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**OCCUPATIONAL PRACTICE IN CHILDREN AND
YOUNG PEOPLE'S MENTAL HEALTH**

ROBERT BROOKS

A thesis submitted to the University of Huddersfield in partial fulfilment of the requirements
for the degree of Doctor of Philosophy

The University of Huddersfield

August 2016

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Conference Presentations

College of Occupational Therapists Specialist Section for Children Young People and Families Conference. Bradford University, November 2010. *Occupation-based Practice in Child and Adolescent Mental Health: What is the Evidence?*

College of Occupational Therapists Specialist Section for Children, Young People and Families London Network, April 2013. *A National Survey of Occupational Therapy Practice in Child and Adolescent Mental Health Services.*

World Federation of Occupational Therapists Congress. Japan, June 2014. *Occupational Therapy in Child and Adolescent Mental Health.*

College of Occupational Therapists Specialist Section for Children, Young People and Families London and South East Child and Adolescent Mental Health Services Network, London, September 2015. *Doing Occupation-Focused Practice in Child Mental Health.*

Abstract

Introduction

The use of occupation in occupational therapy has been regularly debated in the profession's literature. More recently there has been a shift to consider occupation as the core construct of occupational therapy, which informs assessments, interventions and outcomes; this can be described as occupational practice. Studies exploring occupational practice have been limited; this study has sought to address this gap.

Methods

This was a mixed methods study. First, a United Kingdom survey of occupational therapy practice in children and young people's mental health was conducted (n=27). The survey findings were analysed using descriptive statistics. The survey was used as a sampling platform for the second stage of the study. Underpinned by an ethnographic approach, the second study used an observer of participant, interview and document collection methods to explore occupational practice (n=2). A grounded theory approach was taken to data analysis.

Findings

The participants of the survey were 89% female, 49% were at a senior grade and 68% had been qualified for over 10 years. 81% worked in Child and Adolescent Mental Health Services tier 3 or 4. 52% participants had an undergraduate degree in occupational therapy; 64% had no further specialist formal qualifications. Additional training in sensory integration therapy was reported by 34% of participants. The Model of Human Occupation was identified as the most frequently used model of practice. The Sensory Profile was the most regularly used assessment. The participants reported that their interventions commonly focused on talking-style therapies, psycho-education and group work.

The ethnographic study revealed a tension at the study sites between the medical-psychological and occupational practice discourses. To manage this tension, the participants used a generic and profession-specific practice to negotiate being 'one of the team' and being a 'real occupational therapist'. Enacting occupational practice included using the Model of Human Occupation, referrals for occupational problems, conducting assessments of occupation, concluding occupational formulations, and using occupation as an intervention. Interventions were characterised as 'talking about doing' or 'doing occupation' and utilised strategies such as modelling, goal setting and setting a challenge.

Conclusion

The survey has offered a snapshot of occupational therapy practice. This may help the profession understand the demography and practices of the participants. The Occupational Practice Model for Children and Young People's Mental Health, which has emerged from the ethnographic findings of this study, is presented as a tool to guide the use of occupation at the level of theory, perspective and intervention. Further qualitative studies are recommended to support the study findings and a systematic review is suggested to examine occupational therapy interventions in the field.

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List of abbreviations

NHS – National Health Service

OT – Occupational Therapist/Occupational Therapy

WTE – Whole Time Equivalent

Glossary of Terms

Term	Definition
Child and Adolescent Mental Health Services	National Health Service (NHS) provision in the United Kingdom which provides assessments and interventions for children and young people with mental health difficulties (Cottrell & Kraam, 2005).
Child, children, young person, young people and adolescents	The term child or children refers to an individual or group of individuals under the age of thirteen; the terms adolescent or young person and adolescents or young people refers to an individual or group of individuals aged from thirteen to eighteen (Wyness, 2011).
Discourse	The use of languages, representations, practices and common assumptions that are the basis for fields of knowledge, within specific context (Foucault, 2001)
Discursive constructions	Components of discourse, which includes discursive objects, statements of truth, concepts and theories (Hodges, Martimianakis, McNaughton, & Whitehead, 2014).
Occupations	Occupational therapists define occupations as being the everyday things that we do (Molineux, 2010). In Western world cultures occupational therapists commonly classify occupations as work, leisure and self-care (Christiansen, Baum & Bass, 2015).
Occupation-based	When a person's engagement in occupation is used as both the intervention and outcome of occupational therapy (Fisher, 2013).
Occupation-centred	When occupational therapists have occupation at the centre of everything they do; having an occupational lens on the world (Fisher, 2013).
Occupation-focused	That the immediate focus of occupational therapy is on changing a person's occupational performance. This idea focuses on the here and now rather than the future (Fisher, 2013).

Occupational practice	The use of occupation-centred, occupation-focused and occupation-based practice. It is proposed in this thesis as an emerging sub-culture of practice in occupational therapy.
Occupational Practice Model	A conceptual framework developed for this thesis to structure the understanding of occupation in occupational therapy practice at the levels of theory, professional perspective and intervention.
Occupational Practice Model for Children and Young People's Mental Health	A conceptual framework that evolved from the Occupational Practice Model, which integrates the findings from this study into a specific model for occupational practice for children and young people's mental health.
Occupational therapy	A healthcare profession which works with individuals and communities of people to enable health and wellbeing through the participation in everyday occupations (World Federation of Occupational Therapists, 2013)

Chapter One: Background and Context

Introduction

This PhD thesis focused on how occupational therapists use occupation in their practice when working with children and young people with mental health difficulties. The need for this study arose from tensions in my own clinical practice surrounding the use of occupation. This chapter foregrounds the study by introducing the context and outlining my interest in the field, including a brief history of my professional career and the influences of my education and practice. This introduction serves to locate the study within a contemporary healthcare context and situate myself within the research, within occupational therapy and within the study of children and young people. To provide a focused context for the study this chapter will delimit the scope of the study before outlining the structure of this thesis, by providing an overview of each of the ten chapters.

Context Introduction

The mental health of children and young people has been reported to be of world-wide concern (WHO, 2003). Relevant epidemiological data for the United Kingdom is somewhat outdated (House of Commons Health Committee, 2014), an Office of National Statistics study between 1999 and 2004 (Green, McGinnity, Meltzer, Ford & Goodman, 2005) reported that 1 in 10 children and young people aged 5 to 16 years of age will be diagnosed with a mental health difficulty, including conduct, emotional, attentional and neurodevelopmental disorders. More recently it has been reported that young people experience higher levels of anxiety, depression and behaviour problems than they did 30 years ago (Collishaw, Maughan, Natarajan, & Pickles, 2010; Maughan, Collishaw, Meltzer, & Goodman, 2008). These changes have occurred within shifting social and cultural landscape, which has included increased school attainment, substance use and changes to family structure (Nuffield Foundation, 2012).

In the United Kingdom services to address the mental health concerns of children and young people are predominantly provided within the National Health Service (NHS), through Child and Adolescent Mental Health Services. The Royal College of Psychiatrists (2016) has mapped 104 child and adolescent mental health inpatient units in the United Kingdom, the number of outpatient units is not reported. The mental health needs of children and young people have become an important agenda for the NHS (Department of Health, 2014). Current government strategy is emphasising the need for evidence-based interventions, early intervention,

reducing hospital admission and health prevention and promotion (Department of Health, 2015; NHS England, 2014).

Locating Myself in the Study

This section serves to foreground my cultural background, thoughts, actions and assumptions; this forms part of the reflexive strategy that I used to enhance rigour (Darawsheh, 2014). I approached this study with personal and professional motivation to bring new understandings to the use of occupation as a tool to enable the health and wellbeing of children and young people. This motivation was embedded in my professional journey as an occupational therapist. I qualified as an occupational therapist in the United Kingdom, in 1997. I entered the profession at a time of emerging profession-specific theory, but with practice that was closely aligned to medicine. I spent my early career working in hospitals before taking up a post as a community paediatric occupational therapist, working with children with physical disabilities. It was at this stage that my interest in children and young people's health and wellbeing was ignited. I would characterise my practice at that time as addressing the fine motor, gross motor, sensory and adaptive equipment needs of children.

After working in the United Kingdom for a number of years, I took the opportunity to work in New Zealand. It was while in New Zealand that I began postgraduate study with Dr Clare Hocking, Professor of Occupational Science and Occupational Therapy, at Auckland University of Technology. Professor Hocking introduced me to new understandings of occupation through the academic discipline of occupational science. I consider this period of time working and studying in New Zealand as a significant influence on my occupational therapy practice. My new knowledge of occupational science brought an invigorated focus to my work which saw occupation become central to my role as an occupational therapist. My use of occupation in the children's physical health settings in which I was working, was supported by a growing evidence base and by service structures. The focus of my therapy shifted from remediating fine and gross motor skills to interventions, for example, which addressed tying shoe laces or playing football. My new found passion for occupation was further advanced when I attended the 2006 World Federation of Occupational Therapists Congress in Sydney, Australia. Here eminent occupational therapists, such as Professor Mary Law and Professor Rachel Thibeault, spoke inspirationally of the power of occupation to enable health and wellbeing.

When I returned to the United Kingdom in 2007, I took on a new professional challenge, to work as an occupational therapist in a Child and Adolescent Mental Health Service. I had naively expected to be able to translate my work from children's physical health into children's mental health, but I found a stark difference. My role in children and young people's mental health was more generic and the focus of practice was on helping children and young people

to manage emotions and behaviours. I discovered that it was difficult for me to enact occupation in my practice as there was an emphasis on psychological ways of thinking in my team. This psychological thinking pervaded many aspects of the service I worked in, including the diagnostic clinics and interventions. There were specific referral pathways for cognitive behavioural therapy, psychotherapy and play therapy, but there was no referral pathway for occupational therapy. How was I to be an occupational therapist if there were no referrals for occupational therapy?

As I struggled to define my role as an occupational therapist, I recall that I turned to the literature, but failed to find any substantial theory or research to support my practice, perhaps not understanding the implications of this literature silence at that time. There was a tension between my own practice, informed by occupation, and some of my occupational therapy colleagues who appeared to collude with the dominant psychological and medical discourses. Without research, theory or peer support, I too became part of the prevailing discourse. I took on roles such as coordinator of the attention deficit hyperactivity disorder diagnosis clinic, and clinician on the rota to see urgent cases of self-harm. I did seek out ways in which I could bring occupation to my practice. I developed an intervention for parents of children with attention deficit hyperactivity disorder that focused on structuring and balancing daily occupations, and began a play-based intervention for young people with autism spectrum condition. While these provided some local anecdotal evidence that occupational therapy could offer defined interventions, it was not seen by my team as enough to allow occupational therapy specific referrals. Although it was not perceptible to me at the time, my difficulties in developing a profession-specific role, my tensions with colleagues and my own collusion with the dominant discourse would shape the course of this doctoral study.

As I searched to understand and develop my role in children and young people's mental health, I began further post-graduate study with Dr Matthew Molineux, Reader in Occupational Therapy at Leeds Metropolitan University (now Leeds Beckett University). Dr Molineux asked me who was leading research and practice for occupational therapists in children and young people's mental health; I could not suggest anyone. In the literature I had found a study by Fortune (2000) who had suggested that occupational therapists in children and young people's mental health were gap-filling and that their practice was void of occupation. An opinion piece by Harrison and Forsyth (2005) had also proposed that occupational therapists in this setting were paused for action, and were not using profession-specific theory or practice. I felt that these ideas were unhelpful to the profession, yet both held resonance with my own experiences. I began to question whether this experience was the same for other occupational therapists in this field. The issues of embedding occupation into my own practice, the tensions between my experience of occupation in children's physical

health and the lack of occupation in children and young people's mental health, together with the absence of a leader in the field provided the impetus for this study.

I was afforded the opportunity to develop this study while practising as an occupational therapist in Child and Adolescent Mental Health Services in the United Kingdom. The study took shape as a mixed methods design to describe and explore occupational therapy practice in children and young people's mental health, and more specifically, to identify and observe the practice of occupational therapists in this field, who did report using occupation in their work. As I began to develop my study, I was keen to draw out of the data the ways in which occupational therapists used occupation in their interventions. A focus on practice was reflective of my role at that time as a clinician; as my study progressed I moved from clinical practice into academia, which further influenced the direction of my study.

Entering academia brought new dimensions to my study. As an educator of pre-registration occupational therapy students I found myself teaching occupational science; this furthered my theoretical understandings of occupation, but also challenged me to translate these ideas into clinical practice. My difficulties in articulating to students the active ingredients, or strategies, that occupational therapists use in their interventions added further to my desire to use my research to make these explicit. Teaching research methods to students brought me new considerations about knowledge and reality, which began to unravel more philosophical ideas about occupational therapy within broader considerations of health and wellbeing. Coupled with my own reading about the history of the profession, I began to consider the place of occupational therapy in social history and social theory; this further fuelled my aspiration to generate new knowledge and understanding through my study.

Locating Myself in Occupational Therapy

This section of the chapter serves to locate myself within the profession of occupational therapy. Firstly, a definition and characteristics of occupational therapy is offered, before positioning my own practice within that of occupational therapy in the United Kingdom. Occupational therapy has been described by the World Federation of Occupational Therapists (2013) as a profession that works with individuals and groups of people to promote health and wellbeing through participation in everyday activities. However, I have come to appreciate that definitions of occupational therapy have often lacked clarity as they are culturally, historically and situationally bound (Clark, 2010a; Creek, 2006; Creek, 2010; Lycett, 1991; Wilding, 2009). In order to augment a definition, the profession has sought to determine its core beliefs, characteristics, roles, values and behaviours. Early leaders of the profession described their beliefs as shaping body and mind through doing, and the balance of everyday tasks to maintain a rhythm to life (Dunton, 1919; Mayer, 1922; Peloquin, 1991a).

While I believe that these early beliefs are still valid, they are dynamic; the profession has evolved and further detail has been added. My beliefs about the profession hold resonance with both Creek (2006) and Aguilar, Stupans, Scutter and King (2012) who described its professional characteristics as promoting quality of life, assessment of clients' needs, intervention through activity, ethical practice, client-centred practice, reflective practice, empowerment and continuing professional development.

My own experience of occupational therapy practice has been to address the mental and physical health and wellbeing of individuals or groups of people, to enable them to participate and perform occupations, which are meaningful and purposeful to them. I have worked with patients across the lifespan, from new-born babies to older adults and with people with a range of health related difficulties associated with disabilities, illnesses, ageing or circumstances. My occupational therapy practice in the United Kingdom and New Zealand was delivered within established healthcare services. For example, on a hospital orthopaedic ward for people who have had a hip replacement, or on a mental health outpatient rehabilitation centre for someone experiencing depression. I do also hold the belief that occupational therapists can work in non-traditional settings, such as with the homeless and asylum seekers, taking a greater role in population health promotion and prevention (Ikiugu & Pollard, 2015; Thew, 2011; Wilcock & Hocking, 2015).

While the delivery of my occupational therapy practice was shaped by its local contexts, the process in which I engaged and understood clients was typical of that in many Western world settings (Creek, 2003; Townsend & Polatajko, 2013; World Federation of Occupational Therapists, 2013). The occupational therapy process is usually depicted as a cyclical method of gathering information about a client, assessing a client's needs, devising therapy goals, providing intervention, evaluating that intervention, discharging from occupational therapy services or re-starting the process (American Occupational Therapy Association, 2014; Creek, 2003; Townsend & Polatajko, 2013; World Federation of Occupational Therapists, 2013). Figure 1 on page 23 illustrates the occupational therapy process as determined by Creek (2003). There are other representations of the occupational therapy process in the literature, for example the Canadian Practice Process Framework (Townsend & Polatajko, 2013). Creek's occupational therapy process was developed from occupational therapy practice in the United Kingdom, it is therefore commonly used in this country, and was the process that I used in my practice. The specific application of the occupational therapy process in my practice was determined by my clinical reasoning, using my knowledge of the client and their circumstances together with my knowledge and skills (Mattingly & Fleming, 1994). Clinical reasoning has been described as being the art and science of occupational therapy (Rogers, 1982; Wood, 1995).

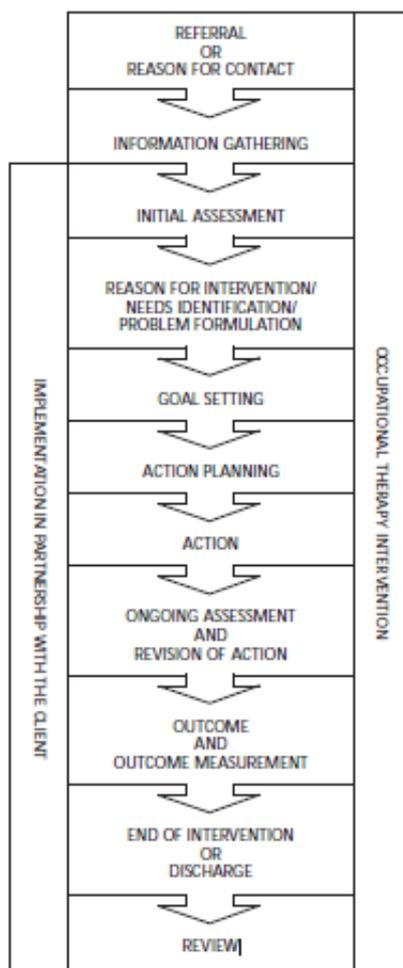


Figure 1 Creek's Occupational Therapy Process (Creek, 2003)

Whilst my use of the occupational therapy process was conventional, the use of occupation as a focus to my practice may have been challenging to some in the profession and to some service managers. I have not been afraid to speak out for the values of the profession, even in settings such as in Child and Adolescent Mental Health Services where my voice was often lost. I have at times been aware of being a man in a very female dominated profession, even more so in children and young people's occupational therapy. However, I have never known any different, with my professional socialisation occurring within this female dominated world. As a gay man I wonder what influence this may have had on my working relationships with women, it may have decreased any perceived dominance and enhanced my influence. As I am placed, through this study, in a position of knowledge and possibly power, I have been conscious of examining how to best influence and change the profession.

Locating Myself in the Understanding of Children and Young People

During my professional career as an occupational therapist I have come to understand childhood as a labyrinth of change influenced by intrinsic biological imperatives located in the person and extrinsic requirements situated in society and the environment. My understanding of young people's lives has been supported by my knowledge of the universal theories of child development, the individual experiences of the young people I have worked with and my appreciation of the study of childhood in history, society and culture. In addition to these professional practice and academic perspectives, I do not need to look too far in the media to see current world-wide illustrations of children and young people, which range from obesity to starvation, and from computer game savvy to educationally deprived. My perspectives of children and young people in the United Kingdom holds sympathy with that of Prout and James (2015), whereby childhood is understood as a social construction, is a variable of social analysis, that children should be seen as active social agents, and that children's relationships and cultures are worthy of study in their own right. I have observed how children and young people's engagement in this postmodern globalised world appears to have brought with it both unification and fragmentation. My experience of working with children over the last fifteen years has certainly reflected this increasing global nature of childhood, from cyber bullying on Facebook for not wearing designer clothes, sexting on Blackberry Messenger, blended families, X-box addictions, and an increased sense of deserving independence but also an increased social diversity of friendships. My understanding of children and young people has also been influenced by occupational theories. I have been drawn to the work of influential children's occupational therapist Case-Smith who contended that ecological and dynamic systems are important emerging theories for understanding children (Case-Smith, Law, Missiuna, Pollock & Stewart, 2010). I believe that children and young people develop occupational selves through a dynamic interaction between the person, the occupation and the environment (Law et al., 1996, Wiseman, Davis & Polatajko, 2005). My understanding of children and young people is therefore informed by developmental and sociological theories of childhood, but has most affinity with an occupational and ecological perspective.

To summarise, the major personal and professional experiences that have influenced the development of the study, presented in this thesis, are:

- Occupation can be the core construct of occupational therapy.
- There is a dominance of psychological ways of thinking in children and young people's mental health.
- Occupational therapy has some universal processes, but a therapist's clinical reasoning is individual.

- Children and young people are active social agents who experience changing occupational behaviours over their lifespan.

What This Thesis Contains

This study was conducted in two phases, a survey and an ethnographic approach study. Within each phase data were produced, analysed and discussed. Figure 2 presents an overview of the study phases, products and outcomes.

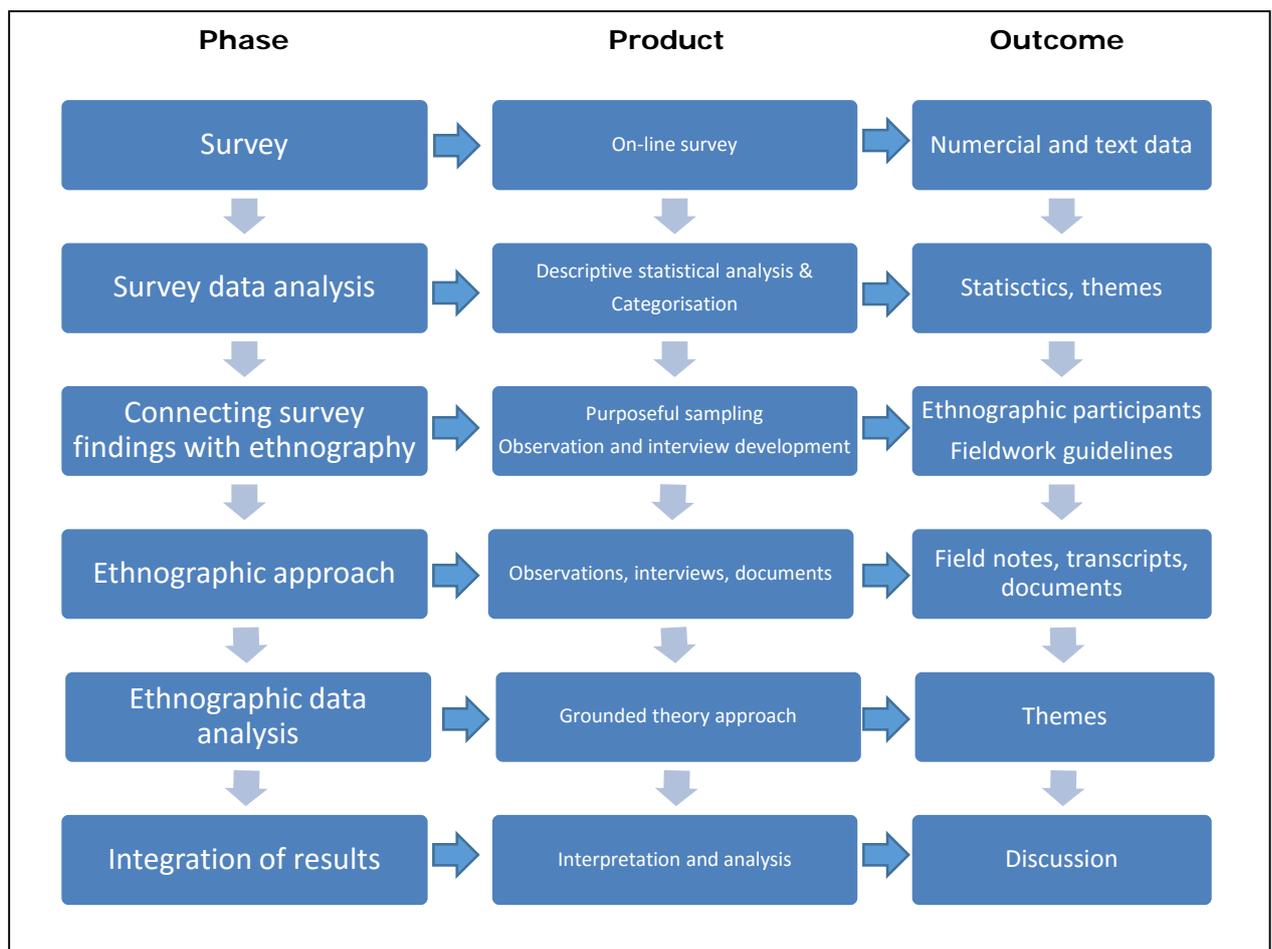


Figure 2 Overview of Study Design

To present the study this thesis is divided into ten chapters. Chapter One has served introduce the context and to locate myself in the study. Chapter Two places the study within the history and philosophy of occupational therapy. It introduces the idea of occupations and defines occupational therapy as understood in this study. Attention is drawn to the evolution of occupational therapy within healthcare services, predominantly in the United Kingdom and

the United States of America. The relationship and tensions that occupational therapy has with medicine are considered. Emerging from the profession's history and contemporary occupational therapy research, theory and practice the Occupational Practice Model is detailed as a conceptual framework for this study.

In Chapter Three, I provide further context by locating the study within children and young people's mental health services in the United Kingdom. This chapter includes a brief history of services before considering current trends in service provision. The Occupational Practice Model is then used to delineate occupational therapy practice in children and young people's mental health, drawing on literature from occupational therapy.

Chapter Four will detail the study's research design. This will include a justification for the research paradigm, methodology and method. More specifically, it will introduce and debate issues surrounding the use of mixed methods and will defend the use of this approach as a strength for this study. The principles and process of research ethics are also addressed.

Chapter Five builds on the discussion in the methods chapter to provide a more specific explanation as to the use of survey method in this study. The design of the survey used in this study will be detailed, including the issues of validity and reliability, recruitment, data collection and ethics. This chapter goes on to present the findings of the survey. The survey data is discussed in relation to current literature, and limitations are offered. Details of how the findings informed the second, ethnographic stage of the study are described.

Chapter Six introduces the second stage of this study, an ethnographic approach. This chapter begins with an introduction to ethnography including its evolution and characteristics. Further attention is drawn to the more focused ethnographic approach used in this study, including the ideas of field work, using grounded theory for data analysis and writing ethnography. This chapter concludes by detailing the strategies which were used to enhance rigour, including a reflexive account. In chapters Seven and Eight I present the ethnographies of The Gateway and The Orchards, respectively. These chapters present the occupational therapists Amanda and Julie and the analysis of the ethnographic data.

Chapter Nine brings a conceptual development to the ethnographic findings; this provides an overall crystallisation of these findings. The ethnographic conclusions are used to develop new understandings of social theory, occupational theory and occupational practice; an Occupational Practice Model for Children and Young People's Mental Health is proposed. Chapter Ten concludes the thesis by documenting the new knowledge that has emerged from this study, including an evaluation of the findings for research, practice and policy. Finally, a study conclusion and dissemination strategy is outlined.

Delimiting the Study

This section of Chapter One serves to delimit the scope of the study in relation to its broader contexts. This study took place between the years of 2011-2016 in the United Kingdom. This period has been recognised as a time of austerity, with cuts to public services, including the NHS. The issues that have arisen in this study are not meant to be a criticism of the NHS, or those who work in it; they are an interpretation of observations, which provide insight into occupational therapy practice. The study was conducted within the reality that I exist, and while I have attempted to explicate and delineate my personal perspectives within that reality, its limitations should be acknowledged. The focus on Western world reality should not be considered a purposeful attempt to disregard other realities, rather, that I was unfamiliar with these contexts. The scope of this study did not include any issues relating to gender, race or sexual orientation in occupational therapy in children and young people's mental health; again, this was not purposefully ignored, rather this perspective would warrant a more detailed and focused consideration in a different study.

The study has bridged practice and theory in occupational therapy. A strength of the study is that it has generated practice-based evidence, supported by a critical realist perspective (Bhaskar, 1998), which has informed both practice and theory. A challenge was to balance implications for theory and implications for practice, and provide depth to both of these. The use of the social theories of Foucault (2001, 2003) and Goffman (1959), in the analysis section of the thesis, has brought additional depth to the findings. However, this study was not a full Foucauldian or Goffman analysis, and as such has drawn upon aspects of their work that were most relevant to the study. A focus on discourse has been used by other occupational therapy researchers, for example Mackey (2007), and such an analysis is suggested in this thesis for future research.

There is the possibility that some tension exists between Bhaskar's critical realist philosophy of the study and the postmodernist perspective of Foucault used in the analysis. While they both agree on the influence of social, historical and institutional contexts on the production of knowledge, the issue of ontology is more problematic. The use of a critical realist perspective was crucial in this study in allowing a qualitative and quantitative methodology to exist together in one study. The survey reported a reality of practice for the participant occupational therapists working with children and young people with mental health difficulties in the United Kingdom. Consistent with Foucault and a postmodernist perspective, the ethnographic study did not report a truth, rather it reported an account of the discursive constructions at that time. The results of the survey informed the ethnography, but were not taken as absolute,

the data of both phases were not combined, but the findings were discussed together to create a version of reality.

Study Question, Aims and Objectives

Question

How does occupation emerge in the practice of occupational therapists in children and young people's mental health?

Aims

1. To critically explore current occupational therapy practice in children and young people's mental health.
2. To critically evaluate the meaning and implementation of occupational practice by occupational therapists working in children and young people's mental health.

Objectives

1. To administer an online survey to scope the current demography and professional practices of occupational therapists working in children and young people's mental health.
2. To use an ethnographic approach to critically explore and synthesise occupational practice by occupational therapists working in children and young people's mental health.

Chapter Two: Occupational Therapy and the Occupational Practice Model

Introduction

This chapter presents occupational therapy and delineates occupational practice as a subculture of practice within the profession. The chapter starts by taking a temporal approach to situate this study within the history of occupational therapy and its renaissance of occupation. To provide further context the relationship between occupational therapy and medicine has been considered, with attention drawn to the issues of disciplinary discourse and power. Underpinned by this historical and cultural landscape of the profession this chapter goes on to present the Occupational Practice Model (see Figure 3, page 36). The Occupational Practice Model was developed and used in this study as a lens through which to understand and explain occupational practice. The Occupational Practice Model was conceived as themes emerged in the literature review for this thesis; it builds on work by Fisher (2013) and McColl (2015). The Occupational Practice Model presents the themes of theory, perspective and intervention which are used to focus the discussion in this chapter. The Occupational Practice Model provided a structure to appraise the existing literature and to identify current challenges and research gaps; this further supported the focus and methodology of the study presented in this thesis as complementing and developing previous research. The themes of the Occupational Practice Model are threaded through this thesis; it is used to appraise occupational practice in children and young people's mental health which is presented in Chapter Three, and it informed the Occupational Practice Model for Children and Young People's Mental Health presented in Chapter Nine.

Occupational Therapy: A Brief History

Moral Treatment and the Arts and Crafts

Many core occupational therapy text books chronicle the use of occupation and activity as a therapy as far back as the Greeks and Romans (Reed & Sanderson, 1999; Schwartz, 2003). Nevertheless, most supporters of occupational therapy agree that the early occupational therapy movement emerged during the moral treatment era of the 18th century (Levine, 1986; Paterson, 1997; Reed, 1986). Moral treatment had developed as a psychosocial intervention to address mental illness through the development of moral strength (Paterson, 1997). This humanitarian approach contrasted with traditional treatments for the insane, which had included flogging, restraint and exorcism (Anthony, 2005; Friedland, 1998). Moral

treatment in the United Kingdom is often associated with the Quaker William Tuke. Tuke founded The Retreat Hospital near York in 1796 (Bing, 1981; Tuke, 1813; Turner, 2002). At The Retreat patients were supervised engaging in occupation work and habit training regimes, such as digging, carpentry, sewing, silver polishing and window cleaning, together with bed rest and gentle walks (Bockoven, 1971; Hocking, 2007; Levine, 1987). The participation in these occupations was thought to divert patients from their anxieties and delusions, helping to restore disordered thoughts and behaviours (Anthony, 2005; Friedland, 1998; Hocking, 2007; Levine, 1987; Paterson, 1997; Reed, 1986). While there is no specific date from which the term occupational therapy was used, it is these workers at The Retreat Hospital that are often designated as the first occupational therapists in the United Kingdom (Turner, 2002).

The number of occupational therapists slowly increased during the early 1900s as an increasing number of asylums for the mentally unwell opened. As well as habit training, occupational therapists engaged their patients in arts and crafts (Hocking, 2008a; Hocking, 2008b; Mayer, 1922; Wilcock, 1991). These creative handicrafts were believed to extol the virtues of happiness in labour and social responsibility, and gave the profession an allegiance with the Romantic Arts and Crafts Movement (Anthony, 2005; Reed, 1986; Reed & Sanderson, 1999). Moral treatment and occupational therapy was not confined to the United Kingdom, the profession also advanced in the United States of America. Indeed, the first occupational therapy training, known as an Invalid Occupation Course for Nurses, was inaugurated by Susan Tracey at Adams Nervine Hospital in Boston, Massachusetts (Turner, 2002).

Diversional Therapy and the Rehabilitation Movement

The expansion of practice beyond the treatment of the mentally unwell was expedited by The Great War of 1914. The emerging occupational therapy profession drew on its background in habit training and the arts and crafts to provide diversional bedside occupations to wounded soldiers recovering in hospital (Rerek, 1971). Carr (1928) described the use of diversional work by occupational therapists with veterans as a way to take their minds away from the horrors of war. The growth of occupational therapy continued during the inter-war period; this has been described as the point at which it became a profession (Woodside, 1971). In 1917 the National Society for the Promotion of Occupational Therapy was formed in the United States of America. The National Society for the Promotion of Occupational Therapy founding members came from a variety of backgrounds, and included a psychiatrist, social worker, architect, teacher and welfare worker (Hagedorn, 1995; Schwartz, 2003; Woodside, 1971). These pioneering occupational therapists all held a common belief in the therapeutic value of occupations to strengthen the mind and the body. In 1927, Dr Elizabeth Casson established the Dorset House School of Occupational Therapy in the United Kingdom. Here, four-month

training focused on the practice of occupations such as carpentry, leather work, wood carving, knitting, crochet, typewriting, tapestry, needlework, weaving, printing and basketry, as well as some basic clinical sciences (Reed & Sanderson, 1999; Woodside, 1971).

As occupational therapy began to establish itself as a profession, the Second World War provided a platform for further professional developments. The Second World War heralded a time of great advances in medical science. This resulted in the increased survival of wounded soldiers. Occupational therapy embraced the context of these medical innovations and became part of a new era of treatment, the rehabilitation movement (Friedland, 1998; Mosey, 1971; Schwartz, 2003). The rehabilitation movement evolved from the expansion of medicine, surgery and pharmaceuticals which enabled people with physical illnesses to survive, become independent and to contribute to society (Hocking, 2007; Mosey, 1971; Peters, 2011). The rehabilitation movement saw occupational therapy advance its own interventions. From keeping people busy or diverted from illness, occupational therapy progressed to the restoration of function and participation in society. Mosey (1971) highlighted this stage as one in which occupational therapists combined arts and crafts with techniques from other disciplines. For example, exercises, prosthetic and orthotic making, psychodynamics and neuromuscular facilitation. Occupational therapists also began to diversify into the use of workshops, tools and machinery to rehabilitate joints and muscles (Friedland, 1998). This diversification was exemplified by Reed (1986) who highlighted the rising use of sanding blocks by occupational therapists in the 1930s to stretch contractures, strengthen muscles and improve exercise tolerance. The technique of examining and modifying work processes and adapting machinery to accommodate 'cripples' was also introduced during this time (Turner, 2002). Occupational therapy continued to make inroads into healthcare across the world; in 1952 the inaugural meeting of the World Federation of Occupational Therapists took place. The World Federation of Occupational Therapists had twenty-eight founding member countries including the United States of America, United Kingdom, South Africa, Sweden, New Zealand, Australia, Israel, India and Denmark (World Federation of Occupational Therapists, 2012).

Specialisation and Marginalisation of Occupation

Building on practice from the rehabilitation movement, occupational therapists in the 1950s and 1960s began to specialise into the areas of physical and mental health. The continued advancement of physical medicine and rehabilitation necessitated therapists with specialist knowledge in anatomy, physiology, kinesiology and neurology. This requirement for medical knowledge was reflected in the training of occupational therapists, which further integrated medicine alongside specific arts and crafts (Schwartz, 2003; Turner, 2002). In clinical practice

occupational therapists often dealt with only one part of the body, such as hips or hands, or one activity need, such as dressing or bathing (Diasio, 1971). This approach to occupational therapy has been termed reductionist, and described as the marginalisation of occupation in occupational therapy (Hocking, 2008b; Shannon, 1977; Turner, 2002). Turner (2002) illustrated such a reductionist approach when describing how fretsaws and lathes continued to be used as a treatment, but with no wood attached and therefore no meaning to the patient. Concurrent with specialisation in physical health, occupational therapists in the field of mental health aligned themselves with psychoanalytical theory. This was thought to be in an attempt to demonstrate more scientific and medical foundations (Schwartz, 2003). It has been suggested that occupational therapists became embarrassed by the use of occupations (Turner, 2002). This period of specialisation was one of conflict for occupational therapists. Philosophically the profession sought to reconcile the reductionist medical paradigm with a more humanist and moral paradigm (Schwartz, 2003). In practice occupational therapists were proud to be supported and prescribed by the medical profession, with its uniforms, jargon and status, yet they also strived for professional autonomy (Colman, 1992; Friedland, 1998; Turner, 2002).

Medicine and the Medical Discourse

Occupational therapy has had, and continues to have, an ambivalent relationship with the medical profession (Peloquin, 1991a; Peloquin, 1991b; Peters, 2011; Reilly, 1962; Reilly, 1969; Rogers, 1982; Wilding, 2009; Wilding & Whiteford, 2007; Yerxa, 1992). This ambivalence stems from a number of incongruities between the professions, ranging from epistemology, models of health, diagnosis and treatment outcomes. The professions have been described as having “a contrasting set of values” (Yerxa, 1992, p. 81) and that they “speak a different language” (Wilding, 2009, p. 9). Occupational therapy has been described as being constrained when it has tried to fit in with the medical model, which is philosophically and epistemologically different (Rogers, 1982; Wilcock, 1999; Wilding, 2009).

Despite this uncertain relationship, occupational therapy has historically had the desire to gain support from medicine in order to obtain society’s approval as a credible health profession (Reilly, 1962; Yerxa, 1992). This sponsorship from medicine has been seen by some social theorists (for example Foucault, 2001; Foucault, 2002; Foucault, 2003) and occupational therapists (Colman, 1992; Creek, 2009; Wilding, 2009) as an example of discursive power. For example, early occupational therapists working with wounded soldiers were not responsible for choosing the occupations of their patients; rather these were prescribed and supervised by the medical officer (Carr, 1928; Colman, 1992). When occupational therapy in the United Kingdom became a regulated profession, the 1960

Professions Supplementary to Medicine Act saw medical practitioners form the majority of its controlling council (Wallis, 1987). While the concerns of power in healthcare had not been the primary focus of this study, as the data unfolded, it was not possible to ignore the issues of discourse and power (see Chapter Nine).

The notions of discourse and power are well rehearsed in the literature, and have origins with the social theorist Foucault (2001; 2002) whose ideas have been of interest to a number of occupational therapists (Creek, 2009; Wilding, 2009). Discourse refers to the use of languages, representations, practices and common assumptions that are the basis for fields of knowledge, within specific contexts (Peterson & Bunton, 2000; Schirato, Danaher & Webb, 2012). Discourse has been described as greater than just thinking or language, these are only the surface appearance; discourses are more and require revealing (Schirato et al., 2012). Foucault (2002) used the term archaeology to describe the examination of historical discursive traces which have shaped the present. Foucault disputed the idea of truth, suggesting that conditions led to some facts being known over others (Mills, 2003). Foucault contended that discourses shape what is deemed as legitimate knowledge, which, in the context of this study, determined mainstream and accepted healthcare (Foucault, 2002; Hodges et al., 2014). The use of Foucault's ideas to examine discourse in healthcare is not new; for example, nursing researchers Cheek and Porter (1997) reported that Foucault offered instruments to contest and interrogate healthcare practices. Similarly, rehabilitation researchers Fadyl, Nicholls and McPherson (2012) described how the work of Foucault had enabled a critical exploration of healthcare. Foucault's ideas have influenced a range of healthcare professions, such as nursing and clinical psychology (Nicholls, 2012). However, the application to occupational therapy is in its infancy (Ashby, Gray, Ryan & James, 2015; Creek, 1997; Mackey, 2007).

Foucault's ideas of discourse and power, and their relationship to occupational therapy and medicine, have been explored by the occupational therapist Creek (1997). She argued that occupational therapy is better understood through a postmodernist perspective, which accepts complexity, and does not adhere to the structuralist scientific endeavour of medicine. Creek (1997) went on to argue that medicine and its trajectory towards understanding causes of disease, finding a cure and eradicating disease are more highly valued than helping someone to be able to get dressed again. Moreover, Creek (1997) suggested that an understanding of the patient from an occupational therapy perspective may be different to that of the doctors, but that this viewpoint may not be accepted as doctors hold the dominant biomedical discourse, this discourse is supported by others which serves to reject the occupational therapy discourse. Creek (2009) went on to suggest that such dominance can be challenged, indeed occupational therapy has, in more recent years, sought to establish its own knowledge-base and practices that make it distinct from medicine (Clark, 2010b; Peters,

2011; Wilcock & Hocking, 2015; Yerxa, 1992; Yerxa, 1998). These emerging ideas are associated with the renaissance of occupation, which is discussed next.

The Renaissance of Occupation

In an attempt to resolve the profession's on-going paradigmatic debate, occupational therapy leaders, Reilly (1962) and Yerxa (1967), used their American Occupational Therapy Association key note lecturers to rally the profession. Reilly spoke of how "Occupational therapy can be one of the great ideas of 20th century medicine" (p.1). Yerxa presented the idea of "Authentic occupational therapy" (p.1). Reilly (1962) considered how medicine had offered occupational therapy a "tranquil and supported setting" (p.3), but that the profession needed to generate its own direction and identity. Reilly (1962) went on to assert that occupational therapy would not survive as an arts and crafts profession for the disabled. Reilly believed that the way forward for the profession was to use research to create knowledge, and demonstrate how occupational therapy is unique. Yerxa (1967) persisted with a similar theme; she called for science to contribute towards an authentic occupational therapy practice which used purposeful activity and function, and enable self-actualisation.

The occupational therapy profession took note of its leaders; the 1970s and 1980s saw developments in theory, research and practice (Schwartz, 2003). Kielhofner (2008) contributed to this conceptual growth by proposing the Model of Human Occupation. The Model of Human Occupation explained the relationship between occupational roles and routines, motivation and the environment. Further detail about the Model of Human Occupation and other theoretical models in occupational therapy will be presented in the next section of this Chapter (see page 44). In practice some occupational therapists began to reconnect with the ethos of occupation; this reconnection was not universal. Many occupational therapists continued to use interventions such as sensory integration (Ayres, 1972) and neurodevelopmental treatment (Bobath, 1980). These interventions aimed to remediate underlying sensory, motor and neurological body functions or structures rather than occupational difficulties. The 1980s also saw the context of healthcare continue to change, this required the re-evaluation of how occupational therapy was delivered (Hagedorn, 1995; Rivett, 1998). In physical health settings shorter hospital admission times resulted in tighter timeframes for intervention. There was also an increasing focus on safe discharge home. In mental health settings the idea of community care was emerging and long stay institutions were closed.

A highly significant development for occupational therapy was the founding of occupational science as an academic discipline in 1989 (Clarke et al., 1991; Yerxa et al., 1990). The role of occupational science has been to act as a basic science to the applied discipline of

occupational therapy (Yerxa et al., 1990). The development of occupational science heralded a new era for occupational therapists (Clark et al., 1991; Molke, Laliberte-Rudman & Polatajko, 2004; Wilcock, 1991; Wilcock, 2005; Yerxa, 1993, Yerxa; 1998; Yerxa, 2000). This era saw a convergence of ideas including the development of theories of occupation (Iwama, 2006; Kielhofner, 2008; Townsend et al., 1997), a new conceptualisation of health through occupation (Pierce, 2013; Wilcock, 1993; Wilcock, 1998; Wilcock, 2001; Wilcock, 2005; Wilcock & Hocking, 2015; Yerxa, 1998), research through occupational science (Pierce et al., 2010; Whiteford & Hocking, 2012), the notion of occupational justice (Durocher, Gibson & Rappolt, 2014a; Durocher, Rappolt & Gibson, 2014b; Nilsson & Townsend, 2010; Whiteford & Hocking, 2012) and occupation-centred, occupation-based and occupation-focused practice (Fisher, 2013; Forsyth, Mann, & Kielhofner, 2005; Gillen & Greber, 2014; Gray, 1998; Pierce, 2003). It is this convergence of ideas of associated with the renaissance of occupation that form the basis for the understanding of occupational practice in this thesis. This understanding has been conceptualised by me in this thesis as the Occupational Practice Model, it is detailed and explained over the rest of this chapter.

The Occupational Practice Model

The Occupational Practice Model is illustrated in Figure 3 on page 36; this conceptual framework developed for this thesis complements and builds on work by Fisher (2013) and McColl (2015), who have also proffered occupation-related taxonomies. Fisher's (2013) work focused on the use of consistent occupational language, and McColl (2015) offered the concept of an occupational toolbox as a metaphor for the variety of tools occupational therapists use in practice. The Occupational Practice Model takes forward the idea of consistent language and the systematic organisation of occupation through three interdependent levels: theory, perspective, and intervention. These are positioned hierarchically to indicate how one formed the basis for the other. The foundation level of theory refers to an occupational theory of humans and health (Njelesani, Tang, Jonsson & Polatajko, 2014; Wilcock, 1998; Wilcock & Hocking, 2015), the construct of occupation (Christiansen, 1994; Molineux, 2004; Nelson, 1988; Reed, Hocking & Smythe, 2013), knowledge created in the academic discipline of occupational science (Wilcock, 2005, Wilcock & Hocking, 2015; Yerxa, 1993; Yerxa, 2000) and the notion of occupational justice (Durocher et al., 2014a; Durocher et al., 2014b; Frank, 2012; Nilsson & Townsend, 2010). The second level is an occupational therapy profession-specific perspective (Njelesani et al., 2014), which is supported by the level of theory and leads to the level of intervention. This perspective uses an occupational lens throughout an occupational therapist's practice. This includes, for example, the design of services, referrals, clinical reasoning, the occupational therapy process, note writing, reports and interactions with colleagues (Fisher, 2013). The final level

of the framework is the enactment of occupation-focused and occupation-based interventions. This refers to a way of practising occupational therapy where the assessment and interventions use occupation as their active ingredient (Fisher, 2013; Gray, 1998). Further detail of each level will now be presented.

