complete the study and facilitate any resulting changes.

**Case studies.** Case studies involve the in depth exploration of a service, incident, activity, process or client (Cresswell, 2006). They differ from case reports in their use of scientific methods, and explore the topic within its real-life context (Salminen, Harra, & Lautamo, 2006). For example: case studies can support a theoretical way of knowing in mental health occupational therapy by providing an example of applying concepts from another discipline into occupational therapy (Schultz-Krohn & Cara, 2000). Case studies could support an evidentiary way of knowing by providing an insight into pet ownership as an enabler of community integration (Zimolag & Krupa, 2010). Case studies can also be used to support a practice way of knowing by investigating the use of smart technology with people experiencing dementia (Evans, Carey-Smith, & Orpwood, 2011).

Case studies are able to explore their topic embedded within its context, which provides a depth of data and understanding that cannot be gained more generalized methods. While exploratory in nature, this method can generate data that leads to hypotheses that can be explored by other methods. This method is relatively easy to apply and is accessible to clinicians, and multiple case studies can be combined to provide more powerful findings. The main disadvantage of case studies are their
individualized nature, which limits generalization. Much also depends on the appropriateness of the case chosen, as it needs to allow for the optimal amount of information to be gathered (Salminen et al., 2006). Despite a long tradition of case reports, there are relatively few case studies in occupational therapy literature.

References


institutional ethnography. *British Journal Of Occupational Therapy, 75*(10), 463-470.


References


Appendix E
Ethics Approvals Received For Portions of This Thesis Involving Research with Human Subjects

DEAKIN UNIVERSITY

Human Ethics Research

Office of Research Integrity
Research Services Division
70 Egan Road Burwood Victoria
Postal 221 Burwood Highway
Burwood Victoria 3125 Australia
Telephone 03 9251 7123 Facsimile 03 9244 6581
research-ethics@deakin.edu.au

Memorandum

To: Dr Genevieve Pepin
   School of Health & Social Development

From: Deakin University Human Research Ethics Committee (DUHREC)

Date: 02 July, 2010

Subject: 2010-127

Trends in theory, education and practice in mental health in occupational therapy in the first decade of the third millennium

Please quote this project number in all future communications

Exemption from Ethics Review was granted for this project on 20/7/2010.

Authorization has been given for Miss Danielle Hitch, under the supervision of Dr Genevieve Pepin, School of Health & Social Development, to undertake this project for the life of the project from 2/07/2010.

This Exemption from Ethics Review is given only for the project as stated in this memo. It is your responsibility to contact the Human Research Ethics Unit, immediately regarding any of the following:

- Any adverse events or events which might affect the continuing ethical acceptability of the project
- All modifications to the research relating to the data or records must be submitted to the Human Research Ethics Unit for review prior to being implemented

In addition, you will be required to report on the progress of your project at least once every year and at the conclusion of the project. You are furthermore required to retain auditable records of the project demonstrating compliance with the National Statement on Ethical Conduct in Human Research (2007) (paragraph 5.2.9) and to produce these if required.

Human Research Ethics Unit
research-ethics@deakin.edu.au
Telephone: 03 9251 7123
Memo

To: Dr Genevieve Pepin  
School of Health and Social Development

From: Secretary – HEAG-H  
Faculty of Health

CC: Danielle Hitch

Date: 11 September, 2012

Re: HEAG-H 1102 2012: Student understandings of the Occupational Perspective of Health

Approval has been given for Dr Genevieve Pepin, School of Health and Social Development, to undertake this project for a period of 1 year from 11 September, 2012 with the following conditions. The approval end date is 11 September 2013.

(i) Identifiers only on questionnaires and not matching to consent form.

The approval given by the Deakin University HEAG - H is given only for the project and for the period as stated in the approval. It is your responsibility to contact the Secretary immediately should any of the following occur:

- Serious or unexpected adverse effects on the participants
- Any proposed changes in the protocol, including extensions of time
- Any events which might affect the continuing ethical acceptability of the project
- The project is discontinued before the expected date of completion
- Modifications that have been requested by other Human Research Ethics Committees

In addition you will be required to report on the progress of your project at least once every year and at the conclusion of the project. Failure to report as required will result in suspension of your approval to proceed with the project.

HEAG-H may need to audit this project as part of the requirements for monitoring set out in the National Statement on Ethical Conduct in Human Research (2007). An Annual Project Report Form can be found at http://www.deakin.edu.au/humsps/research/ethics/ethicssubmissionprocess.php which you will be required to complete in relation to this research. This should be completed and returned to the Administrative Officer to the HEAG-H, Pro-Vice Chancellor’s office, Faculty of Health, Burwood campus by Tuesday 20th November, 2012 and when the project is completed.
Good luck with the project!