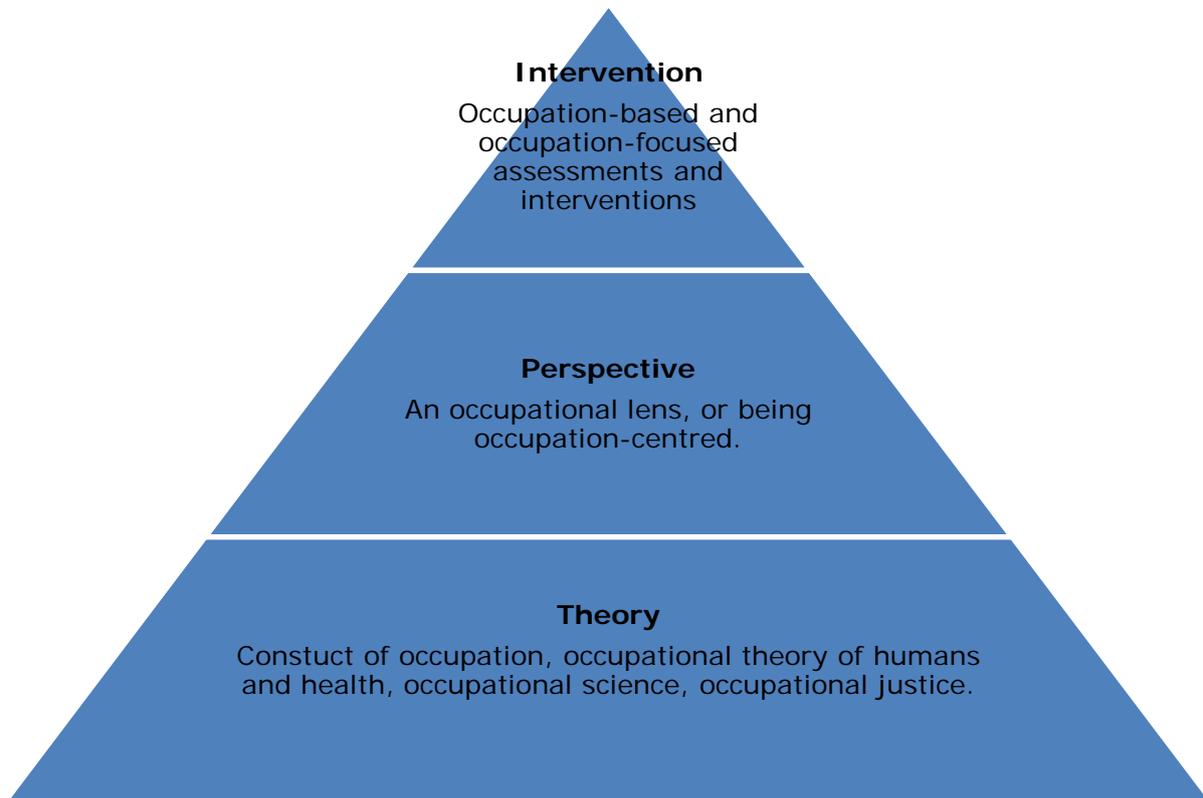


Figure 3 Occupational Practice Model

Occupational Practice Model: Theory

The Construct of Occupations

As occupational scientists began to study occupation, some clarity over the definition of occupation was sought. Occupational therapists have described occupations as the everyday and ordinary things that we do, such as getting dressed, travelling on the bus, or being at work (Clark et al., 1991; Molineux, 2004; Molineux, 2010). Describing or defining these occupations can be complex; occupations have different meanings to individuals and society, change over time, and are influenced by culture and the environment (Iwama, 2006; Jonsson, 2008; Kondo, 2004). A number of occupational therapists have sought to clarify the meaning of occupation, and there is some agreement that an occupation should be meaningful,

recognisable and goal directed (Christiansen et al., 2015; Molineux, 2004; Nelson, 1988; Pierce, 2001a). In an effort to provide consistency across the occupational therapy fraternity the definition "...chunks of daily activity that can be named in the lexicon of the culture" (Yerxa et al., 1990, p. 5) is widely cited by occupational therapists (for example, Case-Smith, Law, Missiuna, Pollock & Stewart, 2010; O'Toole, 2013; Pierce, 2001a) This definition has provided a simple, yet focused, definition of occupation; it embraces individual and societal meaning (Molineux, 2004; Schwartz, 2009; Zemke & Clark, 1996), and is the definition of occupation employed in this thesis.

To assist further in the delineation of occupations, occupational therapists have pursued the development of taxonomies or classifications of occupations (Christiansen, 1994; Christiansen & Townsend, 2010; Reed, Hocking & Smythe, 2011). Christensen (1994) found that the categorisation of occupations was compromised by the different purpose and meaning occupations have across ages, cultures and environments. For example, fishing in some cultures is conducted so that a family can eat while in other societies it represents a recreational pastime. In an attempt to attain a universal classification, some occupational therapists, located in the Western world, have chosen to group occupations in relation to 'why' they are conducted. For example, self-care, productivity and leisure (Canadian Association of Occupational Therapists, n.d.; Christiansen et al., 2015; College of Occupational Therapists, n.d.). The 'why' of occupations reflected the understanding of occupations which I adopted in this study. Nonetheless, a universal classification of occupations has been questioned by some occupational therapists, as representing a Western Euro-American perspective. Iwama (2003) and Kondo (2004) began to examine this cultural bias; they have suggested that occupations cannot be universal as they have culturally constructed meaning. More recently, Kantartzis and Molineux (2011, 2012) used findings from an ethnographic study of a Greek town to suggest that occupational therapists' ideas about occupation were based on Western, Protestant and American values. This limited understanding of occupations suggests that occupational therapist need to further evaluate their application to other societies (Kondo, 2004).

An Occupational Theory of Humans and Health

The theory of occupation is presented in this thesis as a conceptual way of understanding humans and health (Njelesani et al., 2014; Reed, Hocking & Smythe 2013; Wilcock, 1995; Wilcock, 1998; Wilcock, 2007; Wilcock & Hocking, 2015). Yerxa et al. (1990) were the first to detail an occupational theory of humans. They described occupations as "not just something nice to do" (p.7) rather, that humans have a biological need to be occupied. They are hard wired to occupy their time; they have an "occupational brain" (Wilcock, 1995, p.69).

It has been proposed that the need for humans to engage in doing is biologically driven, for example to get food or shelter which enables us to survive, prevent illness, promote health and adapt to the environment (Christiansen & Townsend, 2010; Wilcock, 1993).

In an effort to evaluate an innate biological requirement for occupation Wood (1998) conducted a study of the occupations of zoo chimpanzees. Following observational time-use studies Wood proposed the idea of root occupations. Wood suggested that the root occupations of play and grooming have been maintained and perfected through evolution into the corresponding occupations of play/leisure and self-care seen in humans. This study by Wood also highlighted how the environment played a role in affording the continuation of occupations, which in turn influence biological organisation. Although Wood herself identified a number of limitations to the study, including observations limited to zoo opening times and the difficulty in identifying a typical chimpanzee participant, the study does provide some basis on which to support the notion of an instinctive drive for humans to be occupied.

However, it is contended that it is higher cognitive processes that have enabled humans to construct environments that have altered our need for our occupational brains to fulfil only survival occupational needs (Wilcock, 1995). Occupations have evolved over time, from hunter, gatherer, agriculture and industry to post-industry. Complex self-care, productive and leisure occupations are now woven together in response to cultural forces and it is often difficult to tease out the survival occupations which once dominated. Some occupational therapists have argued that the decline in the need for survival occupations has contributed to global over population (Wilcock 1995; Wilcock, 1998). This raises the question of whether current occupations are balanced and health inducing or whether they are detrimental to human survival (Backman, 2004; Wilcock & Hocking, 2015). For example, could the use of hand held computers, to complete occupations that would have once taken humans much longer, create boredom or burn out? (Wilcock, 1995; Wilcock, 1998; Wilcock & Hocking, 2015). Wilcock (1995) has suggested that society has not adequately considered the occupational nature of humans and the impact this could have on individuals and society.

While the benefits of survival occupations are clear, the benefits of other occupations, such as work and play have yet to be fully established (Wilcock & Hocking, 2015). To articulate how health through occupation could be achieved Wilcock (1999) introduced three tenants of occupation: doing, being and becoming. Doing referred to the carrying out of occupations, being to a sense of feeling connected to oneself and the world and becoming was presented as the notion of where the occupation may take you. Wilcock (1999) proposed that a dynamic balance between doing, being and becoming would enable health. It is through this organisation of occupations that occupational roles, such as brother, student or football

player, flow together across time and space with meaning and purpose (Yerxa, 1990). The notions of doing, being and becoming have offered a structured approach to understanding how human occupation organises itself and evolves into observable patterns of behaviour in the world. An occupational theory of humans represents a theory of human nature for occupational therapists (Wilcock, 1993; Wilcock, 2007). It also frames the ideas of how humans establish and maintain health through evolving occupational roles. It is offered as an alternative to more dominant theories of health, such as biomedicine; occupational therapists have, nevertheless, been influenced by, and continue to have a relationship with, these other models of health which will be explored next.

Relationship with other Theories of Health

Health through occupation offers an alternative perspective to more dominant biomedical and social models of health (Hocking, 2013; McColl, 2015; Reed, Hocking & Smythe, 2013; Wilding, 2009). While occupational purists may reject other models of health, pragmatically it offers a complementary approach. As already discussed, the profession of occupational therapy has had an ambivalent relationship with the medical profession; this ambivalence extends to the underlying theory of biomedicine (Larson, 1999; Russell, 2013; Wilcock, 1999; Wilding, 2009). An occupational perspective of health has a fundamentally different epistemology to biomedicine (Creek, 1997; Wilcock, 1999; Wilcock, 2007; Wilding & Whiteford, 2007). Creek (1997) has argued that an occupational theory of health is better understood through a postmodernist perspective that accepts complexity, and does not adhere to the structuralist scientific endeavour of biomedicine. Creek goes further to state that science and biomedicine have become the truth because a large number of people have given power to this perspective. Biomedicine and its trajectory towards understanding the causes of disease, finding a cure and eradicating disease are currently more highly valued than understanding the health benefits of being able to get dressed again or to go out for a meal with friends.

The relationship between an occupational theory of health and the social model of health has been somewhat subtler than that of biomedicine. The epistemological foundations of these two approaches do have greater congruence (Creek, 2009). The social model of health has emphasised broader determinants of health such as social, cultural, environmental and political factors, as well as aiming to reduce inequality and increase health empowerment, access and collaboration (Blaxter, 2010). Occupational therapists began to view the environment as an enabler of occupation and health when they started examining and modifying work processes and adapting machinery to accommodate 'crippled' soldiers. The adaptation of the environment for those with a disability has become a mainstay of

occupational therapy practice (Law, 1991; Turner, 2002). The consideration of the environment has also become a key component in many ecologically driven models used in occupational therapy practice (Christiansen et al., 2015). Occupational therapists today continue to be involved in environmental adaptation through vocational rehabilitation, universal design and home modifications. In the sphere of healthcare, the social model has had an impact on health service provision, particularly in the areas of health promotion which has been a growing avenue of practice for occupational therapists (Molineux & Baptiste, 2011).

Theories of health are complex, and represent alternative understandings of reality and knowledge. Biomedical and social models of health have informed global directions in health policy and practice; these have become illustrated through the World Health Organisations model of health (World Health Organisation, 2015). The World Health Organisation model of health has changed in response to shifting understandings of the determinants of health (Blaxter, 2010; Engel, 1977). The current model, the International Classification of Functioning, Disability and Health (See Figure 4) is described by the World Health Organisation (2015) as taking a broader view of health and a modern view of disability which considers the contextual factors and the individual.

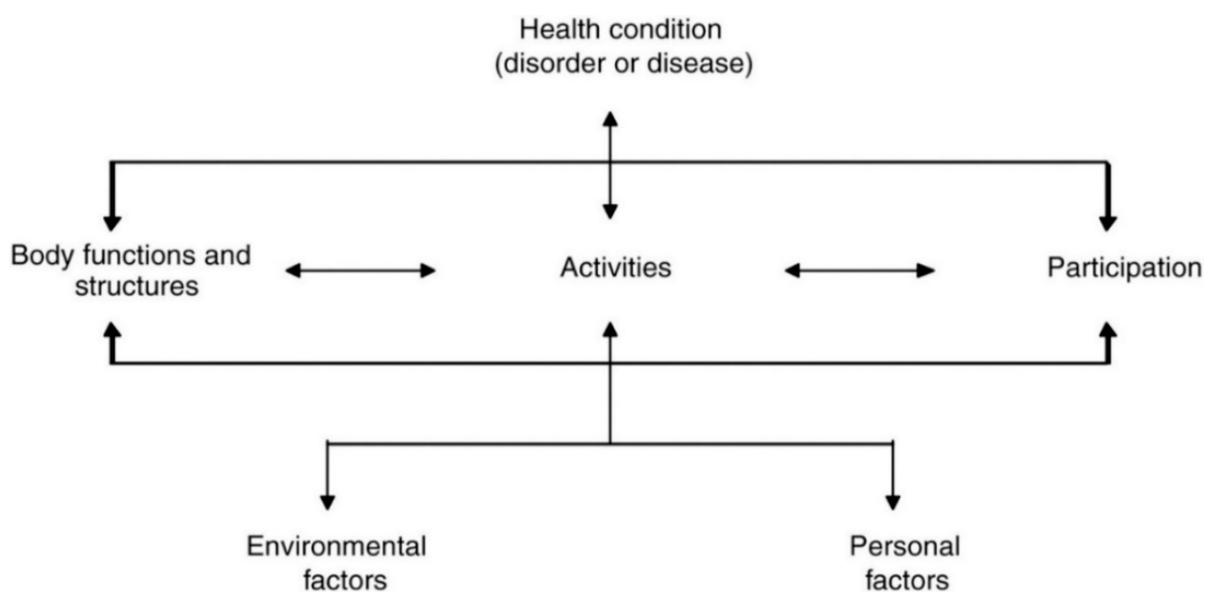


Figure 4 International Classification of Functioning Disability and Health Model (World Health Organisation, 2015)

The International Classification of Functioning Disability and Health is described as biopsychosocial model (World Health Organisation, 2015). It includes environmental factors

(such as the social attitudes or physical environment), personal factors (such as gender or age) as well as the health condition (disease, disorder or injury) as having an impact on bodily functions (such as the respiratory system) and bodily structures (such as the bones or heart), together with the activities (execution of a task) someone can carry out and their ability to participate (involvement in a situation) in life. An important innovation in this model was the idea that health would be determined not just as the functioning of the body but on the ability to participate in everyday life, a concept known as 'health-related functioning' (World Health Organisation, 2015). This approach to health has congruence with an occupational theory of health, and has been seen by some occupational therapists as the recognition of health through occupation embedded in this World Health Organisation model of health (Hocking, 2013; Law, 2002; Townsend, Ryan & Law, 1990).

Occupational Science: Emerging Academic Discipline

The founding of occupational science can be attributed chiefly to Professor Elizabeth Yerxa at the University of Southern California (Yerxa et al., 1990). Occupational science has been established as an academic discipline or branch of knowledge to support a rigorous and systematic way of studying occupation and humans as occupational beings (Christiansen & Townsend, 2009; Clark et al., 1991; Henderson et al., 1991; Pierce, 2013; Yerxa et al., 1990; Wilcock, 1991; Wilcock, 2001; Wilcock & Hocking, 2015; Zemke & Clark, 1996). Its relationship to occupational therapy is as a basic science to an applied discipline; similar to that of anatomy to medicine and physics to engineering (Blanche & Henny-Kohler, 2000; Clark, 1993; Lunt, 1997; Pierce, 2013; Yerxa, 1990). Occupational science has however been described as an interdisciplinary science (Pierce, 2013; Wilcock, 1991; Yerxa et al., 1990; Yerxa, 1991). Yerxa (1993) contended that its occupational focus liberated it from the constraints of conventional academic boundaries. This enabled it to utilise and synthesise knowledge from related fields such as psychology, anthropology and biology.

Occupational scientists believe that occupations are complex, multidimensional in nature and require an understanding of type, purpose, meaning and socio-cultural and historical contexts (Christiansen & Townsend, 2010; Pierce, 2013; Wilcock, 1991). There is a growing body of literature regarding the foundations of occupational science, the study of occupations and the application of occupational science to clinical settings (Clark, 2006b). A range of research approaches have been advocated for the study of occupation; these have included quantitative analysis of observable occupations and qualitative studies that address the cultural, symbolic and social meanings of occupation (Carlson & Clark, 1991; Clark et al., 1993; Glover, 2009; Hocking, 2000; Molke et al., 2004; Pierce et al., 2010). Since 1993 the *Journal of Occupational Science*, a peer reviewed academic journal, has sought to disseminate

research that contributes to the study of occupation. As the quantity of occupational science research has increased Hocking (2012) and Kinsella (2012) have critically considered the ontological and epistemological assumptions of the discipline. Kinsella has described occupational scientists as an “epistemic community” (p. 69) referring to the knowledge-producing nature of the community. Kinsella draws, as has this thesis, on the work by Kuhn and the notion of knowledge paradigms (see page 82). Kinsella suggested that occupational science should be viewed as a new knowledge paradigm, but one that is in its infancy.

Occupational Justice

Occupational justice emerged in the 1990s from the work of Wilcock and Townsend (Townsend, 1993; Townsend & Polatajko, 2013; Townsend & Wilcock, 2004; Wilcock, 1998; Wilcock & Hocking, 2015) as a term to describe the rights of humans to engage in meaningful occupations (Durocher et al., 2014a). Occupational justice has some similarities to social justice in that they both embody the idea of equality, but they ascribe to differing ideologies related to society and to occupation. Originating in the field of occupational science, the ideas of occupational injustice extend current thinking to focus on meaningful occupation as a matter of justice (Durocher et al., 2014a; Durocher et al., 2014b; Stadnyk, Townsend & Wilcock, 2010). As already discussed earlier in the chapter, an occupational perspective has at the heart of it a biological necessity for humans to engage in occupations. It is the right to access and participate in these health-giving occupations that affords us occupational justice; when the right to participate is removed we experience occupational injustice (Whiteford & Townsend, 2010). The protection of occupational rights is seen as imperative to an occupational perspective. A number of specific occupational injustices have been developed, these are presented and defined in Table 1 on page 43; these definitions have been based on a review of occupational injustice by Durocher et al. (2014a).

Occupational Injustices	Definition
Occupational apartheid	Restriction to occupational engagement based on personal characteristics such as gender, race, disability, religion, age, sexuality. For example, asylum seekers.
Occupational deprivation	Preclusion from occupation due to factors beyond the control of the individual, for example political, social, economic or environmental factors. For example, living in geographical isolation.
Occupational marginalisation	Exclusion from occupations due to perceived sociocultural norms (habits, traditions) of who should participate in what occupations. For example, people with a disability not being able to participate in some leisure occupations.
Occupational alienation	Prolonged disconnectedness from meaningful occupations. For example, being a refugee and being unable to carry out meaningful work.
Occupational imbalance	Excessive engagement in one type of occupation, for example over working, or when the timing of occupations is not aligned with normal routines. For example, shift working.

Table 1 Occupational Injustice Definitions (adapted from Durocher et al., 2014a)

The translation of occupational injustice into occupational therapy has been paramount with occupational therapists being empowered to meet the health and justice needs of their clients. This suggestion that occupational therapists address the occupational justice needs of their clients has been embedded in the World Federation of Occupational Therapists Position Statement on Human Rights (2006). The Participatory Occupational Justice Framework (Wolf, Ripat, Davis, Becker & MacSwiggan, 2010; Whiteford and Townsend, 2010) has been proposed as a process for addressing occupational justice at a global and societal level through engagement with governments and communities. While this process is of significance

to those occupational therapists working at this strategic level the translation to everyday practice can seem somewhat abstract for occupational therapists working in traditional healthcare settings (AlHeresh, Bryant & Holm, 2013; Pettican & Bryant, 2007; Townsend, 2012; Townsend & Marval, 2013). Indeed, Durocher et al. (2014a) as well as Hammell (2008) have indicated that there is much further work to do to facilitate the application of occupational justice to practice. Nonetheless, the stage has still been set for occupational therapists to address the occupation injustices of society and consider the relationship between these rights to occupation and health and wellbeing (AlHeresh et al., 2013; Ikiugu & Pollard, 2015; Nilsson & Townsend, 2010; Stadnyk, Townsend & Wilcock, 2010; Townsend & Marval, 2013; Whiteford & Hocking, 2012).

Models of Occupation

There are a number of conceptual models that have been developed, by occupational therapists, to provide a way of looking and explaining human participation and engagement in occupation (Iwama, 2006; Kielhofner, 2008; McColl, 2015; Supyk-Mellson & McKenna, 2010; Townsend & Polatajko, 2013; Turpin & Iwama, 2010; Wong & Fisher, 2015). These frameworks originated in occupational therapy, but offer a conceptual perspective for any health professional. It is not my intention to provide an exhaustive list of models, as there are many (McColl, 2015; Turpin & Iwama, 2010). The two most commonly associated with the Western healthcare setting of this study are the Model of Human Occupation (Kielhofner, 2008; Lee & Kielhofner, 2010; Lee, Taylor, Kielhofner & Fisher, 2008) and the Canadian Model of Occupational Performance and Engagement (Ashby & Chandler, 2010; Townsend & Polatajko, 2013).

The Model of Human Occupation (see Figure 5 on page 45) was developed through research in the United States of America by the occupational therapist Gary Kielhofner. It was first published in 1980 (Kielhofner, 1980a; Kielhofner, 1980b; Kielhofner & Burke, 1980; Kielhofner, Burke, & Igi, 1980). The Model of Human Occupation depicts the human as an open/dynamic system which responds and adapts to changes at a body, environmental and occupational level (Kielhofner, 2008).

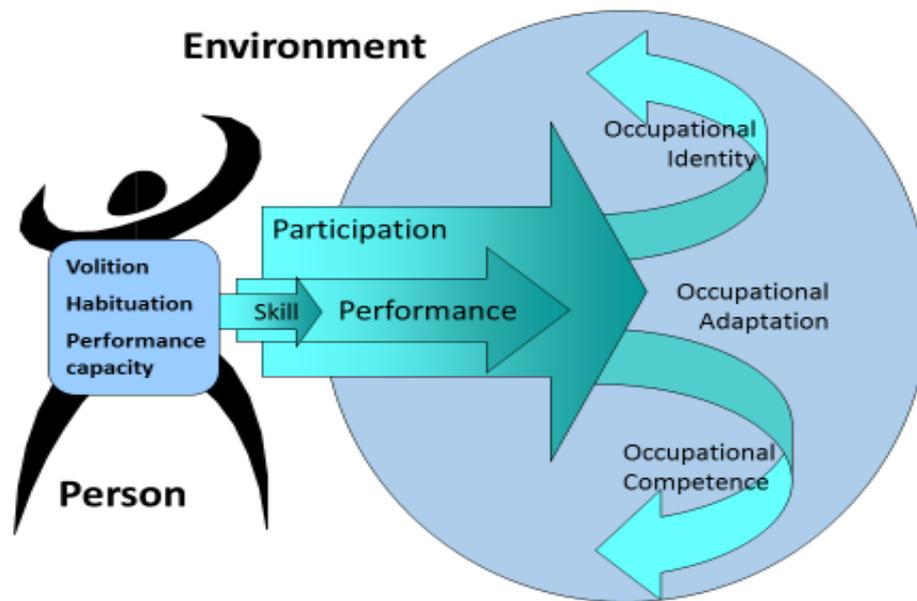


Figure 5 Model of Human Occupation (Adapted from Kielhofner, 2008)

The Model of Human Occupation seeks to explain how occupation is motivated, patterned, and performed (Turpin & Iwama, 2010). The model explains occupational development as the dynamic interaction between volition (values, interests and self-efficacy), habituation (habits and roles), performance capacity (bodily systems such as the musculoskeletal system, cognitive and mental abilities) and the environment (physical, social, cultural, economic and political) (Kielhofner, 2008). The Model of Human Occupation also emphasises the need to understand human occupation in the context of the physical and social environments in which it takes place. The outcome of a person's engagement in occupation is known as the dimensions of doing which refers to the participation and performance of that occupation. The outcomes of participation and performance are the consequences of doing, these include the development of an occupational identity (who you are and who you wish to become), occupational competence (maintaining a pattern of occupation that reflects an occupational identity) and occupational adaptation (achieving identity and competence over time) (Kielhofner, 2008; Turpin & Iwama, 2010).

The Canadian Model of Occupational Performance and Engagement (see Figure 6 on page 46) was developed by the Canadian Association of Occupational Therapists. The model explains the dynamic relationship between the person, their environment and their occupation (Canadian Association of Occupational Therapists, 2016; Townsend & Polatajko, 2013). The Canadian Model of Occupational Performance and Engagement is underpinned by humanistic, learning and developmental theory. The person is located in the centre of the model with

spirituality at its core. Spirituality does not refer to religion rather it refers to the essence of self, although for some this may be via organised religion. The components that make up the person are illustrated as cognitive, affective and physical attributes. The occupations that the person may participate in are classified into self-care, productivity (school or work) and leisure. These are positioned between the person and their environment. The environment includes the physical (natural and built), institutional, cultural and social contexts within which the person engages in occupation (Townsend & Polatajko, 2013).

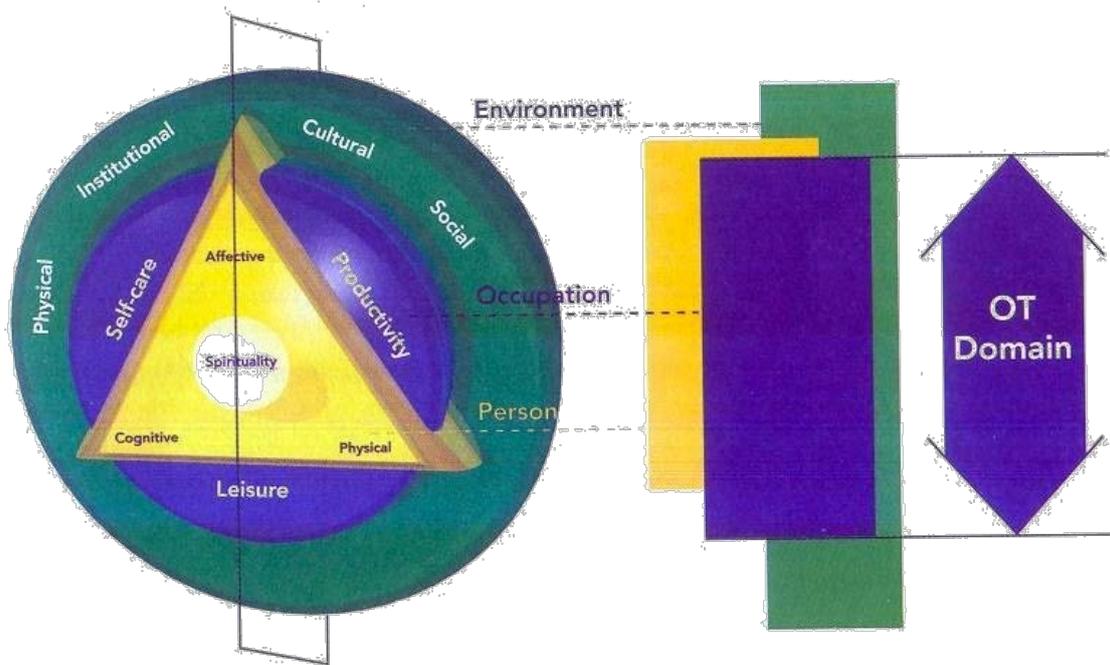


Figure 6 Canadian Model of Occupational Performance and Engagement (Polatajko, Townsend & Craik 2007)

The Model of Human Occupation and Canadian Model of Occupational Performance and Engagement provide a way to visualise the construct of occupation, the relationship between their components and the impact on health and wellbeing (McColl, 2015). It is through these models that occupational therapists, and other health professionals, can describe the occupations that individuals and society participate in. These conceptual models, together with the construct of occupation, an occupational understanding of humans and health, knowledge from occupational science and the notion of occupational justice form first level of the Occupational Practice Model. It is from these theoretical foundations that occupational therapists can bring an occupational perspective to their practice; this perspective forms the next level of the framework.

Occupational Practice Model: Perspective

The second level of the Occupational Practice Model is a professional perspective, this refers to occupation being at the centre of everything; the world is viewed from an occupational lens (Fisher, 2013). When an occupational therapist uses this perspective they make use of the theory of humans as occupational beings, and models of occupation to view their clients. This perspective approaches health and wellbeing through occupation, and as the dominant model of health over medical and sociological models. It also utilises research from occupational science as its knowledge base. The notion of an occupational perspective is not new in occupational therapy literature, although there is a lack of consistency to terminology. Nielson (1998), referred to the idea of a professional stance or perspective, and Yerxa (1998) spoke of a profession-specific lens. More recently Njelesani et al. (2014) described the term occupational perspective as a "...a way of looking at or thinking about human doing" (p. 226) and Fisher (2013) described a similar notion of being occupation-centred. It is not the aim of this thesis to suggest a conclusion to the issue of terminology, indeed perspective, stance, a way of looking and being-centred, all purport similar meaning. What can be concluded is that the use of perspective in the Occupational Practice Model is consistent with current thinking about an occupational view the world.

Achieving an occupational perspective has been reported to be challenging (Colianni & Provident, 2010; DeGrace, 2003; Fisher, 2013; Polatajko & Davis, 2012; Twinley & Morris, 2014; Wilding & Whiteford, 2007; Wilding & Whiteford, 2009). Many occupational therapists continue to work in traditional Western healthcare settings, where biomedical perspectives pervade ideas about the diagnosis of clients, and the interventions they receive (Burke, 2001; Chisholm, Dolhi & Schreiber, 2000; Townsend & Polatajko, 2013). Biomedicine can also influence the language that health care professionals use, and the way that services may be configured, for example in medical diagnostic clinics. Occupational therapy that takes an occupational perspective challenges this biomedical framework, and uses the language, research and practice of occupation (Fisher, 2013; Pettican & Bryant, 2007; Wilding & Whiteford, 2007). Using an occupational perspective is embedded in practice, literature describing this perspective is correspondingly practice based, for example when working with clients with cancer (Dertli, 2007), anorexia (Abeydeera, Wills & Forsyth, 2006) and physical disabilities (Deshaies, Bauer & Berro, 2001) or in service settings such as medical hospital wards (Chisholm, Dolhi & Schreiber, 2000; Rogers, 2007) or hand rehabilitation (Toth-Fejel, Toth-Fejel & Hedricks, 1998). These descriptive articles were mostly educative and included theory related to occupation, suggestions for practice, such as assessments and interventions to use and case examples or reports. While not providing empirical evidence these descriptions were grounded in occupational therapy practice.

To conclude this section, I have proposed in this thesis through the Occupational Practice Model that an occupational perspective can provide a lens through which occupational therapists view the world. It is this perspective that supports the final level of the Occupational Practice Model, which describes occupational therapy interventions that use occupation as their active ingredient.

Occupational Practice Model: Interventions

The interventions provided by occupational therapists have been described as complex as defined by the Medical Research Council (Creek, 2003; Creek, Ilott, Cook & Munday, 2005; Medical Research Council, 2000). The basis for this assertion is that the main intervention strategies of occupational therapy are dynamic and unpredictable. These intervention strategies include the therapist's values, skills and knowledge, the client's history, experience, beliefs, abilities, and occupations, and external influences such as the social, cultural and physical environments (Creek, 2003). This complexity has contributed to difficulties in other health professionals, and society understanding what occupational therapy is or does (Aguilar, Stupans, Scutter & King, 2012). It has also limited the ability of the profession to generate manualised interventions, to maintain fidelity to intervention techniques and to effectively measure the benefit of such interventions (Blanche, Fogelberg, Diaz, Carlson & Clark, 2011). A lack of intervention specificity has led to occupational therapy interventions being described in broad terms; for example, 'practical ways to help with gardening', or 'breaking the task of making a drink down into stages', or 'providing assistive devices for bathing' (American Occupational Therapy Association, 2014). Underpinning these broad intervention descriptions occupational therapy interventions have traditionally been based on biomedical theories and practices which aim to fix body structures and functions (Schell, Gillan & Scaffa, 2013); for example, stretches and splinting to maintain muscle length and support bone structure, or neurodevelopmental interventions, such as Bobath (Bobath, 1980) or sensory integration therapy (Ayres, 1972) to activate neuroplasticity (Kielhofner, 2009). However, in the last two decades there has been a theoretical shift in occupational therapy towards ecological and occupational frameworks for interventions (Polatajko & Mandich, 2004; Townsend & Polatajko, 2013). These emerging intervention frameworks are based on the idea that an individual's occupational development is a result of their interaction with their social, cultural and physical environment (Bronfenbrenner, 1977; Bronfenbrenner, 1986; Christiansen et al., 2015; Csikszentmihalyi, 1990; Kielhofner, 2008; Townsend & Polatajko, 2013). It is these types of interventions that inform the occupation-based and occupation-focused interventions which are the final level of the Occupational Practice Model.

The final level of the Occupational Practice Model considers what occupational therapists actually do as an intervention. The terms occupation-based and occupation-focused have been used to maintain a consistency of language as defined by Fisher (2013). These terms refer to occupation being fundamental to the assessment, intervention and outcome of occupational therapy (Casteleijn, 2013; Clark et al., 1991; Coster, 1998; Gray, 1997; Hocking, 2001; Jackson, Carlson, Mandel, Zemke & Clark, 1998; Pierce, 2001b; Polatajko, Mandich & Martini, 2000). Clarification of terminology has recently been forthcoming from Fisher (2013); a definition of occupation-based and occupation-focused, based on Fisher’s work, is presented in Table 2.

Term	Description
Occupation-based	When a person’s engagement in occupation is used as both the intervention and outcome of occupational therapy.
Occupation-focused	That the immediate focus is on changing a person’s occupational performance. This idea focuses on the here and now rather than the future.

Table 2 Occupation-based and Occupation-focused Practice

The issue of occupational therapy interventions, that have occupation as their main ingredient (occupation-based or occupation-focused), is something that occupational therapists have yet to fully address (Ashby et al., 2015; Gillen & Greber, 2014; McColl, 2015; Pierce, 2013; Polatajko & Davis, 2012; Price & Miner, 2007; Reeves & Mann, 2004; Twinley & Morris, 2014). Research addressing occupation-based and occupation-focused practice has increased as the profession has re-established its own focus on occupation (for example, Law, Baum & Baptiste, 2002). One of the most significant early studies was the Well Elderly Study (Clark et al., 1997; Jackson et al., 1998). This randomised controlled trial evaluated the effectiveness of preventative occupational therapy for older adults. This study was specifically designed to utilise occupation within an occupational therapy intervention programme. The study was evaluated using measurable outcomes related to health, function and quality of life (Jackson et al., 1998). It could be argued that there is some inherent bias to this study as its authors were also those instrumental in developing occupational science. Nonetheless, what

this study did achieve was to demonstrate that occupation-based occupational therapy was of significant benefit as demonstrated on measures that could be readily interpreted by other health professionals.

Since the seminal work by Clark et al. (1997) the evaluation of occupation-based and occupation-focused interventions has been made explicit in a number of studies. For example, in relation to stroke (Gustafsson & McKenna, 2010; Hermann, Herzog, Jordan, Hofherr, Levine & Page, 2010; Roberts, Vegher, Gilewski, Bender & Riggs, 2005; Skubik-Peplaski, Carrico, Nichols, Chelette & Sawaki, 2012), shoulder capsulitis (Earley & Shannon, 2006), brain injury (Dawson, Binns, Hunt, Lemsky & Polatajko, 2013; Doig, Kuipers, Prescott, Cornwell & Fleming, 2014; Linden, Lexell, Larsson Lund, 2011; Mastos, Miller, Eliasson & Imms, 2007), hand therapy (Colianni & Provident, 2010; Jack & Estes, 2010), back pain (Paquette, 2008), psychiatric illness (Schindler, 2010), personality disorder (Hirons, Rose & Burke, 2010), depression (Chippendale & Bear-Lehman, 2012), chronic illness (O'Toole, Connolly & Smith, 2013; White, Lentin & Farnworth, 2013), obesity (Lau, Stevens & Jia, 2013), diabetes (Haltwinger & Galindo, 2013; Piven & Duran, 2014), and older adults with cognitive difficulties and everyday problems (Dawson et al., 2014). These studies were predominantly of a quasi-experimental design with pre and post intervention measures without a control. A small number were true experimental studies or qualitative research. It is not my intention to provide a detailed critique of the research design of each of these studies rather it is the issue of fidelity to occupation as the main intervention strategy which warrants further exploration.

The description of the actual occupation-based or occupation-focused intervention varied across the studies presented above. For example, in the study by Dawson et al. (2014) the intervention was described as a "meta-cognitive strategy-training program" (p. 118) whilst the study by O'Toole et al. (2013) used an "occupation-based self-management group" (p. 31). This broad ranging interpretation of what constitutes an occupation-based and occupation-focused intervention strategy reflects not only the lack of a universal definition, but also the lack of defined interventions that adequately incorporate occupation as their main ingredient. The range of outcomes measures used in these studies also had varying degrees of adherence to occupation. The most common occupational outcome measure was the Canadian Occupational Performance Measure (Law et al., 2014) used by Dawson et al. (2014), O'Toole et al. (2013), Skubik-Peplaski et al. (2012), Schindler (2010) and Hermann et al. (2010). The use of additional outcome measures, such as quality of life, range of movement or motor and process skills, was common across studies. This most likely highlighted the need for studies to demonstrate improvement in participants across a variety of health domains that could be interpreted by a broad range of health professionals.

Although the number of occupation-based and occupation-focused studies continues to grow, the theory to practice translation has been slow. For example, a survey by Mulligan, White and Arthanat (2014) specifically set out to explore the use of occupation-based practice in New Hampshire, United States of America. The sample in this study included occupational therapists of all clinical grades with experience working in paediatrics, hospitals, nursing facilities, outpatient clinics, and mental health settings. The study authors concluded that whilst the occupational therapists in the study understood the concepts of occupation-based and occupation-focused practice their services did not reflect these values. This lack of occupation in practice was characterised by the use of assessments, measures and interventions that addressed body functions and performance skills; these included range of movement or muscle strength. Occupational therapy was also conducted in unnatural settings such as clinics and gyms, rather than in naturalistic settings, such as homes or schools. Similar study findings were elucidated by Pilegaard, Pilegaard, Birn & Kristensen (2014), who found only 9 percent of their 150 participant occupational therapists working in stroke care in Danish Public Hospitals used occupation-based assessments.

Research exploring the use of occupation-based and occupation-focused practice is in its infancy; this reflects the trend in the profession to re-focus on occupation. The delineation of the terms associated with this type of practice are yet to be fully determined; further clarification of this may help with future research. What is evident is that the idea of occupation-based and occupation-focused practice is understood by clinicians and presented in research, but that this does not always translate into a change in clinical practice. The reasons for this are most likely complex and may include a clinician's confidence, tradition, the expectations of the practice setting and institutional constraints (Ashby et al., 2015; Estes & Pierce, 2012).

Chapter Summary

This chapter has outlined a selective, historical picture of occupational therapy. Beginning at the origins of the profession, this chapter has charted its philosophical, theoretical, practice and research journey. With early roots in the Arts and Crafts Movement and Moral Treatment, the profession has also grown-up alongside medicine; however, it has been suggested that these professions have different epistemological foundations. This uneasy relationship with medicine has had significant impact on the profession's practice and research development. In the last thirty years, occupational therapy has sought to establish its own theory and knowledge base; it is through the academic discipline of occupational science that this has been achieved. Occupational science, together with models of occupation, a clearer notion of the construct of occupation, and the introduction of occupational justice has supported an

occupational understanding of humans and health. Occupation has become the dominant construct for occupational therapists.

This chapter has presented the Occupational Practice Model as a framework for understanding the literature pertaining to occupation. This conceptual framework has been developed for this study as a way to understand occupational practice as an emerging subculture of occupational therapy practice. Occupational practice embodies the use of the theory of occupation, utilises an occupational perspective of the world, and uses occupation-based and occupation-focused assessments and interventions in practice. The three levels of the Occupational Practice Model (theory, perspective, intervention) are used in the next chapter as a framework for exploring the literature related to occupational therapy and occupational practice in children and young people's mental health.

Chapter Three: Children and Young People’s Mental Health

Introduction

This chapter will outline children and young people’s mental health, children and young people’s mental health services and occupational therapy in this setting (Evans & Banovic, 2014; Lougher, 2001). A brief history will form the basis on which to discuss current service practice and research (Cottrell & Kraam, 2005). The Occupational Practice Model presented in Chapter Two will be used to highlight a disconnection between occupational therapy and occupation in this setting (Fortune, 2000; Harrison & Forsyth, 2005). This will serve to identify the need for the research presented in this thesis.

Children and Young People’s Mental Health

A Brief History

This section details a history of Child and Adolescent Mental Health Services. Figure 7 presents a timeline that complements this discussion.

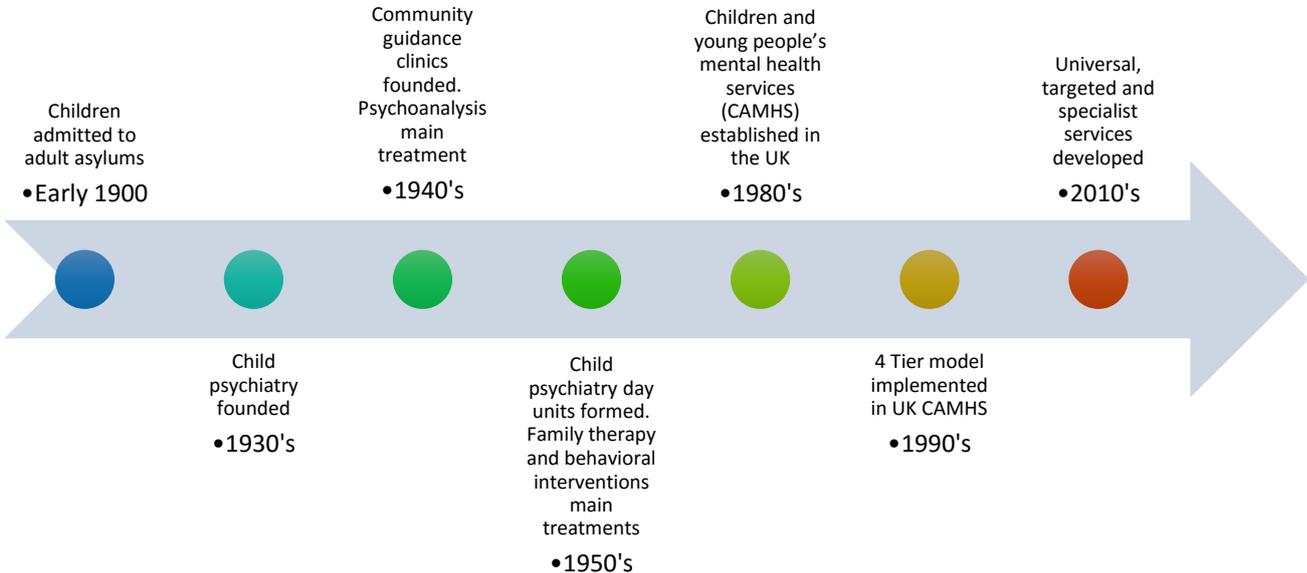


Figure 7 Timeline of Child and Adolescent Mental Health Services in the United Kingdom

In the early twentieth century children with mental health problems were commonly described as being insane, mentally defective, disturbed or mad (Parry-Jones, 1989; Wardle, 1991). The limited comprehension of body and brain development caused doctors to be confused as to how a child who did not yet have a mind could lose it. This deficient understanding of mental health conditions meant that those young people affected were often admitted to adult lunatic or idiot asylums; here physical diagnoses and interventions were regularly applied (Wardle 1991)

The study of childhood in the mid-twentieth century, by psychologists and sociologists, facilitated new understandings of children (Prout & James, 2015). A new appreciation of the complexities of the childhood era led to the emergence of child psychiatry as a medical speciality, distinct from adult psychiatry (Black & Gowers, 2005; Parry-Jones 1989; Wardle 1991). Despite gaining recognition as a legitimate area of clinical practice, child psychiatry did not experience the same expansion in research and practice seen in other areas of medicine during the Second World War. This difficulty in establishing effective medical interventions led to the strong influence of non-medical professions, including psychology, social work, education and psychoanalysis, on the scope of practice of early child psychiatrists (Black & Gowers, 2005; Bracken et al., 2012; Wardle 1991). Psychoanalysis and psychodynamics in particular has had a lasting authority in child and adolescent psychiatry. The work of psychotherapists Anna Freud and Melanie Klein shaped the provision of individual work with the child, through play, to understand the unconscious mind (Freud, 1966; Klein, 1932). This psychodynamic frame of reference became popular in the 1930s and 1940s at newly established child guidance clinics in the United Kingdom (Black & Gowers, 2005; Lougher, 2001). These community-based clinics usually consisted of a psychiatrist, educational psychologist and psychiatric social worker. Psychiatric social workers would become the backbone of child guidance. They offered therapeutic work with parents which endeavoured to change their attitudes and behaviours towards their child (Lougher 2001; Wardle 1991).

The introduction in the United Kingdom of the Education Act (1944) and the National Health Service Act (1948) formalised statutory provision of services to meet the mental health needs of children and young people (Black & Gower, 2005). Community child guidance clinics were phased out in preference of child psychiatry day units run by the local authority. The post-war period in the United Kingdom saw a shift in practice from separate parent and child work towards family therapy, behavioural therapy and group therapy (Parry-Jones 1989; Wardle 1991). Psychiatrists integrated these new therapies with established psychodynamic thinking to develop an eclectic approach to intervention (Cottrell & Kraam, 2005). The mid-twentieth century also saw a range of changes in child psychiatry influenced by policy and professional

developments. The focus of work changed as social workers tackled child protection, rather than offering therapeutic work, and psychologists focused on education and learning (Charman, 2004). Service provision and delivery was inconsistent across the United Kingdom, and was also influenced by diagnostic fads and fashions (Wardle, 1991).

This uncoordinated approach to the provision of mental health services was recognised in the 1980s by the Conservative Government. During the 1980s and early 1990s many of the child psychiatry day units were dismantled to re-emerge as newly titled Child and Adolescent Mental Health Services. Charman (2004) pointed to the 1989 United Nations Convention on the Rights of the Child (Office of the High Commissioner, 1989), and the subsequent Children Act (1989), as crucial points in the history of children and young people's mental health services in the United Kingdom. The recognition of the rights of children shifted the government's agenda towards meeting mental health needs through the provision of adequately resourced and funded services. Cottrell and Kraam, in their 2005 review of the history of Child and Adolescent Mental Health Services, also highlighted the 1987 report into child abuse in Cleveland (Butler-Sloss, 1987) as a crisis which gave prominence to the need for government agencies to work collaboratively. The influence of these events culminated in the NHS review of Child and Adolescent Mental Health Services, 'Together We Stand' (Health Advisory Service, 1995). This was followed by the Health of the Nation Handbook on Child and Adolescent Mental Health Services (Department of Health, 1995). The most defining component of 'Together We Stand' was the introduction of a four-tier model to the provision of Child and Adolescent Mental Health Services (Cottrell & Kraam, 2005; Lougher, 2001; Young Minds, 2010), which is outlined in Table 3 on page 56.

The tiered approach to Child and Adolescent Mental Health Services intended to create assessment and treatment services aimed at maintaining the emotional and behavioural wellbeing of all children and young people. It also heralded a promise of improved services and partnership working across agencies (Charman, 2004; Cottrell & Kraam, 2005). The tier system supported a myriad of therapies including play therapy, child psychotherapy, art therapy, drama therapy, family therapy, behavioural therapy and attachment therapy (Lougher, 2001). In the last decade a number of key documents and policies have further shaped the provision of mental health services in England for children and young people. These are presented in Table 4 on page 57.

Tier	Members and Function
Tier 1: Primary Care	Teachers, General Practitioners, youth workers and school nurses who provide general mental health advice e.g. for tantrums or bedwetting.
Tier 2: Community/multi-agency	Children and young people's mental health workers who help with low level mental health difficulties in community settings, e.g. behavioural problems or fussy eating at home.
Tier 3: Multidisciplinary/specialist	Psychiatrists, clinical psychologists, nurses, social workers and occupational therapists providing specialist mental health assessments and interventions in an outpatient setting e.g. autism, depression.
Tier 4: Day unit/in-patient	Psychiatrists, clinical psychologists, nurses, social workers, occupational therapists, play therapists, family therapists providing highly specialist mental health assessments and interventions in an inpatient setting e.g. psychosis, eating disorders.

Table 3 Child and Adolescent Mental Health Services Tier Structure

Document/Policy	Purpose
Children's Plan (Department of Children, School and Families, 2007)	A strategic plan placing schools at the centre of children's welfare and education.
Child and Adolescent Mental Health Services Review (Department of Health, 2008)	Independent service evaluation with recommendations for local and national strategy and service provision.
Children and Young Person's Act (2008)	Increased the responsibilities of Local Authorities to help children in care.
New Horizons (Department of Health, 2009)	A vision for improving the mental health of all of the population.
No Health Without Mental Health (Department of Health, 2011)	The coalition government's mental health strategy which included a significant investment in Improving Access to Psychological Therapies for children and young people.
Report of the children and young people's health outcome forum (Department of Health, 2012)	Established realistic and achievable outcomes that demonstrate that young people are healthy.
Improving Young People's Health and Wellbeing. A Framework for Public Health (Public Health England, 2014)	A public health approach to young maximise young people's health, including reducing health inequalities and delivering youth friendly services.
Future in Mind – Promoting, protecting and improving our children and young people's mental health and wellbeing (Department of Health, 2015)	A vision for children and young people's mental health. Includes increased health promotion and prevention work.

Table 4 Key Government Policies Relating to Children and Young People, 2007-2015

The policies listed have served to focus service provision on the specific mental health needs of children and young people, emphasising their role as active participants in their mental wellbeing and on the increasing role of preventative health. Alongside influential research evidence this has driven trends in mental health services towards particular interventions (Department of Health, 2015; Evans & Banovic, 2014); the next section will highlight some of these current service delivery and intervention trends.

Current Trends in Child and Adolescent Mental Health Services in England

In the last five years the idea of Child and Adolescent Mental Health Services being divided into four tiers has fallen out of favour as government strategy has leaned towards early intervention and preventing hospital admission (Department of Health, 2015; NHS England, 2014). Children and young people's mental health professionals have begun delivering services that straddle tiers, such as intensive outreach services, and mental health in schools (Children & Young People's Health Forum, 2012; Department of Health, 2011; Department of Health, 2012; Health Select Committee, 2014). This change in the way services are delivered has resulted in the reorganisation of earlier tier structures. New services have emerged described as universal, targeted and specialist (Department of Health, 2015; Evans & Banovic, 2014). Universal services are for all young people and promote good mental health and wellbeing. For example, offering a drop in counselling session to talk over worries at a secondary school. Targeted services are for those young people who already have a specific need, and might be at risk of developing mental health difficulties. This includes, for example, those young people with learning disabilities or in local authority care. Specialist services are for those young people who have complex and severe mental health difficulties. This includes conditions such as eating disorders, self-harm, autism spectrum condition or attention deficit hyperactivity disorder (Evans & Banovic, 2014; NHS England, 2014). To meet the demands of children and young people's mental health difficulties services will inevitably continue to adapt; the desire for effective and evidence-based interventions is a key driver in research and policy. There is a trend for 'talking therapies' such as cognitive behavioural therapy and family therapy to be the dominant style of interventions, which will be discussed next (Department of Health, 2015; Hoagwood et al., 2014).

Cognitive Behavioural Therapy

The use of cognitive behavioural therapy as an intervention is a common theme across the National Institute for Health and Care Excellence guidance for children and young people's mental health; for example, it features in guidance for depression (National Institute of Health and Care Excellence, 2005) and anxiety (National Institute of Health and Care Excellence,

2014). Cognitive behavioural therapy has been seen by some as a 'cure-all' treatment of choice that has taken the limelight from other therapies (Cottrell & Kraam, 2005). Although studies have shown the utility of cognitive behavioural therapy its application to complex and chaotic clinical presentations requires further enquiry (Cottrell & Kraam, 2005; Hoagwood et al., 2014).

The use of cognitive behavioural therapy within Child and Adolescent Mental Health Services has been furthered by the introduction of Children and Young People's Improving Access to Psychological Therapies; a large collaborative project between the NHS and Higher Education Institutions to train therapists. The training enables graduates from a helping profession, and with experience of working with children and young people, to deliver specific cognitive behavioural therapy, systematic family practice and intrapersonal therapy for those young people with emotional disorders, such as anxiety and depression (NHS England, 2015). Children and Young People's Improving Access to Psychological Therapies was originally rolled out as an intervention for adults with mental health difficulties (Clark, 2006a). It was extended to include children and young people in 2011 (NHS England, 2015). The use of psychological therapies is embedded in the government policy 'No Health without Mental Health' (Department of Health, 2011). This policy aimed to introduce primary care mental health services that used manualised and evidence-based interventions which could demonstrate measurable outcomes within specified timeframes (Glasper, 2012). The number of research studies evaluating the effectiveness of Improving Access to Psychological Therapies for adults is limited and currently non-existent for children. While we wait for further research evidence to support its use there has been some professional commentary on its implementation. Timimi (2014) made the bold statement that Children and Young People's Improving Access to Psychological Therapies represented the 'fetishisation' of cognitive behavioural therapy as a treatment modality. Timimi argued that the programme encourages medicalisation and marginalisation of evidence for other treatment modalities. Timimi went on to question the use of outcomes measures within Children and Young People's Improving Access to Psychological Therapies that do not represent real life, and are difficult to use in front-line clinical situations. Opinion on Children and Young People's Improving Access to Psychological Therapies, in the absence of empirical outcomes, is speculative. It is evident that there is some controversy over its implementation and some hesitation as to the validity of the expected results. Despite this uncertainty the United Kingdom Government has continued its investment in staff training, in the manualised therapy, and the roll-out of services. This will have a lasting effect on the landscape of Child and Adolescent Mental Health Services provision.

Family Therapy

Family therapy has foundations in individual and group psychotherapy. It considers the interactions within a family system as well as some of the wider social systems (Barker & Chang, 2013). A review of family therapy by Carr (2014) found there was some evidence for family therapy being used with adolescents with drug and alcohol problems, behavioural problems, bullying, eating disorders, depression and anxiety. Family therapy has been identified by National Institute of Health and Care Excellence as a suitable intervention for a number of child mental health difficulties, particularly eating disorders (National Institute of Health and Care Excellence, 2004). There is currently a large randomised controlled study being conducted into the efficacy of family therapy for the treatment of self-harm (Leeds University, n.d.). Overall it can be concluded that the use of family therapy has gained momentum in child mental health, but as of yet lacks the clinical trials needed to establish fidelity to the therapeutic method and ascertain pre and post intervention outcome measures (Hoagwood et al., 2014).

Pharmacological Therapies

Concurrent with the rise of 'talking therapies', such as cognitive behavioural therapy and family therapy, the use of pharmacological, or drug, treatments has also increased in the last two decades (Hoagwood et al., 2014). Despite this increase in the use of medication the range of drugs used with children and young people remains limited, mostly to serotonin reuptake inhibitors for depression, stimulant medication for attention deficit hyperactivity disorder (Zuvekas & Vitiello, 2012) and antipsychotic medication for psychosis and conduct problems (Harrison, Cluxton-Keller & Gross, 2012). The use of medication with children with mental health problems has at times been controversial and public opinion is mixed. Stimulant medications for attention deficit hyperactivity disorder in particular have been portrayed negatively in the media, yet to date the largest multi-centre randomised controlled trial in child psychiatry has been to establish the efficacy of such medications (MTA, 1999). The scope of pharmacological treatments in child mental health is likely to remain limited. The direction from National Institute of Health and Care Excellence appears to be for talking-style therapies to be first line treatment, with the use of medication as a secondary consideration (National Institute of Health and Care Excellence, 2016).

Targeted Mental Health in Schools

It had been recognised for some time that mental health services at tiers 1 and 2 (see Table 3 on page 56) have required some attention in order for them to better promote good mental health and wellbeing (Department of Health, 2011; Department of Health, 2012; Health

Select Committee, 2014). To address these concerns school-based counselling services for young people in secondary schools were made available in the early 2000s. A service evaluation study has indicated that these counselling services were reactive to students' mental health needs and were most likely to be accessed by females with family issues or males with anger issues (Cooper, 2009; Vostanis, Humphrey, Fitzgerald, Deighton, & Wolpert, 2013). To tackle mental health needs at a much earlier stage the Targeted Mental Health in Schools was a national programme in England for implementing preventative and early intervention mental services. The programme was designed for those young people at risk of or already experiencing mental health difficulties (Department of Children, Schools and Families, 2008). Launched in 2008 Targeted Mental Health in Schools was a component of the government's overall strategy to improve the psychological wellbeing of young people. There were a number of compelling economic and service delivery reasons to focus intervention within a school setting. These included the potential for easier and closer interagency working and the opportunity to access harder to reach children who may not attend traditional hospital-based services (Wolpert, Humphrey, Belsky & Deighton, 2013). The evidence for "...the efficacy of school-based mental health services appears to be extremely promising" (Wolpert et al., 2013, p. 272) with systematic reviews, such as Sklad, Diekstra, Ritter, Ben, & Gravesteyn (2012), indicating that high quality programmes can provide positive measurable outcomes.

To date there has only been one large scale evaluation of the Targeted Mental Health in Schools programme, a randomised controlled trial involving over 30,000 pupils (Wolpert et al., 2013). Outcomes for the study were measured by a range of pupil self-report measures, such as the Strengths and Difficulties Questionnaire (Goodman, 2001). These were supplemented by parents and teacher surveys. The findings have suggested that the programme may reduce behavioural problems in primary school children, although this finding did not extend to children at secondary schools (Wolpert et al., 2013). Additionally, overall no positive benefits to emotional outcomes were found at either primary or secondary school populations. The biggest limitation to the study was the lack of a specific intervention, due to the diverse range of interventions used. The Targeted Mental Health in Schools project evaluation has provided some evidence of the benefits of early mental health intervention for children, particularly those with behavioural difficulties. The programme may address these behaviours before they become entrenched and result in the need for more intensive and costly children and young people's mental health intervention.

Summary: Children and Young People's Mental Health

The mental health needs of children and young people have been recognised as a concern since the mid-1900s. Mental health services to address these concerns have been shaped by psychiatry, clinical psychology and psychotherapy, and have evolved in response to research, government policy and service delivery contexts (Bracken et al., 2012; Cottrell & Kraam, 2005). Interventions for those young people with mental health problems have focused on talking therapies, although there is limited evidence for their success. Maintaining the mental wellbeing of young people has become an important agenda in the NHS. Child and Adolescent Mental Health Services in the United Kingdom continues to be re-configured, with a growing emphasis on health promotion and the prevention of mental health difficulties (Department of Health, 2014).

The discussion in this chapter has so far focused on the broader context and provision of Child and Adolescent Mental Health Services in the United Kingdom; occupational therapy was notably absent from this literature. Occupational therapists themselves have reported being part of children and young people's mental health teams since the 1950s (Bream, 2013; Lougher, 2001), but that they have struggled to carve out a profession-specific role (Fortune, 2000; Harrison & Forsyth, 2005). I will argue in the next section of this chapter that the possible reasons for this are embedded in a disconnection between occupational therapy and the use of occupation in this setting.

Occupational Therapy in Children and Young People's Mental Health

There is very little written about early occupational therapy practice in child psychiatry, although practice seemed to have commenced in the 1950s (Bream, 2013; Florey, 1989; Lougher, 2001). A small number of descriptive papers regarding occupational therapy intervention in child mental health first appeared during the 1960s and 1970s in the *American Journal of Occupational Therapy* and the *British Journal of Occupational Therapy*. These included 'Finger Painting for the Hostile Child' (Llorens & Young, 1960), 'Activity Programming for the Aggressive Child' (Maeda, 1960), and 'Occupational Therapy with Young Disturbed Adolescents' (Bell, 1977). These early papers were case-studies presented in a discussion format. They lacked a clear research design that would be withstanding of any rigour. In 1973, Widdup's journal article was the first to describe occupational therapy practice for a child psychiatric unit. Widdup highlighted the role of the occupational therapist in the assessment of normal and abnormal behaviour, level of functioning and relationships. Occupational therapy treatment at this time consisted of play to facilitate improvements in emotions, relationships and social skills (Widdup, 1973).

There was an absence of further literature describing professional practice until 1982, when Jeffrey reported on the future of practice in the *British Journal of Occupational Therapy*. Jeffrey intended her paper to clarify the role of the occupational therapist. She indicated the staffing levels and facilities required in an occupational therapy department. She also identified the need for post-registration studies and research. In her article Jeffrey (1982) reflected on her own work and research, and described occupational therapy assessments and interventions that were framed by medical and psychotherapy practices, such as sensory-motor work and non-directive therapy. I would suggest that this reliance on psychotherapeutic principles was reflective of the wider profession's alliance with medicine.

A United Kingdom survey of occupational therapists, working in children and young people's mental health (Jeffrey, Lyne & Redfern, 1984) furthered Jeffrey's (1982) findings. This survey suggested that occupational therapists were conducting therapy with foundations in play therapy and family therapy. Further literature during the 1980s and 1990s confirmed the use of play therapy and psychotherapeutic work as the dominant practice of occupational therapists (Reade, Hunter & McMillan, 1999). For example, Jeffrey (1984) presented a single-subject study of an assessment and intervention named 'Developmental Play Therapy'. She underpinned her work with the developmental theories of Freud, Piaget, Erikson, Peller and Hellersberg. Similarly, Copley, Forryan and O'Neill (1987) presented two case-studies which illustrated play therapy and counselling work with children. Also integrating psychotherapy with occupational therapy practice, Telford and Ainscough (1995) wrote a discussion piece in the *British Journal of Occupational Therapy*. This considered the use of psychoanalytical insight with non-directive play therapy. The authors suggested that occupational therapists could use their skills of activity analysis to provide a link between play and psychotherapy whereby the use of graded play could facilitate the engagement of low functioning hard to reach children.

A rather uncoordinated and unscientific approach to the creation of occupational therapy research continued during the 1980s. The only significant contribution came from the *Journal of Occupational Therapy in Mental Health* which dedicated an issue in 1987 to topics surrounding child mental health, for example 'The Application of the Model of Human Occupation: Assessment in Child and Adolescent Psychiatry' (Sholle-Martin, 1987) and 'A Vocational Readiness and Independent Living Skills Programme for Psychiatrically Impaired Adolescents' (Nelson & Condrin, 1987). Again, these studies were case descriptions often using some form of outcome measure, such as a rating scale, observation or interview with no control group or statistical analysis. These studies were, nonetheless, some of the first to describe the use of occupation as an intervention in this field.

Occupational therapy practice and research in children and young people's mental health has struggled to keep pace with the renaissance of occupation seen in other areas of the profession (Bendixen & Kreider, 2011; Fortune, 2000; Hardaker et al., 2007; Harrison & Forsyth, 2005). I propose that there are a number of reasons for this, which will be examined next; to structure this discussion the three levels of the Occupational Practice Model presented in Chapter One: theory, perspective and intervention, will be used. At each level consideration will be given to research and practice evidence. However, research into occupational therapy for children and young people's mental health has been incongruent and uncoordinated, making synthesis and conclusions difficult to draw (Hardaker et al., 2007). Despite this discord in the literature, some synthesis is offered in this chapter. However, it was not always possible to clearly define literature as either addressing occupational therapy at the level of theory, perspective or interventions, so there are at times overlaps.

Theory

The occupational theory of humans and health, including the construct of occupation, occupational science, occupational justice and models of occupation presented in Chapter Two are applicable to all occupational therapists, including those in children and young people's mental health. There have also been theoretical developments specific to the context of children and young people's mental health. Understanding 'what young people do' has been a focus to these theoretical developments, with attention drawn to the doing of children and young people with, and without, mental health difficulties, these are presented next.

Occupations for Children and Young People with Autism Spectrum Condition

To comprehend the occupational lives of young people with autism spectrum condition Marquenie, Rodger, Mangohig and Cronin (2011) considered the experience of dinnertime and bedtimes within families. This qualitative study of 14 mothers used semi-structured interviews to discuss and explore experiences, which were analysed using thematic analysis. The authors clearly described the use of member checking and rich description as strategies for enhancing rigour. The overarching themes of 'centred on autism spectrum conditions' and 'autism spectrum conditions alter meaning' were presented. The first theme described the constant focus on the child and the accommodations made to daily occupations and the second theme emphasised the challenges of dinnertime and bedtime. This study highlighted the need for children with autism spectrum condition to have structure and routine that accommodates idiosyncrasies and allows for meaningful occupations and interactions. Marquenie et al. (2011) suggested that occupational therapists should work with families to help create structure and

understate their individual child's requirements and challenging behaviours as this may allow for the development of more cohesive family time.

The Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association, 2013) guidelines for autism spectrum condition diagnosis include a lack of make-believe and social play as a sign of a possible autism spectrum condition. Play is the major occupation of children and therefore the occupation of play for children with an autism spectrum condition has been given some attention by occupational therapy researchers. A study by occupational therapists Ziviani, Rodger and Peters (2005) added to literature from other professions that identified that the play behaviours in children with an autism spectrum condition differ from typically developing children. In particular, this study of 44 children aged three to seven years found that the play of children with an autism spectrum condition, as measured on the Revised Preschool Play Scale (Knox, 1997), Singer's Protocol for Play Behaviours (Singer, 1973) and Lunzer's Scale of Play Behaviour (Hulme & Lunzer, 1966), lacked play organisation and pretend play. Also considering play behaviours Skaines, Rodger and Bundy (2006) investigated the playfulness of children with autism spectrum conditions. Playfulness has been defined as "the internal disposition to play and is understood as a quality of the child's play rather than simply the child's skill in performing specific activities" (Skaines et al., 2006, p. 505). The Test of Playfulness (Bundy, Nelson, Metzger, Bingaman, 2001) was used by the researchers to score video tapes of children participating in free play with the overall results indicating that children with an autism spectrum condition had less playfulness than typically developing children. While the author of the Test of Playfulness was also on the research team for this study, the raters were blinded to the child's status. The small sample size of both of the studies presented does limit their generalisability. However, both of these studies suggested that occupational therapists should recognise that children and young people with autism spectrum conditions have atypical play behaviours.

Occupations for Children and Young People with Attention Deficit Hyperactivity Disorder

Occupational therapy research has been conducted to understand the daily occupations of children with attention deficit hyperactivity disorder and their families. Segal (2000, 2004) and Segal and Frank (1998) presented a qualitative study over three papers illustrating how families construct, schedule and adapt their daily lives when they have a child with attention deficit hyperactivity disorder. Using interviews from 17 families attending support groups, Segal (2000, 2004) and Segal and Frank (1998) used a grounded theory approach to analyse their data and presented a range of findings and interpretations. The researchers found that families orchestrated detailed modifications to daily occupations in order to accommodate the

needs of their child with attention deficit hyperactivity disorder. Although modifications were eco-culturally bound and individual to each family there were some common times during the day that were problematic. Families highlighted mornings as particularly difficult time due to its associated time pressure which required a number of adaptations to reframe the mundane self-care tasks (such as getting dressed or brushing teeth) into fun, time limited activities which would help maintain concentration and focus. After school homework tasks were also challenging and would require one to one help from a parent. To manage homework tasks mothers in the study described developing cooking strategies that enabled them to cook and help with homework simultaneously. Mothers were found to take a pivotal role in adapting daily occupations and used the strategies of enfolding and unfolding where "Enfolding occupations is doing more than one occupation at a time. Unfolding consists of removing chunks of activities from previously established sequences of enfolded occupations" (Segal, 2000, p. 302). The study presented by Segal (2000, 2004) and Segal and Frank (1998) was conducted in California; differences in the attention deficit hyperactivity disorder diagnostic criteria in the United States of America (American Psychiatric Association, 2013) and Europe (World Health Organisation, 1993) could limit the transferability of the findings to the United Kingdom. The study did highlight the daily occupations that young people with attention deficit hyperactivity disorder find difficult, contributing to the understanding occupational performance for this population.

More recent research in the area of attention deficit hyperactivity disorder has evaluated play occupations (Cordier, Bundy, Hocking & Einfeld, 2009; Cordier, Bundy, Hocking & Einfeld, 2010a; Cordier, Bundy, Hocking & Einfeld, 2010b; Cordier, Bundy, Hocking & Einfeld, 2010c; Pfeifer, Terra, Santos, Stagnitti & Panuncio-Pinto, 2011). Cordier et al. (2009) evaluated the play behaviours of playmates when playing with a child with attention deficit hyperactivity disorder revealing that playmates mirrored behaviours of children with attention deficit hyperactivity disorder. The researchers suggested that children with attention deficit hyperactivity disorder could be demanding playmates and would only play with those children exhibiting similar play traits. This study suggested that children with attention deficit hyperactivity disorder may present with play that differs from children without attention deficit hyperactivity disorder; to explore this idea further Cordier et al. (2009) developed a model of play. Based on their literature review Cordier et al. (2009) postulated that children with attention deficit hyperactivity disorder were less playful and struggled with associative and cooperative play, play transitions and had more negative play behaviours. The authors developed a model that illustrated how the characteristics of attention deficit hyperactivity disorder (inattention, hyperactivity, impulsivity) interacted with elements of playfulness (motivation, internal control, freedom to suspend reality and ability to respond to social cues). An evaluation of the model was conducted using the Test of Playfulness to compare the play

behaviours of children with and without attention deficit hyperactivity disorder (Cordier et al., 2010a). The results indicated that children with attention deficit hyperactivity disorder were significantly less playful and had poor social skills, in particular a lack of interpersonal empathy was found. A lack of empathy can be associated with difficulties with sharing emotional states and understanding others' perspectives. Pfeifer et al. (2011) further contributed to the knowledge surrounding the differences in play between children with and without attention deficit hyperactivity disorder. This Brazilian study with 32 participants (16 with attention deficit hyperactivity disorder and 16 matched typically developing peers) evaluated the play partners, place of play and play activities using the Children's Play Behaviour Questionnaire. However, the validity and reliability of this measure must be questioned as it has the same author as the aforementioned study. The results should therefore be interpreted with caution, but suggest that children with attention deficit hyperactivity disorder preferred to play at school, with games and toys that did not need partners or have rules, when partners were required the preference was for classmates. This study has drawn some parallels to that conducted by Cordier et al. (2009) and has further contributed to our understanding of play occupations for children with attention deficit hyperactivity disorder.

Understanding Time Use

Understanding what children and young people without mental health problems do with their time and the potential impact this may have on their health and wellbeing could be key to developing preventative occupational therapy interventions (Desha & Ziviani, 2007). A study by Passmore (2003) considered what adolescents do with their leisure time. This population-based survey was conducted across schools in Perth, Australia. The Leisure Survey was used to distinguish between achievement leisure (such as team sports), social leisure (such as talking with friends) and time-out leisure (such as reading) as independent variables. These were compared with the dependent variables of self-efficacy, competence, self-worth and mental health as measured by a perceived self-efficacy scale and a self-perception profile for adolescents. The findings support the view that leisure influences mental health, but most strongly through enhancing competency. The results also substantiate the existence of a significant relationship between achievement and social leisure and mental health in adolescents. Furthermore, these results demonstrated that positive mental health is a function of enhanced competencies, self-efficacy and self-worth, and that these are partially influenced through the contribution of leisure experiences (Passmore, 2003). The findings from this study suggested the potential need for occupational therapists to focus on self-belief about occupation as well as on the performance of the occupation itself. In this study self-efficacy appeared to be a prerequisite rather than an outcome of occupational competence and therefore maybe needed to initiate participation in occupations. Although the study was

not able to establish causality, it suggested that leisure participation could be used by occupational therapists as an intervention to maintain mental health and develop self-efficacy and competence.

If having appropriate leisure occupations could contribute towards good mental health, then the lack of something to do could be seen as a risk factor for poor mental health. The idea of leisure boredom as being a risk factor for adolescent risk behaviours was explored in a systematic review by the occupational therapists Wegner and Flisher (2009). Twenty-five studies were included in this systematic review; the majority of the studies were the results of self-report questionnaires. This could perhaps limit the depth of the data, but did enable large participant numbers to be considered. There were a number of findings; these included the idea that social control (such as parental restriction), gender and age influence potential leisure boredom. Young people whose parents took a greater interest in what they were doing had lower levels of boredom, whilst those with greater parental monitoring were more likely to be bored. Overall, gender was not found to be a predictor of leisure boredom; it was found that gay youth who were more bored were less likely to engage in exercise and more likely to rebel. The context of leisure did impact on levels of leisure boredom including access to leisure resources and the availability of free time from school, homework or other chores. A number of personal factors also influenced leisure boredom such as personality, motivation and mood. Wegner and Flisher (2009) went on to evaluate whether there was a relationship between leisure boredom and risk behaviours. The most significant result was a positive correlation between boredom and substance use. The authors identified a number of limitations to their study, most notably the systematic review by only two people having the potential for selection bias. Nevertheless, this paper does offer some tentative support for the development of leisure occupations as a preventative intervention for alleviating boredom and mitigating for the risks of mental health and risk behaviours. What such a preventative leisure intervention could look like has yet to be developed, trialled and evaluated.

A further study to understand what adolescents do with their time was conducted by Hunt, McKay, Fitzgerald and Perry (2013). This study was framed by occupational science and an occupational view of humans and health. The study sought to explore the cultural differences in how young people without mental health difficulties spend their time in Ireland. They found gender difference in time use, this reflected international trends whereby males spend more time on physical activity and females spend more time on personal care. They also highlighted how the basis of many girls' friendships is on social-communication activities which has resulted in an increased use of electronic occupations such as texting and social media. Again, this study of what adolescents 'do' with their time could help occupational therapists consider

what interventions might be appropriate when adolescents are at risk of not 'doing' and therefore at risk of mental health problems.

To summarise this section, the development of occupational therapy theory in children and young people's mental health has been limited, but has centred on understanding how those with and without mental health difficulties use their time and experience occupations. This knowledge builds on profession-wide theoretical developments associated with occupation. Continuing with the structure of the Occupational Practice Model the discussion now turns to the level of perspective.

Perspective

A lack of a profession-specific perspective has potentially limited the ability of occupational therapists to adopt a profession-specific role in the field of children and young people's mental health (Fortune, 2000; Harrison & Forsyth, 2005; Henderson, Batten & Richmond, 2015; Sholle-Martin & Alessi, 1990). It has been suggested that without a clear role occupational therapy in the United Kingdom has been marginalised within already neglected services. In an attempt to consider the professional perspective of United Kingdom occupational therapists, Fortune (2000) completed a qualitative study to address the question: Is current practice in children and young people's mental health occupational in nature? Using six in-depth interviews Fortune used coding followed by theme development to create narratives of therapists' reasoning. Disappointingly for the profession, Fortune (2000) reported the idea that occupational therapists took the perspective of being "gap fillers" (p. 227) and their roles were often devoid of using occupation. The study found a lack of professional identity rooted in roles developing in response to the context, client or colleagues rather than from core occupational therapy values. Fortune concluded from the study findings that without a clear occupational perspective occupational therapists in children and young people's mental health had become philosophically lost and were driven to borrowing concepts from other disciplines. The results of this study need to be considered in the broader context of occupational therapy. Fortune conducted her study at a time when an occupational perspective of humans and health, as presented in Chapter Two, was beginning to take shape. Moreover, the number of interventions that were occupation-based or occupation-focused was minimal.

Without a clear way forward for the profession in children and young people's mental health, occupational therapists struggled to create a professional lens that reflected occupation. In 2005 Harrison and Forsyth asked whether occupational therapists in children and young people's mental health were "poised or paused" (p. 181) to use specific occupational theory, use occupation-based assessments and interventions and to create core roles and skills. This opinion piece detailed the historical picture, complexity of occupational therapy and a lack of

a research evidence base as factors contributing to stalled practice and a lack of a collective vision. Harrison and Forsyth (2005) advocated for the use of the Model of Human Occupation to provide a theory and language to practice and stressed the importance of clinical and academic partnerships to forge research opportunities.

Since the study by Fortune (2000) citing occupational therapists as being gap fillers and the call to be poised for action by Harrison and Forsyth (2005), occupational therapy practice in child mental health has struggled to rise to the challenge of creating an occupation-specific perspective. Indeed, a subsequent literature review by Hardaker, Halcomb, Griffiths, Bolzan and Arblaster (2007) pertaining to the role of the occupational therapist in adolescent mental health, supported the findings of Harrison and Forsyth (2005). Hardaker et al. (2007) suggested that difficulties with professional role identity, a growth in generic working, role-blurring and limited assessments and interventions as particular problems for occupational therapists. Hardaker et al. (2007) went on to suggest that these limitations could be attenuated if occupational therapists were able to clearly articulate their unique theoretical framework to understand the occupational nature of people. To understand and develop the role of occupational therapy in children and young people's mental health, Hardaker et al. (2007) proposed that a survey or interviews could be used to illuminate and share practice. No such survey or interviews have been found to have been conducted, until the one conducted as part of the study presented in this thesis. With developments in the theory of occupation, such as occupational science, and some small advances in occupation-based and focused research over the last decade, it would be hoped that this would be reflected in practice. A recent paper by Henderson et al. (2015), which examined perceptions of the role of occupational therapists in children and young people's mental health, found that other health professionals still struggled to understand the occupational therapy role. The participants of this study did, nevertheless, report that occupational therapists had strong generic skills and fitted into the multidisciplinary team.

It appears that a profession-specific lens has been difficult to achieve for occupational therapists in children and young people's mental health. The literature has suggested that occupational therapists can be good generic mental health workers and that their roles develop in response to the setting rather than from profession-specific skills. While being able to fit into a multidisciplinary team and 'fill gaps' in services may be a desirable trait, it fails to demonstrate an occupational perspective of humans and health or provide a lens from which to enact occupation-based to focused practice.

Interventions

Occupation-focused and Occupation-based Interventions

There are only a small number of studies that have described occupational therapy practice that is either occupation-based or occupation-focused in children and young people's mental health. These studies can be broadly divided into two types: firstly, those studies that included an occupational therapy intervention as a component of a multidisciplinary mental health programme (Dare & Eisler, 2000; Knis-Matthews, Richard, Marquez & Mevawala, 2005; Olson, 2006; Schnell, 2008; Scholz & Asen, 2001); and secondly, those studies that reported occupational therapy as the sole intervention (for example, Wilkes-Gillan, Bundy, Cordier & Lincoln, 2014a).

Reporting occupational therapy as part of an inpatient mental health programme, Olson (2006) used case studies to describe how she employed an occupational therapy group to engage adolescents in activities with their parents. Olson suggested that fostering adolescent-parent relationships could assist an adolescent's occupational development, although she conceded that this was professional opinion and could not be substantiated through her case-study. Providing a somewhat more scientific approach Knis-Matthews et al. (2005) evaluated an occupational therapy programme using the Children's Self-Assessment of Occupational Functioning based on the Model of Human Occupation. The six participants were aged 11-17 years, attended a residential programme and had a psychiatric diagnosis. Following an initial occupational therapy assessment, the young people participated in a range of group activity interventions, including family night and community service as well one to one occupational therapy over 12 weeks. The authors used two case studies to illustrate the interventions in greater detail but disappointingly the Children's Self-Assessment of Occupational Functioning re-evaluation data are not included, so it is not possible to draw anything more than descriptive conclusions, which were mainly positive. Also evaluating occupational therapy as part of an adolescent group programme, Schnell (2008) described a retrospective analysis of the occupational performance of 78 adolescents. Schnell assessed occupational performance using a modified Occupational Therapy Task Observation Scale, which in its original form had good reliability and validity. Despite gaining permission from the Occupational Therapy Task Observation Scale developers to modify the tool, the psychometric properties could be questioned and therefore the reliability and validity of the findings. Further limitations can be drawn from the number of study variables that were identified including alternative interventions and external factors such as the role of family. Additionally, the paper did not describe the interventions, occupational therapy or otherwise. The results showed a positive linear relationship between occupational performance and recovery. Whilst this was an

affirmative outcome it is not possible to establish the cause of this relationship and without a control group recovery and increased occupational performance could have occurred without an intervention. Overall, the generalisability of the findings is limited due to the lack of specificity of intervention and the use of a modified assessment tool.

Occupational therapy has also been included as a component of intervention programmes for adolescents with eating disorders in two of studies (Dare & Eisler, 2000; Scholz & Asen, 2001). Dare and Eisler (2000) involved an occupational therapist in the planning of their day treatment programme for anorexia nervosa and bulimia. The occupational therapist suggested that the programme incorporated "...a number of structured tasks with the adolescents and their siblings..." (p. 14) which were included in the programme. However, the study did not include occupational therapy as a specific intervention; rather, it comprised family therapy, group therapy and a psycho-educational approach. The impact of occupational therapy can therefore not be established. In a similar style of day treatment programme Scholz and Asen (2001) did include an occupational therapy session in their multidisciplinary intervention for young people with eating disorders; this was described as a parallel craft or cooking activity. The occupational therapy in this study was part of a multi-disciplinary treatment programme, including psycho-education and family work as well as weighing and structured eating. The outcomes of these multi-intervention studies by Dare and Eisler (2000) and Scholz and Asen (2001) are difficult to ascertain as no standardised outcome measures were used and outcomes were vague and descriptive in nature. The absence of a defined research design, lack of intervention specificity and limited outcomes question the validity of the results of these studies. It was certainly not possible to ascertain the impact of occupational therapy on the participants.

Occupation-based and occupation-focused interventions delivered solely within occupational therapy have been reported for young people with attention deficit hyperactivity disorder (Cantrill, Wilkes-Gillan, Bundy, Cordier, Wilson, 2015; Wilkes-Gillan et al., 2014a; Wilkes-Gillan, Bundy, Cordier & Lincoln, 2014b). These studies have begun to develop, and evaluate a play-based (and therefore occupation-based) intervention for children with attention deficit hyperactivity disorder. The first study used the Test of Playfulness (Bundy et al., 2001) as a pre and post intervention measure (Wilkes et al., 2014a). The intervention consisted of seven weekly play-based sessions to promote social play with 14 age matched children with and without attention deficit hyperactivity disorder. The study clearly described the intervention and the analysis using a t-test to compare pre and post intervention mean scores on the Test of Playfulness. The results showed a large significant increase in Test of Playfulness scores for both groups that was not as a result of any confounding variables. These results supported the use of a play-based intervention to improve social play skills in children. Follow-up at

eighteen months demonstrated continued improvements on the Test of Playfulness (Wilkes-Gillan et al., 2014b). Further studies are required with a larger number of participants, random sampling and blinding to confirm generalisability.

An occupation-focused approach has also been used to understand and treat anxiety. Christie (2007) used a single-subject study to present the occupational therapy assessment and intervention of an 11-year-old girl with anxiety. While Christie understood the girl's difficulties as a disruption to her occupations related to play, school and the family, she used counselling, cognitive behavioural therapy and family therapy as the intervention strategies. While positive outcomes such as enjoying school and making friends are described by Christie these were narrative in nature rather than measureable outcomes. Tokolahti, Em-Chhour, Barkwill and Stanley (2013) have offered a study with more definitive outcomes and with occupation-based assessments and interventions. Their nine-week group intervention was designed to address occupational participation and engagement and aimed to use graded and scheduled occupations to teach behavioural and cognitive strategies. A variety of outcomes measures were used to determine occupational, behavioural as well as general health outcomes. Thirty-four participants aged 10-13 years of age took part in the study which showed a statistically significant change in their anxiety levels as measured by the Child Behaviour Checklist. In addition, there was an overall improvement in health and functioning. The lack of a control group and the small sample size mean the results cannot be generalised. However, it was the first study using a manualised occupational intervention with this group of children and young people.

The number of studies reporting the use of occupation-based or occupation-focused interventions for young people with mental health problems is limited. The rigour of the research design of these studies has varied, meaning that it is has not always been possible to generalise or transfer the findings to other situations. There have also been a small number of studies of occupation-based and occupation-focused interventions for young people at risk of mental health difficulties, which are detailed next.

Interventions for Children and Young People at Risk of Mental Health Difficulties

In an alignment with an occupational perspective of health, occupational therapists are not only working with young people who already have mental health difficulties but also those who may be at risk (Bazyk & Bazyk, 2009; Paul-Ward, Lambdin-Pattavina & Haskell, 2014; Precin, Timque & Walsh, 2010). Historically, interventions in the area of children and young people's mental health have focused on those with a diagnosed mental illness, provided in

psychiatric settings. More recently occupational therapists have used a public health model to expand the scope of their service (Arbesman, Bazyk & Nochajski, 2013). Occupational therapy interventions that focus on public health have the potential to help adolescents to maintain their mental health. Such programmes are not exclusive to occupational therapy; in the United Kingdom programmes such as Targeted Mental Health in Schools are an example of a health promotion and prevention intervention. Studies examining occupational therapy with at risk youth have considered diverse populations, been located in diverse geographical locations and used diverse research methodologies.

At a broad population level Simó-Algado, Mehta, Kronenberg, Cockburn and Kirsh (2002) detailed an occupational therapy intervention for children survivors of war. Simó-Algado et al. advocated for occupational therapy to fight against occupational injustice and to prevent mental health difficulties, particularly post-traumatic stress. The occupational therapy programme was delivered in Kosovo with children and young people aged 6-14 years at risk of mental health difficulties as a consequence of war. The intervention was grounded in the Model of Human Occupation (Kielhofner, 2008) as well as a community-based and health promotion approaches. The intervention sought to train local community members to work with children. The authors provided a clear description of the theoretical underpinnings and the practical training the local community members received. The interventions were occupation-based such as play, but the focus and outcomes of the sessions appeared to be on emotional expression rather than occupational participation. Measureable outcomes were not used but the authors described how "Through engagement in occupations the children were able to look and find meaning in their experiences and give new meaning to their daily lives" (p. 213). Simó-Algado et al. believed that the children's spiritual potential, resilience and visions for the future had been affected by the programme. It is unfortunately not possible to authenticate these assertions; indeed, some qualitative children's narratives would have supported the study outcomes. The preventative aspect of this study is equally hard to establish and whether the children in the programme did or did not go on to develop mental health problems as a result of war is not known.

Also addressing health prevention, Bazyk and Bazyk (2009) used a phenomenological research design to examine an occupation-based group for urban youths in the United States of America. The study evaluated an intervention described as a one hour, weekly occupation-based programme which included "...conversation time, participation in a structured leisure occupation, and a short closure discussion" (Bazyk & Bazyk, 2009, p. 71). The programme was evaluated using interviews with 10 young people aged 9-12 years. The major finding was the need for occupations that were perceived as fun, novel and challenging. In addition, the participants learnt ways to express their feelings, particularly anger. The study findings did

suggest that occupational enhancement (providing opportunities to do things) had the potential to alleviate occupational injustices.

Sensory Integration Theory and Sensory Integration Therapy

While there are limited studies reporting occupation-based and occupation-focused interventions, the literature is saturated with studies that have used sensory integration therapy. Sensory integration therapy is not an occupation-based or focused intervention, rather its aim is to remediate underlying sensory processing. Sensory integration therapy has had a strong and long history with occupational therapy, indeed the participants of the survey and ethnographic phases of this study report its use in practice, and therefore some overview in this thesis was deemed necessary.

Sensory integration is a theoretical framework for understanding the processing of sensory information by the body and central nervous system. It was developed in the 1950s by the occupational therapist Dr Jean Ayres (Parham & Mailloux, 2014). Sensory integration theory postulates that sensory information is received from the five common senses of touch, vision, smell, taste and hearing along with the two hidden senses of proprioception (knowledge of body position in space) and vestibular (balance) (Parham & Mailloux, 2014). Sensory integration theory is a neuromaturational and hierarchical theory that suggests that the development of sensory processing requires a pyramid of abilities that build on each other. While the theory of sensory integration has gained some credence, sensory integration therapy designed to 'fix' problems with sensory processing has yet to clearly demonstrate effectiveness (Case-Smith, Weaver & Fristad, 2015; Lang et al., 2012). Sensory integration therapy focuses on the selective transmission of sensory information into the central nervous system; the interpretation and organisation of this information produces an adaptive movement strategy and feedback to the sensory systems (Parham & Mailloux, 2014). Research into the effectiveness of sensory integration therapy overall has not been conclusive (Mandich, Polatajko, MacNab & Miller, 2001). Nonetheless, it continues to be used in clinical practice, particularly with children with autism spectrum condition and attention deficit hyperactivity disorder, who are commonly seen in children and young people's mental health (Case-Smith et al., 2015; Chu & Reynolds, 2007a; Chu & Reynolds 2007b; Lang et al., 2012).

Chapter Summary

Children and young people's mental health services have lacked investment and research which has resulted in a lack of effective interventions. The professions of psychiatry, clinical psychology and psychotherapy have dominated professional practices in mental health services. This has created a reliance on talking-style therapies, and in particular cognitive

behavioural therapy. Whilst mental health services for young people have traditionally been reactive, there is a growing move towards health promotion and prevention approaches. Services for those young people who require specialist mental health interventions are likely to still continue to be offered on an outpatient and inpatient basis.

Occupational therapy has become somewhat marginalised in child mental health services due to the strength of clinical psychology, psychotherapy and psychiatry and the dominance of evidence-based interventions such as cognitive behavioural therapy. Occupational therapy in children and young people's mental health has also struggled to keep pace with developments in the use of occupation seen in other areas of the profession; there are a number of potential reasons for this. Firstly, there had been no clear leader driving practice and research. Secondly, the number of occupational therapists in this specialised field is small, disparate and often working in isolation from other members of the profession. Thirdly, I have argued that there is a disconnection between the enactment of occupation-based and occupation-focused interventions, the adoption of a professional perspective that embodies occupation and the use of research that espouses an occupational perspective of humans and health.

Chapter Four: Research Design

Introduction

This chapter will outline the overall research design of the study presented in this thesis. I will detail how this study was underpinned by critical realism, which guided and supported the use of a mixed methodological approach, using a survey method and ethnographic approach. The survey and ethnography were separate but related parts of this study and therefore this chapter serves as an overarching guide to this study's research design. A more detailed presentation of the survey and ethnographic research methods are presented in Chapters Five and Six respectively.

Research Question

How does occupation emerge in the practice of occupational therapists in children and young people's mental health?

Aims

1. To critically explore current occupational therapy practice in children and young people's mental health.
2. To critically evaluate the meaning and implementation of occupational practice by occupational therapists working in children and young people's mental health.

Objectives

1. To administer an online survey to scope the current demography and professional practices of occupational therapists working in children and young people's mental health.
2. To use an ethnographic approach to critically explore and synthesise occupational practice by occupational therapists working in children and young people's mental health.

Research Ethics

Ethical approval for this study was given by the University of Huddersfield School of Human and Health Sciences Research Ethics Panel and the NHS National Research Ethics Service (National Research Ethics Service reference 11/YH/0181, see Appendix 10). The author of the study conducted this research within the ethical boundaries set out in the Health and Care Professions Council Standards of Proficiency for Occupational Therapists (Health and Care

Professions Council, 2007; Health and Care Professions Council, 2013) and the College of Occupational Therapists Code of Ethics and Professional Conduct (College of Occupational Therapists, 2010; College of Occupational Therapists, 2015). Further ethical considerations and permissions are detailed for each stage of the study, in Chapter Five and Chapter Six.

Rationale for the Study Design: A Research Framework

The research design for this study is presented as a methodological journey, beginning with the design of a research framework (see Figure 8 on page 79). The purpose of the research framework, developed for this study, was to bring coherence to the choice of research paradigm, methodology, method, and data analysis (Davis, 2012; Evans, Coon & Ume, 2011; Greene, 2006; Harrits, 2011; Onwuegbuzie, Johnson & Collins, 2011). Congruence between these critical areas of research design helped to defend the research outcomes (Carter & Little, 2007; Onwuegbuzie et al., 2011; Plowright, 2011). The use of a research framework is supported by Creswell (2009) who suggested that research designs should be made more explicit to demonstrate methodological rigour. The research framework for this study was adapted from work by Carter and Little (2007) and included key principles from Creswell (2009), Bryman (2006), and Crotty (1998). I propose that there was a transactive relationship between the components of the framework, meaning that they were mutually informative, rather than hierarchical. This dependent relationship between the components reflected a cycle of research design whereby a decision regarding an element of the framework had a reciprocated action or influence on both previous and subsequent elements (Harrits, 2011).

Having established a theoretical framework for the research design, this study was superimposed into the framework, this is shown in Figure 9 on page 79. Figure 9 illustrates how this study used mixed methodology (quantitative and qualitative) and mixed methods (survey, observations, interviews, and document review), underpinned by a critical realist research paradigm (epistemology and ontology). My decision and defence of this research design requires some explanation and discussion, which is presented next.

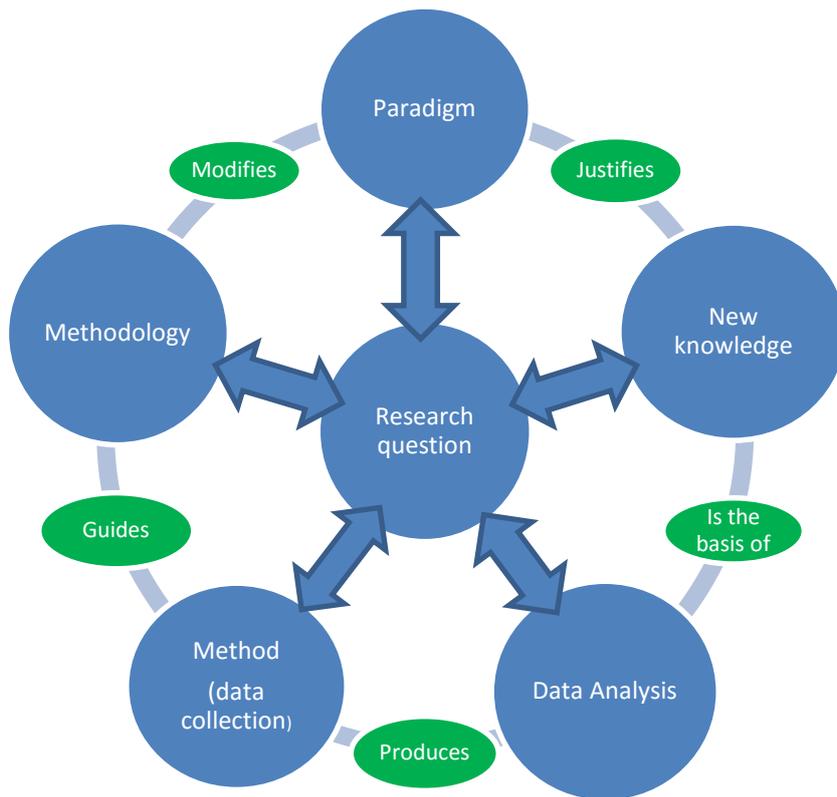


Figure 8 Research Design Framework

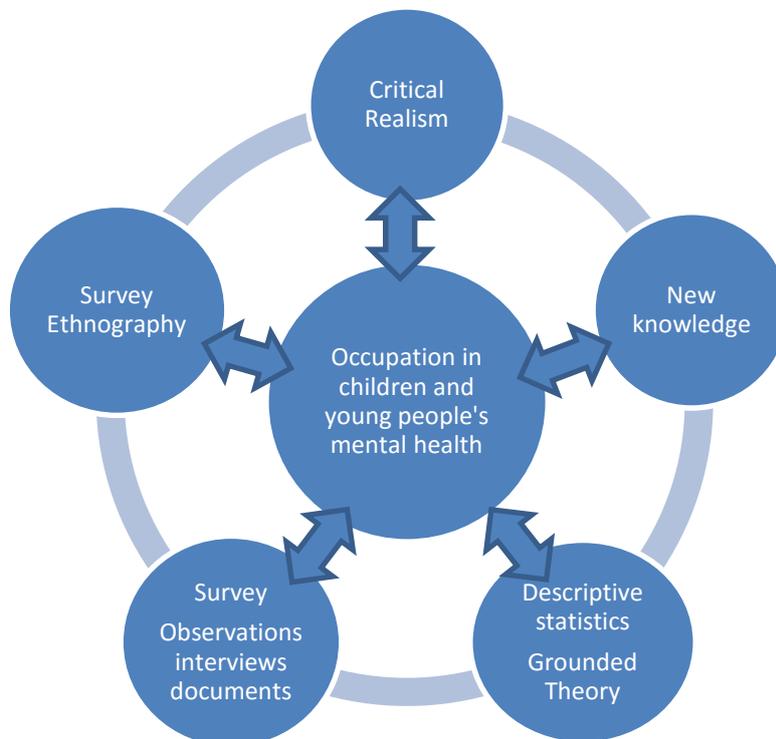


Figure 9 Research Design of this Study

Research Paradigms

The discussion in this section begins with research paradigms; a paradigm can be described as the most abstract or philosophical notion in research design. It refers to an overarching world view or set of principles that guides action (Creswell, 2009; Tashakkori & Teddlie, 1998). Paradigms in research are usually associated with the terms epistemology and ontology. Epistemology is concerned with the nature of knowledge and what is or should be acceptable knowledge within a discipline. Ontology is concerned with how reality is constructed and whether objective entities have a reality without humans (Bryman, 2016; Crotty, 1998). This study embraced a critical realist paradigm, with a realist ontology and both a subjective and objective epistemology. The ideas of the philosopher Kuhn (1996) are used to advocate for this as an appropriate design for this study.