Signature Redacted by Library

Steven Sawyer

Secretary
HEAG-H
Appendix F

Matrices map the constructs of conceptual practice models used in case studies to doing, being, becoming and belonging.
### Jack - Occupational Adaptation (Bouteloup & Beltran, 2007)

<table>
<thead>
<tr>
<th>Person System</th>
<th>Performance Components</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sensorimotor, cognitive, psychosocial</td>
<td>Genetic, environmental, experiential</td>
</tr>
<tr>
<td><strong>Doing</strong></td>
<td><strong>Work, play and self care</strong></td>
</tr>
<tr>
<td>Difficulties with visual pursuit</td>
<td>Low SES has reduced access to resources to support his doing</td>
</tr>
<tr>
<td>Avoids crossing midline</td>
<td>Performs chores to pocket money</td>
</tr>
<tr>
<td>Delayed motor planning and sequencing</td>
<td>Attends school, due to transition to high school</td>
</tr>
<tr>
<td>Uncoordinated gross and fine motor</td>
<td>Independent for self care tasks</td>
</tr>
<tr>
<td></td>
<td>Reducing his use of violence to settle issues</td>
</tr>
<tr>
<td><strong>Being</strong></td>
<td>Student role involves participation in a range of occupations</td>
</tr>
<tr>
<td>Eyes sore after eye movement screening</td>
<td>Keen interest in Star Trek</td>
</tr>
<tr>
<td>Mixed dominance</td>
<td>Confident in self care tasks</td>
</tr>
<tr>
<td>Poor proprioception</td>
<td>Improved motivation and confidence to write</td>
</tr>
<tr>
<td>Good balance, tone and visual perceptive skills</td>
<td></td>
</tr>
<tr>
<td>Intellectual difficulties</td>
<td></td>
</tr>
<tr>
<td></td>
<td>No longer a victim of bullying</td>
</tr>
<tr>
<td></td>
<td>Encouraged to make choices as part of his therapy</td>
</tr>
<tr>
<td>Becoming</td>
<td>Tends to avoid task he has difficulties with, and reluctant to persist. Has reduced violent outburst and improved emotional control. Aim to continue this and work on compliance with instructions.</td>
</tr>
<tr>
<td>----------</td>
<td>-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Belonging</td>
<td>Nursing staff identified issues with academic skills, but not with his mother.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Wants to repeat Year 7</th>
<th>Would like to be better at writing. Building on existing skills (i.e. tying shoe laces). Enthusiastic about writing when it’s about his interests.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Several friends at school with whom he plays. Difficulties playing with siblings due to rapid escalations to violence.</td>
<td>Lives with his mother and older sibling. Financially and materially under resourced family. Client of CAMHS team for some years. Plays with friends his age at school. School has expectations of performance.</td>
</tr>
</tbody>
</table>
Clients in forensic hostel – Canadian Model of Occupational Performance (Clarke, 2003)

<table>
<thead>
<tr>
<th>Occupational Performance</th>
<th>Performance Components</th>
<th>Environment</th>
<th>Spirituality</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doing</td>
<td>Identifying and prioritising the aims of intervention</td>
<td>Identifying the performance components that contribute to performance problems</td>
<td>Identifying the environmental components that contribute to performance problems</td>
</tr>
<tr>
<td></td>
<td>Difficulties with self care, productivity and leisure</td>
<td>Detailed activity analysis</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Protocols for group and individual activities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Being</td>
<td>Residents as experts in their needs</td>
<td>Unique strengths of resident and therapist identified</td>
<td>Residents identify a sense of self, of value and importance to them.</td>
</tr>
<tr>
<td></td>
<td>Improved engagement in therapeutic interventions</td>
<td>Increased feelings of empowerment, autonomy and satisfaction.</td>
<td>Highlighting of individual strengths</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Improved motivation and treatment compliance.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Not appropriate for clients with cognitive dysfunction or unstable mental state</td>
<td></td>
</tr>
<tr>
<td>Becoming</td>
<td>Setting of client-led goals</td>
<td>Action plans formulated to work on performance</td>
<td>Action plans formulated to work on performance</td>
</tr>
<tr>
<td>Belonging</td>
<td>Occupations needed to reintegrate residents into the community</td>
<td>Strengths within the community identified and needs of people with mental health problems and offending behaviour</td>
<td>Highlighting of individual resources</td>
</tr>
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</tr>
<tr>
<td></td>
<td></td>
<td>Sub-culture of people with mental health problems and offending behaviour</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Needing to re-integrate into society and re-establish social networks</td>
<td></td>
</tr>
</tbody>
</table>
### William - Non-linear Dynamic Theory (Haltiwanger, 2007)