The Influences of Kuhn

The perspective of research paradigms and their associated epistemology and ontology followed in this study has been influenced by some of the ideas of Kuhn (1996), a philosopher of science and the author of the book *The Structure of Scientific Revolutions* (1996). This study holds a view of paradigms consistent with Kuhn's suggestion, that there will be competing accounts of knowledge (epistemology) and reality (ontology), and that research will never reveal a truly objective account of the world. Kuhn proposed that at any one time a particular discipline will hold a notion of the truth based on a consensus within that community (Bird, 2000; Kaiser, 2012). While Kuhn did not define what he meant by a discipline, I would argue that occupational therapy could have this remit. Indeed, this suggestion is supported by the occupational therapists Kinsella and Whiteford (2008) who described occupational therapy as an epistemic community which produces its own knowledge.

A further notion of Kuhn's, and one that has held resonance with this study, is the idea that the evolution of science means that knowledge discovered in the past should not be deemed unscientific or irrelevant; rather, that it has become incompatible with our current understandings (Bird, 2000; Hammersley & Atkinson, 2007; Kaiser, 2012; Kuhn, 1996; Morgan, 2007). Kuhn (1996) wrote that we should not be "...seeking the permanent contributions of an older science to our present vantage..." (p. 3), rather we should accept a cycle of acceptance and rejection of knowledge. This position offers some assurance that occupational therapy has not conducted unwarranted research in the past; rather that research has been part of a larger process of scientific evolution. Kuhn (1996) argued that at some point in this scientific revolution knowledge paradigms would become incompatible and one paradigm may rise to the forefront over the other. He described this as a process of

periodic 'paradigm shifts' that will open up new ways of knowing and understanding (Kuhn, 1996). Applying Kuhn's ideas to knowledge development in occupational therapy allows there to be a place for research from a range of epistemological perspectives. These perspectives can concurrently exist until one becomes more dominant. This notion can be applied to the idea that occupational practice could become the dominant knowledge paradigm within occupational therapy (Tornebohm, 2014; Yerxa, 1993).

While the concepts presented by Kuhn have great potential for this study and occupational therapy, questions have to be raised as to which knowledge paradigm could develop acceptable knowledge, and what is an acceptable reality? Debate surrounding acceptable knowledge and reality uncovers two traditionally competing understandings of the world; positivism and interpretivism. These two contrasting ideas offered two different paradigms, or accounts of knowledge and reality, for framing this research. To offer some conclusion as to the paradigmatic position of this research study it is necessary to present some of the paradigmatic debates.

Positivist Paradigm

The scientific paradigm has been used to study the natural world (for example biology, physics, and chemistry). It contends that reality exists independently of humans and that this reality can only become knowledge when it reveals itself and is experienced through human senses (Bryman, 2016; Walliman, 2006). Natural sciences have been used to describe, understand and predict the naturally occurring world. Positivism is the label for social science research that has attempted to emulate research from the natural sciences (Bryman 2016; Greene, 2006; O'Reilly, 2012). Positivism endeavoured to measure social structures using quantitative methods and contended that the social realm could be calculated in a similar way to the natural realm. Positivist research within social sciences attempted to emulate natural science research by aiming to test a hypothesis and gain objective facts which can be generated into generalisable laws. A positivist paradigm has an ontological position of realism meaning that reality exists independently from humans. This ontology suggests a social order that can be uncovered through careful research (Bryman, 2016; McEvoy & Richards, 2006). Positivism also holds an objective epistemology, an idea that places knowledge and meaning about objects in the object itself; it is the researcher who must discover this meaning in an objective way.

The fundamental argument against the proposal of positivism as a way of understanding the social world is that the social world is different to the natural world (Howe, 1992). There are a number of ideas that support this assertion of difference. Firstly, that human beings change their behaviour and are reflective, therefore a realist ontology is not possible. Secondly,

humans' process information in a subjective way through their senses, therefore the objective epistemology of positivism is flawed. Additionally, not everything can be experienced, for example you cannot see electricity but accept its existence because of its effects. Finally, while positivist studies can determine the existence of something they cannot explain the cause of or explain why something happens (Howe, 1992; O'Reilly, 2012).

The use of the positivistic paradigm as a way of understanding reality and developing knowledge within occupational therapy has been described as running "...contrary to its philosophical perspective..." (Galle & Whitcombe, 2006, p. 187). Attempting to establish objective facts and consider cause and effect in relation to occupations which are socially constructed would appear to be incongruent (Forsyth et al., 2005; Reagon, Bellin & Boniface, 2010). The use of a positivist paradigm within health research has gained credence within the medical profession; correspondingly, occupational therapy fostered an allegiance with this approach (Galle & Whitcombe, 2006; Reagon et al., 2010). This perceived affinity with the positivist paradigm has resulted in the development of occupational therapy research that has focused on occupation but has measured outcomes related to body structures and functions (Duncan & Nicol, 2004). Reagon et al. (2010) have contended that occupational therapy should embrace multiple truths that reject a positivist perspective. As an alternative to positivism the interpretivist paradigm offers a perspective of knowledge developed within the social realm.

Interpretivist Paradigm

Interpretivists have suggested that the social world requires a different way of examination as it is totally different to the natural world (Bryman, 2016; Crotty, 1998). Interpretivists view humans as actors in their social and cultural world (Curtis & Curtis, 2011; David & Sutton, 2004). An interpretivist paradigm seeks to explain the relationship between events, rather than establish a cause and effect (O'Reilly, 2012). An interpretivist paradigm incorporates a subjective epistemology and relativist ontology (Bryman, 2016; Crotty, 1998). A truly interpretivist paradigm refutes natural order and embraces a socially constructed world discovered thorough interpretation (Sale, Lohfeld, & Brazil, 2002). Interpretivism recognises a subjective epistemology meaning that the world is created through our interpretations. Interpretivism rebuffs the idea of an objective reality waiting to be discovered and adopts the position of a relativist ontology that needs to be constructed by the mind; this reality may differ from person to person. A socially constructed reality is constantly changing and evolving and represents a view at that time and therefore does not offer definitive knowledge (Bryman, 2016; Crotty, 1998; Johnson & Onwuegbuzie, 2004). An interpretivist paradigm has been the mainstay of social science research in disciplines such as anthropology, sociology and human

geography. Occupational therapists have cited the interpretivist paradigm as providing an epistemological foundation for the understanding of people's complex occupational lives (Creek, 2003; Forsyth et al., 2005; Reagon et al., 2010; Wicks & Whiteford, 2006). Occupational therapists have commented that positivism and interpretivism can complement each other; as there is a need to understand both facts and meaning (Duncan & Nicol, 2004; Karlsson & Tham, 2006).

As discussed earlier in this chapter, the transactive nature of the research framework (Figure 9) meant that decisions regarding a research paradigm were considered within the framework as a whole. While wearing my 'Kuhnian' hat I could accept that the paradigms of positivism and interpretivism can coexist and both offer a way of understanding the world. A significant part of the research philosophy debate is that these paradigms should not be combined. There are purists of each approach who have contended that these two paradigms offer two absolute standpoints which have no common ground and "cannot and should not be mixed" (Johnson & Onwuegbuzie, 2004, p. 14). This may not be an issue for research that clearly sets out to ascertain knowledge within a positivist or interpretivist paradigm. Nevertheless, it was of concern for this study, which used a mixed methodology approach (qualitative and quantitative) and therefore straddled both research paradigms. To adhere to this long-standing paradigmatic impasse this study used neither a positivist nor interpretivist paradigm but used a bridging and "...reconciliatory approach" (Walliman, 2006, p. 20) known as critical realism.

Critical Realism

Realism in social science accepts subjective experience but also contends that there are also underlying structures that cause phenomena that we may not even be aware of (Bryman, 2016; Crotty, 1998; Curtis & Curtis, 2011; David & Sutton, 2004). Critical realism is "...the most prominent manifestation of realism" (Maxwell, 2012, p.14) and is associated with the influential philosopher Roy Bhaskar. The critical realist paradigm is seen as empowering social scientists to interface with the natural sciences (Bhaskar, 1998; Bhaskar, 2011). It has been described as embracing "...a coherent account of the nature of nature, society, science, human agency and philosophy" (Bhaskar, 2011, p. 148). Critical realism contends that there is no objective reality or definite knowledge and that there is always the possibility of other accounts of reality (Maxwell, 2012). Knowledge and understanding developed within a critical realist paradigm does require careful observation and measurement. That knowledge is one way of knowing that reality and is therefore conjecture. Critical realists assert that the conclusive truth can never be found and findings are fallible and biased (Bhaskar, 1998; Bryman, 2016; Creswell, 2009; Crotty, 1998).

A critical realist paradigm has been described as offering "...researchers a middle-ground..." (DeForge & Shaw, 2012, p. 85) where there are truths about the world which provide a reference point for theories to be tested. However, researchers can only ever empirically test aspects of the world that are accessible. Critical realists use both inductive and deductive reasoning. This approach has been named retrodution and described as: "Moving from the level of observation and lived experience to postulate about the underlying structures and mechanisms that account for the phenomena involved" (McEvoy & Richards, 2006, p. 71).

Supporting the use of critical realism in this study, it has been posited as a promising paradigm for health research (Angus & Clark, 2012; Cruickshank, 2012; McEvoy & Richards, 2003; Nairn, 2012). It has also been suggested that it offers a rationale for combining qualitative and quantitative methods (McEvoy & Richards, 2006). A critical realist paradigm therefore offered a world view that made it possible for this research study to describe the demography and practices of occupational therapists and observe occupational practice within one study. Using a critical realist paradigm enabled this study to generate one way of knowing the truth. The use of a critical realist perspective gave this study congruence with the occupational therapy profession with roots in both medical (positivist) and social (interpretivist) sciences. Research in occupational therapy has had difficulty reconciling its relationship between these traditional paradigms and critical realism as a reconciliation approach has offered this study a way forward (Duncan & Nicol, 2004). Similarly, occupational science as a foundation science for occupational therapy has also considered legitimate research paradigms (Carlson & Clark, 1991; Rudman & Dennhardt, 2008) suggesting that a combination of positivist and interpretivist approaches will bring strength to research designs.

To summarise this point, this study utilised a critical realist paradigm, which is justified through the paradigmatic debates of positivism and interpretivism. While it was easy to become tangled in these philosophical disputes, this thesis will not answer or end this debate, but has offered a solution for this study. The discussion now moves on to the research methodologies of this study. As already described there was a dependent relationship between the elements of the research framework, therefore a decision at the level of paradigm had already gone some way to guiding this methodology.

Research Methodologies

In the simplest form there are three research methodologies: qualitative, quantitative and mixed (which uses both qualitative and quantitative methodologies) (Bryman, 2016). This study used a mixed methodology, which can be described as incorporating qualitative and quantitative research strategies in one study (Leech & Onwuegbuzie, 2009). The mixing of methodologies has caused some controversy within the sphere of research design (Brannen,

2005; McEvoy & Richards, 2006; Tashakkori & Creswell, 2007; Tashakkori & Teddlie, 1998). Some justification of such a research design is therefore warranted. To do this will require some explanation of the other two methodologies.

Qualitative and quantitative methodologies have traditionally been described as opposites (Creswell, 2009). Qualitative methodology is associated with words, descriptions, opinions, feelings and meaning. Quantitative research meanwhile is allied with numerical data and statistical analysis to test relationships between variables. There are those who have argued that qualitative and quantitative methodologies are incompatible as they have different ontological and epistemological foundations (Brannen, 2005; Sale et al., 2002). As discussed above, the use of a critical realist paradigm has helped to deconstruct this dichotomous relationship between paradigms and therefore supported this study to embrace the use of both methodologies. The use of two research methodologies is supported by Crotty (1998), Newman and Benz (1998) and Creswell (2009) who rejected the notion of mutual exclusivity and contend that research methodologies should be considered on a continuum rather than opposites.

With the acceptance of some allegiance between qualitative and quantitative methodologies, the use of mixed methodology has become more acceptable in health and social science research (Brannen, 2005; Mason, 2006). There is mounting agreement that researchers should pragmatically use whichever methodologies enable them to best answer the question they are exploring (Duncan & Nicol, 2004; Johnson & Onwuegbuzie, 2004; McEvoy & Richards, 2006; Mason, 2006; Onwuegbuzie & Leech, 2005; Sale et al., 2002; Tashakkori & Teddlie, 1998). The use of mixed methodologies in this study was characterised by the use two different methodologies which complemented each other, but they were not combined (Sale et al., 2002). Each part contributed to the overall aims of the study but there were two distinct phases of the research design. This style of methodological research design provided a further congruent element to the research framework presented in Figure 8 and Figure 9. This leads the discussion to the practicalities of which methods or tools were used to gather the research data.

Research Methods

The use of a mixed methods approach to research is not new in health and social sciences research; it has become increasingly popular in disciplines such as education, psychology, nursing and occupational therapy (Ivankova, Creswell & Stick, 2006; Kielhofner, 2008; Leech & Onwuegbuzie, 2009). Morgan (1998) has suggested that the reason for an interest in mixed methods research design by health and social care researchers is because of "...the complexity of the many different factors that influence health" (p. 362). A survey of published

occupational therapy research concluded that mixed methods were used in 14 percent of studies (Mortenson & Oliffe, 2009). Despite a number of occupational therapy studies making use of mixed methods Mortenson and Oliffe (2009) found inconsistency in the rationale, theoretical positioning, terminology and methods employed. The decision to use the mixed methods of a survey and ethnography to collect research data was made early on in the research process. Morgan (1998) asserted that once a researcher had a clear grasp of the paradigms and methodologies for their research they are free to consider combining research methods at a practical or technical level.

There are a number of possible classifications or typologies of mixed methods research (Hall & Howard, 2008; Johnson, Onwuegbuzie & Turner, 2007; Teddlie & Yu, 2007). These range from the use of each method as a separate component to a fully integrated design (Bryman, 2006; Caracelli & Greene, 1993; Greene, 2006; Leech & Onwuegbuzie, 2009; Teddlie & Tashakkori, 2009). Although different mixed methods research authors present different typologies there appears to be a consistency in developing a study that has considered the design, priority, sequence and mixing of the research methods (Bryman, 2006; Caracelli & Greene, 1992; Creswell & Plano Clark, 2007; Ivankova et al., 2006; Morgan, 1998; Teddlie & Tashakkori, 2009). This study has used the ideas of Morgan (1998) and Creswell and Plano Clark (2007) as a basis for its design, priority, sequence and mixing, which are presented next.

Methods: Design

Firstly, Morgan (1998) deemed that the motivation for combining research methods should be for one method to enhance the other which he called 'complementarity'. Complementarity uses the strengths of different methods to assist in addressing the complexities of the research aims and objectives, especially when there is a clinical application. Using different terminology but presenting a similar idea is the concept of an 'explanatory design' by Creswell and Plano Clark (2007). In an explanatory design the research has two-phases where phase two builds on and helps to explain the first phase. Creswell and Plano Clark identified a variant of the explanatory design called 'participant selection' where the first method gathers preliminary data and guides purposefully sampling of the participants for the second method. This study used an explanatory participant selection variant research methods design whereby a survey gathered initial data and directed the sampling of participants for the ethnography.

Methods: Priority-Sequence

Building on the explanatory mixed methods design is the idea that one method is described as the principal research method which is enhanced by the second method. With many different methods to choose from Morgan (1998) proposed a Priority-Sequence Model to assist with the decision making process. An adaptation of Morgan's model is presented in Figure 10 on page 88; the highlighted sections show the priority-sequence for this study. In Morgan's (1998) priority-sequence model one research method should take priority over the other and one research method should precede the other. In this study the priority research method was ethnography and the complementary method a survey, the sequence was survey to ethnography. This type of study design is described by Morgan as a classic mixed methods design where "...a preliminary survey or census of a field setting either to guide the selection sites and informants or to provide a context for understanding..." (Morgan, 1998, p. 369).

The rationale for this sequence and priority was that the survey data provided an overview of the subject and the ethnographic data enabled further deeper explanation. While this study maintained the suggested two-phase sequence, the survey included eighteen closed questions and two open-ended questions resulting in mostly numerical data but also a small amount of text data. This first phase therefore cannot be strictly described as the quantitative phase, therefore Figure 10 on page 88 illustrates a quantitative/qualitative survey phase followed by a qualitative ethnographic phase.

This study's research method can at this stage in the discussion be summarised as having an exploratory design (with a participant selection variant) with sequential timing (quantitative/qualitative followed by qualitative) and a qualitative priority. The consideration now falls to the level of mixing that occurs in the research methods, a central consideration in a study with a mixed methods research design (Ivankova et al., 2006).

	Priority Decision	
	Principal Method: Quantitative	Principal Method: Qualitative
Sequence Decision	Complementary Method: Preliminary Qualitative Preliminary Qualitative → QUANTITATIVE	Quantitative Preliminary Quantitative → QUALITATIVE (quantitative/qualitative → QUALITATIVE)
	Complementary Method: Follow-up Qualitative Follow-up QUANTITATIVE → Qualitative	Quantitative Follow-up QUALITATIVE → Quantitative

Figure 10 Priority Sequence Decision Model (adapted from Morgan, 1998)

Methods: Mixing

In this study the research methods of a survey and ethnography have not been mixed, they represent two distinct phases of the research design. Where the mixing has occurred was in the discussion and creation of new knowledge. Creswell and Plano Clark (2007) suggested that there are three possible strategies for mixing data: merged, embedded or connected. This study has connected the data from its two phases where "...one type of data leads to...another type of data..." (Creswell & Plano Clark, 2007, pp. 83-84). To connect the data, the analysis in this study was sequential. The analysis of both the numerical and text data from the survey led into the ethnography. The findings from the survey were used to help focus the observations and interviews that formed the ethnography. The results of the phases of the research have been integrated, where possible, into the discussion of the study findings, which are presented in Chapter Ten.

Chapter Summary

This chapter has outlined the overall mixed methodology design of the study presented in this thesis. The use of critical realism has been posited as providing a sound theoretical foundation for the understanding of reality and creation of new knowledge. This study has used survey and ethnographic methods which have complemented each other through an exploratory

design, with sequential timing, a qualitative priority and mixing that occurred during the study's discussion. The focus of the next chapter is on the survey phase of the study.

Chapter Five: A Survey of Occupational Therapy Practice

Introduction

An overview of the research design of this study was detailed in Chapter Four; this chapter builds on this outline to describe in greater detail the rationale, design, and implementation of the survey phase of this study, including its reliability, validity and usability. This chapter will go on to present the findings of the survey, discuss the results and illustrate how these were connected to the ethnographic phase of the study. The use of a survey was underpinned by this study's use of mixed methods, mixed methodology and a critical realist paradigm. The critical realist paradigm supported the use of a survey method to generate knowledge of a reality of occupational therapy practice. The purpose of the survey was to provide both an understanding of occupational therapy practice in children and young people's mental health, as well as to offer a platform for purposeful sampling for the ethnography. The survey contributed to both aims of the study and aimed to fulfil the first objective as outlined on page 79.

Rationale for Using a Survey Method

A survey has been defined as a way of systematically collecting information through questions about the characteristics of a population (Fowler, 2009; Oppenheim, 2001; Sue & Ritter, 2012). Surveys are often utilised to collect data from a dispersed participant group, over a large geographical area and/or where there are financial restrictions (Edwards et al., 2002). Surveys have been used in a number of occupational therapy studies. These have included, for example, to understand clinical practice and to gather demographic information such as grade, qualifications and training (for example, Cronin-Davis & Spybey, 2011; Drummond, Coole, Brewin & Sinclair, 2012; Kingston, Williams, Judd & Gray, 2015). Correspondingly, the survey used in this study asked occupational therapists questions about what theories, models, assessments, interventions and outcomes they used as well as gathering demographic data. The survey captured a snap shot of occupational therapy practice in children and young people's mental health.

Survey Design

There are number of methods for administering surveys including by postal mail, phone or face-to-face interviews or online, which now includes smart phone applications (Andres, 2012;

Rhodes, Bowie & Hergenrather, 2003; Sue & Ritter, 2012). The first consideration in the survey design was therefore what would be the best method of survey administration to use. As the objective of the survey was to evaluate occupational therapy practice across the United Kingdom the use of phone and face-to-face interviews was eliminated, as this did not offer a time and cost-effective data collection strategy. This left postal mail or an online survey as possible options. Current literature on survey design suggests that traditional postal surveys, requiring participants to complete a paper-based survey and return their response by mail, have been associated with response rates as low as 16 percent (Lusk, Delclos, Bureau, Drawhorn & Aday, 2007). A low response rate reduces the sample size and can produce a bias to the results, which jeopardises validity (Cook, Dickenson & Eccles, 2009; Edwards et al., 2002). A small number of studies have evaluated strategies to improve response rates to postal surveys (Cook et al., 2009; Edwards et al., 2002). The strategies reported in these studies included contacting people in advance, including a reply envelope, offering incentives and sending reminders (Edwards et al., 2002). Although a number of these strategies were found to be of some benefit Cook et al. (2009) concluded that overall survey response rates from healthcare professionals are low. In light of these proposed difficulties the use of a postal survey for this study did not appear to be the most prudent option and the use of online surveys was seen as a more viable alternative (Sue and Ritter, 2012), as will now be explored.

Online Surveys

The use of online surveys as a research method is growing but is still in relative infancy (Andres, 2012; Rhodes et al., 2003; Sue & Ritter, 2012). Literature searches on the subject led to a growing number of books and journal articles dedicated to the design and implementation of online surveys (for example, Braithwaite, Emery, de Lusignan & Sutton, 2003; Gaiser & Schreiner, 2009; Sue & Ritter, 2012). The literature included research and opinion from a range of disciplines including computer science, behavioural science, communication, culture and research design (Fan & Yan, 2010; Kays, Gathercoal & Buhrow, 2012). There were also papers that considered the use of online surveys specifically with health professionals (Braithwaite et al., 2003; Lusk et al., 2007; Matteson et al., 2010). Overall, there was some consensus that online surveys could provide a comparable format for data collection when compared to paper-based surveys. Additionally, the literature suggested that online surveys could be appropriate for use with healthcare professionals, might provide improved data accuracy and may reduce socially desirable responses (Braithwaite et al., 2003; Kays et al., 2012; Sue & Ritter, 2012).

There were a range of potential advantages, disadvantages and limitations to online surveys discussed in the literature (Barchard & Williams, 2008; Rhodes et al., 2003). These have been

considered with caution as there was both limited literature and limited agreement across the literature; this lack of accordance may have reflected the contemporary nature and rapid evolution of online surveys as a research method. The major advantages of online surveys were the low costs and the ability to data collect from participants over a large geographical area (Barchard & Williams, 2008; Kays et al., 2012; Sue & Ritter, 2012). The use of online surveys has been linked to more incomplete answers, missing items and a wide ranging response rate, possibly associated with their over-use in society (Braithwaite et al., 2003; Fan & Yan, 2010; Lusk et al., 2007). In addition, it has been suggested that there are a number of socio-economic and personality factors that can affect the response rate to online surveys. These included access to the internet and computer literacy, age, sex, race, conscientiousness and openness to experience (Braithwaite, et al., 2003; Fan & Yan, 2010; Lusk et al., 2007). In conclusion, there did not appear to be any agreement in the literature that online surveys pose any greater limitations than postal surveys. Indeed, they offered a more cost and time effective research tool. Consistent with this conclusion an online survey was developed and implemented for this study.

Having adopted an online survey as the research tool for the study the platform for creating, hosting and analysing the survey was the next consideration (Sue & Ritter, 2012). The University of Huddersfield provided access to Bristol Online Surveys (2016) for students, therefore this host was used. Bristol Online Surveys are an online web-based survey service which provide survey design software, anonymity for participants, secure data storage and encryption, password protected account and data reporting (Bristol Online Surveys, 2016)

Designing Questions

The online survey was designed to contribute to both aims of the study and specifically address objective one (see page 77). Objective one considered the demographic and current professional practices of occupational therapists working in children and young people's mental health. Andres (2012) and Sue and Ritter (2012) have reported that when designing a survey, it is important to ask the right questions, use everyday language, be short and simple, ask one question at a time and not be leading. The overall survey design was influenced by my own clinical and academic knowledge of occupational therapy, together with current relevant theory and research. In addition, informal discussion was held with occupational therapists working in the field of children and young people's mental health to further guide the content of the survey. The final version of the survey had 20 questions divided into three sections (a copy of the final version of the survey can be found in Appendix 11). The first section covered issues of consent; the second main body of the survey comprised questions relating to participant demography and professional practice. This main

body of the survey gathered data regarding job title and area of work, qualifications, years qualified, further training, models/frames of reference/theories used in practice, assessment tools and interventions used in practice. The final section of the survey contained details of the study follow-up process. The majority of the questions collected nominal or ordinal data and included the use of Likert scales. In addition, there were two open-ended questions that collected qualitative data in the form of words and sentences. While the overall survey content was designed to understand occupational therapy practice the individual questions were developed through a process of conceptual development. The process of developing the questions was instrumental in designing a survey that was both a valid and reliable tool and these issues are considered next (Andres, 2012; Sapsford, 2007; Sue & Ritter, 2012).

Validity

The validity of a survey refers to the relationship between the survey questions and the concepts they purport to measure (Sue & Ritter, 2012). The research aims and objectives of this study guided the focus of the concepts to be addressed within the survey. The study's aims and objectives included the broad notions of demography and professional practices of occupational therapists. The process of transforming these abstract concepts into tangible ideas was the basis for the survey's construct and content validity. Construct validity refers to how well the concept is being measured and content validity refers to whether the questions relate to that concept (Lavrakas, 2008). In order to create a way of evaluating the concepts of demography and professional practice they were transformed into measurable entities (Andres, 2012). To do this demography and professional practice were given nominal definitions before being developed into specific measurable indicators or latent constructs (Andres, 2012); these are presented in Table 5 on page 94.

Concept	Nominal Definition	Measurable Indicators/Latent Constructs
Demography	The professional characteristics of occupational therapists.	<ul style="list-style-type: none"> • Gender • Job title • Grade • Years qualified • Area of work • Qualifications • Specialist training
Professional Practice	The broad range of knowledge and skills associated with being an occupational therapist.	<ul style="list-style-type: none"> • Occupational therapy process • Assessment • Interventions • Outcomes

Table 5 Measurable Indicators and Latent Constructs

Demography was given the nominal definition of ‘the professional characteristics of occupational therapists’ and was developed into the specific measurable indicators of gender, job title, grade, years qualified, area of work, qualifications and specialist training. Professional practice was given the nominal definition of ‘the broad range of knowledge and skills associated with being an occupational therapist’. This multifaceted concept was not a phenomenon that could be directly measured and it was not possible to develop this definition directly into measureable indicators. The concept of professional practice was therefore developed into latent constructs. Latent constructs have been used in social science research, particularly in surveys, to measure behaviours that indicate a concept that cannot be directly measured (Byrne, 1998). The development and refinement of the latent constructs was guided by discussions with occupational therapists, reflection on my own practice and consideration of literature relating to professional practice and service provision. Additionally, the College of Occupational Therapists Code of Ethics and Professional Conduct (at that time College of Occupational Therapists, 2010) and the Health and Care Professions Council Standards of Proficiency for Occupational Therapists (at that time Health and Care Professions Council, 2007) were reviewed to provide some guidance on professional behaviour and values. Following refinement, the nominal definition for professional practice was expounded into latent constructs that reflected the occupational therapy process of assessment, intervention and outcome. In addition, the latent construct of clinical reasoning was included to represent

how a clinician’s clinical decision making is determined by their knowledge of theory, research and clinical experience. It is acknowledged that these constructs represented one way of understanding professional practice and were influenced by the researcher’s geographical location, education, professional practice, knowledge, research interests and the study aims and objectives. The latent use of constructs enabled questions to be devised that assessed an underlying construct (Andres, 2012). An example is illustrated in Figure 11 whereby the question “What assessments do you use?” included a range of options for participants to choose from which were determined through clinical experience, research, theory and discussion with occupational therapists.

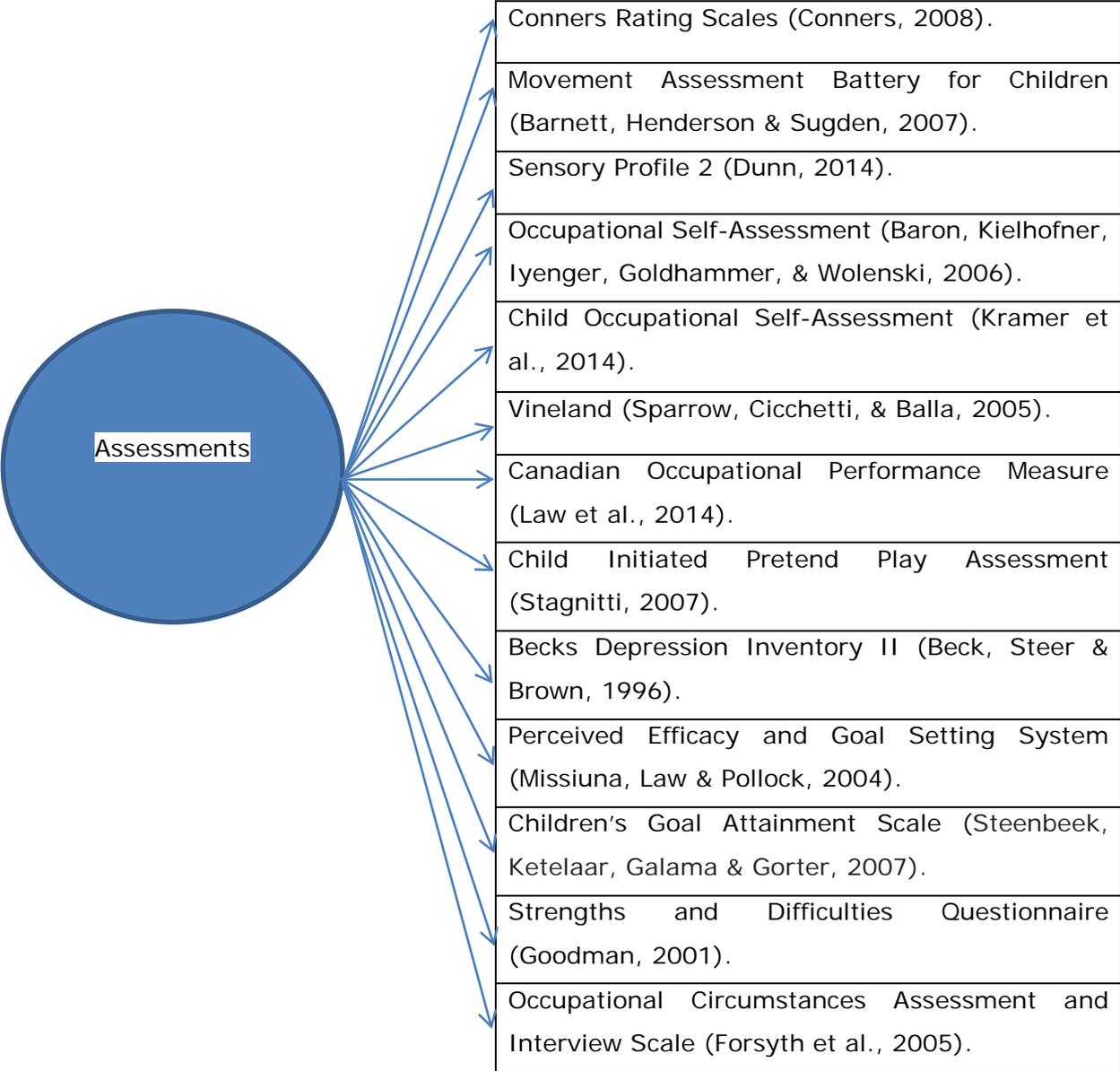


Figure 11 Example of Question Development

The use of a rigorous and transparent process to develop questions from concepts supported the survey's construct and content validity. The discussion of survey validity has so far been related to the development of closed questions that required a deductive approach to formulation. The survey also included two open questions regarding occupational therapy outcomes and professional roles. These questions relied on an inductive approach to development. This style of question was used to generate more in-depth responses and the inclusion of precise indicators would have been incongruous. The validity of these questions was established when themes were generated a priori; the full qualitative categorisation of the open questions is presented on pages 113 to 115.

To further establish the validity of the survey it was piloted in a paper format, with two occupational therapists, working in children and young people's mental health. Conducting a pilot is seen as good research practice to confirm construct and content validity, as well as ascertain face validity (Oppenheim, 2001; Sue & Ritter, 2012). The results of the pilot study confirmed face validity and established validity. One of the occupational therapists in the pilot study suggested the addition of a further category within the question relating to professional title and the other participant did not feel any changes needed to be made. To further demonstrate rigour to the design of the survey the issue of reliability was also addressed and is discussed next.

Reliability

Reliability is the ability of the survey to achieve similar results under similar conditions and is generally associated with experimental research (Andres, 2012). As the survey was not conducted under such controlled research conditions it is potentially a theoretical requirement in this situation. What was achieved was the design of questions that were unambiguous which enabled participants to answer consistently therefore reliability was established through the format of the questions themselves (Sapsford, 2007; Sue & Ritter, 2012). The format and wording of the questions was considered concurrently with the development of the question content. Poor wording or response options could have jeopardised both the validity and reliability of the survey (Sue & Ritter, 2012). All of the questions referring to participant consent were closed-ended questions with yes or no being the only responses. This design was appropriate as a no answer to any consent question would preclude the participant's answers from being included in the study. Apart from the consent questions all questions also included the option 'prefer not to answer', this was included following review and advice from the National Research Ethics Service Committee (see Chapter Four for details of ethical approval).

The seven questions examining the demography of occupational therapists used closed-ended questions to collect nominal data. These questions employed the use of multiple-choice options. For example, "How many years have you been qualified as an occupational therapist?" with the response options being: 0-4 years, 5-9 years, 10-14 years, 15-19 years, 20-24 years, 25-29 years, 30-34 years, 35-39 years, 40+ years. This style of question design forced participants to give one answer and facilitated the submission of full data sets from participants. The use of ranges for some questions did create issues for data analysis as no mean could be established; the limitations of the survey will be discussed later in this chapter.

Of the six questions regarding professional practices four used closed-ended questions and two used open-ended questions. The closed-ended questions considered referrals to occupational therapy, practice models, assessments and interventions. The responses for these questions were multiple-choice options developed to reflect the latent constructs. Participants were able to choose more than one option as this echoed the complexities of professional practice which had been described by the occupational therapists when developing the survey. In addition to being multiple-choice, the questions relating to assessment and intervention tools also used ordinal rating scales for occupational therapists to indicate whether they performed a particular activity occasionally, regularly or not at all. The lack of a definition of occasionally and regularly became a limitation to the interpretation of the study findings, which will be discussed later in the chapter; interval scales such as every day, once a week, once a month would have been a better design. The two open-ended questions asked participants to give two examples of occupational therapy goals and to provide a description of their understanding of the role of the occupational therapist. Open-ended responses were appropriate for these questions which had a broader range of possible answers that were unique to each occupational therapist rather than there being specific indicators.

Study Population

A population refers to the individuals or group to which you want to apply the findings of your research to, in this case occupational therapists working in children and young people's mental health. To gather the opinions of everyone in this population the study would have needed to conduct a census and have the ability to require everyone to answer every question. While gathering an opinion from all occupational therapists may have been appealing it was certainly not a practical option for a small scale study aiming to reach a geographically diverse, and potentially difficult to reach, population. A more practical solution was to sample from the population.

Sampling

Sampling refers to the recruitment of participants that are representative of the study population (Sapsford, 2007). The challenge for this study was to find out the total population of occupational therapists working in children and young people's mental health and therefore to know what would be a representative sample. If the sample population was representative of the whole study population then the results had the potential to be generalised (Andres, 2012; Sue & Ritter, 2012). A number of issues arose in relation to understanding the total and representative sample which ultimately limited the generalisability of the findings; these issues will be discussed.

The use of probability sampling, which encompasses random, stratified and cluster sampling, has been seen as a gold standard research sampling method whereby each member of a given population has equal chance of being chosen to participate in a study (Andres, 2012; Sue & Ritter, 2012; Teddlie & Tashakkori, 2009). To be able to employ probability sampling it would have been necessary to access all occupational therapists working in children and young people's mental health in the United Kingdom, which was not an achievable option. Sapsford (2007) and Sue and Ritter (2012) have commented that probability sampling is often not practical and that it is necessary for researchers to consider the use of non-probability sampling. This sampling strategy uses the researchers' knowledge of the study population to select the sample (Andres, 2012). Non-probability sampling has been criticised for being subjective and that it may not represent the intended population (Sue & Ritter, 2012); however, Andres (2012) proposed that as long as the strategies used are transparent then the research findings could be generalisable. Non-probability sampling does not mean that the researcher haphazardly recruits participants, rather strategies are employed to assist in the selection of participants. This study used non-probability sampling and in particular convenience and snowball sampling. Convenience sampling is the use of participants that are easy to reach and snowball sampling refers to the use of existing participants to recruit further participants (Denzin & Lincoln, 2011).

The College of Occupational Therapists is the professional body that represents occupational therapists in the United Kingdom and was used for the convenience sampling. At the time of the study the College of Occupational Therapists had 29,924 members (J. McCarthy, 2011, personal communication). In addition to general membership the College of Occupational Therapists has a number of Specialist Sections. These offer specific resources to those working in a specified area of practice such as older people, neurological practice or trauma and orthopaedics. For this study the Specialist Section for Children, Young People and Families and the Specialist Section for Mental Health were approached to provide a convenience

sample of occupational therapists. There are limitations to the representativeness of this sample as it is not a requirement to practice for occupational therapists to be a member of the College of Occupational Therapists or a Specialist Section. The total number of Specialist Section members in March 2011 was: Specialist Section for Children, Young People and Families, 318 and Specialist Section for Mental Health, 302 (J. McCarthy, 2015, personal communication). The Specialist Sections advised that they do not record what area of clinical practice members work in. It was therefore not possible to establish the number of participants working in children and young people's mental health. This sampling method was a pragmatic way forward for participant recruitment.

Recruitment and Data Collection

The research committees for Specialist Section for Children, Young People and Families and Specialist Section for Mental Health were provided with details of the study, including NHS and University ethical approval. Written agreement to advertise the study and recruit from their membership database was provided from both Specialist Sections. An email was distributed on behalf of the researcher to all members of the Specialist Sections inviting members to participate in the online survey. The researcher did not receive any details of the members of the Specialist Sections or contact members directly. The invitation email included details of the study, ethical approval and a link to the online survey hosted by Bristol Online Surveys (2016). Participants were also encouraged to create a snowball effect to recruitment by passing the email and link onto colleagues who may not be members of the Specialist Sections. In addition to recruitment through an email to the Specialist Sections membership databases the Specialist Section for Children, Young People and Families included a recruitment letter with a web link to the study in their August 2011 newsletter (see Appendix 12). Recruitment to the survey through the Specialist Sections was found to be limited, therefore a broader recruitment strategy was considered. Accordingly, the College of Occupational Therapists also placed a letter of recruitment and web link into the May 2012 OT News magazine (see Appendix 13).

The survey was available for eleven months between August 2011 and June 2012. A response rate for the survey cannot be established as the number of surveys distributed and the number of occupational therapists working in children and young people's mental health is not known. The online survey was started by 36 participants; all participants gave informed consent to take part in the study. Following data cleansing 27 fully completed surveys were able to be included in the data analysis. The data from the nine participants who did not fully complete the survey cannot be used as these occupational therapists may have gone on to

complete a new survey meaning their data would be repeated. It was not possible to ascertain the reasons for non-completion.

Ethics

The principles of ethics that were of concern for the survey were informed consent, anonymity and data security (British Psychological Society, 2013; Ess, 2007). A number of strategies were employed to ensure that participants were able to give valid informed consent; it was nonetheless recognised that there were limitations when face-to-face verification was not possible. Firstly, the survey had a clear inclusion and exclusion criterion, which helped to verify the characteristics of those taking part in the study (British Psychological Society, 2013). This criterion included being a Health and Care Professions Council registered occupational therapist and working with children and young people with mental health difficulties. Secondly, the design of the survey required participants to read a participant information sheet before they could take part; this included information on the study's risks, benefits, confidentiality, rights to withdraw and data storage. Participants were also given the opportunity to email the researcher to ask questions. Thirdly, participants could not progress to the survey without using a check box to select yes to three questions concerning informed consent; these included confirmation that they understood the participant information, their right to voluntary withdrawal, and agreement to anonymised quotes in publications (British Psychological Society, 2013). Rights to withdraw were limited if a participant had completed the survey anonymously; nine participants did not fully complete the survey, and as it was not known if the participants had withdrawn their informed consent, this partial data was not included in the final data analysis. It was not possible to ascertain whether participants had properly engaged in these informed consent measures. However, the use of check boxes has been reported as good practice to show some engagement with the process (British Psychological Society, 2013; Ess, 2007).

The issue of anonymity was dealt with in two ways, firstly Bristol Online Surveys encrypted the survey responses so that participants could not be traced to their data (Bristol Online Surveys, 2016). Secondly, participants were not required to provide any personal details, such as name or location. If participants wanted to receive a summary of the results of the survey, or be considered to take part in the second phase of the study, they were asked to provide an email address. To ensure anonymity, the researcher separated the email information from the responses when they were printed out. To safeguard data security any survey data that was printed out was kept in a locked cabinet when not in use. All of the electronic data was stored on the Bristol Online Surveys password protected website, only accessible by the researcher.

The survey was given ethical approval by the University of Huddersfield School of Human and Health Sciences Research Ethics Panel and National Research Ethics Service (see Appendix 10). This approval was forwarded to the College of Occupational Therapists Specialist Section for Children, Young People and Families and Specialist Section for Mental Health; the Specialist Section for Mental Health research committee questioned whether site specific research and development approval was required by all possible NHS participant recruitment sites. Clarification was sought from a local NHS research and development governance manager, who confirmed that NHS site specific approval would not be needed from all sites, as the recruitment of subjects would take place through the College of Occupational Therapists. The NHS research and development governance manager did request that clear guidance was given to participants that the completion of the survey should be done in non-salaried time, this was therefore added to the participant information page of the survey.

Data Analysis

The Bristol Online Surveys (2016) tool collected and provided basic statistical analysis of the quantitative data using descriptive statistics. Further analysis and organisation of the data into table and graph form was completed by the researcher using Microsoft Excel 2010. Bristol Online Surveys (2016) provided the qualitative data from the open questions in an unanalysed format and this was analysed by the researcher using systematic categorisation.

The results of the survey are presented in the next section of this chapter. The data is presented in the order in which it was included in the online survey. The quantitative data is illustrated using tables and graphs as well as descriptive statistics. The percentages described have been rounded up or down to whole numbers and therefore do not always add up to 100 percent. Additionally, for some questions, participants could select multiple options/answers, therefore the total number of responses exceeds the total number of participants. The data described for these questions reflects either the percentage of participants that chose each item or a frequency count. The qualitative data is presented as categories with supporting quotes from the data. Overall the design and format of some questions on the survey and the type of data collected affected the capacity for meaningful analysis. The limitations to the survey and its data are discussed later in the chapter.

Survey Findings

Gender

Eighty-nine percent (n=24) of the participants were female and 11 percent (n=3) were male, see Figure 12.

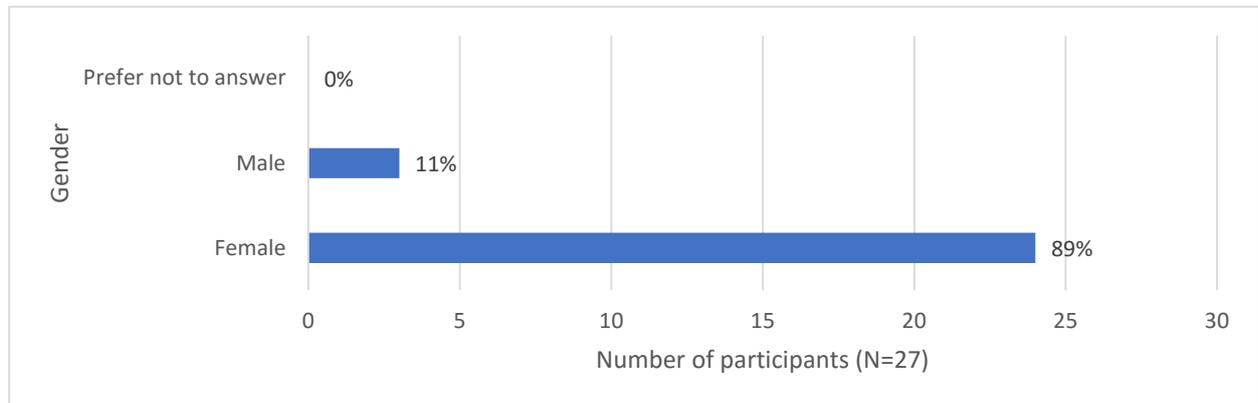


Figure 12 Gender

Job Title

Of the 27 participants 85 percent (n=23) had the job title Occupational Therapist. The remaining 15 percent (n=4) indicated they had another title, which was described as a Children and Young People's Mental Health practitioner or Mental Health Specialist. These results are presented in Figure 13.