<table>
<thead>
<tr>
<th>Doing</th>
<th>Macrosopic (Perception)</th>
<th>Mesoscopic (Meaning)</th>
<th>Microscopic (Intention)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Improved function through detoxification and recovery</td>
<td>Formation of new habitual patterns</td>
<td>Delegation of unpleasant tasks to secretary</td>
</tr>
<tr>
<td>Being</td>
<td>“I can’t file my taxes. I can’t face my challenges. I am a failure”</td>
<td>“There is no meaning in my job. I do not want to think about what I have lost”</td>
<td>Not accounted for during his previous hospital admissions</td>
</tr>
<tr>
<td></td>
<td>Severe depression</td>
<td></td>
<td>Previous experiences.</td>
</tr>
<tr>
<td></td>
<td>Alcohol use</td>
<td>Formation of new behavioural patterns</td>
<td>Subcortical emotions.</td>
</tr>
<tr>
<td></td>
<td>Fears of disapproval, accepting responsibility, exposing his inadequacies, embarrassment and failure.</td>
<td>Life roles as a husband, father and work supervisor</td>
<td>Chemical changes to brain due to alcohol use.</td>
</tr>
<tr>
<td></td>
<td>Greater self belief</td>
<td>Finding of greater meaning by having a purpose in life.</td>
<td></td>
</tr>
<tr>
<td>Becoming</td>
<td>Putting off dealing with major life issues</td>
<td>“I can return to my habituation of supervision people at a new level”</td>
<td>Ongoing chemical changes due to detoxification.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Goals as a future reference point</td>
<td>Enables the seeing of new goals.</td>
</tr>
<tr>
<td>Belonging</td>
<td>Therapist perturbs by challenging his belief</td>
<td>Volunteered as a construction supervisor for a housing programme</td>
<td>Active in the Alcoholics Anonymous community, mentoring newly recovered alcoholics</td>
</tr>
</tbody>
</table>
### Sharon - Collaborative Therapeutic Homework Model (Luboshitzsky & Gaber. 2000)

<table>
<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td>Doing</td>
<td>Unemployed</td>
<td>One to one therapy, three times a week for 30 minutes per session.</td>
<td>Cleaning and arranging apartment prioritized as most important</td>
<td>Task analysis Systematic repetitive graded activity</td>
<td>Evaluation of performance of homework tasks</td>
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<tr>
<td>Personal neglect</td>
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<tr>
<td>Decreased function in the home</td>
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<tr>
<td>Good motor skills</td>
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<tr>
<td>Being</td>
<td>Hx negative schizophrenia symptoms</td>
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<tr>
<td>Deteriorated emotional state</td>
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<tr>
<td>Excessive tension</td>
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<tr>
<td>Interests in lectures, films and reading</td>
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<tr>
<td>Processing problems with using knowledge, temporal organization and use of space and objects</td>
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<tr>
<td>Most satisfying activities were going to a movie and/or lecture</td>
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<tr>
<td>Developing self control and self monitoring techniques</td>
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<tr>
<td>Stated life is more meaningful than ever.</td>
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<tr>
<td>Development of problem solving strategies</td>
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<tr>
<td>Becoming</td>
<td>Five goals set – improved domestic function, improved self care, commencing 1-2 leisure activities, improved social function</td>
<td>Re-evaluation of goals</td>
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<tr>
<td>Belonging Repeated</td>
<td>hospitalizations Mother Hx schizophrenia, so little support Avoiding all contact with authorities Socially isolated</td>
<td>Asking of advice and help from others regarding self care and presentation Called friend and arranged to see movie together Focused on interpersonal relationships with family</td>
<td></td>
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</tbody>
</table>
Key: 1) careful identification of the clients problems, 2) goal setting using behavioural terms, 3) contractual agreement between therapist and client, 4) ranking of goals to ensure the first one addressed makes the most difference to the client and is the most feasible, 5) selection of an acceptable form of skills training for the client, 6) systemic skill and behavioural training using homework task
<table>
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<tbody>
<tr>
<td><strong>Doing</strong></td>
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<td><strong>Being</strong></td>
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<tr>
<td><strong>Becoming</strong></td>
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<tr>
<td><strong>Belonging</strong></td>
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<tr>
<td>Ms. L – Model of Human Occupation (Pizur-Barnekow &amp; Erickson, 2011)</td>
</tr>
<tr>
<td>---------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>Performance</strong></td>
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<tr>
<td><strong>Doing</strong></td>
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<td></td>
</tr>
<tr>
<td><strong>Being</strong></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td><strong>Becoming</strong></td>
</tr>
<tr>
<td><strong>Belonging</strong></td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>
Appendix G

Databases searched for evidentiary ways of knowing

Academic Search Complete
AgeLine
AHFS Consumer Medication Information
AMED - The Allied and Complementary Medicine Database
America: History and Life with Full Text
Applied Science & Technology Full Text (H.W. Wilson)
Applied Science & Technology Source
Art & Architecture Complete
Art Source
Avery Index to Architectural Periodicals
Business Source Complete
CINAHL Complete
Communication & Mass Media Complete
Computers & Applied Sciences Complete
Criminal Justice Abstracts with Full Text
eBook Academic Collection (EBSCOhost)
eBook Collection (EBSCOhost)
EconLit
Education Research Complete
Education Source
E-Journals
Environment Complete
ERIC
European Views of the Americas: 1493 to 1750
Garden, Landscape & Horticulture Index
Global Health
GreenFILE
Health Business Elite
Health Policy Reference Center
Health Source - Consumer Edition
Health Source: Nursing/Academic Edition
APPENDIX G: DATABASES SEARCHED

Historical Abstracts with Full Text
Humanities International Complete
Humanities Source
International Bibliography of Theatre & Dance with Full Text
Jewish Studies Source
Legal Source
LGBT Life with Full Text
Library & Information Science Source
Library, Information Science & Technology Abstracts
MAS Ultra - School Edition
MasterFILE Premier
MEDLINE
MEDLINE Complete
Mental Measurements Yearbook
MLA Directory of Periodicals
MLA International Bibliography
News (AP, UPI, etc.)
Newspaper Source Plus
OTDBase
Philosopher's Index
Political Science Complete
PsycARTICLES
PsycBOOKS
PsycEXTRA
Psychology and Behavioral Sciences Collection
PsycINFO
PsycTESTS
Regional Business News
Religion and Philosophy Collection
Scirus
Scopus
Social Work Abstracts
SocINDEX with Full Text
SPORTDiscus with Full Text
APPENDIX G: DATABASES SEARCHED

The Serials Directory
Urban Studies Abstracts
Web News
# Appendix H

Peer review journals containing articles identified in this thesis

<table>
<thead>
<tr>
<th>OT Journal</th>
<th>Non OT Journal</th>
</tr>
</thead>
<tbody>
<tr>
<td>American Journal of Occupational Therapy</td>
<td>A Life in the Day</td>
</tr>
<tr>
<td>Australian Occupational Therapy Journal</td>
<td>Academic Psychiatry</td>
</tr>
<tr>
<td>British Journal of Occupational Therapy</td>
<td>Acta Neurologica Scandinavica</td>
</tr>
<tr>
<td>Canadian Journal of Occupational Therapy</td>
<td>Acta Psychiatrica Scandinavica</td>
</tr>
<tr>
<td>Hong Kong Journal of Occupational Therapy</td>
<td>Activities, Adaptation &amp; Aging</td>
</tr>
<tr>
<td>Indian Journal of Occupational Therapy</td>
<td>Adapted Physical Activity Quarterly</td>
</tr>
<tr>
<td>Irish Journal of Occupational Therapy</td>
<td>Administration and Policy in Mental Health</td>
</tr>
<tr>
<td>Israel Journal of Occupational Therapy</td>
<td>Administration and Policy in Mental Health</td>
</tr>
<tr>
<td>Journal of Occupational Science</td>
<td>Adolescent Psychiatry</td>
</tr>
<tr>
<td>Journal of Occupational Therapy, Schools, &amp; Early Intervention</td>
<td>Advances in Mental Health</td>
</tr>
<tr>
<td>Mental Health</td>
<td>AeJAMH (Australian e-Journal for the Advancement of Mental Health)</td>
</tr>
<tr>
<td>New Zealand Journal of Occupational Therapy</td>
<td>Age and Ageing</td>
</tr>
<tr>
<td>Occupational Therapy in Health Care</td>
<td>Aging &amp; Mental Health</td>
</tr>
<tr>
<td>Occupational Therapy in Mental Health</td>
<td>Alzheimer Disease &amp; Associated Disorders</td>
</tr>
<tr>
<td>Occupational Therapy International</td>
<td>Alzheimer's &amp; Dementia</td>
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</tr>
<tr>
<td>Occupational Therapy Journal of Research</td>
<td>Alzheimer's Care Quarterly</td>
</tr>
<tr>
<td>Physical &amp; Occupational Therapy in Geriatrics</td>
<td>Alzheimer's Care Today</td>
</tr>
<tr>
<td>Physical &amp; Occupational Therapy in Pediatrics</td>
<td>American Journal of Alzheimer's Disease and Other dementias</td>
</tr>
<tr>
<td>Scandinavian Journal of Occupational Therapy</td>
<td>American Journal of Evaluation</td>
</tr>
<tr>
<td>WFOT Bulletin</td>
<td>American Journal on Mental Retardation</td>
</tr>
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<td></td>
<td>Annals of Leisure Research</td>
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<tr>
<td></td>
<td>Archives of Clinical Neuropsychology</td>
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<td></td>
<td>Art Therapy: Journal of the American Art Therapy Association</td>
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<td></td>
<td>Asia Pacific Disability Rehabilitation Journal</td>
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<td></td>
<td>Assistive Technology</td>
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<td></td>
<td>Australasian Journal on Ageing</td>
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<td></td>
<td>Australasian Psychiatry</td>
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<tr>
<td></td>
<td>Australian &amp; New Zealand Journal of Psychiatry</td>
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<tr>
<td></td>
<td>Autism</td>
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<tr>
<td></td>
<td>Autism Research</td>
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<tr>
<td></td>
<td>Autism Research and Treatment</td>
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<tr>
<td></td>
<td>Autism: The International Journal of Research &amp; Practice</td>
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<tr>
<td></td>
<td>Behavioral and Cognitive Psychotherapy</td>
</tr>
<tr>
<td></td>
<td>Behaviour Change</td>
</tr>
<tr>
<td></td>
<td>Biological Psychiatry</td>
</tr>
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<td></td>
<td>Bipolar Disorders</td>
</tr>
</tbody>
</table>
BMC Geriatrics
BMC Health Services Research
BMC Medical Education
BMC Public Health
BMJ Open
BMJ: British Medical Journal
(International Edition)
BMJ: British Medical Journal (Overseas & Retired Doctors Edition)
Brain & Development
Brain Injury
Brain Research
British Journal of Forensic Practice
British Journal of General Care
British Journal of Psychiatry
British Journal of Social Work
British Journal of Therapy & Rehabilitation
Canadian Child and Adolescent Psychiatry
Canadian Family Physician
Canadian Journal of Community Mental Health
Canadian Journal of Psychiatry
Canadian Journal on Aging/La Revue canadienne du vieillissement
Canadian Public Policy
Chang Gung Medical Journal
Chronic Illness
CJNR: Canadian Journal of Nursing Research
Clinical Gerontologist: The Journal of Aging and Mental Health
Clinical Neuropsychologist
Clinical Psychology & Psychotherapy
Clinical Rehabilitation
Clinical Supervisor
CMAJ: Canadian Medical Association Journal
Cochrane Library
Community Development Journal
Community Mental Health Journal
Comprehensive Psychiatry
Counselling & Psychotherapy Research
Current Opinion in Psychiatry
CyberPsychology & Behavior
Cyberpsychology, Behavior, and Social Networking
Dementia
Dementia & Neuropsychologica
Dementia and Geriatric Cognitive Disorders
Developmental Medicine & Child Neurology