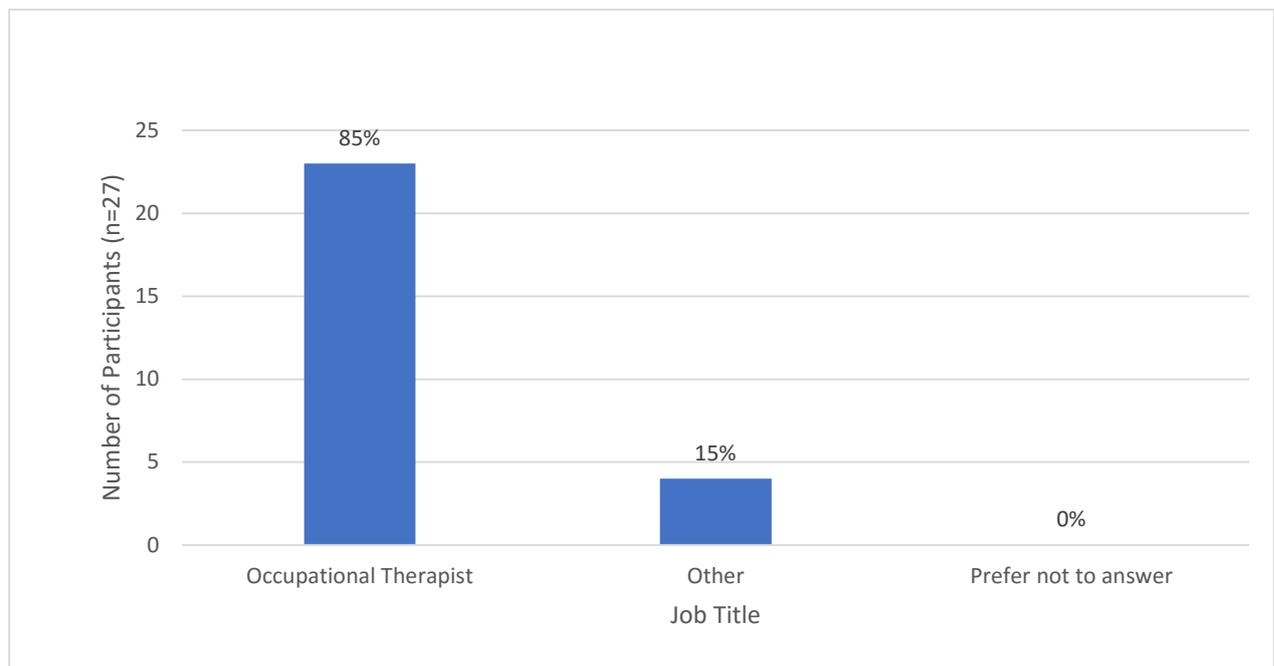


Figure 13 Job Title

Job Grade

The majority of the participants were employed by the NHS and were subject to Agenda for Change for Change banding. Agenda for Change is the pay system for NHS staff (excluding medical doctors, dentists and senior management). It includes pay bands 1-9 with band 8 having four bands (8a, 8b, 8c, and 8d). Occupational Therapists enter the pay system at band 5 and can progress up to bands 8 and 9 for senior positions (NHS Employers, 2015). Figure 14 details the participants' banding. Most participants were at band 7 (41 percent, n=11) or band 6 (30 percent, n=8). One participant was at band 8a (4 percent), one participant at band 8b (4 percent) and two at band 5 (7 percent). The remaining 15 percent (n=4) were either in posts that had split bandings (meaning some hours were paid at one band and some hours at a different band) or did not follow Agenda for Change banding; this may have been due to working for a charity, social enterprise or a private organisation that did not use the NHS pay banding.

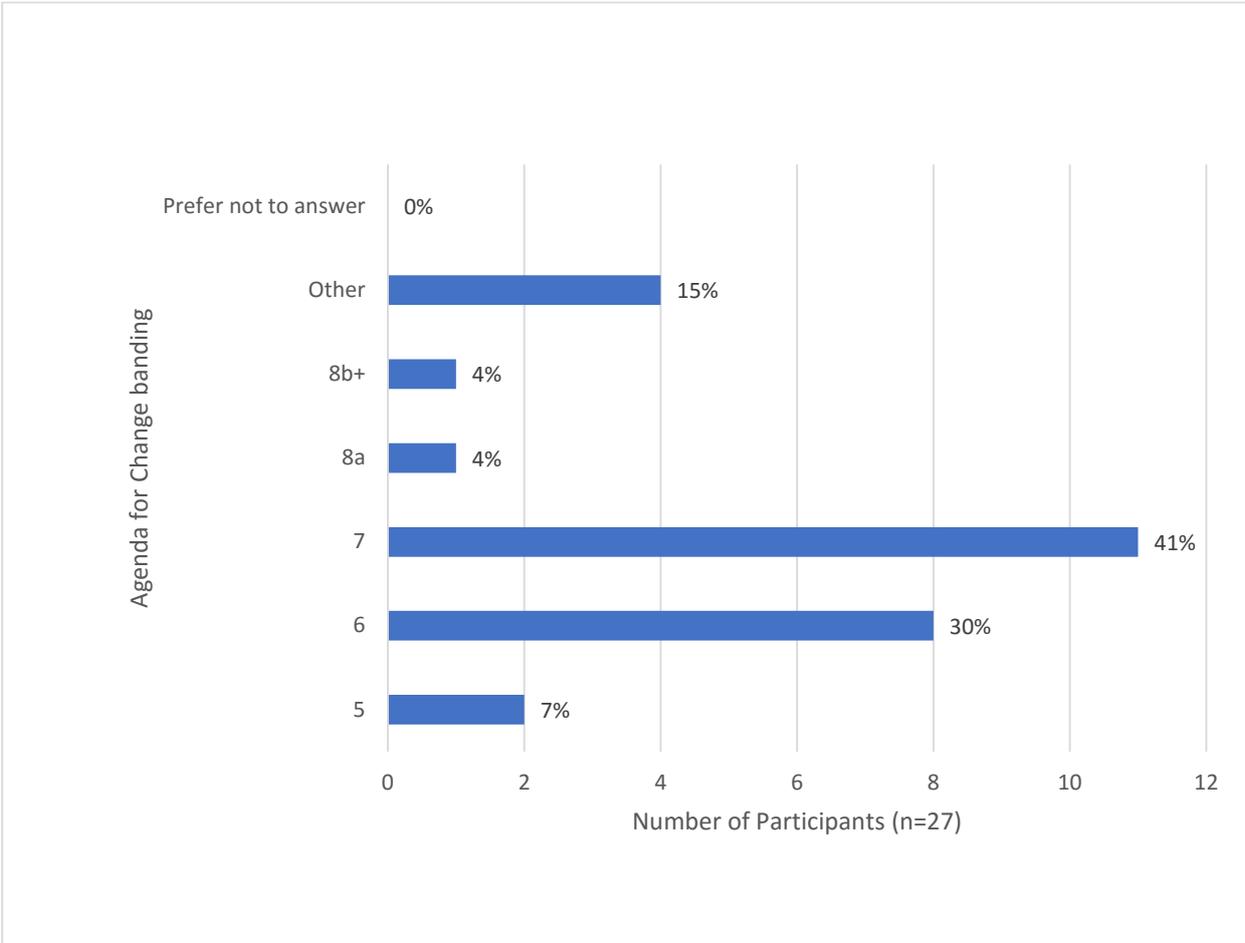


Figure 14 Job Grade

Years Qualified

Many participants had been qualified as an occupational therapist for between 10 and 14 years (41 percent, n=11). The number of years qualified for the remaining participants were spread in low numbers across each of the other year bands: 0 and 4 years: 15 percent (n= 4), 5 and 9 years: 7 percent (n= 2), 15 and 19 years: 11 percent (n=3), 20 and 24 years: 11 percent (n=3), 25 and 29 years: 11 percent (n=3), 30 and 34 years: 4 percent (n=1), 35 and 39 years: 0 percent (n=0), Over 40 years: 0 percent (n=0). These results are presented in graph form in Figure 15. It was not possible to calculate the mean number of years that participants had been qualified as an occupational therapist as the data collected was in ranges of years rather than specific years.

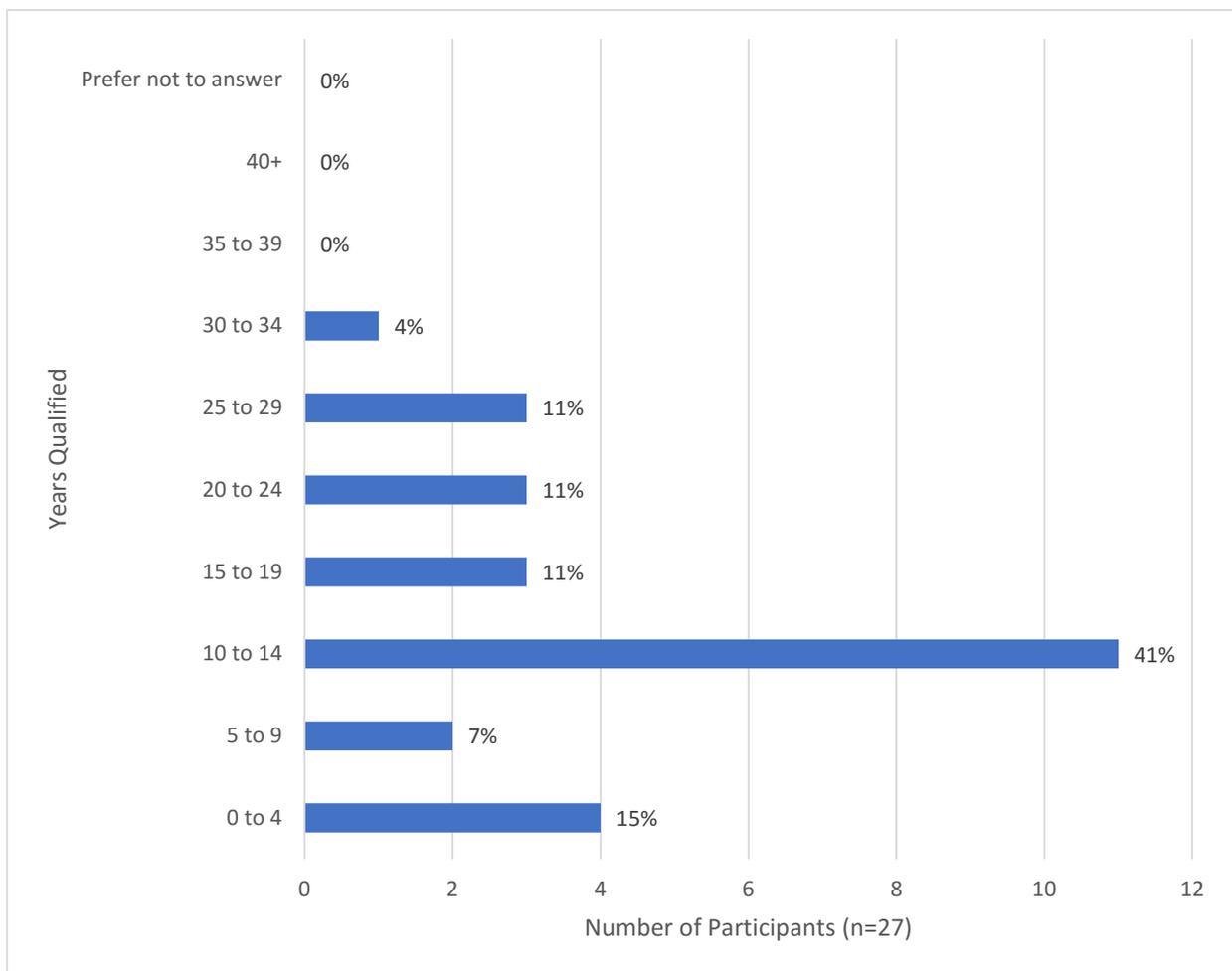


Figure 15 Years Qualified

Area of Practice

Participants were asked which area of children and young people’s mental health they worked in; the responses are presented in graph form in Figure 16. The response options given in the survey were related to the NHS Child and Adolescent Mental Health Services Tier structure; this was presented in Chapter Three in Table 3 on page 56. Overall, there were 31 responses, this indicated that some participants provided more than one response. The percentages described for this question are therefore the percentage of participants that chose each option. Of the 31 responses, 13 (42 percent) participants worked at Tier 4 (inpatients), 12 participants (39 percent) at Tier 3 (specialist outpatients) and three (10 percent) participants at Tier 2 (community). There were two (7 percent) participants that gave an ‘other’ response; these participants reported that they worked outside the traditional NHS Child and Adolescent Mental Health Service Tiers structure and were offering services that straddled Tiers. The examples given by these participants were working at Tier 3.5 offering an adolescent outreach service and working in a service that combined the work of Tiers 2 and 3. One participant (3 percent) selected ‘prefer not to answer’ for this question. As there were 31 responses from 27 survey participants it may be that those respondents that did not select ‘other’ also worked either outside of the traditional Tier structure or worked some time in one tier and some time in another tier, although this cannot be verified by the data.

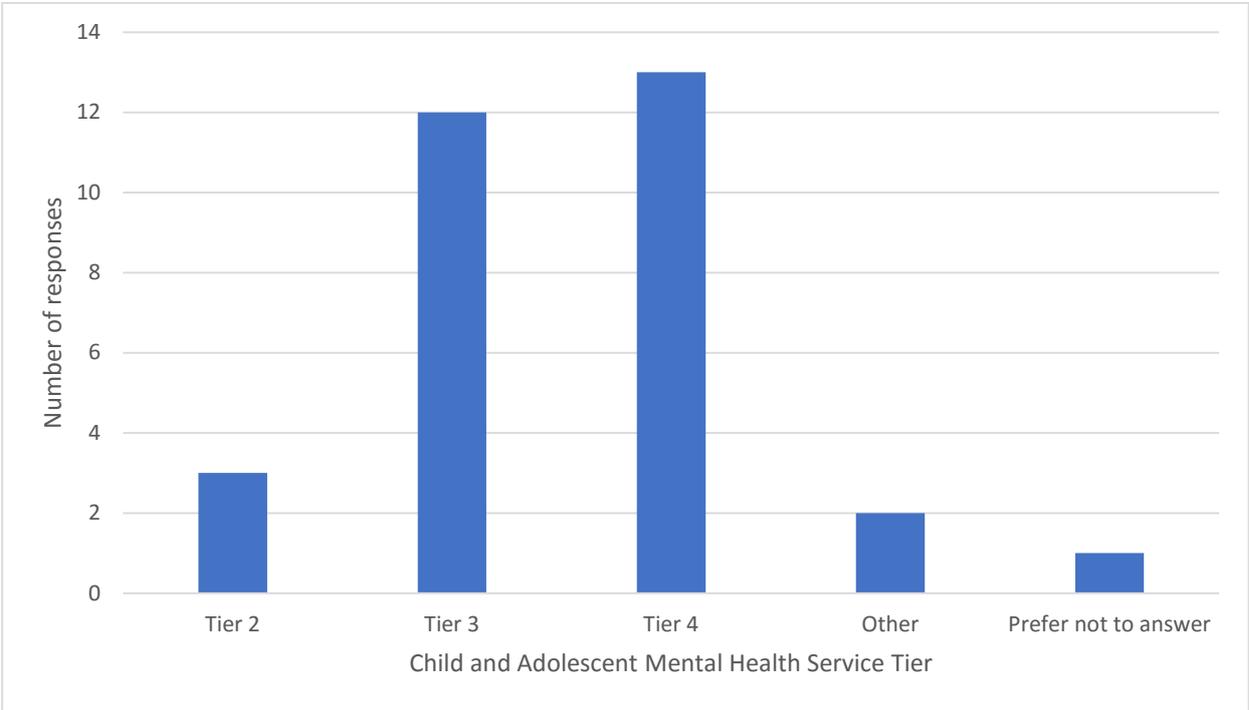


Figure 16 Area of Practice

Qualifications

Participants reported their occupational therapy qualification. There were 33 responses indicating that some participants provided more than one answer therefore for this question the percentages described are the percentage of participants that chose each option. The findings are presented in graph form in Figure 17. An undergraduate degree in occupational therapy was the most prevalent response (52 percent, n=17). A smaller number of responses were recorded for diploma (24 percent, n=8), postgraduate diploma (12 percent, n=4) or postgraduate master's (6 percent, n=2) qualification in occupational therapy. There were no participants who had a doctoral qualification. There were two responses (6 percent, n=2) reported in the 'other' option and these qualifications were reported to be a graduate diploma and a Master's Degree but not in occupational therapy.

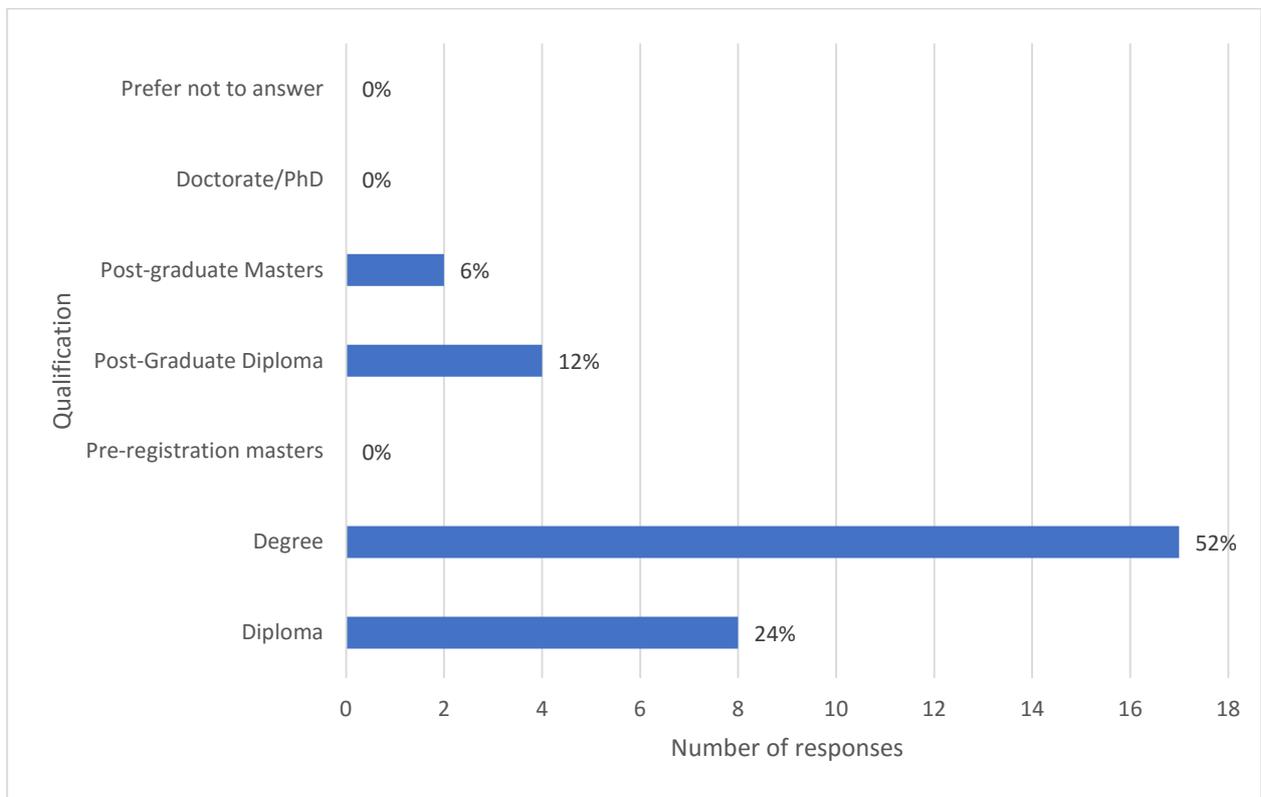


Figure 17 Occupational Therapy Qualifications

In addition to their occupational therapy qualification participants were asked a further question to indicate if they had any specialist qualifications, such as a post-graduate certificate or diploma. The results are presented in Figure 18 on page 107. There were 28 responses to this question, therefore percentages have been calculated to show the percentage of participants that chose each option for this question. Eighteen participants (64 percent)

indicated that they had no specialist qualifications in addition to their occupational therapy qualification. One participant (7 percent) reported having a family therapy qualification and one participant (7 percent) had a qualification in cognitive behavioural therapy. Eight participants (29 percent) selected the 'other' option and all of these participants provided further details. The further qualifications described included group work, children and young people's mental health, sensory attachment, sensory integration therapy, and young people's wellbeing.

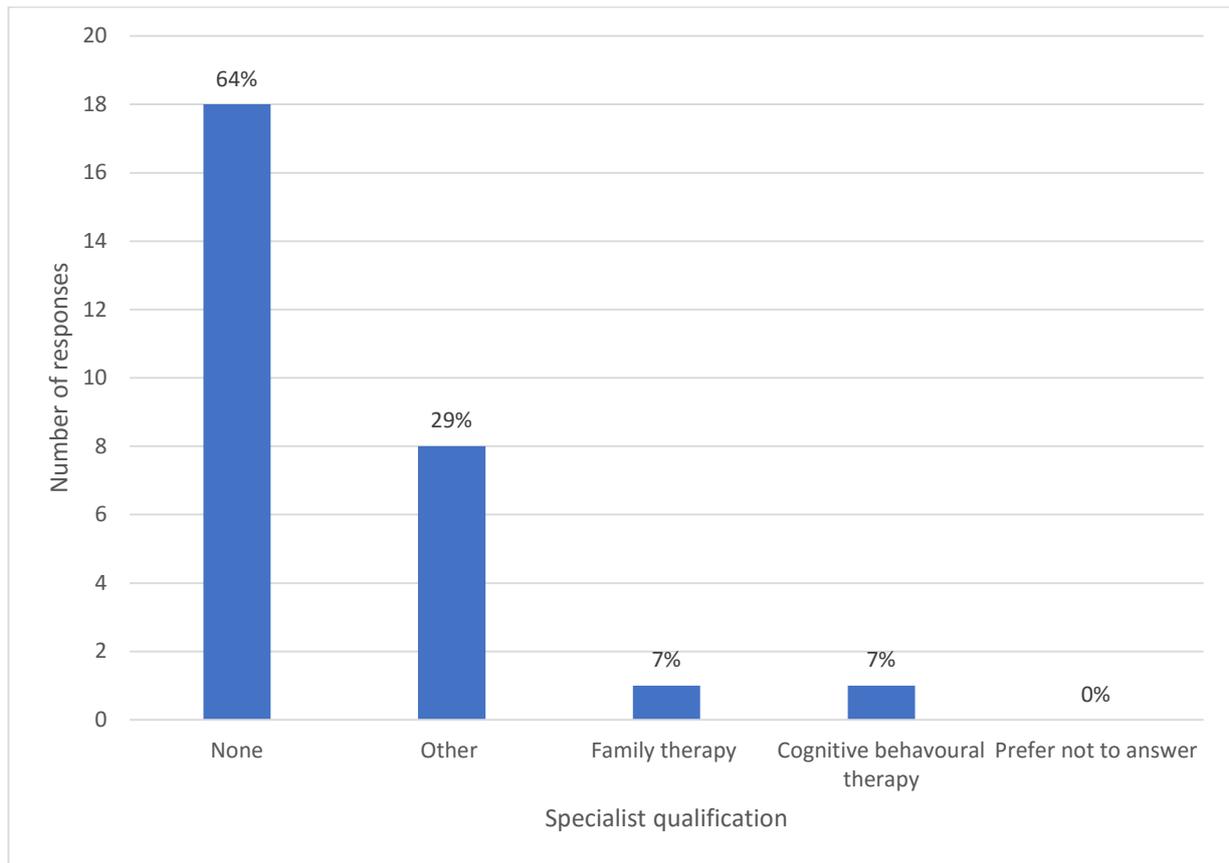


Figure 18 Specialist Qualifications

As well as academic qualifications the occupational therapists were asked to consider what additional training they had, such as short courses or in-house training. Participants were able to indicate as many options as were relevant for them and many gave more than one response, therefore the percentages described for this question reflect the percentage of participants that chose each option. The results are presented in Figure 19 on page 108. The most prevalent training was sensory integration therapy (n=15, 34 percent). Other training included cognitive behavioural therapy (n=8, 18 percent), theraplay (n=2, 5 percent), cognitive orientation to daily occupational performance (n=1, 2 percent), eye movement desensitisation and reprocessing therapy (n=1, 2 percent). Fourteen percent (n=6) had no

additional training and 25 percent (n=11) reported having 'other' training. There was a diverse range of other training completed which included the alert programme, art therapy, family therapy, dialectical behaviour therapy, psychotherapy, mentalisation based therapy, solution focused therapy and motivational interviewing.

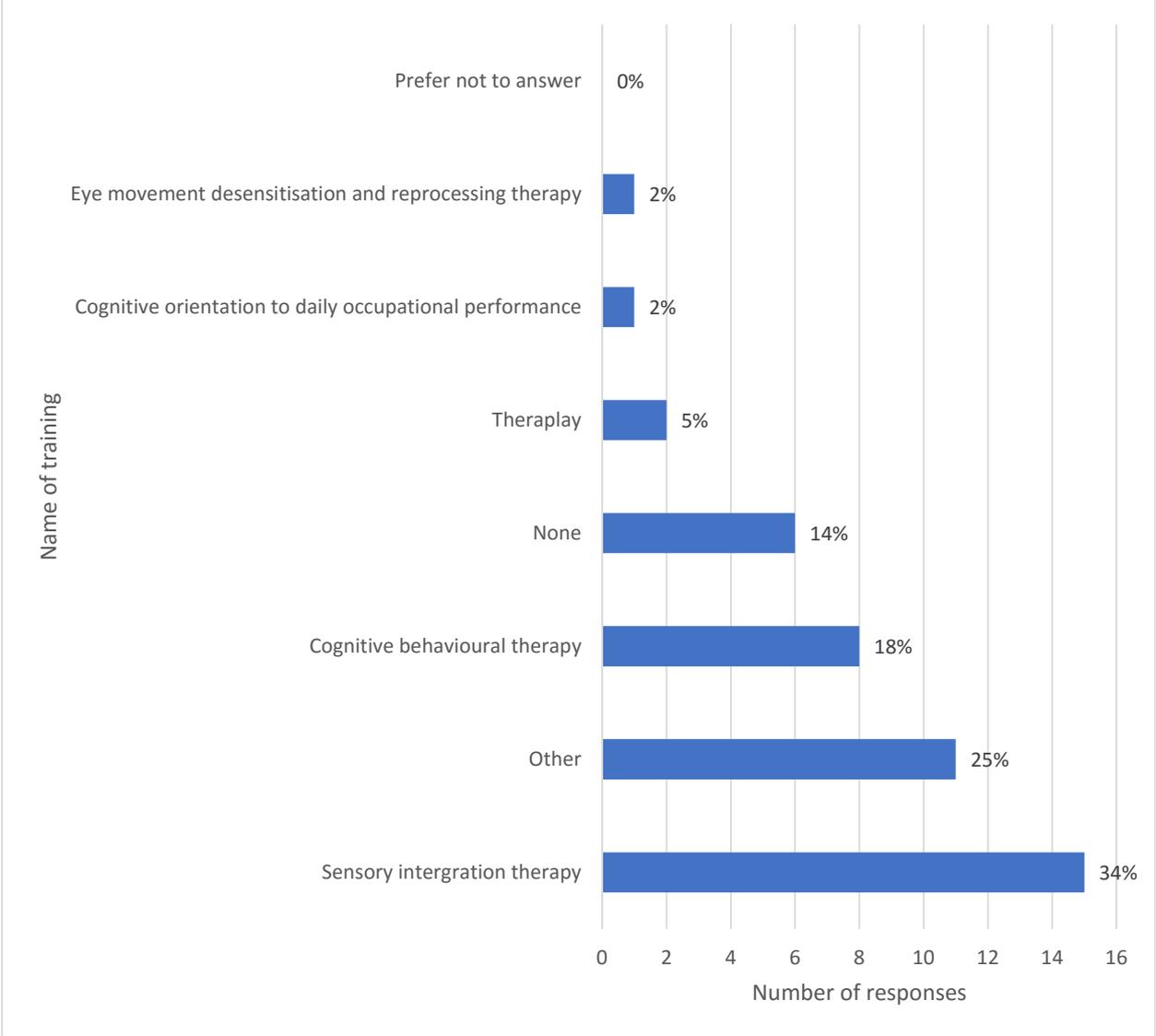


Figure 19 Additional Training

Referrals

Forty-eight percent (n=13) of participants were able to receive direct referrals from colleagues for occupational therapy. This included through a blanket referral system, whereby all patients are referred to occupational therapy, or a specific referral for an occupational therapy assessment and intervention; the full results are presented in Figure 20 on page 109.

Fifty-two percent (n=14) of participants were unable to receive direct referrals for

occupational therapy. Participants were asked to provide further details of the referral process and all 27 provided a comment. The written comments indicated that there was a wide variety of referral methods employed and that these often reflected local team and organisational structures. The short comments provided were not suitable for thematic analysis, but some recurring categories were observed. Participants working in a Tier 4 setting often described receiving blanket referrals (meaning everyone was referred) and that occupational therapy was offered as part of the inpatient package of intervention for all young people. Other participants described how referrals would be made to the children and young people's mental health team and that depending on the nature of the referral, cases were allocated based on a team member's skills and/or interests.

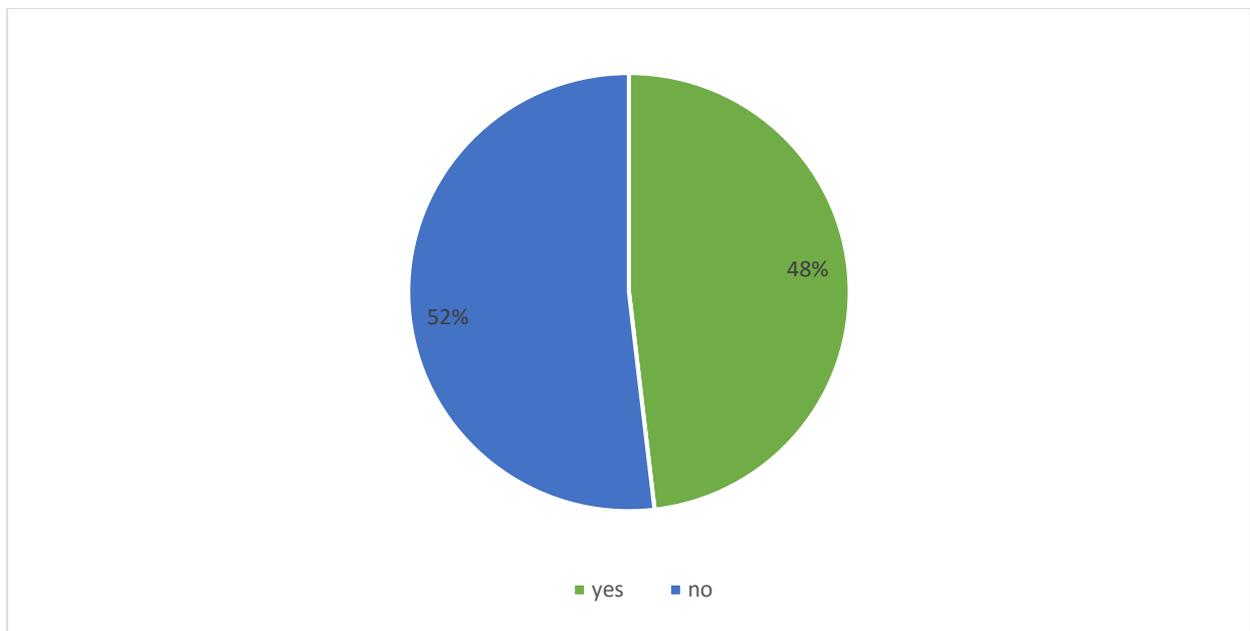


Figure 20 Direct Referral to Occupational Therapy

Models and Theories Used in Practice

Participants were asked to indicate the frames of reference, models and theories that they used to guide their practice. Participants were able to select as many responses as were relevant for them, therefore the results presented in Figure 21 on page 110 show a frequency count. The responses indicated that the Model of Human Occupation (n=20), generic child and adolescent mental health (n=18) and sensory integration (n=18) were the most frequently used models of practice. Occupational therapists also used cognitive behavioural (n=13), neurodevelopmental (n=10) and psychodynamic (n=9) models of practice with some frequency. The least frequently used models of practice were the Canadian Model of Occupational Performance (n=6), Occupational Performance Model (n=4), rehabilitation

(n=3), Person-Environment-Occupation Performance Model (n=1) and Kawa Model (n=1). Two participants used no underlying models or theories. In addition to selecting from the pre-selected list of models ten participants also selected the 'other' option and provided details of other models that they used. The 'other' responses included: narrative, brief solution focused therapy, occupational adaptation model, attachment, mentalisation, outreach model and the Model of Creative Ability. Two responses also indicated that a formal model was not used but that a more eclectic approach was used.

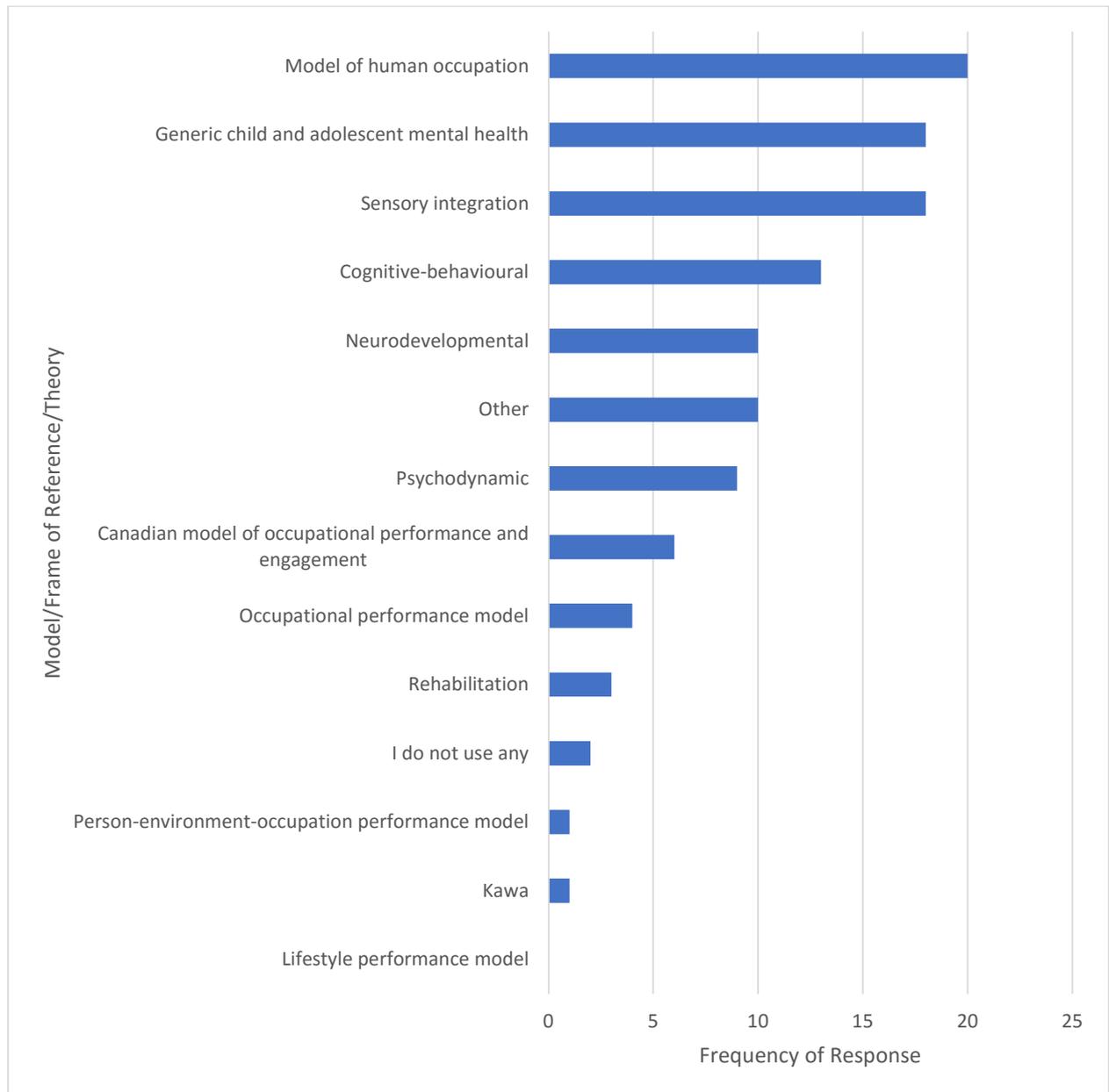


Figure 21 Models and Theories used in Practice

Assessments

Participants were asked to comment on which assessments they used in practice from a list of thirteen commonly used in children and young people’s mental health. Participants had to select for each assessment whether they used it never, occasionally, regularly or select other and provide further information. Participants were also able to list any other assessments they used that were not in the pre-assigned list. As all participants had to indicate a response to each assessment tool and could only select one frequency of use for each tool, the data can be described as a percentage of the sample (n=27) for that assessment tool. The results of this question are presented in Figure 22.

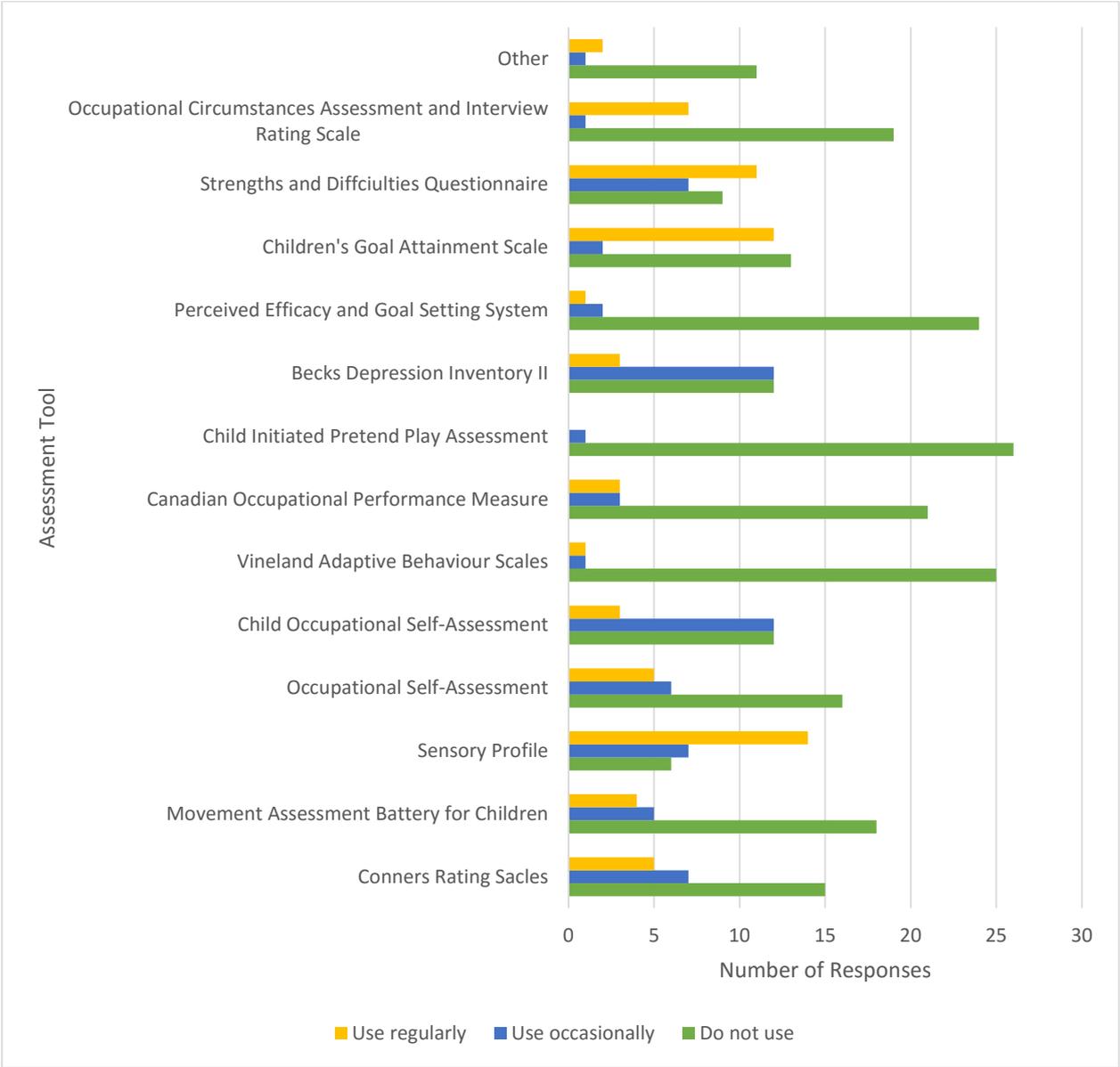


Figure 22 Assessments

The most 'regularly' used assessment tools were the Children's Goal Attainment Scale (Steenbeek, Ketelaar, Galama & Gorter, 2007) (44 percent), Sensory Profile 2 (Dunn, 2014) (52 percent), and Strengths and Difficulties Questionnaire (Goodman, 2001) (41 percent). The most 'occasionally' used assessment tools were the Becks Depression Inventory II (Beck, Steer & Brown, 1996) (44 percent), Child Occupational Self-Assessment (Kramer et al., 2014) (44 percent) and Sensory Profile 2 (26 percent). The most 'not used' assessments were the Child Initiated Pretend Play Assessment (Stagnitti, 2007) (96 percent), Vineland Adaptive Behaviour Scales (Sparrow, Cicchetti, & Balla, 2005) (92 percent), and the Perceived Efficacy and Goal Setting System (Missiuna, Law & Pollock, 2004), (89 percent). Participants who selected 'other' provided details of a variety of other assessments that they used. The most frequent other assessment used was the Model of Human Occupation Screening Tool (Parkinson, Forsyth, & Kielhofner, 2006) as well as other locally developed non-standardised tools.

Interventions

Participants were asked to report on the interventions that they used with children and young people from a list of 13 commonly used in child mental health. Participants had to select for each intervention whether they used it never, occasionally, regularly or select other and provide further information. Participants were able to select as many interventions as were relevant for them and did not have to respond to each question. This question design did limit the ability to compare the frequency of use for different interventions. It has therefore been most useful to present these results as a frequency count rather than as a percentage. The results are presented in Table 6 on page 113.

The occupational therapist participants reported that the most 'regularly' used interventions were psycho-educational, talking therapy and group work. The most frequently 'occasionally' used interventions were relaxation and cognitive behavioural therapy. Participants frequently 'did not use' eye movement desensitisation reprocessing, play therapy or cognitive orientation to daily occupational performance. Participants provided detail of other interventions that they used and these included family work (as opposed to formal family therapy), behaviour management and parenting, solution-focused therapy and Theraplay.

Intervention	Do not use	Use occasionally	Use regularly
Play therapy	15	3	1
Non-directive play therapy	8	9	2
Cognitive behavioural therapy	0	15	7
Talking therapy	0	9	14
Family therapy	2	8	10
Sensory integration therapy	6	5	9
Cognitive orientation to daily occupational performance	11	3	0
Psycho-educational	0	7	15
Lifestyle redesign	6	7	7
Coaching	7	8	4
Relaxation	2	17	4
Eye movement desensitisation reprocessing	15	0	0
Group work	2	6	13
Other	3	2	4

Table 6 Interventions

Occupational Therapy Goals

Participants were asked to provide two examples of common/frequent aims or goals to their therapeutic work. All 27 participants provided a response and these varied from single words to short paragraphs. The qualitative data generated from this question was not suitable, nor was it intended for a full qualitative data thematic analysis as the data lacked sufficient depth to consider any meaning. To provide a way of reviewing the data the five phases of qualitative data analysis detailed by Braun and Clarke (2006) were used to guide a systematic categorisation process.

The final categories are presented in Table 7 on page 114 and represent the content of occupational therapy goals. The goals were categorised as including the child's difficulty, such as a medical diagnosis or condition; these were often related to neurodevelopmental and emotional problems such self-harm, challenging behaviour, autism spectrum disorder, sensory-motor problems, anxiety, poor self-esteem/confidence. For example, participant 11 described a goal as "teaching coping strategies to reduce anxiety", participant 25 described

how they would “promote emotional regulation and integration” and participant 23 explained a therapeutic goal as “understanding the nature of your ASD condition...”

Category	Sub-Categories
Mental health difficulties seen in Child and Adolescent Mental Health Services	<ul style="list-style-type: none"> • Neurodevelopmental • Emotional
Therapeutic Interventions	
Therapy outcomes	<ul style="list-style-type: none"> • The action of therapy • Occupations • Skills and knowledge (non-occupational)
Context of therapy	<ul style="list-style-type: none"> • Home and family • School and social

Table 7 Occupational Therapy Goals

The goals also described the therapeutic interventions, which were the strategies used by therapists to carry out their therapy. These strategies included psycho-education, help, support, strategies, fun, rehabilitation, teaching, encouragement, exploration, promote, build and using activity. For example, participant 6 described how they would “Build confidence in being with and around peers” and participant 8 indicated that they would “support a young person to develop sufficient self-regulation skills to be able to re-engage with education”.

The therapy outcomes were also included in the goal. The outcomes described what the therapist was hoping to achieve with the child, young person or their family. The outcomes first used an action word such as improve, increase, raise, enhance, understand, recover, change or regulate. The outcomes could be further described as being framed within occupation or without occupation. Those related to occupation used words such as occupational enrichment, lifestyle, roles, habits, routines, self-care, school, leisure or play. For example, participant 8 described their therapy outcome as “to explore lifestyle balance in order to support YP to develop a range of roles and occupations”. Those outcomes not related to occupation included those related to skill, knowledge, independence, risk reduction, confidence or self-esteem, as illustrated by participant 13 “Improve knowledge and skill”. Finally, occupational therapists described the context of their therapy in their therapy goal,

for example a physical environment such as school or a social environment such as friends or family. An example can be seen in the response from participant 10 who described how their therapy goal would be “To support families in working together towards enhancing occupationally enriched home environments to support young people’s recovery”.

Role of Occupational Therapy

The final question relating to professional practice asked participants to consider how they would describe their role as an occupational therapist to others. The same process of data analysis was used as described above. A table of the categories developed is presented in Table 8. Overall, the occupational therapists described how they focused on everyday life, and that they saw their role as being an enabler of wellbeing. To achieve this the participants described how their role was to carry out assessment and interventions and that it was important for them to be part of the wider multidisciplinary healthcare team.

Category	Sub-category
A focus on everyday life	
The process of therapy	Assessment Intervention
Working together	
Enabler of wellbeing	

Table 8 Role of Occupational Therapy

Discussion of Survey Findings

This section of the chapter will discuss the survey findings and compare and contrast them with similar studies. The previous most recent survey of occupational therapy in children and young people’s mental health in the United Kingdom was in 1984 (Jeffrey et al., 1984). To bring some more contemporary findings to the discussion a 2011 survey conducted in Australia (Hardaker et al., 2011) has also been used in this discussion, although there is some sampling, cultural and geographical limitations to direct comparisons. The survey data were also used to inform the ethnographic part of this study and as a purposeful sampling strategy; the key points taken forward from the survey to the ethnographic phase of the study and the sampling strategy will conclude this chapter.

The gender of occupational therapists in children and young people's mental health in this study was predominantly female. This was representative of the wider profession at the time of the survey (J. McCarthy, personal communication, 2016), and reflective of previous studies (Hardaker et al., 2011; Jeffrey et al., 1984). Whilst the title 'occupational therapist' was most commonly reported by participants, the use of the title 'children and young people's mental health worker' was reported by 15 percent of respondents. A similar finding was uncovered in Australia, and may reflect the creation of healthcare posts with generic titles, which has been reported to be on the increase in other areas of mental health (Reeves & Mann, 2004). The decline in professional title use may suggest a potential decrease in occupational therapy specific posts; this may serve to further marginalise occupational therapists working in children and young people's mental health services.

The overall seniority of occupational therapists that took part in the study was high. In 1984 Jeffrey et al. reported 81 percent of posts being at a senior grade, this study reported 79 percent at this level. This could suggest that this clinical area is seen by healthcare providers and clinicians as being specialist, or that the small number of reported lower grade posts reflected a lack of entry level or development posts, or it could be that there are more senior occupational therapists who are members of a College of Occupational Therapists specialist section. The seniority of the therapists was echoed in the number of years qualified which, on average, was 10 to 14 years. These findings contrast with those reported by Hardaker et al. (2011) who found that their participants were generally less experienced; this could be due to a professional culture difference between the United Kingdom and Australia. The possible absence of entry level posts in the United Kingdom has the potential to impact on the future recruitment of appropriately skilled occupational therapists into this clinical area.