Disability & Rehabilitation: Assistive Technology
Disability & Society
Disability and Rehabilitation
East Asian Archives of Psychiatry
Education and Training in Developmental Disabilities
Ergonomics and Health Aspects of Work with Computers
European Archives of Psychiatry & Clinical Neuroscience
European Child & Adolescent Psychiatry
European Eating Disorders Review
European Journal of Neurology
European Psychiatry
Evidence Based Medicine
Focus on Autism and Other Developmental Disabilities
Frontiers in Integrative Neuroscience
Geriatrics & Gerontology International
Gerontechnology
Gerontology & Geriatrics Education
GeroPsych: The Journal of Gerontopsychology and Geriatric Psychiatry
Health & Social Care in the Community
Health and Quality of Life Outcomes
Health Care for Women International
Health Services Management Research
Health Sociology Review
Hong Kong Journal of Psychiatry
Industrial Health
Infant Mental Health Journal
Infants & Young Children
International Journal of Rehabilitation Research
International Journal of Forensic Mental Health
International Journal of Geriatric Psychiatry
International Journal Of Group Psychotherapy
International Journal of Japanese Sociology
International Journal of Mental Health Nursing
International Journal of Methods in Psychiatric Research
International Journal of Psychiatry in Clinical Practice
International Journal of Psychiatry in Medicine
International Journal of Psychosocial Rehabilitation
International Journal of Qualitative Studies on Health and Well-being
International Journal of Rehabilitation Research
International Journal of Social Psychiatry
International Journal of Therapy and Rehabilitation
International Psychogeriatrics
Issues in Comprehensive Pediatric Nursing
Issues in Mental Health Nursing
Journal of Adolescence
Journal of Advanced Nursing
Journal of Affective Disorders
Journal of Aging Research
Journal of Aging Studies
Journal of Allied Health
Journal of Applied Arts & Health
Journal of Attention Disorders
Journal of Autism & Developmental Disorders
Journal of Behavior Therapy and Experimental Psychiatry
Journal of Behavioral Health Services & Research
Journal of Child Neurology
Journal of Child Psychology & Psychiatry
Journal of Child Sexual Abuse: Research, Treatment, & Program Innovations for Victims, Survivors, & Offenders
Journal of Dementia Care
Journal of dental research
Journal of Dual Diagnosis
Journal of Evaluation in Clinical Practice
Journal of Gay & Lesbian Social Services
Journal of Human Genetics
Journal of Interpersonal Violence
Journal of Mental Health
Journal of Multidisciplinary Healthcare
Journal of Nervous & Mental Disease
Journal of Neural Transmission
Journal of Neurotherapy
Journal of Paediatrics & Child Health
Journal of Primary Prevention
Journal of Psychiatric & Mental Health Nursing
Journal of Psychiatric Intensive Care
Journal of Psychology: Interdisciplinary and Applied
Journal of Psychotherapy in Independent Practice
Journal of Rehabilitation
Journal of Religion and Health
Journal of Sport & Exercise Psychology
Journal of Telemedicine & Telecare
Journal of the American Academy of Child & Adolescent Psychiatry
Journal of the American Geriatrics Society
Journal of the American Medical Directors Association
Journal of Trauma & Dissociation
Journal of Undergraduate Research
Journal of Vocational Rehabilitation
Journal of Youth & Adolescence
Journals of Gerontology Series B: Psychological Sciences & Social Sciences
Kaosiung Journal of Medical Sciences
Kobe Journal of Medical Science
Learning in Health & Social Care
Leisure/Loisir
Les comorbidités psychiatriques chez les adolescents souffrant du trouble d'hyperactivité avec déficit de l'att
Macau Journal of Nursing
Medical Decision Making
Medical Journal of Australia
Medicine, Health Care and Philosophy
Mental Health & Social Inclusion
Mental Health in Family Medicine
Mental Health Practice
Mental Health Review Journal
Mental Health, Religion & Culture
Mental Illness
Music Therapy Perspectives
Nagoya Journal of Medical Sciences
Neuropsychobiology
Neuropsychological Rehabilitation
Neuroscience Research
Nordic Journal of Psychiatry
Nurse Education in Practice
Nursing & Residential Care
Pediatric Physical Therapy
Perceptual & Motor Skills
Personality and Mental Health
Perspectives on School-Based Issues
Primary Care Mental Health
Professional Case Management
Progress in Neurology and Psychiatry
Progress in Neuro-Psychopharmacology & Biological Psychiatry
Psychiatria Danubina
Psychiatric Bulletin
Psychiatric Rehabilitation Journal
Psychiatric Rehabilitation Skills
Psychiatric Services
Psychiatry & Clinical Neurosciences
Psychiatry Research
Psychiatry: Interpersonal & Biological Processes
Psychogeriatrics
Psychological Assessment
Psychology and psychotherapy: Theory, research and practice
Psychophysiology
Psychosis
Qualitative Health Research
Quality of Life Research
Reflective Practice
Research in Autism Spectrum Disorders
Research in Developmental Disabilities
Residential Treatment for Children & Youth
Revista Brasileira de Psiquiatria
Revista da Escola de Enfermagem da USP
Scandinavian Journal of Caring Sciences
Scandinavian Journal of Disability Research
Schizophrenia Bulletin
Schizophrenia Research
Social Cognitive & Affective Neuroscience
Social Indicators Research
Social Psychiatry & Psychiatric Epidemiology
Stress & Health: Journal of the International Society for the Investigation of Stress
Substance Abuse
Substance Use & Misuse
Technology & Disability
The Canadian Alzheimer's Disease Review
The Gerontologist
The International Journal of Aging and Human Development
The International Journal of Mental Health Promotion
The Internet Journal of Allied Health Sciences and Practice
The Journal of Alternative and Complementary Medicine
The Journal of Nervous and Mental Disease
The Journal of Primary Prevention
The Journal of Social Psychology
The Journals of Gerontology Series A: Biological Sciences and Medical Sciences
Therapeutic Recreation Journal
Topics in Geriatric Rehabilitation
Topics in Language Disorders
Trials
Appendix I
Articles about intervention for each sub-category

Table II
*Articles about personality/behaviour diagnoses and schizophrenia by year*

<table>
<thead>
<tr>
<th>Year</th>
<th>Personality/Behaviour</th>
<th>Schizophrenia</th>
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<tbody>
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<tr>
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<td>2011</td>
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<tr>
<td>2012</td>
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</table>
Table I2
Articles about mood and organic diagnoses by year

Table I3
Articles about child and adolescent, and drug and alcohol diagnoses by year
Table I4

*Articles about ambiguous and anxiety diagnoses by year*
Appendix J
Articles about lived experience for each sub-category

Table J1
Articles about lived experience for people with personality / behaviour diagnoses and schizophrenia by year

Table J2
Articles about lived experience for people with child and adolescent, and organic diagnoses by year
Table J3

*Articles about lived experience for people with mood and anxiety diagnoses by year*

![Graph showing articles about mood and anxiety diagnoses by year from 2000 to 2012.](image1)

Table J4

*Articles about lived experience for people with drug and alcohol, and personality / behaviour diagnoses by year*

![Graph showing articles about drug and alcohol, and personality / behaviour diagnoses by year from 2000 to 2012.](image2)
Appendix K

Articles about programs for each sub-category

Table K1

*Articles about adult, and child and adolescent programs by year*

Table K2

*Articles about forensic and older adults programs by year*
Table K3

*Articles about private and vocational programs by year*
Appendix L

Methods Used To Support the Three Ways of Knowing In Mental Health OT

<table>
<thead>
<tr>
<th>Type of Evidence</th>
<th>Method</th>
<th>No. of studies</th>
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<td>Pre-post</td>
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<td></td>
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<td>Logic Model</td>
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<td>Cost Effectiveness</td>
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<tr>
<td>Interpretative Biography</td>
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</table>
### Survey One

This part of the survey is asked about your understanding of theoretical models in occupational therapy. Thinking back over your studies as an occupational therapy student, please the top five models you feel you have been exposed to. On a scale of 1-10 (with 1 being ‘no understanding’ and 10 being ‘excellent understanding’), how would you rate your current understanding of them.

<table>
<thead>
<tr>
<th>Understanding</th>
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Now we are interested in understanding how confident you feel in applying these models to practice. For the same five models you identified above, please rate your current confidence in their use. The scale remains 1-10, but this time 1 is ‘no confidence’ and 10 is ‘complete confidence’.