Most participants were qualified to degree level; this is likely to reflect the overall picture of the occupational therapy profession. The majority of occupational therapists did not have formal additional qualifications; this is consistent with the findings of Jeffrey et al. (1984) and Hardaker et al. (2011). Moreover, it was reported in this study that the additional qualifications of occupational therapists were related to children and young people's mental health, but not specifically occupational therapy, for example a postgraduate diploma in mental health. This survey did not include the discovery of the reasons for such a low number with a postgraduate qualification; the absence of qualifications specific to occupational therapy and children and young people's mental health could be a contributing factor. Attendance at short courses and training was reported in the survey to vary widely; this again was similar to previous findings (Jeffrey et al., 1984). Training in sensory integration therapy was frequent, as well as other training related to children and young people's mental health,

but not specific to occupational therapy. Jeffrey et al. (1984) reported that their study participants had an interest in play therapy training; this finding is not replicated in this study.

The use of theories, models and assessments in practice was not considered by Jeffrey et al. (1984), as their survey focused on occupational therapy services rather than individual therapists. The use of theories or models in practice was overwhelmingly reported in this study, with the Model of Human Occupation most frequently used. The use of a range of Model of Human Occupation assessment tools was also reported. The frequent use of the Model of Human Occupation theory and its assessments reflected the findings of other studies of occupational therapy practice in adult mental health (Craig, Chacksfield & Richards, 1998; Lee et al., 2012; Melton, Forsyth & Freeth, 2010). The use of sensory integration theory was also reported to be high and this was mirrored in the use of sensory integration assessment tools. The Model of Human Occupation and sensory integration could be described as theoretically divergent; the Model of Human Occupation is an occupation-focused theory while sensory integration addresses body structures and functions. The reported use of both theories may suggest a diverse role for occupational therapists in children and young people's mental health.

This study has reported that the use of psycho-education, talking therapy and group work were the most frequently used interventions by occupational therapists. The broad nature of the questions in the survey limited the ability to further explore what specific strategies were used during these interventions. The survey's qualitative question on occupational therapy goals did throw some light on the possible focus of interventions; these were reported to include help, support, strategies, fun, rehabilitation, teaching, encouragement, exploration, promote, build and using activity. These findings suggest that it may be difficult for occupational therapists to describe the specific intervention strategies or active ingredients that they use in their interventions; similar findings were reported by Hardaker et al. (2011) who found that communicating and counselling were the most frequently used occupational therapy tasks during interventions. The categorisation of the role of occupational therapy revealed that the participants of this study were concerned with children's health and wellbeing and that they did have a focus on everyday life. Hardaker et al. (2011) reported similar, although more specific, findings that occupational therapists were concerned with everyday activities such as leisure, self-care, employment, community activities and school.

In conclusion, the survey presented in this thesis has offered a snap shot of occupational therapy practice in children and young people's mental health. The demography of participants remains similar to that reported by Jeffery et al. in 1984, although the creation of generic titled posts is now being reported. Post qualification training continues to be limited

and lacking a focus on occupational therapy. This survey reported on the use of models of practice, assessments and interventions for the first time; the use of the Model of Human Occupation and its assessments is encouraging, although the use of sensory integration theory and sensory integration therapy also appears to dominate practice. Overall, there appeared to be some possible incongruence reported in this study, between the role of the occupational therapist, the models that they used and the types of interventions that they delivered. Interventions that may be associated with other professions, such as cognitive behavioural therapy and family work, are being used by occupational therapists together with other generic style therapies, such as talking therapy, but these currently lack specificity to occupation.

Survey Limitations

The main limitations of the survey were in the design of some of the question, the low number of responses and a number of hindrances encountered. To address the latter first, despite the use of a purposeful recruitment strategy the number of responses to the survey was low. It was not possible to establish the number of occupational therapists working in the arena of children and young people's mental health in the United Kingdom, therefore the representativeness of the sample is not known. The findings of this survey have therefore been considered with caution and can only be representative of the participants. The 1984 survey by Jeffrey et al. identified occupational therapists for their study by writing to all district occupational therapists in NHS health authorities in England and Scotland. They achieved an 83 percent (n=55) reply rate, a higher figure than this study. It was not considered possible to use a similar recruitment strategy as NHS occupational therapy services are now structured at an organisational level rather than at a district level which would have required NHS ethic research and development approval from each organisation. On reflection a random sampling of organisations with children and young people's mental health teams may have resulted in a higher number of participants. The possible low response rate for this study could reflect the limited numbers of therapists who are members of the College of Occupational Therapists Specialist Section for Children, Young People and Families or Specialist Section for Mental Health. Hardaker et al. (2011) used a similar recruitment strategy to this study, although they opened the survey up to occupational therapists working in adult mental health who worked with young people up to the age of 25, which could have contributed to a greater number of responses (n=63). Without a central register of occupational therapists working in children and young people's mental health in Australia, their study also could not establish the representativeness of the sample.

There are a number of limitations related to the research design of the survey questions, which limited the usefulness of the data. The design of some of the survey questions allowed participants to select more than one answer, resulting in difficulties calculating accurate descriptive statistics. These errors were reflective of the novice use of surveys by the researcher, and only became apparent after multiple responses, so did not arise in the paper-based pilot study. The use of open-ended questions, which resulted in qualitative data, also had some limitations. The depth of responses was not adequate for full thematic analysis therefore a categorisation method was employed. This surface interpretation did not withstand the rigours of true qualitative analysis which could limit the findings.

A number of obstacles were encountered during the survey which caused limitations to the speed of recruitment. First, the request from the College of Occupational Therapists Specialist Section for Mental Health to clarify the need for site specific research and development approval delayed recruitment by several months. Secondly, the College of Occupational Therapists withdrew their offer to promote the study in its publication OT News due to a lack of publication space, but then rescinded this decision. This delayed advertisement of the study by 6 months. Thirdly, due to the timing of publication of the College of Occupational Therapists Specialist Section for Children, Young People and Families newsletter there was a 3-month delay in advertisement of the study.

Although not necessarily a limitation, it is necessary to draw attention to the reality in which I was situated when I created the survey questions. Despite a rigorous strategy to develop questions that were reflective of constructs, these constructs were informed by my education, training, work practice and history, experiences and interpretation of relevant literature; Chapter One has detailed how I have situated myself in this study. As such the survey findings report other occupational therapists' agreement with my reality that was proposed in the survey. These shortcomings have the potential to create bias in the questions, particularly with my focus on understanding the use of occupation in occupational therapy.

Taking the Findings Forward

As presented in Chapter Four, the mixed methods design of this study included the informing of the two phases of the study. The findings from the survey were used to inform the ethnography; this strategy was also consistent with the ethnographic approach, which is detailed in Chapter Six. Below are the five key issues/questions taken forward:

- How are occupational therapy models used in practice; how do different practice models fit together?

- What are the specific active ingredients or strategies used in occupational therapy interventions?
- What is an occupational therapist's role in a children and young people's mental health team?

Sampling for the Ethnographic Stage of the Research

Twenty-two of the survey participants agreed to be considered for the second ethnographic stage of the study. In the absence of universal criteria for determining the degree to which a clinician's practice is occupational in nature, a standard was developed for this study; see Table 9.

Criteria	Where demonstrated
Uses frames of reference/theories/models underpinned by occupation, for example the Model of Human Occupation.	Survey question 14: What frames of reference/theories/models do you use?
Uses assessments associated with the constructs of occupation, for example Canadian Occupational Performance Measure.	Survey question 15: What assessments do you use?
Indicates that they use occupation-based or occupation-focused interventions.	Survey question 16: What interventions do you use?
Describes therapy goals that include occupation as the outcome.	Survey question 17: Describe a common therapy goal.
Uses occupation to describe their role	Survey question 18: How would you describe your role?

Table 9 Sampling Criteria

The criteria were not designed to be applied as an absolute inclusion and exclusion benchmark; most of the participants demonstrated some of the criteria, but none of the participants met all of the criteria. The responses from four participants were identified as being most consistent with occupational practice. These four were approached by email and then by phone to take part in the second phase of the study. After receiving information about the study two declined to take part; one was about to go on maternity leave and the other cited capacity issues in her service. The remaining two were keen to take part and recruitment and ethical process were progressed.

Chapter Summary

This chapter has detailed the design of the survey phase of this mixed methods study, which was an online survey using Bristol Online Surveys. The rationale for the use of an online survey was described together with details of how the study's validity, reliability and study ethics were established. The recruitment strategy included the use of the College of Occupational Therapists Specialist Section for Children, Young People and Families and Specialist Section for Mental Health together with snowballing and additional recruitment through College of Occupational Therapists publications. The results of the data have been presented, discussed and related to relevant literature. A number of study limitations have been identified. Finally, the connection between the next ethnographic phase of the study has been explained as well as the sampling process for the ethnography. The next chapter will introduce the ethnographic approach taken in this study.

Chapter Six: The Ethnographic Approach

Introduction

The purpose of this chapter is to describe and justify the research design taken in the ethnographic phase of this mixed methods study. The chapter will begin by defining the ethnographic approach that was used in the study. To explain this research design, this chapter will locate the study within ethnographic traditions and evolutions, including its origins, characteristics, methods, application, and relevance to occupational therapy. This chapter will go on to detail how this study addressed the recruitment of participants, access to the field, data collection and data analysis before outlining ethical considerations. This chapter concludes with a section on reflexivity; this serves to add rigour to the two ethnographies which are presented in Chapters Seven and Eight.

The Ethnographic Approach

The study presented in this thesis used a focused ethnographic approach, which preserved the cultural traditions which define ethnography, but adopted a structure which has been identified in the literature as being more suitable for the evaluation of contemporary understandings of culture (Hammersley, 1992; Knoblauch, 2005; LeCompte, 2002; Wall, 2015). The structure of the ethnographic approach of this study will be described and justified in this chapter, it can be summarised as being underpinned by a critical realist ontology, (Hammersley, 1992), as using a focused research question, and a shorter, more directed period of field work (Knoblauch, 2005; Wall, 2015). The field work was characterised by the researcher being an observer of participation, which was augmented with interviews and document collection (Spradley, 1980; Tedlock, 2000). The study adopted the use of fractured, but focused cultural sites, where the participants were from a range of locations (LeCompte, 2002). An iterative process of data analysis was informed by grounded theory, which became more focused over time (Charmaz & Mitchell, 2007). To address issues of rigour, and to assert the findings as more than the researcher relativist view, the use of reflexivity was used as a tool of critical reflection throughout the ethnographic approach (Porter, 1993).

Origins of Ethnography

Ethnography has its foundations in nineteenth century anthropology. The term 'ethnology' was used to describe the process of comparing observations, artefacts and stories of exotic lands with the Western world (Gobo, 2008; Hammersley & Atkinson, 2007; Madden, 2012; O'Reilly, 2012; Tedlock, 2000). Ethnography as a research method emerged from ethnology

during the twentieth century. Anthropologists began to conduct field work, spending extended periods of time with tribes in an attempt to understand their culture, organisation, beliefs and values (Hammersley & Atkinson, 2007; Tedlock, 2000). The work of Malinowski in his book *Argonauts of the Western Pacific* (1922) has been cited as one of the seminal texts using ethnography as a scientific research method (Brewer, 2000; Gobo, 2008). Malinowski spent two years conducting field-work to learn first-hand about the village life of the Kula Tribe on the Trobriand Island. Malinowski suggested that through systematic observations it was possible to describe the structures, customs, traditions, daily life (including the boring and routine), ways of thinking and feeling within a culture (Malinowski, 1922; O'Reilly, 2012).

As well as being used to describe foreign cultures, ethnographic methods were also embraced by sociologists wanting to investigate communities closer to home (Hammersley & Atkinson, 2007). William Foote Whyte, a sociologist at the Chicago School of Sociology, used ethnographic research methods to study a Boston suburb. This study was presented in his book *Street Corner Society* (1943). Whyte, like Malinowski, had wanted to understand the culture of a place by gaining an understanding of the lives people lived. Whyte moved into the Boston suburb at the centre of his study, immersed himself in the daily life of the residents, became friends with his neighbours and sought to understand the culture of the people. Through his time in the neighbourhood, seeing things from the inside, he revealed an ordered social structure of families and gangs which provided cohesion, values and beliefs within the society (Whyte, 1943). Since the early ethnographic studies by Malinowski (1922) and Whyte (1943) ethnography has become a familiar research method within social sciences research (Brewer, 2000; Tedlock, 2000). The study presented in this thesis held sympathy with the early traditions of ethnography, but also echoed more recent successions.

The Evolution of Ethnography

The ethnographic method of Malinowski and Whyte was based in naturalism and humanism, with philosophical roots in positivism; it aimed to uncover the truth by getting close to and revealing the inside (Brewer, 2000). The ability of ethnographers to have access to this reality has been challenged; anti-realists have proposed that the version of reality reported by ethnographers represented a selected reality which was not theoretically neutral; such claims have been described as the crisis of ethnography (Brewer, 2000; Denzin, 1997; Hammersley, 1992). In response to this crisis of representation and legitimation, ethnography as a research method evolved (Brewer, 2000; Wall, 2015); it was applied within different disciplines and considered within different research frameworks (Hammersley & Atkinson, 2007). The ethnographic study presented in this thesis embraced a kind of post-modernism: a critical realist perspective, which asserted some of the convictions of realism but also recognised a

relationship between social structure and social action. This philosophical position has been supported by the work of Hammersley (1992) who led the evolution of ethnography in his book *What is wrong with Ethnography?* He posed the question “To what degree can ethnographic accounts legitimately claim to represent an independent social reality?” (p. 2). Hammersley (1992) proposed the use of subtle realism as an ontological position for ethnography, where multiple realities are all as equally valid. This position has not been universally accepted; indeed, it has been criticised as offering ethnographers a “smorgasbord” (Banfield, 2004, p. 55), which allowed researchers to select a view of whatever reality they choose. It was proposed by Porter (1993) and Banfield (2004) that subtle realism lacked a defined ontology meaning that its subtlety failed to consider and make explicit the underlying relationship between social structure and human action.

The ontological and epistemological debates surrounding subtle realism led Porter (1993) and Banfield (2004) to offer critical realism (Bhaskar, 2011) as a more philosophically and practically sound alternative for ethnography. Accordingly, this study adopted such a critical realist stance. Critical realism does have some similarities to subtle realism; it takes the position of accepting objects as real but as influenced by underlying structures (Banfield, 2004). Importantly for this study, a critical realist philosophy supported the scrutiny and evaluation of a culture that is known to the researcher (Gobo, 2008). The reporting of the data can of course be subject to interpretation by the researcher, and therefore has the potential to be viewed as the researcher’s relativist view. While Porter (1993) accepted this as a limitation of critical realism the use of critical reflection was offered as a process for becoming aware of these personal understandings (Rees & Gatenby, 2014). Correspondingly, the use of critical reflection was used in this study, and is reported at the end of this chapter.

Supported by a critical realist philosophy the idea of focused ethnography has recently been reported in the literature as an emerging ethnographic methodological movement (Cruz & Higginbottom, 2013; Higginbottom, Pillay & Boadu, 2013; Knoblauch, 2005; Wall, 2015). This evolution of ethnography has been presented as a research approach that can consider specialist cultures and subcultures in specific and fragmented contexts, which may be known to the researcher (Knoblauch, 2005; LeCompte, 2002; Mayan, 2009; Roper & Shapira, 2000; Wall, 2015). First introduced by the sociologist Knoblauch (2005), focused ethnography has largely been used in practice-based disciplines to enhance the understanding of practice within specific culture or subcultures (Daack-Hirsch & Gamboa, 2010; Higginbottom et al., 2013; Kelley, Parke, Jokinen, Stones & Renaud, 2011; Kilian, Salmoni, Ward-Griffin, Klooseck, 2008; Smallwood, 2009). Indeed, occupational therapy (Harrison, 2005a; Harrison, 2005b) and physiotherapy (Chipchase & Prentice 2006a; Prentice & Chipchase 2006b) researchers have begun to use this research approach. Cruz and Higginbottom (2013) and Wall (2015)

have suggested that focused ethnography differs from traditional ethnography in a number of ways, including having a defined research question and a researcher with inside knowledge of the culture, which facilitates shorter-term field visits. These characteristics held resonance with the approach taken in this study, as the field was known to the researcher and was conducted over a time limited period. In accordance with a focused ethnographic approach, LeCompte (2002) has suggested the need for a broader definition of a cultural site; LeCompte asserted that the trajectory of culture has transformed and that ethnographic studies should evolve as a research method to embrace dynamic cultures. Focused ethnography has been criticised for being brief and lacking methodological rigour, which brings into question the credibility of findings (Knoblauch, 2005; Wall, 2015). The use of strategies to maintain rigour, such as a clear methodological framework, triangulation and reflexivity have been suggested as ways to mitigate for such criticism.

Ethnography and Occupational Therapy

Ethnography in healthcare research has been given some authority in nursing (Higginbottom, 2013; Roper & Shapira, 2000; Sorensen, Olsen, Tewes & Uhrenfeldt, 2014), physiotherapy (Chipchase & Prentice, 2006a; Chipchase & Prentice, 2006b; Thomson, 2011) and occupational therapy (Harrison, 2005a; Harrison, 2005b; Huot, 2015). Some degree of credence has also been given from medicine (Cole & Crichton, 2006; Goodson & Vassar, 2011). A number of occupational therapy scholars have advocated an affinity between occupational therapy and qualitative research methods (Borell, Nygard, Asaba, Gustavsson & Hemmingsson, 2012; Huot, 2015; Lawlor, 2003; Lawler & Mattingly, 2001; Yerxa, 1991; Wicks & Whiteford, 2006). A specific alliance between occupational therapy and ethnography has been proposed (Inhorn, 2007; Lawlor, 2003; Lawlor & Mattingly, 2001). Lawlor (2003) suggested that occupational therapy and ethnography have shared domains of concern. These included an attention to daily life, socio-cultural influences, lived experience, and meaning and understanding through narrative. In accordance with this partnership ethnography has been used in occupational science research to understand the culture of occupations (Aldrich & Dickie, 2013; Crepeau, 2015; Dickie, 2011), and in occupational therapy research to explore professional practice (Prodinger, Shaw, Laliberte Rudman, 2015; Spencer, Krefting & Mattingly, 1993) and to understand people's experiences of occupational therapy (Ashby, Fitzgerald & Raine, 2012; Horghagen, Fostvedt & Alsaker, 2014). The ethnographic approach used in the study presented in this thesis embraced this affiliation and tradition between occupational therapy and ethnography.

Access to the Field

The process of identifying occupational therapists that used occupational practice from the survey responses was described at the end of Chapter Five. The two occupational therapists were the initial gatekeepers for this study. Obtaining permission to integrate into their daily lives required the fostering of relationships, processes and permissions (Angrosino, 2007; Gobo, 2008; Hammersley & Atkinson, 2007; O'Reilly, 2012). The occupational therapists were instrumental in facilitating this process by speaking with their managers and their teams about the research. Once the managers and teams were committed to the study, site specific Research and Development approval was required; this process is detailed in the Ethical Considerations section of this chapter (see page 131). Following Research and Development approval both of the main ethnographic sites were visited to discuss the research process with the occupational therapist and to meet with their team members. Both occupational therapists facilitated access to the young people that took part in the study by providing them with participant information and consent forms in advance of the field work period. Ethical issues related to the young people's involvement in the study are discussed later in this chapter.

As well as the practical and ethical issues associated with access to the field, there were also considerations about the researcher's knowledge of the field. In a conventional ethnography the researcher usually has limited or no knowledge about the field of study; it is the process of ethnography that is used by the researcher to clarify the unknown (Hammersley & Atkinson, 2007; O'Reilly, 2012). A limited knowledge of the field supports the researcher to enter as a stranger or outsider. This outsider perspective can be advantageous to data validity, but can be a threat to the depth of data collection. As the data collection requires the cooperation of those being studied; the introduction of a researcher to the field can initially result in distrust of the researcher's motives resulting in participant façade behaviour and the hiding of reality (Leininger, 1985). The ethnographic study reported in this thesis evolved from my own professional practice; as a practitioner turned researcher I brought with me knowledge of the field (LeCompte, 2002; Leininger, 1985). This position has been described as 'insider knowledge' (Knoblauch, 2005). Such a position was advantageous to me gaining informant rapport, enabled the use of focused data collection and facilitated deeper data analysis. Insider knowledge is not without its difficulties; the greatest concerns of insider knowledge are the researcher's biases and heuristics which have the potential to influence the reliability and validity of the research data. The use of reflexivity was used in this study to address the limitations associated with insider knowledge in ethnography, this is reported on page 138.

Field Work

Field work is an umbrella term for a number of data collection methods used in ethnographic research. The main tools of the ethnographic researcher are his eyes and ears (Boyle, 1994; Campbell & Lassiter, 2014; Gobo, 2008). Data collection in ethnography typically uses observation, interviewing and archival research, with field notes being the mainstay of traditional ethnography (Angrosino, 2007). Field work begins with participant observation of the cultural site and group. Traditional ethnographies included extended periods of participant observation, often over several years, where the researcher lived in the society (Angrosino, 2007; Boyle, 1994; Campbell & Lassiter, 2014; Gobo, 2008; O'Reilly, 2012). As ethnographic methods have evolved, the extent to which ethnographers participate, and are involved in the culture, has become a matter of some debate (Hammersley & Atkinson, 2007; O'Reilly, 2012; Tedlock, 2000). The level of participation in contemporary ethnographies has become more varied, from complete participation to non-participation, depending on the nature of the research (Gobo, 2008; O'Reilly, 2008; Spradley, 1980; Tedlock, 2000). The very nature of participant observation has also been debated. Tedlock (2000) has suggested that it may not be possible to study the social world without being part of it. He described the position of participant observer as an oxymoron which "...implies simultaneous emotional involvement and objective detachment" (p. 465). Tedlock has proposed that the term observer of participation may better describe participant observation in contemporary ethnography. This style of observation best described the method used in this study. However, there were occasions where the level of participation became greater, for example when young people or professionals would engage with the researcher in therapy or in team discussion.

As well as the level of participation in the culture under study the length of involvement has also been considered (Gobo, 2008). A required time frame for ethnographies is not dictated in the literature. Published ethnographies in occupational therapy suggested varying lengths of time spent with study participants including two years (Dickie, 2011), 72 days (Aldrich & Dickie, 2013), and 36 hours (Krusen, 2011). This study used a period of five days at each ethnographic site. At the south of England site this was five consecutive days, at the north of England site this was two consecutive days and three single days spread over three weeks. The field work usually took place between 8am and 6pm on weekdays. This period of time was appropriate for a focused ethnographic study which was underpinned by critical realism, had a research question, was exploring a subculture, had researcher insider knowledge and used more a directed period of data collection. The emphasis of the field work was on cultural understandings of occupational therapy, which maintained an alliance with traditional ethnography. Five days of field work did present some limitations to data collection, for

example only being able to observe one weekly team meeting; it did, however, provide a focused immersion in the occupational therapists' work with children and young people.

The field work involved the observation of participants in their daily routine. This included attending their meetings, going with them to lunch, sitting in their offices, travelling with them by car, bus and train, listening to phone calls and office conversations, exploring what was on their desks, in their draws and in their filing cabinets. The occupational therapists, and in some cases also their team members, were also observed seeing children, young people and families in clinics, homes and in community settings. To facilitate the recording of these observations field notes were taken. Field notes are the ethnographer's written account of what they see and hear. They have been described as being the core of ethnography (Emerson, Fretz & Shaw, 2011). O'Reilly (2008) described how initially the ethnographer needs to "...pretend you know nothing, but also know enough to fit in" (p. 96). Accordingly, my field notes initially recorded anything that might be relevant; over time they became more focused, I did not take anything for granted and suspended any preconceptions that I may have (Gobo, 2008). To assist me with the writing of field notes I used Spradley's (1980) Nine Dimensions of Descriptive Observation; these are illustrated in Figure 23.

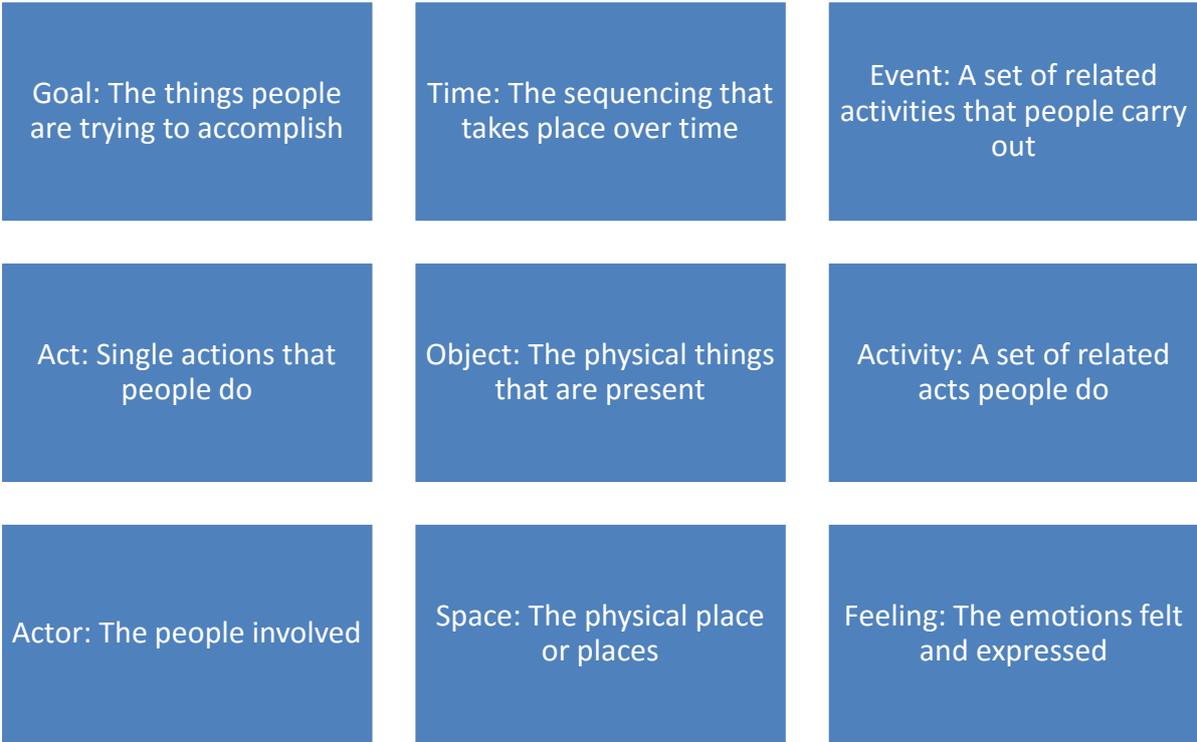


Figure 23 Nine Dimensions of Observation (Spradley, 1980, p. 78-86)

Through the use of Spradley's (1980) dimensions of observation the field notes were used to give a thick description of the setting. The term thick description has been described by Fetterman (2010) as presenting a wink rather than a blink on a situation, meaning it should provide a detailed description which makes explicit cultural and social observations. I used a spiral bound note book to record detailed field notes. As recommended by O'Reilly (2012) field notes were recorded contemporaneously, or as soon as possible after, to avoid any loss of data (Emerson et al., 2011). Lawlor and Mattingly (2001) described the importance of unobtrusive observations for the ethnographer to maintain relationships in the field. There were times during the field work when it was not appropriate to be writing, for example during sensitive conversations between the occupational therapist and their patient. On these occasions field notes were made as soon as possible after the event. A new note book was used for each site and the field notes were written in black pen on one side of the paper. The opposing side of the paper was left blank so that any additional notes, thoughts, ideas and possible themes could be recorded. These were recorded in red pen during or after the observation.

My field observations recorded the physical environment, such as the layout of furniture and the decoration of the room and the social and cultural environment, such as who was present and where they sat. At times I made small drawings in the field notes to illustrate the layout of the room; this was particularly useful during multidisciplinary team meetings. A considerable amount of the content of the field notes was directed to recording what was happening; at times I described the general flow of topics and discussions while at other times it seemed important to record the exact words used. An attempt was also made to describe how things were said and to mention any other non-verbal gestures (Emerson et al., 2011; Van Maanen, 2011). In addition to formal periods of observation I also used a considerable amount of informal observation and discussion; for example, with occupational therapists travelling in their car or with team members at lunch breaks. These more familiar observations were jotted down in note form and expanded as field notes at an appropriate time.

Throughout the day and again at the end of each day of observation I reviewed my field notes. Any additional details were added and ideas and patterns identified in the data. This review process was described by Emerson et al. (2011) as the first process of transforming data "from field to desk" (p. 39). After each day I completed a formal reflection. Through the field notes and reflections, I found that new ideas evolved, and there were more questions that needed exploring. The following day these were investigated further, ideas tested out and insights refined (Charmaz & Mitchell, 2007; Emerson et al., 2011; O'Reilly, 2012; Van Maanen, 2011).

The field work data came predominantly from observations in the field but four interviews at each site were also recorded. Interviews were offered to both occupational therapists and to any members of their team. Interviews in ethnography have been described as being about quality rather than quantity and have been established as a tool for exploring and clarifying observations (Gobo, 2008). The interviews conducted in this study were semi-structured in nature. There were some general topics for discussion, such as tell me about your role and the team you work in, but the flow of conversation was led by the interviewee. This style of interviewing is suitable for ethnography because it encourages people to reflect, think and offer their feelings and opinions (O'Reilly, 2012). Following field work the interviews were transcribed verbatim and used as part of the analysis process described later in this chapter.

The collection of documents was a final data collection tool utilised in this study. Both occupational therapists gave me permission to explore their desks, draws, filing cabinets, cupboards and shelves. A range of documents were described in the field notes or photocopies taken if appropriate. The documents included national and local policy documents, journal articles, and minutes of meetings, books, assessments and intervention resources such as work sheets, hand-outs and group programmes. These documents were included in the analysis, often triangulating with observations and interview findings.

Ethical Considerations

The overall NHS and University ethical approval for this study was detailed on page 77; this section focuses on issues pertinent to the ethnographic phase of the study. The issue of informed consent for the occupational therapists began at the time of recruitment when both occupational therapists were provided with participant information and spoken to on the phone to answer questions. Both occupational therapists negotiated access to the field on the researcher's behalf. Once the occupational therapists and their teams had agreed to take part in the ethnographic phase of the study, an NHS Research Passport and site specific Research and Development approval were gained from their employing NHS organisations. Site specific approval ensured that The Trusts had capacity and capability to support the research. To ensure informed consent from clinicians I attended a team meeting, at each ethnographic site, a week before commencing the study, to introduce the study and to answer any questions. At this stage of the research process participant information was left at the site for the occupational therapist (see Appendix 6) and their team members (see Appendix 9). Consent forms (see Appendix 2) were also provided and these were collected when I returned to start the field work, and before commencement of the data collection. Both of the occupational therapists gave informed consent. In most cases the team members had also completed the consent forms before my arrival for data collection; a small number had

forgotten but were happy to provide consent to participate in the study when asked. No one refused to provide consent; two team members at one site did not consent to the use of direct quotes, and therefore these have not been included in the findings.

The issues of children and young people's consent and capacity were a key ethical concern of this study (Alderson, 2007; Carnevale, MacDonald, Bluebond-Langer, & McKeever, 2008; Morrow & Richards, 1996). Prior to commencement of the data collection, the occupational therapists were sent participant information, assent and consent forms for children aged 5 to 10 years (see Appendix 4, Appendix 1, and Appendix 3), participant information, consent and assent forms for young people aged 11 to 15 years (see Appendix 8, Appendix 2 and Appendix 1), participant information and consent forms for young people and parents/carers aged over 15 years (see Appendix 5 and Appendix 2). The participant information sheets were designed to use age appropriate language, and included details of the study, risks and benefits and right to withdraw, in accordance with the ethical principles of respect and beneficence (Greaney et al., 2012). The participant information and consent/assent forms associated with the study were given to or sent out by the occupational therapists to those children, young people and parent/carers who had appointments during the data collection period. The participant information sheet included the researcher's contact details, should potential participants wish to ask any questions; no contact was received from potential participants. It was important that no coercion to take part was used, and children and young people received their booked appointment regardless of whether they took part in the study (Moore & Savage, 2002). During the data collection periods the researcher spoke to each child, young person and parent/carer to check their understanding of the study and to get their voluntary consent prior to any data collection. Written consent was gained where possible, although with discretion I used verbal assent and consent when a participant's own signature was not possible (Wiles, 2013). All children aged between 5 and 10 years required parental consent and their own assent, young people aged 11 to 15 years were able to give their own informed consent but also required parental assent. Young people and parents/carers aged over 15 years of age gave their own consent. The assessment of a participant's capacity to give their own voluntary consent was done through discussion with the occupational therapist (Alderson, 2007; Carnevale et al., 2008). Any children or young people seen for urgent or unplanned appointments were not included in the study as they had not been given sufficient time to consider taking part.

While a clear process for providing participant information and gaining informed consent was in place for this study, as a study in real life and in changing contexts this process was, at times, challenging to implement. Ethnographic and observation research has been highlighted in the literature as being a complex environment for research ethics (Boulton & Parker, 2007;

Moore & Savage, 2002). In this study, it was the changing context of people that was most challenging, for example, a young person and their mother had been sent participant information and consent forms in advance of our home visit, on arrival at the house grandma was also present; grandma had not received the study details in advance. On another occasion a social worker visited a young person in the middle of their occupational therapy appointment, and on a further occasion a team meeting had visitors from another department. On all of these occasions the decision was made to stop recording data.

The final ethical issues for the ethnographies were confidentiality and anonymity. Confidentiality refers to the non-disclosure of identifiable information about research participants (Wiles, 2013); anonymisation is the way in which researchers ensure confidentiality is not broken, through the use of pseudonyms. The ethnographies reported in this study collected confidential data about the participants on consent forms, in written field notes and audio recordings; measures were put in place to protect this data. All data were handled in compliance with the United Kingdom Data Protection Act (1998). All consent forms collected while in the field were stored as soon as possible in a locked cabinet, and separate to the field notes. Audio files were transferred from the Dictaphone, as soon as possible, to a password protected university computer, only accessible by the researcher, and the original recording deleted. Interview transcripts were transcribed verbatim, identifiable information was removed and the hard copies stored on a password protected university computer. In the field, participants were given a number, which was also recorded on their consent form. To ensure participant confidentiality in this thesis and in future publications, the names of the occupational therapists, children, young people, parents/carers and the settings have been given pseudonyms (Wiles, 2013). The process of selecting a participant's pseudonym has been discussed by Dearnley (2005), with advantages of openness and collaboration reported when participants self-select, but also the risk of inappropriate name selection. The pseudonyms in this study were selected by the researcher from popular names of the participant's estimated birth era and location (Office of National Statistics, 2016). The multidisciplinary team members that were part of the study are named by their profession, for example mental health nurse or clinical psychologist. The breaking of confidentiality was only highlighted in relation to the safeguarding of children and young people on the consent form for the occupational therapist.

Strategies to Enhance Rigour

This section will address the strategies used in the ethnographic phase of the study to enhance the quality of the research process and the credibility of the findings. The issues of establishing rigour or trustworthiness in qualitative research have been debated in healthcare literature

for some time (Ballinger, 2004; Rolfe, 2006; Stanley & Nayar, 2014; Thomas & Magilvy, 2011). The notion of rigour in traditional ethnography was confirmed through the use of validity, reliability and generalisability; these terms hold a history with traditional ethnography's commitment to naturalism and positivist enquiry (Brewer, 2000). The challenge of anti-realism brought with it an attack on the legitimacy and utility of such claims of ethnographic data. Postmodern ethnographies without structure have been criticised for being too subjective and therefore lacking in rigour. As a critical realist ethnography this study accepted that there were competing versions and perspectives of reality, but equally sought to make truthful knowledge claims. For the purpose of this study, the qualitative research terms credibility (truth-value), transferability (applicability), dependability (consistency), and confirmability (neutrality) have been used to meet the requirements for demonstrating trustworthiness in the research, and its findings (Lincoln & Guba, 1985; Rolfe, 2006; Thomas & Magilvy, 2011).

Credibility (Truth-Value)

The term credibility has some similarities with internal validity in quantitative research, it is an indication of the confidence in the truth of the findings, that they are believable (Lincoln & Guba, 1985; Ritchie & Lewis, 2014; Thomas & Magilvy, 2011). A number of strategies were employed in the study to establish credibility; these were mainly situated in the data collection and analysis phases of the research process. The use of persistent observation during data collection was a tool used to enhance the depth of field work. Persistent observation was revealed during data collection through the use of daily formal reflections and continuous annotation of field notes; this enabled multiple contextual factors to be considered and expanded, which led to emerging insights and further questions (Lincoln & Guba, 1985). These insights were explored further the next day to confirm, refute or develop; further persistent observation led to the refinement of the most salient factors. The interviews also acted as persistent observations and as a way to confirm findings; the semi-structured format facilitated the further interrogation of emerging themes.

To complement persistent observations, some member checking was also used as a way to further enrich and confirm the data. The member checking included debriefing and discussion of my observations with the participants as a way of checking the participant's reality, my understanding of that reality, identifying mistakes and identifying where challenges to the data could be made (Holloway & Wheeler, 2009). The usefulness of member checking has been questioned, as it may invade privacy, break anonymity, and due to the time scales for checking may no longer reflect the reality of the participant (Goldblatt, Karnieli-Miller & Neumann, 2011). The usefulness in ethnography of member checking field notes has been

questioned as being time consuming, unethical and abstract (Bryman, 2016; Holloway & Wheeler, 2009). Privacy and anonymity were not an issue for the occupational therapists in the study as I was fully engaged in their professional work. However, they did not have lengthy periods of time to review field notes so discussions were held daily with them to report back ideas and themes from the field notes; these discussions often took place informally, for example while travelling on the bus or in the car between appointments. These discussions created deeper insights but participants rarely challenged my observations; this could have been reflective of the researcher-participant power dynamic. Member checking with team members who were interviewed did not take place as the transcribing was completed sometime after the field work, risking changes to their reported reality. It was not appropriate to member check written field notes with the children and young people in the study, as no contact details were required to take part in the study, therefore member checking would have broken anonymity.

The use of technique triangulation was used to support the credibility of the data (Brewer, 2000; Hammersley & Atkinson, 1997; Holloway & Wheeler, 2009; Shenton, 2004). The study collected data through observations, interviews and documents; these sources were compared with each other, with similarities providing greater confidence to concepts inferred from the data. This technique also illuminated differences between data, which were as valuable as similarities. Credibility was also established during the analysis and write-up of the ethnography. The use of the words of the participants, or the emic perspective, was used to support the analysis, showing that the view points of the participants formed the basis of the findings. This was done through the use of verbatim quotes from field notes and interviews. The use of reflections and reflexivity was an important instrument for establishing credibility, by identifying my own possible influences and bias during the data collection and analysis. My reflexive approach is discussed further on page 138.

The use of peer scrutiny and peer debriefing was used as a way of checking the truthfulness of findings (Lincoln & Guba, 1985). My PhD supervision with experienced qualitative researchers enabled challenges to be made of the data when my closeness to the data may have clouded detachment. Colleagues, familiar with occupational therapy, but not children and young people's mental health, were also utilised to test out hypothesis and emerging methodological explanations. Presentations of different stages of the research at national and international conferences (see page 4) acted as a form of peer review, with peer questions testing the research design and findings (Shenton, 2004).

Transferability (Applicability)

Transferability describes the extent to which findings have applicability in other similar contexts, so that others could apply the research findings (Brewer, 2000; Ritchie & Lewis, 2014). Pivotal to establishing transferability in the study was the detail of the research context and the use of thick description. This thesis contains information about when the study took place, which locates this research in a political and cultural milieu. Details of where the study took place had to be somewhat obscured to maintain the anonymity of participants, but it was possible to locate the study within broad geographical contexts in the United Kingdom. The nature of an ethnography is to provide a thick description, Chapter Seven and Chapter Eight start with a detailed description of the research settings, including the physical, social and cultural environment. This has served to make explicit the site of the study so that others can evaluate the applicability to their own setting. The nature of the study participants also contributed towards the transferability of the findings. The occupational therapists were selected from all of the respondents to the survey as using occupation as a focus to their work, using the criteria described on page 121. It is acknowledged that those completing the survey were self-selecting, and the nature of them being a College of Occupational Therapists Specialist Section member could indicate a greater involvement in professional practice issues. The children and young people seen as part of the study were determined by the occupational therapists, they were asked to continue with their appointments as usual, although it is not known if cases were selected so as to demonstrate specific types of occupational therapy practice. The potential selective nature of the participants could limit the representativeness of the target population (Ritchie & Lewis, 2014).

In addition to situating the study context and the nature of the participants, transferability was established through the use of a transparent research methodology. The use of a clear research framework (see Chapter Four) has positioned the ethnographic approach within critical realism, mixed methodology and methods. The research framework supported the use of a comprehensive and systematic data analysis process; the use of a constant comparison method to clarify the data served as an approach to strengthen the transferability. The use of data, such as verbatim quotes and field notes, in the ethnographies presented in Chapters Seven and Eight is used to show how the interpretation of the data has remained true to the original accounts. The use of words used by participants to describe social phenomena, such as being a 'real' occupational therapist, makes clear claims about the meaning ascribed to them. Overall, the transparency of the data analysis and the data interpretation has contributed towards the transferability of the study findings.

Dependability (Consistency)

The term dependability refers to the repeatability of the study, meaning would the same results be achieved if the observations were completed again. The applicability of replication in qualitative studies has been raised, as studies are complex and context laden. Ritchie and Lewis (2014) and Lincoln and Guba (1985) have contended that for qualitative research findings to have wider inference dependability should be pursued. Dependability was determined in this study through the reporting of logic in the research process. The idea of an audit trail has been used to show this logic in the study context, methodology, analysis and personal response (Darawsheh, 2014; Lincoln & Guba, 1985). This audit trail is evidenced in the raw data, data reduction, data synthesis, process notes and personal reflections (Lincoln & Guba, 1985).

The logic in the context of the study was established in Chapters Two and Three, which detailed occupational therapy and children and young people's mental health. The Occupational Practice Model served to provide a detailed analysis of the lens of occupation, as understood by this study. Further specified context was articulated in the research methodology, through the use of the research framework, outlined in Chapter Four (see Figure 9 on page 79). This framework reported the study's epistemological and ontological foundations in critical realism which were used to establish the use of mixed methodology and mixed methods to inform the data and new knowledge. Further methodological logic has been described in the process of participant selection, this was discussed above (See Transferability).

The audit trail also traces confirmability through the data collection and data analysis. The recording of field notes, informed by the structure suggested by Spradley (1980), the use of audio recording of interviews and the use of transcribing verbatim, all show transparency of process. Clear description of how the data were collected, including triangulation, and a well-defined description of data analysis using a grounded theory approach add further to the dependability of the study findings. Finally, the audit appraises the use of reflective appraisal, which was addressed in this study, through the use of reflexivity.

Confirmability (Neutrality)

Confirmability refers to the researchers concern for objectivity (Lincoln & Guba, 1985; Shenton, 2004). Confirmability is indicated when credibility, transferability and dependability have been established. Confirmability has been considered in this thesis through the use of an on-going reflexive account, which is discussed next. This reflexive account was

underpinned by the credibility, transferability and dependability indicators already discussed in this chapter (Brewer, 2000).

Reflexivity

The use of reflexivity is well documented in qualitative healthcare research literature (Darawsheh, 2014; Frank, 1997; Jootun, McGhee & Marland, 2009; Lambert, Jomeen & McSherry, 2010; Walker, Read & Priest, 2013); indeed, the occupational therapist Linda Finlay has been at the forefront of promoting this tool as a component of research rigour (Finlay, 1998; Finlay, 2002a; Finlay, 2002b; Finlay, 2006). Reflexivity has been described as an essential component of an ethnographic study (Band-Winterstein, Doron & Niam, 2014; Brewer, 2000; Finlay, 2002a; Hammersley & Atkinson, 1997). The application of reflexivity in this ethnography accords with its critical realist perspective, which understood there to be multiple and competing narratives. Reflexivity acknowledges that the researcher is part of the social world under study and is concerned with how the identity of the researcher critically influenced the research process (Brewer, 2000; Finlay, 2002b; Hammersley & Atkinson, 1997; Mauthner & Doucet, 2003). I used reflexivity as a tool for the critical analysis of my actions, values, behaviours and interpretations, which became integral to situating myself in the research process and outcomes. The evidence for this personal reflexive approach was found in the research notebooks that I kept while developing the study; these detailed the decisions I made, my thoughts and emotions, and the meetings with my PhD supervision team (Brewer, 2000). In addition, while collecting data I used annotations in my field note books to keep a record of impressions and emerging ideas. I also wrote a more formal daily reflection as a way to capture potential bias as the data unfolded. During the data analysis and writing-up I referred back to my notebooks, annotations and reflections, but the study benefitted from further reflexivity through PhD research supervision and peer discussion, which supported the crystallisation of my findings.

My use of reflexivity in this thesis began in Chapter One, when I located myself within the study, within occupational therapy and delimited the study; this served to address the integrity of the researcher. Chapter Two and Chapter Three have located the wider relevance for the study, and established the setting and context. Chapter Four and Chapter Six further strengthened my reflexive stance by describing the theoretical framework within which this ethnography was situated; Chapter Six will also go on to outline the grounds on which the data were analysed and interpreted. To advance the illustration of reflexivity in the study I have used relevant extracts from my evidence to focus issues that arose throughout the research process.

Reflexivity in the Research Process

This section presents insights into the way in which I influenced the research process. The use of reflexive activities throughout the research process has been used to demonstrate my integrity, laying open to scrutiny the dynamics of my thinking, decision making, insights and learning, which have served to enhance the trustworthiness of the study. Acknowledging that there are multiple ways to present reflectivity, this account of the research process is offered through three stages, as defined by Finlay (2002a): pre-research, data collection and data analysis.

Pre-Research

The process of reflexivity began with the inception of the study; as I embarked on this pre-research stage I was careful to reflect on my relationship with the study topic and design (Band-Winterstein et al., 2014). As I have detailed in Chapter One, I was working as an occupational therapist, and experiencing some frustrations with service limitations being imposed on the use of occupation in my practice. While this provided an important driver for the research, it also impacted on my ability to have an objective stance on the subject. My literature searching, at that time, focused on studies and opinions on the use of occupation in occupational therapy. Whilst this literature began to defragment my personal ideas it also brought new insights; my research notebook recorded how my experiences and knowledge of occupation informed the study:

- *Occupations can be a determinant of health and wellbeing, and reject the biomedical model as the dominant model of health.*
- *Occupations are socially constructed, individually experienced, purposeful and meaningful.*
- *Occupational development in children and young people is informed by dynamic systems theory.*
- *Occupational outcomes are an outcome of occupational therapy.*
- *The use of occupational narratives can inform an occupational therapist's understanding of a child or young person.*
- *Occupations take place in natural settings.*
- *Occupational science provides the academic basis for occupational therapy.*

Concurrent with my pre-research reading I made contact with Dr Pollie Price, Associate Professor Occupational Therapy, at the University of Utah, regarding her 2007 article 'Occupation Emerges in the Process of Therapy'. I discussed with her definitions of occupation-based practice and the criteria she used to identify occupational therapists who used this

approach in her study (P. Price, personal communication, 2010). Her passion for the use of occupation in occupational therapy provided further verification that this was the right research topic for me. Dr Price also led me to examine different research methodologies, including ethnography, phenomenology and grounded theory. As a novice researcher I was also guided by the experience of my supervision team; the following extract from my supervision notes illustrates the supervisory discussion regarding the study's potential epistemology and ontology, and how this could inform occupational therapy:

Discussion regarding occupational therapy and post-positivism. How do we generate knowledge in occupational therapy?

Further discussion considered an underlying research ontology for the study, Annie suggested subtle realism (read Hammersley) as a possible way forward that would support a critical realist paradigm.

Further discussion regarding the extent to which the study is mixed methodology/methods. Agreed that overall it has two components which will inform each other, although data will not be combined. The study is therefore mixed at a methodological and paradigmatic level, but not at the of level research methods.

The use of a reflexive approach in the development of the overall methodological framework for the study (see page 139), and the positioning of the ethnography within that, gave me confidence and transparency to the foundations of the study. I began my data collection with some trepidation as I transitioned from the role of clinician to the role of researcher.

Data Collection

My data collection began with the negotiation of access to the field. My position, at that time, as a practising occupational therapist was potentially advantageous to agreeing access and establishing trust. My role as a novice ethnographic researcher, conversely, brought some naivety to the data collection. This extract from my reflective diary, on my second day in the field, described how I began to adopt the position of researcher in the field, and how the quality of my field work entries improved:

I am becoming more confident in my recording of ethnographic data today when with young people. I have been feeling like I am there as a researcher rather than an occupational therapist – yesterday it seemed more difficult to not want to be the therapist, rather today I was recording what was happening. I am recording verbatim quotes and the general conversation; I have been able to record some of the context but need to work on this – facial expression, detail of the environment, tone, intonation.

I had originally expected to structure my field notes using Spradley's (1980) Nine Dimensions. The reality was that a much more free-flowing and chronologically structured approach was needed to capture unfolding observations; the Nine Dimensions were held in mind and provided a useful reflective tool to add further detail to field notes.

I was conscious of how my role as a researcher may impact on my relationship with the participants; ethnography can be intensive and intrusive for the participant. As an experienced occupational therapist, and by the time of data collection an academic, I was aware of possible power imbalances, which could lead to the obscuring of reality. This extract, from my field work notes, illustrates my awareness of the anxiety of the occupational therapist at the beginning of the data collection:

I arrived at the office about 10 minutes early and was asked to sit in the waiting room, I was informed several times that the occupational therapist was here but she took some time to arrive - after speaking with her later in day she described being a little apprehensive about me coming, which perhaps delayed her arrival.

Being part of the children and young people's mental health teams brought me my own anxiety of not being accepted. I recorded two occasions in my reflections where I felt that information was being hidden from me:

It seemed that the occupational therapist had to get used to me being there also and there were some conversations in the morning that appeared to me more whispered, maybe so that I could not hear them - this did not feel exclusionary rather that I had not yet earned the right to hear everything.

Today I felt much more comfortable in the team, as would perhaps be expected the more time I am around. I spoke with the occupational therapist about how she was finding it - she said sometimes she or colleagues feel that they cannot say things.

While the trust of the occupational therapists and the teams developed over time I was surprised at how open the children, young people and families were to my inclusion in their occupational therapy. I worked hard to adopt a position of observer of participation and to not become involved in the therapy or engage too much with the young people, although this was not always possible. I became aware that the very nature of my presence may have changed the observed reality, as noted in one of my reflections:

I have been surprised at the ease that young people are happy to have a researcher present – in fact some of them seem keen to have me there. In today's second session though I was obviously having some impact on what the young person wanted to say

– she said a couple of times that she wanted to speak to the occupational therapist when I wasn't there – I did leave before the end of the session to allow the young person some time alone, I did wonder how my presence had impacted on the young person.

Having insider knowledge can bring tensions during an ethnographic study. My shared knowledge of the world of occupational therapy for children and young people risked heuristics and bias. Finlay (2002a) discussed that as an occupational therapist researching occupational therapists it was important to understand where participant and researcher ideas were shared and where they were diverted. The extract below is taken from a daily reflection during data collection; it illustrated where I began to question how my professional views and pre-conceptions were influencing my data collection lens:

This first home visit again has given me an initial insight into a therapy intervention that was about the occupations of self-care and productivity rather than a talking therapy type of session. My concern at this stage is that I am viewing an occupational perspective because that is what I am looking for. I have endeavoured to record everything that I see and hear, not just what I want to, although this is not without difficulty. I have been searching for an occupation-based approach and could have found it! I also need to consider what I share about my own practice – so as not to influence what the occupational therapist may feel I am looking for or what she thinks I am looking for, which in reality is an open agenda.

Hearing or observing what I wanted to find was a threat to creating an unbiased ethnography, I felt that I needed to balance this within a study that was being conducted by an occupational therapist about the culture of occupational therapy practice. To tackle this potential bias, the annotations in my field notes were used to locate challenges to my own ideas, in particular it drove attention to how occupational therapists addressed children and young people's emotions, feelings and sensory issues. I also began to see some similarities in the researcher-participant understanding of the practice reality, the next reflection extract illuminates this:

I am beginning to see some patterns in the work of the occupational therapist. She does not start sessions talking about thoughts and feelings but will often start with what the young person has been doing or an occupational difficulty – for example, why has school been difficult for you this week? This seems to set the tone for the session to focus on occupation. She does acknowledge the young person's thoughts and feelings but looks at these within the context of occupation.

My reflexive practice during the data collection supported the emergence of a complex picture of uniting and divergent perspectives. Understanding the relationship I had with the participants enabled me to understand the limits that may have been placed on the observed reality and social phenomenon. Acknowledging where my personal views may have influenced the data collection will not have totally eliminated bias, but did illuminate where and how my views could be mitigated.

Data Analysis

A consistent pattern of annotating field notes, debriefing participants and daily reflections during data collection, provided a reflexive platform for the data analysis stage. The data analysis began during the data collection, as illustrated in my reflective accounts:

Today's session has really got me to begin to think about some of the themes that are emerging out of the research, I have listed these in the back of my field work observations book.

With only one day left I need to try out some of my ideas about her practice – discuss what I think with the occupational therapist in an interview and ask a colleague about what I am observing. There are beginning to be some good examples of triangulation.

The process of data analysis was challenging (Finlay, 2002b), it took place during a busy time, balancing my roles as part-time researcher and full-time academic. This period of time was also one of feeling divorced from the realities of clinical practice, which presented in my mind as a theory and practice dilemma, as I pursued sense of my data. My data analysis was also greatly influenced by the experience of my PhD supervision team, and with a change in my Director of Studies a more sociological stance was brought to my work. The data analysis proved challenging and time consuming. I found PhD supervision and peer debrief important mechanisms for challenges to be made of the data. The study had generated significant amounts of data, including field notes with annotations, interview transcripts, documents, and reflections. A reflexive approach was crucial to my use of a grounded theory approach to data analysis. The use of analytical notes and a diary were used to record and defend how and why decisions were made. While distinct turning points in the data analysis were not always perceptible, on reflection more detailed shifts in thought regarding the data analysis process would have been useful. The convergence of understandings through the Occupational Practice Model, and sociological notions of social theory, brought voice to otherwise silenced accounts of power, discourse, and a new conceptualisation of occupational practice (Finlay, 2002b). My adherence to the grounded theory approach, as determined by Charmaz and Mitchell (2007), including constant comparison, served to strengthen the links I made

between the data and the reality of the participants. Whilst I had a definite data analysis phase, as is consistent with many ethnographies, the data analysis continued during the write-up as further nuances in the data were unveiled.

A Grounded Theory Approach to Data Analysis

Accounts of the data analysis process in ethnography can be somewhat elusive in the literature (Gobo, 2008; Hammersley & Atkinson, 2007). O’Reilly (2012) described how the absence of clear guidance appeared to imply that ethnographers had an implicit sense of how to transition from field notes to writing-up. O’Reilly (2012) contested the idea that such a hidden process existed and encouraged ethnographers to show transparency in their data analysis procedures. The use of a framework for data analysis has also been encouraged by Hammersley and Atkinson (2007); however, they also warned ethnographers that there was no recipe or formula for making sense of data. To demonstrate both analytical rigour and flexibility an on-going and iterative analysis was used in this study; it could best be described as being informed by grounded theorising as described by Charmaz and Mitchell (2007). While the purpose of this research was not to generate theory, the use of grounded theory strategies is supported by a range of ethnographic writers as a way to generate cultural explanations (Charmaz & Mitchell, 2007; Emerson et al., 2011; Hammersley & Atkinson, 2007; O’Reilly, 2012). Charmaz and Mitchell (2007) have suggested six data analysis strategies for using a grounded theory approach in ethnographic data analysis, these were used in this study and are presented in Table 10.

Data Analysis Strategies
1. Data Collection
2. Coding the data
3. Theoretical sampling
4. Selective Coding/Memo-making
5. Integrating the analysis
6. Writing ethnography

Table 10 Grounded theory approach to ethnographic data analysis (Charmaz & Mitchell, 2007, p. 162-171).

The six strategies presented above were used to guide an on-going analysis of the data in a spiral fashion while continuing in a linear fashion with the research (O’Reilly, 2012). This

funnel structure to the analysis enabled it to become more focused over time (Charmaz & Mitchell, 2007; Emerson et al., 2011). The analysis process I will describe next was used separately for each of the two ethnographic sites and was integrated with the field work practices described on page 129 of this chapter. Recording written field notes began the processes of analysis from the moment I put pen to paper and continued to the time this thesis was finalised (Hammersley & Atkinson, 1995). Data was predominantly collected using observations and field notes. As I recorded in a note book ideas and themes were recorded in the margin. Due to the focussed period of data collection these ideas and themes were coded at the end of each day of observation. Line-by-line coding often associated with grounded theory was not used as the writing of field notes can already be seen as a layer of analysis; observations were therefore coded within their descriptive context (Charmaz & Mitchell, 2007). The coding strategy I used at this stage could be described as open coding, using post-it notes to record codes of everything in the data set. This analysis strategy enabled emergent codes to be considered early in the study; these were then further examined or discarded through informal discussion with the participants and subsequent field observations. There were shifts in the focus of the research as it unfolded and moved from describing the cultural phenomenon to testing out ideas and explanations. Some ensuing field observations became more focussed, for example on meaning, action, structures, or actors. Interviews were also used as a tool to further clarify and expand on emergent codes. The idea of theoretical sampling is a key component in grounded theory, its use in this ethnography is more nuanced and the use of interviews was used as a form of theoretical sampling to fill out accounts and gaps in the data (Charmaz & Mitchell, 2007). At the end of each data collection period an initial set of codes had been developed from the field notes, these were then further developed by the researcher away from the data collection site.

Selective coding and memo-making took place after the field work as a way to sort, organise and look for patterns in the data. Following coding in the field, the open codes were categorised in search of cultural patterns. The use of selective coding and memo writing was used to help guide the re-ordering and integration of the data (Emerson et al., 2011). In addition, the audio recordings were transcribed verbatim and collected documents scrutinised, this created further codes. My immersion in the field, recording data by hand in field notes, transcribing interviews myself and reading and re-reading the data many times brought me a sense of closeness to the data and to the reality that I observed (Hammersley & Atkinson, 2007). At this stage unifying themes were identified across the data, mapping the social organisation of the team and the occupational practice of the participants. Theoretical sampling was not used in the traditional grounded-theory sense of going back to the field, but further email and phone discussions were held with the participants to clarify meaning and add any missing data.

The closing stages of the data analysis sought to integrate the analysis and begin the writing of the ethnography (Charmaz & Mitchell, 2007). This stage had some similarities with the constant comparison method used in grounded theory (Hammersley & Atkinson, 2007) whereby themes were compared with the raw data and memos were written to describe how these represented the social world of the participants (Charmaz & Mitchell, 2007; Emerson et al., 2001). Through this process of systematically comparing and sorting the data a more coherent understanding was developed and shaped the writing of the ethnographies which are presented in the next two chapters.

Writing Ethnography

The next two chapters present the ethnography of the two field work settings; Chapter Seven will introduce the occupational therapist Amanda and her work at 'The Gateway'. Chapter Eight will present the occupational therapist Julie and her work at 'The Orchards'. The writing of the ethnography has been described as a key component of the research process, but that there is no single defined way in which to do it (Hammersley & Atkinson, 2007). Consistent with the ethnographic approach described in this chapter, the findings are more focused than a traditional ethnography (Roper & Shappira, 2000). Chapters Seven and Eight begin by providing a description of the setting, the team and its culture. Following this, an analysis of the occupational practice in each setting is given. The findings are supported with excerpts from my field notes, which include verbatim quotes as well as verbatim quotes from interviews, as such these include some grammatical and spelling errors; the use of (...) shows where material has been edited out and ... indicates a pause. On pages 166 and 179 quotes from internal documents are not fully referenced as to do so would reveal the study location and break confidentiality.

Chapter Seven: Ethnographic Analysis of The Gateway

Introduction

This chapter will introduce the first ethnographic site, The Gateway; this includes presenting the occupational therapist Amanda and the team that she worked with. This ethnographic account contributed to the second aim of the study - to critically consider the meaning and implementation of occupational practice by occupational therapists working in children and young people's mental health; and to the second objective of the study - to use an ethnographic approach to critically explore occupational practice by occupational therapists working in children and young people's mental health. While the attention of my observations and field notes were on Amanda, her practice unfolded and was enacted within the culture of her team and organisation; to reflect this the chapter is divided into two main parts. Firstly, The Gateway service, its team, activities and culture will be presented. Secondly, an analysis of the occupational practice of Amanda is reported.

The Gateway: Organisation and Structure

The Organisation

The Gateway adolescent mental health team was part of a large Community NHS Foundation Trust located in the South of England in a mainly urban and suburban area. The Trust specialised in mental health, learning disabilities and physical health for children, adults and older people. Services were delivered in acute, community and forensic settings. The Trust had four children and young people's mental health teams, located in different areas of the region. Each of these teams was configured slightly differently, although overall the service provision was similar - to provide assessments and interventions for young people with mental health difficulties aged 0-19 years of age. The Gateway adolescent team worked with 12-19 years old; to reflect this client group the term 'young people' is used throughout this chapter.

The Grand Tour: The Office

The Gateway team were located in a three-storey building. Through the main front door there was a reception desk and to the left a patient waiting area. The reception desk was managed by administrative staff who would let people in and out of the building, greet patients and phone staff to let them know that their patients or visitors had arrived. Staff were required to sign in and out of the building in a book located on the reception desk. The patient waiting area had low chairs positioned against the wall. There was a small selection of children's toys

and a play area as well as crayons and paper for drawing. On the wall of the waiting room was a display for 'patient feedback' with the message 'You said, we did'. The display had a description of feedback from patients and what the service had done to address this feedback. There were other posters on the waiting area walls. Many of these were related to mental health charities or local health initiatives.

To the right of the reception desk on the ground floor were wooden and glass double doors accessed by a security keypad. Immediately through these doors and to the left was a secretary's room, photocopying room and a meeting room. Ahead was a flight of stairs. On the first floor The Gateway team offices and treatment rooms were located. In addition, there were spaces for managers of other teams located in the same building. The main Gateway team office was an open plan office. The office was shared by the occupational therapist, nurses, clinical psychologists, psychotherapists, psychiatrists and students in clinical training. The office was in the corner of the building and desks were positioned along four walls with an island of three desks in the middle of the room. There were large windows above the desks on the two external walls. Staff had their own desk, or shared a desk if they worked part-time hours. Each desk had a chair, filing cabinet, shelves, computer and phone.

There was a kitchen on the first floor for use by all staff in the building. Each team had their own tea, coffee and milk and these were labelled in the fridge and cupboards. There was a dining table and chairs in the kitchen; these were rarely used, drinks and lunch were usually consumed in the office. The kitchen was not a place of great conversation but members of different teams located in the building would pass the time of day with each other. On the same corridor as The Gateway team office were a number of therapy rooms. These were labelled for art therapy, family therapy, psychotherapy and clinical psychology. These treatment rooms had low tables and chairs and specific therapeutic items in them, such as a dolls house, art materials or toys, depending on the discipline that used the room. In addition to treatment rooms there were also a number of single person offices on the first floor corridor. These were for the consultant psychiatrist, lead clinical psychologist, lead psychotherapist and the team manager.

The Participants: The Team

At the time of the study The Gateway team had been established for three years. A pilot service had been running for three years prior to this. The service had been developed following consultation with stakeholders, clinicians and young people. The Gateway team was an adolescent mental health intensive outreach team; it had been created to work with young people with significant mental health difficulties, often with compounding complex social situations, who struggled to access traditional mental health services. The purpose of the

intensive outreach team was to prevent hospital admission. Pam (who is introduced on page 149), a consultant psychiatrist, described the team during a conversation with her about the team’s history and function:

So the adolescent team well was initially was quite a small team, and it, it, it worked mainly with, it has always worked with the heavier end adolescents, erm...but then we got extra money in order to try and reduce admissions which because we don't have our own inpatient unit, we had some very long and very expensive admissions [so] a case was put together for a larger team with a view to reducing admissions, so the adolescent team largely works now with the higher risk, at risk of admission young people, but has some slightly, you know, sort of stepped down kids that, who you could, who need to remain, you know, with a consistent person for a while. So there is a mix of cases. And we also provide kind of intensive support... (Interview)

The Gateway offered a service between 9am and 5pm Monday to Friday. The medical staff also provided a 24 hour on call service. All of the team, with the exception of medical staff, were case-coordinators. As a case-coordinator, clinicians would take overall responsibility for coordinating a young person’s journey through The Gateway service. In addition to being a case-coordinator, clinicians would also offer profession or modality-specific interventions. These interventions included occupational therapy, family therapy, cognitive behavioural therapy, dialectical behaviour therapy, psychoanalytical psychotherapy, group work and mentalisation. Case-coordinators could refer young people to others in the team for these modality-specific interventions. The Gateway team had 13 members with a variety of professional backgrounds and with a range of clinical grades, who worked full and part time hours. These are listed as whole time equivalents (WTE) in Table 11.

1 (WTE) Team manager (nurse) 1 (WTE) Occupational therapist 1.25 (WTE) Clinical psychologist 0.9 (WTE) Consultant psychiatrist 1.5 (WTE) Specialist doctor	1 (WTE) Psychotherapist 0.5 (WTE) Family therapist 2 (WTE) Nurse practitioners 1.5 (WTE) Substance misuse nurses
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Table 11 Gateway Team Members

In addition to the core team members, art and play therapists could be referred to if required. There was also a number of administrative staff who supported the team. The ethnography presented in this thesis focused on the practice of the occupational therapist Amanda, and

four other team members also agreed to be interviewed; collectively these five people formed the key informants for the ethnography. A brief description of their roles is as follows:

Amanda, Occupational Therapist: Amanda worked as a band 7 occupational therapist, she was in her mid-30s and had been working as an occupational therapist for ten years. Amanda qualified from a post-graduate training programme at a university in the United Kingdom. Amanda had previously worked as an occupational therapist in an adult mental health service and had moved jobs to work in Child and Adolescent Mental Health Services about two years ago. Amanda was the only occupational therapist in the team. Her role was to provide occupational therapy assessments and interventions, as well as contribute to generic team work.

Pam, Consultant Psychiatrist: Pam was the most senior member of The Gateway team. Pam's role was to provide psychiatric assessments, contribute to risk management, decide whether young people should be admitted to hospital inpatients, prescribe medication, make diagnoses, supervise and teach junior medical staff. Pam did not usually care-coordinate but she did provide complex case consultation.

Helen, Specialist Doctor: Helen was a middle-ranking doctor who had been in the team for eighteen months. Helen's role included assessing young people for medication and assisting other clinicians when there were issues of risk, as well as taking a lead with neurodevelopmental conditions.

Daniel, Clinical Psychologist: Daniel was a senior clinical psychologist. Daniel provided specialist psychological therapies including cognitive behavioural therapy and dialectical behaviour therapy. Daniel led group intervention as well as providing one to one psychological assessments and treatments.

Morag, Trust Lead for Occupational Therapy: Morag was not part of The Gateway team, she had an office in a nearby hospital. Morag had professional, strategic and leadership responsibility for the occupational therapists within the Trust. She worked alongside other professional leads for clinical psychology, physiotherapy, arts therapies and dietetics and reported to the Therapies Director for the organisation.

The Participants: The Young People

The Gateway team would each see a small number of young people, referred to by the team as 'cases'. The team were able to offer young people regular appointments. These would range from several times a day to once a week. Appointments could be at The Gateway building, in young people's own homes, or in community settings. Young people were seen with their partners, mums, dads, siblings, social workers, or on their own. The young people had a range of mental health diagnoses. These included chronic fatigue syndrome, behavioural difficulties, self-harming, anxiety and low mood. Many of the young people were not attending school. Five young people were directly observed receiving occupational therapy. Brief descriptions of their circumstances are detailed below:

Stacy was a 16-year-old young woman. She lived in her mum's flat with her one-year-old daughter, and a younger sibling. Stacy had been diagnosed with low mood and had in the past self-harmed. Amanda had been seeing Stacy weekly for the past month. Stacy was having difficulties with managing and attending school, exams and the practicalities of coping with a young baby.

Charlotte was a 13-year-old teenager. Charlotte lived in a suburban area with her parents and younger sister. Her mum was at home and joined her for some of the occupational therapy session. Charlotte had been diagnosed with chronic fatigue syndrome. Amanda was seeing Charlotte weekly. The focus of occupational therapy was managing college and daily life at home.

Andrea was a 17-year-old teenager seen at her children's home. Andrea had a history of risky behaviours, including self-harm and violence towards others; she also had a long history of social difficulties and low mood. Andrea was a relatively long-term case for Amanda. Andrea's current concerns were arranging to move out of the children's home and live on her own.

Liz was a 15-year-old teenager, living with her parents. She was seen by Amanda at home with her mum present. Occupational therapy sessions were twice a week. Liz was refusing to go to school and had withdrawn from daily life due to social anxiety. Amanda was working with Liz to get her back into school, social and family activities.

Rachel was a 17-year-old woman, seen at the youth service office with her boyfriend. Rachel had suffered from panic attacks and anxiety. Rachel was keen to start a family but had recently had a miscarriage. She wanted to manage everyday life better.

Life in the office

The office was where administrative tasks took place. There was not a typical content to a day in the office; case discussions would vary. There were nevertheless typical types of work that took place. These included the writing up of clinical notes, completing electronic patient records, writing reports and letters, liaising with colleagues, making phone calls, checking emails and attending meetings. While there was a productive atmosphere to the office there was also a considerable amount of office talk. The office talk was sometimes productive but at other times seemed to distract the team from getting on with the job.

Office talk took up a considerable amount of people's time. Office talk was mostly used as an informal way to talk about cases. Regardless of the case, colleagues listened into conversations and offered opinions and suggestions, this contributed to a sense of shared ownership of cases. The following excerpt is from field notes describing part of daily office work and office talk:

As Amanda got off the phone she immediately began discussing the case with Daniel. Daniel stopped writing notes to listen. Amanda reiterated and elaborated on the morning's events to Daniel. She explained how the young person had written a letter saying she didn't want to attend today as she was fine and that Amanda had made her mum not trust her; she wanted things to go back to the way they were. Amanda talked with Daniel about what would be the best thing to do next. Daniel suggested writing back, Amanda agreed this was a good idea. The open plan nature of the office meant that it was difficult to have conversations without others overhearing. The psychotherapist sat completing paper work had stopped to listen. He offered Amanda some further discussion about the case and offered to help formulate the letter to the young person. Amanda thanked him for the support and the conversation ended quickly and everyone returned to work (Field notes).

At times it seemed that cases were over discussed. Over discussion of a case was observed when too many clinicians contributed to a case discussion; each clinician would bring a new perspective and ideas which appeared to overwhelm the case-coordinator. Office talk would also mean clinicians were continually breaking from their work. It seemed that it was expected that you would break from your work to listen or contribute to office talk. Those that were

not contributing to office talk were often encouraged by others to join in, sometimes to their frustration. The open plan nature of the office contributed to the amount of office talk; it was difficult to have a conversation with a colleague or on the phone without others listening. Despite these frustrations, The Gateway team valued office talk as a way of providing informal case supervision.

Meetings

Daily Team Meeting

Each morning at 9am a thirty-minute team meeting was held in the meeting room on the ground floor of the building. The team members would pull chairs together into a circle to discuss cases. The level of importance of this meeting seemed low, represented by the often low attendance and swiftness of discussions. There did not appear to be anyone in charge of the meeting, although Pam would often take the lead. Notes of the meeting were supposed to be written to record any concerns and document team decisions; this was not consistently done. At the meeting cases, referrals and discharges would be discussed. It was also a place of support for clinicians; any potential risks, such as self-harming behaviours were raised. The morning meeting was attended by most people on a Monday morning and attendance would vary over the week. On a Friday attendance picked up as clinicians wanted to discuss the management of cases for the weekend. The following description from the field notes illustrates a typical meeting and case discussion:

9am, team meeting to discuss cases. The meeting room was painted beige in colour, had low chairs, and everyone sat crossed legged. Present were the occupational therapist, two psychiatrists, clinical psychologist, and two nurses. The occupational therapist and psychiatrists were the most talkative during the meeting with the two nurses saying very little. Notes of the meeting were taken by the clinical psychologist.

Amanda began the discussion with her case; a young teenage girl who may need to be admitted to inpatients due to self-harm. Amanda opened her discussion by outlining how the young person was not attending school and living with mum, who was struggling to work because of the situation. Amanda last saw the young person on Friday at The Gateway, but they refused to come inside and had to be seen in the car in the car park. The team discussed the mental state of the young person. Amanda reported that the young person had said that they are not at risk, but they had been self-harming. The clinical psychologist wondered if there were concerns about attachment. Amanda acknowledged this could be an issue but was a little dismissive. Amanda moved the discussion onto the possibility of the young person accessing the

hospital school. The team agreed this could be an option but the hospital schooling could only be provided from 11am to 1pm. Amanda suggested to the team that the young person could be involved in voluntary work or out of school activities, an idea that got a general sense of approval. Amanda reported that during a previous session the young person he had talked to them about their future work possibilities. The young person would like to work at Wilkinson's and be a tattooist. Amanda wondered if the young person was worried that if they talked about the future it would make people think they were well and not in need of any help?

The team discussed the possibility of hospital admission, the conversation was mainly led by Pam, the consultant psychiatrist as she appeared to be the gatekeeper to hospital admission. Pam felt it would need to be a planned admission with planned goals; in the meantime she suggested that there should be regular checks on the young person's mental state. Other team members added to the discussion asking about the possibility of support for mum, perhaps offering mum a session on her own. The team felt that this was a good idea and Pam offered to provide this additional support. Amanda seemed happy with the plan to provide family support and look at a planned admission. After some nods of agreement and checking that the plan had been recorded the discussion closed and the team moved on to the next case (Field notes).

The daily meetings gave clinicians an opportunity to give a snap shot of their cases. The short length of the meetings meant that cases were discussed quickly and a plan of action decided. A number of cases were usually discussed each day and this facilitated a sense of shared responsibility for cases. The meeting also provided immediate support to the clinician; the joint holding of any risks seemed to be important, so that this became a team rather than an individual responsibility. The issue of risk management is explored further on page 155.

Business and Formulation Meeting

The business and formulation meeting was held on a Wednesday at 11am. This meeting was more formal than the daily meeting; clinicians were expected to attend. This meeting took place in a large room. The room was set up with a variety of differently sized chairs arranged in a circle around a coffee table. The Team manager kept the meeting to a strict timeframe. The meeting was led by the team manager and had the purpose of a business meeting followed by a detailed case presentation and discussion. Business items for discussion varied but included service delivery such as therapeutic groups, case-coordination, working hours and funding. Some agenda items were for information while others were for discussion and the issues were recorded in minutes. All staff were given opportunity to talk and everyone's

views were respected. Following the business items, the case presentation took place. Cases were presented by staff on a rota system. The case presentation followed a set formula which clinicians were kept to by the team manager. The purpose of the case presentation was to get formal supervision and discussion from the team to understand and develop an action plan for a case. The case formulation meeting was generally thought to be of benefit by the team, although the rigidity of its format caused some frustration.

The Gateway: Culture of Practice

Team Roles

Team roles at The Gateway reflected a number of factors including professional background, team history, qualifications and training. The role of case-coordinator was a common team role; the team members also adopted roles associated with their professional training, for example Helen was an approved clinician and could section young people under the Mental Health Act (1983). The psychiatrists were not case-coordinators, but had the role of gatekeepers to hospital admission for young people. Keeping young people out of hospital was a key performance indicator for the team, and admission usually required permission to be sought from the medical staff, as described here by Pam:

...obviously the psychiatrists somewhat are involved erm... in usually in deciding whether or not a child needs admission and certain amounts of the administration varying depending on who else is around in the team...I might write a letter or I might phone up the unit...(Interview)

Psychiatry, clinical psychology and psychotherapy had been part of The Gateway team since its inception, this gave them some degree of seniority in the team. This seniority was reinforced through profession-specific offices and treatment rooms for psychiatry, clinical psychology, and psychotherapy. Despite the notion of team seniority, grading did not hinder day to day practice. Staff would support and advise each other regardless of their professional role. Overall there was cohesion to the team and the senior members of staff saw their role as being to facilitate other team members' clinical decisions.

Although all staff held their own cases there was a team culture of sharing the responsibility and direction of assessments and interventions with young people. This sharing of cases was evident in the office talk, daily meeting and case formulation meeting, which have already been discussed. This layered approach to case discussion reflected the team's need to discuss their complex, and at times risky cases. Managing risk was frequently mentioned as a key role for the team, as illustrated in discussions about the role of the team with Pam and Amanda.

(...) contributing to risk management particularly around, you know, highly suicidal or self-harming people (...) (Interview)

(...) erm risk management erm crisis management erm our team is specifically set up to manage crisis so a lot of our focus is around that and that can become quite generic although I think the way we all deal with it is quite different (...) (Interview)

Nevertheless, Helen did raise the issue that the anxiety of clinicians was often around perceived risk and that this could be different to the actual risk, as illustrated in her interview:

(...) I think especially in our team where we deal with high risk clients there can be a difference between the actual risk and the perception of the risk. (Interview)

The sense of risk did give the team the role of being 'experts' in risk management. The team identity of being experts appeared to help to justify their intensive specialist service. This identity was also influenced by their role to keep young people out of hospital. Keeping young people out of hospital was a key performance indicator for the team, which was recorded by clinicians on a form and placed in a clearly labelled and prominent tray in the office.

Mentalisation Discourse

The theory or framework that informed the clinical practice of The Gateway team was an important factor in defining the team's structure and culture. All members of the team were keen to talk about the mentalisation approach that they used (Bateman & Fonagy, 2013). Mentalisation refers to the ability to understand and attend to our own and others' mental states of mind and intentions. Mentalisation was originally developed by clinical psychologists and psychoanalysts for adults with personality disorders, but has been modified for work with hard to reach young people (Sharp, 2006); this approach is called adolescent mentalisation-based integrative treatment (referred to as mentalisation throughout this thesis) (Bevington, Fuggle, Fonagy, Target & Asen, 2013; Fuggle et al., 2015).

The Gateway team had all received training in mentalisation and offered this as a core or generic way of understanding and helping young people. It is suggested that mentalisation was the dominant discourse at The Gateway. Mentalisation had been embedded into the description of the team on their website, on leaflets for parents, young people and other professionals. It was also used to frame their clinical notes and formal and informal case discussions. Pam offered some insights into her understanding of mentalisation:

(...) Mentalisation in a nut shell is...is...can I say it now, well it is about sort of making sense of the thinking process of someone else and helping support them and...when things have calmed down you try to unpick with...and make sense for them what was

going on, what did they do, what happened and how did it all work out. So I mean, it is supposed to be something that is part of most mental health (...) And they have various other kind of approaches to help erm...to try and make sense of the network for instance they have got what they call the...where they look at where you consider what each part of the network thinks they want to do including the young person and family, which obviously is quite interesting 'cause you try and figure out, you put yourself in the position so you go well actually what do I think the social worker is trying to do, what are their aims, what do I think the parent or what does the parent think they want, and often, you know that's kind of connected in mentalisation because you are trying to figure out and then actually that brings up interesting questions because all sorts of assumptions are made by professionals. So I think lots of interesting ... (recording unclear) ...for formulation...for making sense of...if people have had a particular session and they want to try and think about it there is a framework to support discussion and thinking about things. So I suppose, its erm, which obviously would, could be part of any teams' approach, really. So it is not sort of like, you know, sort of, sort of ...exclusively about mentalisation but it is about bearing in mind the mentalisation and we will see, it is thought to be useful in and has I think a certain amount of evidence for adults, adults using it to treat adults, particularly with borderline personality disorder, but obviously with adolescents it is a bit more complicated, so erm so yeah (Interview).

Mentalisation had been adopted by the team after considering other alternative frameworks for practice. The team were overall positive about the use of mentalisation; Helen did, nonetheless, identify some notion that it was currently the 'on trend' approach to treatment which perhaps had not been fully researched:

(...) well, I like it very much, I think it is very good but I think like all sort of emerging theories there is sort of that period of time where erm it's almost like a religion and there is a bit preaching and kind of almost brain washing going on erm and it takes a few years before people start sort of stepping back and criticising the model and acknowledging its limitations...I think again that is my personal view that we are sort of in that sort of preaching period and that there has not been enough thought and criticism...and I think it is a very robust model and it could potentially pull people together but I think like any new theory it can cause a lot of resistance when you are sort of imposed upon it because it is so trendy, everybody talks about that and the sort of pressure to mentalisation because that is what's in the mood. I think the challenge is remembering that we have a lot of richness in the team, a lot of diversity

and yes mentalisation unifies us but we don't want it to sort of cancel out, cancel out our sort of the expertise that everybody can bring (Interview)

In day-to-day practice the team encouraged each other to use the mentalisation approach when discussing cases. Daniel in particular described how he felt that mentalisation enabled good clinical formulation by seeing things from other people's perspectives. While this overarching approach brought some cohesion to formulation it was also important to individual team members to be able to practise using their professional training, as illustrated here by Amanda:

(...) Mentalisation allows us to work within our own our own professional framework but with an overarching framework for the young people so that does become quite generic but allows you to work how you would normally as an occupational therapist or a psychologist (Interview).

The use of the mentalisation appeared to have a unifying effect on the team and contributed to the shared ownership of cases, and gave the team a common language in their office talk, team meetings and when talking to young people and families; as such it was the dominant discourse.

The Gateway: Summary

The Gateway team worked intensely with young people; the team focused on complex and at times risky cases. The risks associated with working with vulnerable young people gave the team an identity of being experts and specialists. The team used mentalisation as a framework to understand young people, which represented the team's dominant discourse. Members of the team used a number of formal and informal strategies to support each other including office talk, team meetings and a formulation meeting. Having provided a description and analysis of the functions, practices and culture of The Gateway team, the discussion now focuses on an analysis of Amanda's occupational practice.

Discovering Occupational Practice at The Gateway

This section of the chapter serves to detail the occupational therapy practice of Amanda; as Amanda has been identified through her survey responses as having a focus on occupation, her occupational therapy practice is described in this thesis as occupational practice. Amanda's occupational practice can be understood as a number of discursive constructions which contributed to an occupational practice discourse. To explore this idea, the discussion is structured into two main parts. Firstly, focus is given to Amanda's occupational practice with young people and families; this highlights the specific strategies that were used in her

practice. Secondly, Amanda's practice is considered as part of the overall structures and functions of the team; this serves to contextualise occupational therapy within young people's mental health services at The Gateway.

Occupational Formulation

Attention is given in this section to the way in which Amanda thought about or 'formulated' ideas about young people through an occupational lens. While the use of such a lens brought a focus to Amanda's work, this view was disconnected from the usual lens of The Gateway team. The Gateway team predominantly used a medical psychiatric or psychological diagnostic framework to understand and label the mental health problems of young people, for example a diagnosis of depression or anxiety. This diagnosis was usually based on the Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association, 2013). The team would use medicalised labels to aide decisions about which discipline or intervention modality would be best suited to work with a young person. The Gateway team were initially unclear what mental health diagnosis might be suitable for intervention from occupational therapy. When I explored this with them further they that considered cases suitable for occupational therapy could include young people with chronic fatigue syndrome, neurodevelopmental difficulties, psychosis or eating disorders. What did become evident was that referrals to Amanda for occupational therapy were not usually associated with a medical or psychological diagnosis. Rather, they were associated with an occupational problem, such as school attendance or the need to explore employment or careers. Clinicians referring for occupational therapy found it easier to describe the day-to-day problems they wanted occupational therapy to address rather than name the diagnosis or symptoms to be treated. The idea of occupational therapists being referred to for occupational or everyday difficulties was supported by Morag, who aimed for occupational therapists within the organisation to work on, what she described as, "*occupational needs*" (*Field note*), rather than medical or psychological needs. Receiving referrals for, and addressing the occupational needs of young people, was described by Amanda as some of her key roles in the team:

*Erm I would say well the referrals I get that are specifically for occupational therapy would usually be around...functional issues it would be around school, erm be around employment or my older age group erm...it would be around practical living skills (...)
I also get things around physical health so erm chronic fatigue syndrome erm people who have got other disabilities or people who have had periods of illnesses where it has sort of taken them out of education for a while and that has increased their emotional difficulties so those are the referrals that do come in my direction
(Interview).*

A referral of a young person for an occupational need transcended traditional medical and psychological diagnosis, bringing a new understanding of a young person. Addressing occupational needs contributed to Amanda being seen as having a specialist role within the team. This expertise was not seen as being of the same calibre as psychotherapy or psychology; the reasons for this lack of speciality status may have stemmed from occupational therapy's infancy in the team and lower grading than clinical psychologists and psychotherapists.

Following a referral to occupational therapy, Amanda used a process of assessment to understand and describe a young person's difficulties. This process was described at The Gateway as an 'occupational formulation'. The term 'formulation' was used by other health professionals in the team, particularly 'psychological formulation' by clinical psychologists. The term 'diagnosis' was also used, but had more medical connotations, usually referring to a specific medical diagnosis, such as attention deficit hyperactivity disorder. A 'formulation' in its broadest sense referred to a clinician's understanding of a case. This formulation was either from a profession-specific perspective, for example a psychological formulation, or through the use of mentalisation. The use and meaning of the term formulation was commonly understood at The Gateway, although the focus of the formulation was flexible.

The use of occupational formulations demonstrated a shift in thinking away from traditional constructions of mental health; it embraced formulating about young people at the level of participation in daily life, rather than at the level of symptoms or aetiology. The use of occupational formulations set Amanda's lens on the world at a disjuncture with other perspectives of the team and it added to the notion of her providing a specialist intervention. Amanda used a range of occupational formulations, these were mostly in the form of narratives or statements about occupational participation and engagement. Examples included descriptions of problems with hobbies, school and college, friendships, eating meals, household chores, household management, shopping, work and sleep. Further context was usually provided in the formulation describing the individual and their physical, social and family environments. Amanda developed her occupational formulations through her observations and conversations with the young person and their family. Occupational formulation was commonly an on-going 'process' although at times it became an 'event' whereby a formal formulation would be used in a report or at meeting. For example, the Team Leader at the case formulation meeting asked Amanda to come back to the team "*when you have come to your occupational formulation*" (Field notes).

To support Amanda in developing her occupational formulations she had access to a range of standardised assessment tools (see Table 12 on page 160). The occupational therapy

assessments were predominantly associated with the Model of Human Occupation, which supported the use of occupation as her domain of concern.

Occupational Therapy Assessments	Generic Mental Health Assessments
<ul style="list-style-type: none"> • The Short Child Occupational Profile (Bowyer et al., 2008). • Paediatric Volitional Questionnaire (Basu, Kafkes, Schatz, Kiraly, & Kielhofner, 2008). • Assessment of Communication and Interaction Skills (Forsyth, 1998). • Occupational Self-Assessment (Baron, Kielhofner, Iyenger, Goldhammer, & Wolenski, 2006). • Child Occupational Self-Assessment (Kramer et al., 2014). • Model of Human Occupational Screening Tool (Parkinson, Forsyth, & Kielhofner, 2006). • Occupational Circumstances Assessment Interview and Rating Scale (Forsyth et al., 2005). • Occupational Performance History Interview-II (Kielhofner et al., 2004) • Canadian Occupational Performance Measure (Law et al., 2014) 	<ul style="list-style-type: none"> • Children’s Goal Attainment Scale (Steenbeek, Ketelaar, Galama & Gorter, 2007) • Revised Children’s Anxiety and Depression scale (Chorpita, Ebesutani, & Spence, 2015). • Strengths and Difficulties Questionnaire (Goodman, 2001). • Moods and Feelings Questionnaire (Angold et al., 1995).

Table 12: Assessment Tools

While Amanda had access to these assessment tools she was not observed using them in practice during the period of the research. Amanda did talk of using occupational therapy assessments; for example, at the team formulation meeting she stated *“I would like to use one of the OT ones [assessments] to help prioritise some goals for her”* (Field notes). Members of The Gateway team referred to Amanda using occupational therapy-specific assessments but they were unable to name any, for example *“I know a little about what they might be, but not very well”* (Interview). This suggested that the use of occupational therapy

assessment tools was limited to specific occasions. This limited use may have stemmed from a tension that existed between the use of an occupational therapy specific assessment and formulation process and the team's use of mentalisation. Mentalisation provided a common framework that could be understood by the team and was the cultural norm assessment process. Amanda had explored the use of a young people's mental health occupational therapy care pathway based on a training event that she had attended. This care pathway illustrated a flow diagram that began with the use of occupational therapy assessments such as the Model of Human Occupation Screening Tool (Parkinson, Forsyth, & Kielhofner, 2006), Short Child Occupational Profile (Bowyer et al., 2008), Occupational Circumstances Assessment Interview and Rating Scale (Forsyth et al., 2005), Occupational Performance History Interview II (Kielhofner et al., 2004) or Canadian Occupational Performance Measure (Law et al., 2014) as an initial assessment. Further assessment was completed depending on the young person's presenting difficulties. The care pathway described how the occupational therapy assessment process should follow with case formulation, goals, interventions and outcome measures. The use of mentalisation as a universal framework challenged the implementation of such a profession-specific occupational therapy assessment process; the processes and language of mentalisation had become embedded in the team structures and culture; these discursive constructions were difficult for Amanda to subvert.

Occupation as an Intervention

The Gateway team defined occupational therapy as a specialist intervention, and as described earlier in the chapter, the team would refer young people to occupational therapy to address their occupational needs. It was evident that what specifically occupational therapy intervention would be, was not always clear to team members. Daniel was unable to name any occupational therapy interventions; Pam also struggled to articulate what occupational therapy would entail, she even mentioned basket weaving, albeit jokingly. Amanda did find it difficult to articulate what her occupational therapy interventions and strategies were. However, strategies did emerge in observations of her practice and these had five main components: creating space for occupation, the Model of Human Occupation as a theoretical framework, occupation as a tool of engagement, a focus on occupational goals, and talking about doing. In addition, strategies could be delineated for each type of intervention; these served to maintain her occupational therapy practice at the level of occupation, and therefore represented her occupational practice, they are summarised in Table 13 on page 162, and discussed in further detail next.

Intervention	Strategy
Creating space for occupation as an intervention	Situating the young person in the context of an occupation Use the setting to facilitate an occupation
The Model of Human Occupation Theoretical Framework	Addressing volition, habituation, occupational roles and occupational identity
Occupation as a tool of engagement	Collaborative practice
Occupational Goals	Setting specific occupations as the outcome of occupational therapy A 'just right' challenge
Talking about doing	Problem solving Grading Pacing

Table 13 Occupation as an Intervention

Creating a Space for Occupation

The first intervention strategy was for Amanda to create a physical and theoretical space for occupation. Amanda's interventions were mostly delivered in settings away from The Gateway office; creating this physical and theoretical space for occupational therapy was important for Amanda. The physical separation of Amanda from The Gateway environment created a freedom from mentalisation that allowed Amanda to bring an authenticity (see Yerxa, 1967) to her occupational therapy practice, and to use the language of occupation. Amanda's occupational therapy sessions took place in contexts that were both naturalistic and community orientated. There were two reasons for the use of naturalistic therapeutic settings. Firstly, to situate the young person within the context of their occupations; for example, occupational therapy with Liz at home where she cooked and baked with her mum. Secondly, to use the setting to facilitate engagement in an occupation; for example, using a community setting with Rachel which meant she had to travel on the bus. In this way the context of the occupational therapy became part of the therapy itself. The use of home and community settings reflected Amanda's goals of occupational therapy that were focused on managing mental health through everyday doing and developing independence. The use of naturalistic settings was not exclusive to Amanda, although within her team Amanda would see young people in community settings more frequently than anyone else. It could be argued that the lack of a profession-specific room at The Gateway pushed Amanda out into the community. Despite being "allowed" (*Field note*) to use treatment rooms at The Gateway, Amanda was

resolute that the community was her preferred setting for seeing young people. A visit to Stacy exemplified a community visit; here Amanda discussed occupations related to Stacy becoming independent in running her own home, looking after her child and going to college. The session started outside on the balcony while Stacy had a cigarette before being continued in the house. The beginning of the session is described in field notes:

When Amanda arrived Stacy was having a cigarette outside the front door, she seemed happy to see Amanda and their greeting was casual and friendly. Amanda engaged Stacy in some social chit chat while she finished her cigarette, finding out how she was and what she had been up to.

Stacy took Amanda inside the flat and into the living room where her mum was sat on the sofa and one baby was playing with toys sat in a high chair and the other was bouncing up and down in the baby bouncer. The room was oppressive and dark and was filled with balloons from a recent birthday. The walls were adorned with family photographs and drying washing covered clothes airers and radiators.

After introductions and pleasantries Amanda began discussing with Stacy how she could make plans to live on her own. They talked of taking small steps, organising the practical things and developing skills such as budgeting, security, cooking, buying white goods and paying bills. Amanda focused on the idea of independence but allowing others to provide support by keeping up relationships with her Mum and her Nan. There was a clear bond between Stacy and her mum and Amanda played to this strength by encouraging her mum to be part of the conversation and using mum as an expert "you should learn from your mum about buying nappies in bulk" as well as using mum to praise Stacy "you are good at cooking".

Amanda was also keen to guide Stacy on other areas of her life including parenting, college and work. They talked of how to access college courses, where to apply and where to get funding from. Stacy's mum suggested she get a Saturday job in a hairdressers washing hair and sweeping up (Field notes)

Amanda's delivery of occupational therapy was not limited to home situations; she also saw young people in community settings such as the Youth Service, schools, and on one occasion in the car in the car park. Often these community settings were chosen for older young people who were well enough and able to travel to their appointments on their own. Community settings did not always offer a natural setting for the participation of young people in their daily occupations. For example, Amanda met with Rachel and her boyfriend at the Youth Service offices. Amanda used a small office usually used by the sexual health nurses which

had an examination table, vaccines fridge, sink, desk and chairs. Although not an ideal setting for intervention the location facilitated Rachel, who suffered from anxiety and panic attacks, to leave the house and travel on public transport. The focus of Rachel's occupational therapy was to support her to look at work opportunities. Travelling to an appointment and being on time was part of achieving this.

Using The Model of Human Occupation

Amanda's approach to interventions was underpinned by the Model of Human Occupation, although this was done implicitly rather than explicitly. The use of Model of Human Occupation concepts could be seen in Amanda's attention to volition, habituation, occupational roles and an occupational identity. An emphasis on habituation was achieved through the establishment of routines in daily life, this was a frequent focus of Amanda's interventions. For example, with Liz she described the aim of their therapy as, to *"Get you into that thing I harp on about...routines!"* (Field notes). Again, with Charlotte she asked *"Are you getting into a routine?"* (Field notes). Amanda used daily and weekly scheduling as a tool to look at what young people were doing with their time. Her occupational therapy intervention was often to work with the young person to enable them to participate in more, or a better balance of, daily occupations. For those young people with low participation levels routines in the home were addressed, such as getting up and getting dressed. Many young people were not in education, training, voluntary or paid work and the development of routines was seen as a graded way to achieve this; the use of grading will be discussed further later in the chapter (see page 171). An example of developing a routine can be seen in Amanda's work with Charlotte:

Amanda: "Are you getting into a routine?"