<table>
<thead>
<tr>
<th>Confidence</th>
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This part of the survey is about the Occupational Perspective of Health, also known as Wilcock’s model. Please answer the following questions to the best of your ability, and ask questions if you’d like more information.
On a scale of 1-10 (with 1 being ‘no understanding’ and 10 being ‘excellent understanding’), how would you rate your current understanding of:

<table>
<thead>
<tr>
<th>Understanding</th>
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<tbody>
<tr>
<td>The Occupational Perspective of Health as a whole</td>
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<td>How these dimensions interact and influence each other</td>
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<td>How the Occupational Perspective of Health relates to practice</td>
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Now we are interested in understanding how confident you feel in applying this particular model to practice. Please rate your current confidence in its use, with 1 being ‘no confidence’ and 10 being ‘complete confidence’.

<table>
<thead>
<tr>
<th>Confidence</th>
<th>1</th>
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You will be aware of the topic of the lecture today, and had the opportunity to see the presentation on DSO. Briefly, can you describe why you have attended the lecture today, and what you are hoping to get out of it?

Thank you.
Survey Two

Given the lecture you have just heard, we would like you to re-rate your understanding of Wilcock’s model, as presented in the DB3 format. On a scale of 1-10 (with 1 being ‘no understanding’ and 10 being ‘excellent understanding’), how would you rate your current understanding of;

<table>
<thead>
<tr>
<th>Understanding</th>
<th>1</th>
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<tr>
<td>The Occupational Perspective of Health as a whole</td>
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<td>How these dimensions interact and influence each other</td>
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<td>How the Occupational Perspective of Health relates to practice</td>
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</table>

Now we are interested in understanding how confident you feel in applying this particular model to practice. Please rate your current confidence in its use, with 1 being ‘no confidence’ and 10 being ‘complete confidence’.

<table>
<thead>
<tr>
<th>Confidence</th>
<th>1</th>
<th>2</th>
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</tbody>
</table>

How relevant do you think this theory is to the identity of occupational therapy as a profession. Please rate your current confidence in its use, with 1 being ‘not at all relevant’ and 10 being ‘completely relevant’.

<table>
<thead>
<tr>
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<th>1</th>
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</tbody>
</table>
In terms of how the model was presented and explained, which three aspects of this format did you most like or connect with?

1.

2.

3.

Conversely, which three aspects of this format did you least like or connect with?

1.

2.

3.

Do you have any other comments you’d like to make on this lecture or the topic?
Thank you.
Appendix N

Lecture: The Professional Identity of Occupational Therapy: Who are We and What Do We Stand For?
THE PROFESSIONAL IDENTITY OF OCCUPATIONAL THERAPY:

WHO ARE WE AND WHAT DO WE STAND FOR?

Danielle Hitch
Tuesday September 11th, 2012

THIS LECTURE WILL …
• Outline a critical analysis of the professional identity of occupational therapy
• Propose the Occupational Perspective of Health as a framework for this identity
• Present the latest iteration of the OPH – The Pan Occupational Paradigm (POP)
A NON-LINEAR MODEL OF CRITICAL ANALYSIS

- **DESCRIPTION**
  - Set of beliefs, attitudes and understanding about your role, within the context of work \(^1\)
  - Our identity has been questioned – how are we distinguished from PTs or SWs? \(^2\)
  - We lack confidence, and see power as repressive rather than something we should seek \(^3\)

- **ANALYSIS**
  - How
  - Why
  - What
  - If?
  - So what?
  - What next?

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DESCRIPTION

• **Who** is affected? **Who** might be interested?
  – OTs but also those who work with and refer to them
• **When** does this occur?
  – Whenever and wherever OT’s engage in their work role

IDENTITIES ARE CONSTRUCTED IN DIFFERENT WAYS

• Fourth year placement - palliative care client, who passed away during the placement
• Eureka moment – it all came together when using theory to frame my debrief with my supervisor
• That sense of ‘I get it’ has guided my professional identity ever since
WHAT DO YOU THINK?

Who are we and what do we stand for?

ANALYSIS

• **How** does it work – in theory/practice?
  – Assumption: Theory is the basis of our professional identity and directly influences practice
  – Three levels of theory in OT (paradigm, conceptual practice models and theories)
## APPENDIX N: SURVEYS

### A PARADIGM OF OT

**Why** this argument/theory/suggestion/solution?  
**Why not** something else?  
- The Occupational Perspective of Health (OPH) is the only current theory of OT that operates at the level of a paradigm  
- Broad assumptions, no technology or guidelines for treatment, addresses beliefs and values
OPH

• Developed by Ann Wilcock, who had a leading hand in the development of this school
• Used history of ideas to explore the role of occupation in human life across time and disciplines
• Not confined to OT, many disciplines included in history

OPH

• Equal weight to health and illness
• Occupation is at the centre of everything
• Occupation is essential to healthy living and wellness
OPH

- Context of occupation, health and survival
- ‘Healthy survival’ is the primary role of the human brain, which is enacted through engagement with occupation.
- Health / order is achieved (for individuals, communities and populations) when all essential needs are met and capacities (physical, mental and social) are maintained, developed, exercised and in balance.

OPH

- Survival depends on existing in a sustainable relationship with the environment, which enables its ongoing use as a resource and support.
- Illness / disorder therefore occur when needs are unmet, capacities are unfulfilled or environments are exploited or disrespected.
ANALYSIS

• Despite being around for the past 15 years, the OPH remains largely unused in OT
• OT’s refer to doing, being, becoming and belonging, and it appeals on an intuitive level
• Why did this occur? Why was that done (or not)?
FACTORS FOR USE OF OPH

• Accessibility of detailed information
  – Very scholarly, dense work
  – Not written for OT per se, but those who want to go in a more public health direction
  – Pitched at public health, but uses the language of OT. No ongoing research from public health

FACTORS FOR USE OF OPH

• Dichotomous focus on health and illness
  – Might be an artefact of public health focus
  – Wellbeing is spoken of more in the text (physical, mental and social)
  – Inconsistency can introduce confusion and encourage assumptions which may not be relevant
FACTORS FOR USE OF OPH

• Vaguely defined terms
  – No definitions provided for health, illness, wellbeing, doing, being, becoming or belonging
  – Being is particularly hard to grasp. ‘how people feel about what they do’. Only considering the incorporeal aspects of being, Wilcock effectively separates it from the bodily, physical aspects of being

FACTORS FOR USE OF OPH

• Doesn’t reflect the dynamic nature of occupation
  – Current presentation encourages a static / linear approach
  – Unable to capture the flexible, moving nature of these elements
FACTORS FOR USE OF OPH

• Limited cultural basis
  — explicitly developed from a Western perspective, and strongly influenced by a scientific approach
  — all examples are Western European and most are from the Christian tradition
  — expresses a particular OT cultural background

ANALYSIS

• What are the alternatives?
  — There are no other OT paradigms, so only alternative at present is to modify the OPH

• What if this or that factor were added/removed/altered?
POP

• Pan Occupational Paradigm
• Humans are occupational beings and their wellbeing is directly influenced by their occupational engagement
• OT way of knowing about occupation is one perspective amongst many, and that all forms of knowledge generated are of equal value to our understanding

MODIFYING THE OPH

• Accessibility of detailed information
  – Clearer and more accessible format
  – Owning the OT perspective
MODIFYING THE OPH

• Dichotomous focus on health and illness
  – Define these terms
  – Highlight wellbeing along with health

MODIFYING THE OPH

• Vaguely defined terms
  – Along with health/illness/wellbeing, define doing, being, becoming or belonging
  – Critical analysis of all research published referencing OPH, around how the terms are used and have developed
DOING

Doing is the medium through which people engage in occupations, and the skills and abilities needed for doing accumulate across time. Doing involves engaging in occupations which are personally meaningful, but not necessarily purposeful, healthy or organized. Doing involves being actively engaged, either overtly (i.e. observable, physical) or tacitly (i.e. mental, spiritual). Doing follows broadly similar patterns across the population, and humans are able to adapt their doing to greater and lesser degrees according to circumstance.

BEING

Being is the sense of who someone is as an occupational and human being. It encompasses the meanings that they invest in life, and their unique physical, mental and social capacities and abilities. Occupation may provide a focus for being, but it also exists independently of it through ongoing processes of reflection and self discovery. Being is expressed through consciousness, creativity and the role people assume in life. Ideally, individuals are able to exercise agency and choice in their expression of being, but this is not always possible or even desirable.
BECOMING

Becoming is the perpetual process of growth, development and change which accompanies a person throughout their life. It can be directed by goals and aspirations, which can arise through choice or necessity, from the individual or from groups. Regular modifications and revisions of goals and aspirations help to maintain momentum in becoming, as does the opportunity to experience new or novel situations and challenges.

BELONGING

Belonging is a sense of connectedness to other people, places, cultures, communities and times. It is the context within which occupations occur, and a person may experience multiple belongings (across a range of areas) at the same time. Relationships are essential to belonging, whether they be with a person, place, group or other factor. A sense of reciprocity, mutuality and sharing characterizes belonging relationships, whether they are positive or negative.
MODIFYING THE OPH

• Doesn’t reflect the dynamic nature of occupation
  – Need to use a format that demonstrates this

• Limited cultural basis
  – Ensure all dimensions are treated equally
  – Highlight the universality of dimensions of occupation
APPENDIX N: SURVEYS

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POP


EVALUATION

• This is to come! POP has just been formulated and needs to be evaluated over the coming years
• Today’s survey is the beginning of this process of evaluation

[Add Presenter contact details here]
TAKE HOME MESSAGES

• OT professional identity is grounded in our shared beliefs and understandings of occupation

• POP provides a paradigm level overview of these

TAKE HOME MESSAGES

• While paradigms can’t directly guide practice, they can give overall guidance when you’ve lost your occupational bearings

• Regardless of your identity, ensure you have a comfortable spiel
AND HERE’S MINE …

Occupational therapists are health professionals with expertise in enabling you to do, be, become and belong. We focus on your priorities and preferences, and use a range of methods to help you be all you wish to be.

REFERENCES

1. Professional identities [http://www.faculty.londondeanery.ac.uk/ed-learning/interprofessional-education/professional-identities](http://www.faculty.londondeanery.ac.uk/ed-learning/interprofessional-education/professional-identities)