Charlotte: "Yes, I have been swimming and to the stables"

Amanda: "When does college start?"

Charlotte: "Next week"

Amanda: "What have you been doing to get ready for your course?"

Charlotte: "Nothing"

Amanda: "Do you know what your first day will look like; will you have to carry things around?"

Charlotte: "I am going to get my mum to phone up and find out"

Amanda: "Make sure you get information about what you will have to do, things like break times and carrying things...how about things at home, things to help out or things that you enjoy?"

Charlotte: "Not done much, not doing needlecraft. I have helped mum with a stir fry...we are supposed to be making cakes this afternoon"

Amanda: "What about your room? Have you been keeping it tidy? You might want to do this before college starts as you might not have the energy...how about stripping the bed, perhaps just doing the bottom sheet?"

Amanda: "what about exercise?"

Charlotte: "I have been swimming and to the stables"

Amanda: "What about the Wii or the trampoline...what about getting out and about, using the bus, going out with other people?"

Charlotte: "Some of my friends suggested doing something this weekend but nothing happened"

Amanda: "What could you do about it?" (Field notes)

Amanda regularly talked with young people about developing a routine for school or college. For example, she discussed with Charlotte what she needed to get ready for school, how she would carry things about and what she would do at break times. Amanda would also take the idea of establishing routines into school; she frequently liaised with schools regarding a young person's reintegration into school life with an adapted timetable. For example, when working with Stacy *"I am sure we can come to an agreement with school about how to manage this"* (Field notes).

Amanda addressed occupational roles and occupational identity by aiming to engage young people in school, college, volunteering and employment. She spoke of setting up a summer volunteering occupational therapy programme. Amanda's resources files at The Gateway contained many leaflets about local activities and projects for young people. Amanda also had a folder with details of a previous summer group she had run to produce a young people's newsletter. The aims of this group had been to *"allow group members to develop community leisure interests and provide a structure in the summer"* (document). Amanda's focus on volunteering was linked to helping young people into employment and for some young people gaining employment was the goal of occupational therapy. Amanda often spoke about careers with young people, she would suggest careers websites and college courses. As well as aiming

to establish occupational roles and identity out of the home, she also considered roles and identity within the family as important. For example, when working with Stacy, Amanda used family members in therapy to facilitate the development of family roles such as daughter, sibling and mother. Amanda's attention to occupational roles and occupational identity demonstrated a theoretical alignment to the Model of Human Occupation and her commitment to health through occupation.

Therapeutic Engagement on a Different Level

The ability to engage young people in a therapeutic process was not unique to Amanda; her colleagues also discussed the ways and means of engaging with young people. Amanda did see the skill of engagement as an area of strength for her, and occupational therapists more generally:

(...) I think engagement is a big thing for me...I like engaging with people and talking to people and I enjoy building up therapeutic relationships...Client-centred drive that we [occupational therapists] are trained in fits with our personalities and that gives a strong sense of, you know, you want to do things collaboratively with someone. They need to feel on board and they need to be part of the process rather than being done to, which I think sometimes is my sense of how it has worked in our team at times. It has been like this treatment prescribed and this is what you will engage in rather than what do you want and where are you at the moment and negotiating it, so I think that really informs my practice coming from a client-centred sort of direction and also a sort of participation. I really like the patient experience stuff and the participation stuff, getting people involved in their treatment and again I think that it is to do with me as a person but also a lot to do with again coming from the perspective that you have to have some engaged in something in order to do anything to support them (Interview).

Amanda had elaborated here on how central collaboration and involvement of young people was to her occupational therapy interventions. She also considered that providing client-centred interventions required a collaborative decision making process with young people, rather than the use of pre-determined prescription of interventions. She viewed the skill of therapeutic engagement and being client-centred as being an essential tenet of her professional practice, and that it was part of an occupational therapist's training. Amanda's skills of engagement were recognised by others in her team, as illustrated here by Helen:

She knows how to engage with people, she is really good with hard to reach young people, err she is very good at negotiating and compromising, she is always available and I think also her demeanour and attitude and you know always a smile on her face

and I think that really helps a lot and also I think she has a lot of experience (Interview).

Amanda found engagement with young people easy because she addressed issues of everyday life. She did not require young people to sit down and talk about feelings or relationships but focused her conversation on the everyday; this was seen by the young people as less threatening. Amanda described this idea as engagement 'on a different level' which was distinctly different from therapeutic engagement by other healthcare professionals:

(...) it would also be around engagement and engagement at a level that is different to something like engagement with psychotherapy. So I think it is on, it's on the reason they are referred to me is for a bit of work first before they maybe have more defined treatment, just to engage them in something, something that is focused on what they want to do, something that is focused on activity and interests. Which is usually a starting point for our young people, because it is something that is really lacking in their lives (...) (Interview).

Amanda's ability to engage with young people on a different level was also described by Helen and Pam. They spoke of Amanda's ability to engage with hard to reach young people. Amanda demonstrated this different level of engagement when working with Liz who was difficult to engage with, as illustrated in this field note:

Liz was sullen when we saw her at her home. She sat on the sofa with her hair over her face for most of the session with Amanda. The session focused almost entirely on helping Liz to attend school as she had not been for the last week but she was not clear or not willing to say why not. The issue of school was evidently a topic of argument between Liz and her mum and they bickered throughout the session. Amanda trod a fine path so not as to alienate Liz, she suggested strategies to support Liz back to school including going to the hospital school, being picked up for school each day, half days or learning online. Liz put up a range of arguments including "school are being idiots", "I can't trust school", "I lost my timeout card", and having a "mental block". Liz also tried to take the conversation off topic a number of times to talk about clothes, tidying her room, posters in her room, One Direction, chavs, dying her hair, World of Warcraft and eating marshmallows. Amanda negotiated these diversions by bringing the conversation back to attending school and the possibility of a meeting at school to put a plan in place. Amanda asked Liz who she would like at the meeting. The discussion around reasons for not attending school led the conversation to the future and Liz began to talk of wanting to attend gigs and move out of home. Amanda used this to talk with Liz about what liked to do and what she

was doing with her time. Liz talked about computer games, Facebook and watching weird things on You Tube. Towards the end of the session Amanda brought Liz to the here and now asking her what she was going to do with her afternoon (Field notes).

Engaging young people on the level of occupation or at a different level to other professions made occupational therapy a powerful tool for engaging with young people. This tool also brought a strength to Amanda's position at The Gateway as others would look to Amanda to work with cases described as 'difficult to reach'. Amanda posited that occupational therapy should be the first line of intervention for young people on a trajectory to mental health recovery. Amanda described how a young person's occupational needs, such as getting dressed or seeing friends, could be seen as a young person's most basic needs. Once these basic needs were in place other emotional needs could be explored by other members of the team: *"If someone can't manage on a day-to-day basis and have the basic skills or the basic needs that they have met then there is no way that you can work on the other issues that they may have emotionally or otherwise"* (Interview). Amanda's ability to engage young people at the level doing was supported by setting occupational goals and characterised by talking about engaging in occupations, which will be explored next.

Occupational Goals

The next intervention strategy focused Amanda's occupational therapy on addressing occupational problems. Amanda negotiated occupational goals with young people to create an understanding of what could be achieved in therapy and what could be done outside of the session; it was used as a strategy to create a 'just right' challenge. An example of occupational goal setting can be seen in Charlotte's therapy session:

- Amanda to liaise with college about a meeting to discuss return to lessons
- Charlotte to get up at 9.30 each day to aid getting in a daily routine
- Charlotte to use a daily timetable and weekly schedule to provide a structure of activities
- Charlotte to find a leisure interest outside of the house

Amanda addressed a range of goals with young people including baking, using a cash machine, budgeting, paying bills, using the washing machine, cooking, keeping safe, getting up in a morning, changing the bed sheets, carrying school bags, getting to school, meeting up with friends. She described her goals to Andrea as: *"I am being really practical so you will succeed"* (Field notes). Amanda's goals consistently addressed occupational participation and engagement rather than symptom management, this reflected her commitment to an occupation as the outcome of her therapy.

Talking About Doing

The mainstay of Amanda's intervention was the use of a talking-style of therapy. Her talking acknowledged young people's feelings and emotions, but it was focused on occupation, as illustrated in the field notes below, which describe part of her occupational therapy with Andrea:

This session seemed to be more uncontained than others; Andrea was restless, would talk off topic and pushed professional boundaries. Amanda adapted her therapeutic style to maintain control by being very clear but at the same time relaxed. Andrea sat with her legs over the arm of the sofa for the whole session, often facing the opposite way from Amanda. Amanda covered several topics related to Andrea's imminent move into a self-contained flat. Amanda tried to get Andrea to consider some of the practicalities of the move, although the conversation reflected Andrea's 'here and now' approach to life. Amanda's focussed on occupation as she spoke to Andrea about eating, and cleaning at her new flat:

Amanda: "What are you eating at the moment?"

Andrea: "Not much"

Amanda: "You do look like you have lost weight?"

Andrea: "I am eating toast at lunch time and a meal in the evening – KFC, McDonalds, pasta, and roast dinner, something like that"

Amanda: "Have you thought about budgeting? How about a trip to the supermarket to see how far your money will go. You are going to get annoyed about people nagging you about this; it would be hard for anybody to manage on that amount of money"

Andrea: "You're pushing it today aren't you?"

Amanda: "What about laundry? How are you using the washing machine...Will you have a washing machine in the flat...What will motivate you to do some washing?"

Andrea: "When things are dirty"

Amanda: "What about cleaning your room?"

Andrea: "The support worker will do that...I have realised that it's going to be bloody hard"

Amanda: "I am being really practical so that you will succeed"

Amanda continued to talk with Andrea about her future education and the possibility of getting a job; Andrea was fairly ambivalent towards this idea. As the conversation continued Andrea became more agitated and angry and Andrea said she was “fucking fuming”. Amanda asked if moving out was bringing up feelings of endings and Andrea began talking of the ending of relationships with friends, staff at the children’s home as well as her anxiety of transferring to adult social care. Andrea also spoke of some thoughts of cutting herself with glass. At this point Amanda acknowledged her feelings and began talking about managing feelings when things end. She did however relate her current feelings to how she would manage her emotions when in her flat on her own. Amanda suggested a number of strategies to help – crisis plan with phone numbers, keeping busy (social and leisure activities), and distraction - listening to music. (Field notes).

The excerpt illustrates how Amanda’s interventions used a talking therapy style to explore practical issues relating to a young person’s doing in everyday life. On a number of occasions Amanda suggested that she and the young person could engage in an occupation together. For example, in the field notes above Amanda described *“how about a trip to the supermarket”* (Field notes); similarly, when working with Stacy, Amanda discussed *“going to college to look at a bursary”* (Field notes), and when planning with Charlotte she talked about *“going on the computer next time to have a look at applying for a course”* (Field notes). However, the doing of occupations as a therapy was not observed during the data collection, and Amanda discussed how she placed a greater emphasis in her sessions on preparing for engagement in occupation rather than the engagement in occupation itself. This approach may suggest an incongruence between her description of practice which was about doing, but a practice reality that does not actually use doing.

The talking about doing that Amanda used in her occupational therapy used the specific strategies of problem solving, grading and pacing. The strategy of problem solving was a component of the talking-style therapy which used focused questioning; this I have termed ‘occupational questioning’, due to its focus on what young people are doing. The following quotes, taken from field notes across cases, illustrate occupational questioning as a problem solving strategy:

“What else are you doing with your time at home?”

“When was the last time you went out of the house?”

“What are you going to do this afternoon?”

“Anything else about school?”

"Today we are going to concentrate on school"

"What has made it difficult for you to go to school this week?"

"What are you doing with your time, anything productive or just mooching about?"

"What about doing some of the things you enjoy?"

"What are you going to do with your day?"

"What about work?"

"Do you think you will get bored?"

"What will your first day (at college) look like?"

"How about things at home, things to help out or that you enjoy?"

"What about getting out and about, using the bus, going out with other people?"

"What are you doing?" (Field notes)

The problem solving strategy was used by Amanda to facilitate the young person to strategise or problem solve about occupational issues. Within the problem solving strategy Amanda would use the skill of grading as a way to modify an occupation to better suit the ability of the person; for example, providing greater verbal commands or increasing the time given. Amanda also used the skill of pacing to spread or space occupations across a young person's day. These intervention skills were seen by The Gateway team as being unique to occupational therapy, as described by Pam:

(...) we have got a young woman chronic fatigue so the idea about having an assessment of skills and a practical approach, to kind of grading, erm you know to physical activity and all that sort of stuff and assessing erm, you know, you know, a young persons... 'cause we have another young man, although Amanda has never seen him yet who has got kind of a probably a chronic psychotic illness, but thinking about skill building thinking about what he can and what can't do and activities and so on and I think about that as part of her role and also thinking about her knowing a bit more about activities out in the community so work or education, or you know, those sorts of things that can be another part of helping a young person get on with things (...) (Interview).

Examples of grading and pacing are seen throughout Amanda's clinical work. For example, when discussing returning to school with Liz and Charlotte she suggested grading the return

to school lessons by using an online learning tool to catch up with work missed. This further field note extract illustrates a further example of grading with Charlotte:

Amanda discussed with Charlotte about her helping out at home, Charlotte reported that she had helped mum with some cooking this week and was looking forward to baking this afternoon. Charlottes mum expressed an interest in her keeping her room tidy when she went back to school. Amanda was concerned about the amount of energy Charlotte would have once she was back at school. Amanda suggested that to start with Charlotte should just make her bed, adding that other activities could be added in time... (Field notes).

Amanda used the strategies of grading and pacing when working with Liz to get her back to school. Amanda suggested pacing the amount of time at school from a couple of hours to a full day over a two-week period and grading the amount of therapist support to get to school. Amanda's use of grading and pacing an intervention was at the level of discussing and planning participation in occupations, rather than the implantation of these plans. Amanda did again report plans to use these skills in practice, for example to visit Liz each morning to provide verbal encouragement to help her attend school.

To summarise this section, Amanda's occupational therapy interventions were characterised by a talking-style therapy that facilitated engagement and maintained a focus on occupation through the use of the Model of Human Occupation, which served to guide her therapy towards establishing daily routines and achieving occupational roles and identity. A focus on occupation was achieved through the use of intervention strategies which included problem solving, grading and pacing. These discursive constructions contributed to an occupational practice discourse which was commonly enacted when Amanda was working one-to-one with young people. However, Amanda also brought occupational practice into her wider practice as part of The Orchards team, this presented some discursive tensions which will be explored next.

Negotiating the Discourse

The discussion begins by situating Amanda's theoretical perspective and professional language within the mentalisation approach used in the team. As already discussed earlier in this chapter, mentalisation pervaded many aspects of the structure and culture of the team; it was the dominant team discourse. Amanda described that, as an occupational therapist working in a multi-disciplinary team, she was willing to accept mentalisation as a theoretical middle ground, but that she was prepared to fight her corner for her occupational practice discourse:

...I come from adult mental health previously and I think OTs in adult mental health tend to work in a framework around, well kind of meeting in the middle really. Because you have to because you are the only OT in the team you have to erm fight your corner as an OT but also prove that you can be part of a team and work alongside everyone and provide the functions that you need to provide to keep the team going erm... so that has influenced me a lot kind of trying to get that balance and also working with all the different professional having been a lone OT in my team in my last 3 posts. It means I have had to take from other people around me, a lot from nurses and psychiatrists and psychologists and social workers so I pick up skills from them as well but I do really hold on to the fact that I became an OT because I wanted to be an OT and the things I am really interested in are how someone manages on a day-to-day basis (Interview).

While Amanda made use of mentalisation theory, her practice was predominantly theoretically informed by the Model of Human Occupation (Kielhofner, 2008). Amanda described how this profession-specific perspective *"... gives me a professional language, others have a professional language and we [occupational therapists] have our own"* (Interview). Amanda described her growing relationship with the Model of Human Occupation as a perspective for her practice:

I think over the last few year I have become more and more interested in Model of Human Occupation as a tool that...fits the way I see things and it kind of breaks things down and particularly the volition aspect is really missed in a lot of non-OT specific things. That is a motivator for me so I think Model of Human Occupation probably underpins what I do. It is not very explicit in what I do but I do use some of the tools erm but I try and keep when I am feeding back to the team and when I kind of write letters like therapeutic letters to service users I try and actually use some of those aspects that are broken down in Model of Human Occupation to fill in the gaps of the OT bit...I just don't think that those bits come into any other models that we use, you know, it doesn't come into mentalisation but then mentalisation would fit in as part of it so it fits quite nicely together, that is my main kind of OT model of or framework (Interview).

Amanda used the Model of Human Occupation as a discursive construction to create a theoretical space for occupation within the broader mentalisation approach of the team. The Model of Human Occupation brought a new 'occupational way' of thinking to The Gateway team; Morag described how this occupational way of thinking *"made her colleagues [in medicine and clinical psychology] feel uncomfortable"* (Field notes). This feeling of discomfort

was located in The Gateway team's hesitant approach to occupation, feeling that occupation was specialist, yet not wanting to give this specialism too much power. An example of this could be seen at the formulation meeting when Amanda's focus on a young person's volition and habituation was reframed by colleagues either into a mentalisation framework or a psychological formulation. The dominance of medical and psychological ways of thinking was perpetuated through the team's use of the mentalisation approach, which reinforced this as the dominant discourse. Amanda saw her occupational lens as a complementary approach to mentalisation, but that to fit in with and be accepted by the team she needed to use both. The notion of being one of the team was also reflected in Amanda's position as a care co-ordinator. Whilst Amanda accepted occupational therapy specific referrals, her role as a care coordinator also required her to take on any case referred to The Gateway team. These cases were often not for occupational needs but for emotional, behavioural or relationship difficulties. To be part of the team Amanda felt it important to be seen to be taking on these cases. Balancing a desire to take on cases and be one of the team with a desire to be seen as a specialist was an ongoing challenge for Amanda.

As well as her work as an occupational therapist Amanda had some generic team roles; these roles included case-coordination, taking telephone referrals and being on the emergency rota to see children who had self-harmed and conducting risk assessments. The ability to be able to contribute to generic work was seen as a core part of being one of The Gateway team. The way that Amanda approached her generic work was influenced by her occupational practice, as described in an interview with her:

...Erm care-coordination so kind of day-to-day management of cases and caseload erm risk management erm crisis management erm our team is specifically set up to manage crisis. So a lot of our focus is around that and that can become quite generic although I think the way we all deal with it is quite different though. I think the actual task that we set is generic but I think the way I manage risk maybe very different to how other members of the team manage risk...I think it is more; I do more of a positive risk management strategy and try to think of practical ways of distraction. Which all the team members do to a certain extent but I think the focus is quite different so while I will focus on the here and now...I think other team members might be looking more at the kind of whys in the risk management framework anyway, erm. I always think that because we are in a mentalisation framework that that does make some of the stuff we do as a team more generic because we are all working in the same framework erm...but I do think that mentalisation allows us to work within our own our own professional framework but with an overarching framework for the young people

so that does become quite generic but allows you to work how you would normally as an OT or a psychologist (Interview).

Amanda articulated and demonstrated that she had both profession-specific and generic roles but that within her generic roles she would approach things differently to other members of the team, taking a more practical, here and now approach. Whilst mentalisation were discursive theories for understanding it was acceptable to infuse generic work with profession-specific perspectives. Amanda infused occupation into generic work during case discussions and presentations. For example, when talking with Daniel about a young person with an eating disorder she described how *"she won't be able to go out and socialise, do community things"* (Field notes). During a team formulation meeting Amanda used the mentalisation framework for presenting the case; Amanda however, maintained a focus on occupation by discussing the young person's interests in cake decorating and desire to become a teacher as protective factors, as well as the use of emergency bag at school which included fondant cake decorating as a coping strategy. A further example was observed when discussing cases at a team meeting when Amanda began by detailing the young person's school non-participation and then went on to identify school, voluntary work or out of school activities as possible interventions.

Despite the infusion of occupation into generic work, the use of words associated with occupation met some barriers from the team. To overcome this barrier Amanda explained how her occupational therapy practice was to support young people in the *"doing"* of their everyday lives, as she described in an interview:

(...) I think my biggest function in the team is around doing because I think it is around practical things for young people it is around managing day-to-day living supporting young people to meet their own goals and supporting them to have all aspects of their lives be a bit more balanced so school or employment or training and the everyday things they are doing to build their independence and also leisure interests so getting them involved in their community and thinking about what they enjoy doing because a lot of young people we see are very focussed on school or their difficulties are focused on things they like and enjoy (Interview).

The use of the word 'doing' rather than the word 'occupation' was an approach that Amanda had adopted to translate her own professional language for the rest of the team. Modifying her language did result in a self-limiting explanation of occupational therapy which worked against her promotion of occupation, as was described by Pam when she indicated that occupational therapists do less thinking than other professionals in the team:

I think that Amanda brings a much more potentially, erm a more practical down to earth approach to doing, more than, not more than thinking, but you know obviously I think of the psychotherapist as thinking and a bit of doing and I think of an occupational therapist as doing lots and thinking less...and you need both I suppose (Interview).

Pam's comment suggested that the thinking underpinning occupational therapy was not clear and that this contributed to a restricted understanding of the profession.

Chapter Summary

This chapter has presented a description and analysis of The Gateway and the occupational practice of Amanda. The analysis has illustrated how mentalisation was the dominant discourse at The Gateway team. This discourse was supported through discursive constructions, such as the allocation of treatment rooms and the arrangement of the formulation meeting. Mentalisation has foundations in psychology and psychotherapy and as such the language of these professions was embedded in the lexicon of The Gateway team, such as during office talk, at the daily team meeting and through the use of 'formulations' to understand and explain young people's mental health difficulties. A medical perspective also held some authority at The Gateway; a diagnosis was used as a medical label and the medical doctors in the team were gatekeepers to hospital admissions. The team discursive structures served to reinforce mentalisation as the dominant discourse, supported by biomedicine. The use of mentalisation also brought team cohesion through a shared sense case ownership, which supported their work with vulnerable and at risk young people.

The use of mentalisation was revealed in Amanda's work as an occupational therapist; this presented some tensions with her own occupational practice. Amanda adopted the language, structure and practice of mentalisation when interacting with her team members; this involvement with the dominant discourse helped to secure her position as being seen as 'one of the team'. However, there were times when she resisted mentalisation, for example by asserting an occupational formulation as a way of understanding a case. This formulation was supported by her use of Model of Human Occupation constructs, which were at times at a disjuncture with the medical and psychological constructs which were the practice norm at The Gateway.

When working directly with young people Amanda's occupational practice was characterised by the use of occupation throughout. This was achieved partly by delivering therapy in young people's homes and in other community settings which created a physical and theoretical space way from The Gateway office and mentalisation. The purpose of Amanda's therapy was

to address the occupational needs of young people, this focus was supported by the referral of cases to occupational therapy which related to the everyday doing of young people, in the context of their mental health difficulty. Her interventions were predominantly of a 'talking-style therapy' which was underpinned by the Model of Human Occupation, including volition, occupational roles and routines. Observations of Amanda's practice revealed profession-specific interventions that enabled her to engage with young people and address occupational needs through the use of goal setting, problem solving, grading and pacing; this practice formed part of the occupation-practice discourse.

Chapter Eight: Ethnographic Analysis of The Orchards

Introduction

The purpose of this chapter is to present Julie's occupational therapy practice at The Orchards. As with the previous chapter this ethnographic account contributed to the second aim and the second objective of the study, as outlined on page 79. This chapter is structured into two main sections. Firstly, the study setting is described, including the key participants; following this the culture of practice at The Orchards is explored with attention drawn to the theoretical frameworks that supported clinical practice. Secondly, this chapter focuses on the occupational practice of Julie, including her professional language and perspectives; specific consideration is given to the intervention strategies that Julie used when working with children and young people.

The Orchards: Organisation and Structure

The Organisation

The Orchards was part of an NHS Trust in the North of England. The Trust provided community physical health services, acute mental health services and learning disability services. The Trust covered a wide geographical area that included one large city, several big towns and a substantial rural region. The organisation aimed to deliver high quality care, across diverse communities, by locally meeting individual needs. The Trust was led by a chief executive and board; this included directors for the professions of medicine and nursing. The organisation employed a lead for allied health professions, representing for example occupational therapists, clinical psychologists and dieticians at a senior level; this was a non-executive position. Children and young people's mental health services were provided by two centres, one of which was The Orchards. While these two centres provided broadly similar services although there were local differences due to staffing, buildings and population. The Orchards offered assessments and interventions for any children and young people with mental health difficulties, aged 5 to 18 years of age; accordingly, the terms 'children and young people' are used throughout this chapter.

The Grand Tour: The Office

The Orchards was situated in a large Victorian house that had been converted into consulting rooms and offices in a suburb of a large town. The building had its own car park and was surrounded by trees. The main front door had a speaker intercom to enter, with the reception

room and desk positioned immediately to the left as you entered. The administrative staff at the reception desk greeted patients, informed staff that their patients or visitors had arrived, and took phone calls. The reception room was also the photocopying and typist's room and was full of filing cabinets and shelves. A large whiteboard on the wall was used by staff to write on and indicate whether they were in or out of the building. There were often staff in the reception room; it was a hub of activity.

The patient waiting room was opposite the reception room; this was a small but bright room. There were posters about local services, such as mental health and children's charities, and public and patient service involvement on the wall. A range of magazines were laid out on a large table, and a fish tank and a water cooler were positioned in opposite corners of the room. Also on the ground floor of the building was the staff kitchen and lunch room, The Orchards' staff shared tea, coffee and milk and there was a fridge for lunches. The lunch room was laid out with tables and chairs round the edge of the room, as it also acted as a corridor to the kitchen. There were posters on the wall advertising team nights out and team fundraising activities. In one corner were shelves stacked with files of resources, such as information on community organisations, research articles and Trust information.

The Orchards' building was a maze of rooms and staircases; there were four floors. On the ground and first floor there were rooms for working with young people and families. Some rooms had a specific purpose, such as an art room for art therapy, a play room for play therapy and a room with a one-way mirror for observations during family therapy. There were also non-specific treatment rooms which had low tables and chairs for talking-style therapies; these rooms often also contained some toys or games for use when working with children and young people. All staff were able to book and use any rooms. Staff offices were located on the second and third floors. Offices were not profession-specific and varied in size from two persons to six persons.

The Participants: The Team

The Orchards' team was an established Tier 2 and Tier 3 children and young people's mental health team set up to:

(...) help children and young people in our local area who may be having problems. They may be very upset or very angry, they may be behaving in unusual ways, or their family or carers, friends or teachers may be very worried about them (Internal Document).

Young people could be referred to The Orchards by any health or social care professional working within the Trust's geographical area. Services were offered Monday to Friday between

8am and 5pm. There was an on-call evening and weekend service offered by the medical staff. Young people were seen at The Orchards’ building, at their homes or in community settings. Appointments were usually an hour long, depending on the individual circumstances and the nature of the work. The team offered a range of discipline specific interventions, such as psychotherapy and occupational therapy, or treatment modality specific interventions, such as cognitive behavioural therapy and family therapy. There were specific assessment and intervention services for children and young people with attention deficit hyperactivity disorder, eating disorders, autism spectrum condition, severe learning disability, and substance misuse, those in the youth offending system and looked after children. As well as offering direct work with young people, some members of The Orchards’ team also provided advice and consultation to other healthcare professionals, for example to a school nurse or general practitioner. The members of The Orchards’ team are detailed by number and whole time equivalent (WTE) in Table 14. There were a range of grades within each profession; the team also included administrative staff.

1.0 (WTE) Team Manager (nurse)	3.0 (WTE) Psychiatrists
1.6 (WTE) Occupational therapists	2.5 (WTE) Primary Mental Health Workers
2.0 (WTE) Clinical Psychologists	0.4 (WTE) Psychotherapist
1.0 (WTE) Family therapists	0.6 (WTE) Play therapist
0.4 (WTE) Art therapist	0.9 (WTE) Social workers
5.0 (WTE) Nurses	1.0 (WTE) Support worker

Table 14 Orchards Team Members

All of The Orchards’ team were part of this study through field observations, for example observations were made at staff meetings and in the lunch room. The ethnography presented in this chapter centred on the practice of the occupational therapist Julie within the context of The Orchards’ team. Julie and two of her team members were interviewed as part of the data collection, collectively these were the key professional informants for this study. They are presented below:

Julie, Clinical Specialist Occupational Therapist: Julie was a band 7 occupational therapist, she had been working as an occupational therapist for ten years. Julie had worked in a range of clinical settings before moving into children and young people’s mental health five years ago. Julie’s role was to provide occupational therapy assessments and interventions

as well as contribute to generic team work, such as assessments for attention deficit hyperactivity disorder and autism spectrum condition.

Lisa, Mental Health Nurse: Lisa worked as a primary mental health worker offering consultation to front line healthcare professionals, such as general practitioners, school nurses and health visitors. She also offered short term one to one work with young people.

Bina, Support Worker: Bina had been employed by the Trust to build links with the Asian community. Bina worked with all members of the Orchards' team and would deliver therapy under the direction of a qualified healthcare professional. Bina would also assist with any translation or interpretation required by the team.

The Participants: The Young People

There were five young people who were observed receiving occupational therapy from Julie. Most of the young people were only seen once but Angela was seen on three different occasions. Angela, Paul and Mike were seen on a one to one basis by Julie. Matt and John attended with their parents and were seen by Julie and colleagues from the team.

Angela was an 18-year-old woman who lived with her parents and was seen at home. Angela had chronic fatigue syndrome. Julie had been seeing Angela for about a year and Bina had also been delivering occupational therapy interventions under Julie's direction. Angela was having difficulty managing school and home life; her current occupational therapy interventions was to identify volunteering opportunities.

Paul was a 14-year-old teenager. Paul was not attending school and had some ongoing relationship difficulties with his dad. Julie saw him on his own in the creative arts room at the Orchards. Julie had seen Paul a couple of times, he was difficult to engage in the therapy process and seemed to be ambivalent towards help from Julie.

Matt was an 8-year-old boy seen with his mum for an assessment for an autism spectrum condition. This assessment appointment was with Julie and the team's paediatrician. The assessment used the Autism Diagnostic Observation Schedule. This semi-structured assessment examined the specific areas of a child's play, relationships, behaviours and thoughts that are associated with an autism spectrum condition.

Mike was a 13-year-old teenager with a diagnosis of attention deficit hyperactivity disorder. Mike was having difficulties at school, which had resulted in him being excluded. Mike's parents attended the Orchards with him and met with the clinical psychologist, while Mike met with Julie. Julie used the Play Station games console to engage Mike while she talked to him. Mike was restless and struggled to give more than one word answers.

John was 10 years of age. John had attachment and behavioural difficulties. He was seen with his mum and the clinical psychologist at the Orchards for Theraplay. Theraplay is a semi-structured manualised play-based intervention that addresses child-parent relationships.

Life in the Office

The Orchards' team was shaped by its culture and structure, and the interaction between the team members, children, young people and families within this context. Most members of the team would arrive at work between 8am and 9am and sign in at reception. First appointments of the day were typically at 9am, children and young people were not normally seen after 5pm for safety reasons. Many staff stayed beyond 5pm to complete paperwork. While there was an overall temporal pattern to the day and the week the clinical cases varied each day. A typical day for the members of The Orchards' team would involve seeing young people for assessments and interventions and carrying out associated paperwork. There was a general sense of business at The Orchards with people getting on with work behind closed doors or rushing out of the office to see young people in the community. Seeing cases, discharging cases and taking on new referrals was an underlying priority for The Orchards' team. Team members would receive caseload management supervision from the team manager, the purpose of this supervision was to facilitate the timely discharge of cases.

When not conducting clinical work clinicians would spend time in their offices completing electronic patient records, writing or dictating letters and reports, making phone calls, planning treatment sessions and checking emails. The Orchards' kitchen and social room was

a hub of activity and social support. The physical structure of The Orchards' building meant that small offices were scattered across several floors; this seemed to give a sense of isolated working, but the kitchen and social space brought the team together. Talking in the social room and the kitchen, while making a cup of tea or eating lunch, provided a switch-off period for clinicians where clinical work could be temporarily forgotten. However, this period was often short-lived and clinicians were soon rushing back to work.

Meetings

Weekly Team Meeting

A team meeting was held every Tuesday afternoon, this was chaired and minuted by the team manager. Attendance at the meeting was encouraged but not mandatory. Agenda items were mostly business related; these included staffing levels, training, team statistics, organisational drivers and strategies. The team meeting was well attended and staff would sit on tables and chairs to crowd into the small meeting room. The meeting was clearly led by the team manager, but everyone was given the opportunity to speak, such as in discussions about a new post that was being advertised. People's engagement in the team meeting depended on the agenda items, with senior staff being more involved in discussion than junior staff. The meeting was productive and decisions were made or plans made for information to be brought back, for example a small working party was agreed to conduct a time and motion exercise for activity-based costing. The meeting also served as a place for support, for example discussions were held about a peer support group to manage complex cases.

Clinical Discussions Meeting

All of the Orchards' team had been allocated to a clinical discussions group. These groups had five or six members and were used as a form of group supervision. At the clinical discussion group cases were discussed and advice and support sought from colleagues. A clinician was expected to bring all of their cases, at some point, to the clinical discussion meeting; the outcomes of the discussion were agreed and recorded on paper in a file. The meetings were a way of safeguarding patients, clinicians and managing any risks. Julie's clinical discussion group met on a Friday once a month. In her group were a social worker, primary mental health worker, psychotherapist, junior occupational therapist and a community support worker. The meeting took place in an office on the second floor. Everyone sat on low chairs round a central coffee table. There was no chair or lead for the meeting and clinicians would indicate at the beginning of the meeting if they had anything to discuss. In the extract from field notes below Julie presented one of her cases:

Julie began by describing the case of a 14 year old male with chronic fatigue syndrome; he had a past medical history of anxiety and a viral infection. Julie had become involved after his attendance at school declined; when she met him he described being bullied at school. Julie described how his daily routine included home tutoring and playing with his dog, but that he had “dropped out of normal life” and had “no contact with the outside world”. She felt that he had an enmeshed relationship with his mum, had few friends and social life, and had poor motivation for change. Julie ended her description saying “the less you do the less you want to do”.

There was lots of nodding around the room and a few seconds silence as people considered their responses. There did not appear to be any order or hierarchy to the way people contributed to the discussion, and the child psychotherapist began by wondering whether the work was with mum and if she might sabotage any work with the young person? The junior occupational therapist suggested looking at life transitions, to help him think about his future such as growing up and moving away from home. The primary mental health worker asked about what things they did as a family and that perhaps a family session might be useful? Julie considered all of the suggestions and wrote down some notes, there was plenty of nodding in agreement at the suggestion that the family should be involved, and Julie added that the mum wanted the young person to be more confident as “he is a bit like a shadow, very passive”. Julie thought her challenge would be to get him out of the house and she would look to see if she could use the dog as an incentive to start the process. There was general agreement that this seemed like a good idea and Julie summarised the plan to see the family together at the Orchards as well as continue with one to one work. The outcome of the discussion was written in the clinical discussions file. (Field notes).

This example of a case discussion begins to draw out how individual professional practice shaped the identity and culture of The Orchards’ team. For example, Julie as an occupational therapist focused her presentation on the young person’s daily routine and school participation; however, her psychotherapy colleague began to reframe the case as difficulties with mother and son relationships, a perspective which was reinforced by the primary mental health worker. The discussion also centred the young person within their family, which also situated the young person’s possible difficulties within family relationships. The idea of family systems was central to The Orchards’ approach to working with children, young people and families, which was revealed further during field observations and interviews, and is discussed next.

The Orchards: Culture of Practice

Systemic-Medical Discourse

The Orchard's team were not overt in their use of a collective framework for practice; however, it was evident, through observations of clinical practice, team meetings, case discussions and interviews with clinicians that the nature of the work at The Orchards could be described as using a 'systemic approach'. The term systemic has roots in psychotherapy and examines relationships and patterns of behaviour within family systems (Carr, 2014). The Orchards' team took the principles and values of the term systemic but broadened its conceptualisation to include other systems in the child's life, such as school, community, work and friends. Whilst this broader view redefined the notion of systemic, it did suggest an authority of psychotherapeutic thinking in The Orchards' team. Julie described her ideas about the team's systemic approach:

Rob: Do you think that your team has...an overarching philosophy about how they work with children and young people?

Julie: Erm...I am trying to think of the overarching philosophy, I think it works in a very systemic way that's erm... and very much about working in partnership with children and young children. I think we are very proactive in terms of involving families, erm...and supporting children and young people in getting on with everyday lives, erm...around the kind of five outcomes of Every Child Matters (...) Generally, I think systemic, it probably is one of the main philosophy's you know, in terms of a therapeutic approach it seems to have quite erm a lot of prominence in erm, but me now as an occupational therapist I won't say I am a system therapist, but you do think about systems but you think about systems in different ways, erm (Interview).

A team framework underpinned by a systemic approach was also described by Lisa when talking about The Orchards' team philosophy:

Well, I think, I think it would be about wanting to understand whatever the difficulties or issues or concerns that a young person is presenting with, the aim would be wanting to try and understand as much as possible alongside that young person, but in the context not in isolation, but in the context of that young person's world. So that means that young person as an individual that young person's family, community and school because obviously we...schools are very much part of our thinking. So erm part of an assessment would usually be asking how is school, erm, you know, would it be helpful to liaise with the key person in school, so that's a systemic approach as opposed to I guess in adults, I have never worked in adult mental health, but I could you know it

is perhaps more erm, I don't know, individual thinking rather than thinking of the child.
(Interview).

The systemic approach, which valued the systems in a child's life, could be described as the dominant discourse at The Orchards. This systemic discourse was represented through the team's values and language, for example in the way in which children and young people were described during clinical discussion meeting, as illustrated on page 183. A systemic discourse was not the only dominant discourse at The Orchards, other discursive constructions denoted that a medical discourse was also influential. Such medicalised models were revealed through The Orchards' team cultural norm to use a medical diagnosis as the language to describe a young person's mental health presentation, for example depression or anxiety. A young person's diagnosis would often guide the type of intervention that The Orchards' team would refer a young person for. These interventions were often guided by a medical, psychological or psychotherapeutic frame of reference, such as cognitive behavioural therapy for anxiety; this served to reinforce the dominant discourses. A medical culture of practice was also represented through the use of multidisciplinary diagnostic assessments for autism spectrum condition and attention deficit hyperactivity disorder. The assessment criteria for autism spectrum condition and attention deficit hyperactivity disorder were based on those in the Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association, 2013). By performing these assessments there was an inferred notion that a clinician accepted a medical approach to practice, although there was some resistance to this, which is explored later in the chapter.

While the presence of assessments for autism spectrum condition and attention deficit hyperactivity disorder implied an authority of medicine this did not translate into a hierarchy within the assessment process. For example, Matt was seen for an autism spectrum condition assessment by Julie and a paediatrician. They took equal roles in the conduct of the assessment, both contributed to the discussion following the assessment and both had an equal say on the final decision about a diagnosis. The absence of an overt team hierarchy could also be seen in the social organisation of the team. Different professions and grades of staff shared offices, and rooms for assessments and interventions at The Orchards could be booked and used by anyone. The ability for each profession to have its own referral criteria, its own assessments and interventions gave each profession its own speciality, reinforcing a flat organisational structure.

Despite the flat organisational structure, medical and systemic practice had a pervasive influence and authority on The Orchards' team. These two approaches functioned together, and have been described in this thesis as the systemic-medical discourse. This discourse

structured the team traditions, such as the clinical discussions meeting and informal case discussions. This discourse also served to inform collaborative practice, which acted as a mechanism to reinforce the dominant discourse, as described here by Lisa:

(...) we work sort of collaboratively, I know when I meet new clients I always explain that I am part of a team here, and that the team is made up of...erm different professionals, professionals with different backgrounds. Obviously we have got nurses, we have got occupational therapists, art therapists, play therapists, doctors, so there is a range so, but always I feel that we do work in collaboration with, we will ask erm, the advice opinions. We have erm assessment teams which are multi-professional so that erm, the other thing that helps us work collaboratively, so it's not that you might be allocated a case so within The Orchards to do an initial assessment, so we are not working in isolation. Every erm patients should after they have had their initial assessment whether that takes one or two appointments be brought to the assessment team for discussion about what might be the most helpful way forward so it is sort of collative thinking and thoughts about what might be helpful. (Interview)

Lisa described that while clinicians worked individually with children and young people they sought advice from colleagues. This collaboration in practice was done either formally through the clinical discussions meeting or informally when talking about cases in the office. A systemic-medical discourse enabled clinicians, regardless of their professional background, to be able to collaborate about cases using the dominant discourse of the team. The embedded nature of these traditions acted as a mechanism to marginalise other professional cultural identities, this was particularly evident for occupational therapy, and this is discussed later in this chapter.

To summarise, The Orchards was a multidisciplinary team providing assessments and interventions for young people with mental health difficulties. The team offered profession-specific and generic assessments and interventions. The generic work consisted of assessments for autism spectrum condition and attention deficit hyperactivity disorder; these were framed by a medical approach. The team also used the notion of 'systemic practice' as a way to understand children and young people. The roots of this approach lie within psychotherapy; the Orchards' team embraced a wider understanding that encompassed profession-specific systems relevant to the child or young person. Overall, a systemic-medical culture of practice was the dominant discourse at the Orchards, which influenced and reinforced the structures and traditions of the team. This discourse acted to marginalise other professions, particularly occupational therapy, and this is discussed in the next section.

Discovering Occupational Practice at The Orchards

The discussion in this section is centred on Julie's practice as an occupational therapist; as Julie has been identified through her survey responses as having a focus on occupation, her occupational therapy practice is described in this thesis as occupational practice. This practice could, in general, be divided into two parts: firstly, practice that took place with other members of the team, such as conducting an assessment for autism spectrum condition, which was not specifically occupational therapy and could be described as generic team work; and secondly, the practice of occupational therapy, usually one-to-one with young people, either as an appointment at The Orchards or in a community setting, such as someone's home. The latter is presented first, as this informed the former.

An Occupational Therapy Case

An occupational therapy case referred to the types of children and young people that Julie would see for occupational therapy. This section of the chapter illustrates the ways in which Julie established, maintained and managed her occupational therapy cases within the broader milieu of the Orchards' team. Cases at The Orchards were predominately described through a medical diagnosis, a young person's diagnosis would often direct the type of intervention they received. This link between a medical diagnosis and intervention was less prescriptive for Julie. Julie's colleagues would refer a range of cases to occupational therapy, with a range of medical diagnoses, including behavioural difficulties, chronic fatigue syndrome, anxiety, autism and phobias. Julie had determined that a referral to occupational therapy should indicate the impact of the mental health difficulty on daily life, regardless of the medical diagnosis. In the context of The Orchards, an occupational therapy case was able to move beyond a medical label or diagnosis. This released Julie from the restrictions of specific interventions for specific medical conditions and opened up occupational therapy for children and young people with a broad spectrum of difficulties. However, this meant that occupational therapy cases were disconnected from the dominant medical-systemic understanding of cases at The Orchards. This disconnection led to some uncertainty from team members about what could be a suitable case for occupational therapy. In Lisa's interview transcript her filled pauses and wording illustrated her uncertainty about what makes an occupational therapy case:

Rob: Are there any particular erm types of cases that you might think she might deal might be more suited?

Lisa: Yes, I think there are, where a young person is struggling...with...erm...their sort of daily activity and functioning at home or at school and that thinking around that

could be helpful because sometimes erm... I don't know... perhaps where that may not be thought about or they might be sort of blinkered or not even that 'Oh!' we wouldn't have thought about that be able to shine a light on something from a different angle. (Interview).

This uncertainty could reflect that Lisa, as a nurse, was more drawn to the systemic-medical approach, and thus struggled to understand how occupational therapy fits within this framework. Indeed, an uncertainty about occupational therapy cases was not universal, Bina described the types of cases she might refer to occupational therapy; as a support worker Bina may have had less of a commitment to the dominant discourse and based her explanation on the work she has done with Julie:

People who are experiencing anxiety, those sort of cases where erm, thinking about fears of everyday activities or things that get in the way or make it harder so doing what would be seen as everyday challenges and tasks. (Interview).

Bina described how a case was suitable for occupational therapy when it connected together a mental health diagnosis and an impact on daily life; when both of these components were present then a case was suitable for occupational therapy. Julie's perspective also reflected that of Bina's as illustrated in an interview; here Bina talked of the kind of cases she believed others in the team thought she should work with:

...They know that I work in a very practical way with people and they know that I do work with a lot of young people with anxiety and anxiety-related issues from a very practical point of view (...) I get quite a lot of girl's, young people with chronic fatigue which people think that is very much an OT because of the practical way that you are looking at a person and how they spend their time and activity sort of grading and erm...I am trying to think what else I get erm... I get a lot of younger children, I get children where there might be say anxiety issues where erm you know and I don't think this is particularly an OT kind of role but I have picked up a few young people with kind of phobias. I have got a boy with a balloon phobia, I have had a boy with a button phobia, I have had a boy with a phobia of money but they are all phobias that have an impact on them in daily life which has stopped them doing things, I think that is how I see it...(Interview).

This twofold requirement for a mental health need and occupational need was supported by an organisational document that detailed the role of the occupational therapists in children and young people's mental health services at The Orchards. This document described occupational therapists as working with a range of illnesses to address occupations relating

to work, school, relationships and play through individual and group interventions. This reinforced the notion of the need for occupational therapy cases to be focused around an occupational need, not just a medical or psychological need. The existence of such a document could suggest an appeal by occupational therapists for an understanding of their profession from others in the team or perhaps an appeal by the team to understand occupational therapy. This appeal could be an example of resistance that Julie sought against the systemic-medical practices described earlier in the chapter.

Getting support and supervision to manage occupational therapy cases was something that Julie had some difficulty sourcing, especially as the most senior occupational therapist in the team. Julie had individual case supervision with an art therapist colleague; she described how this supervision was a useful time to discuss general clinical issues, but that it lacked the occupational therapy focus that she would like. She found her supervisor used a psychotherapeutic approach to clinical work which did not always fit with her occupational therapy cases. Julie's supervision reflected how psychological and psychotherapeutic thinking about cases was seen at The Orchards as an authoritative theoretical lens, and something necessary or desired by other professions. It also reflected a hierarchy whereby psychologists and psychotherapists supervised other professions. Nevertheless, profession-specific supervision was, in Julie's case, seen to be a more desirable activity. As well as individual supervision Julie attended a clinical discussions meeting, Julie used this meeting to gather others perspectives on her occupational therapy cases; Julie would also give her own professional views on other team members' cases. Julie used the meeting as a way to reinforce to her colleagues her focus on occupation, and a practical approach to intervention; she did this by concentrating her case presentations on young people's difficulties with school, daily routine, friendships and family roles. Reflecting a profession-specific perspective at the clinical discussions meeting was not unique to Julie, for example her psychotherapy colleagues presented and discussed cases with a psychodynamic approach. An example can be taken from the clinical discussions meeting described on page 183, here Julie described the young person's difficulties with doing at school and in daily routine, and the psychotherapist reframed the young person's difficulties to be associated with family relationships. All clinicians at the meeting also framed their cases within a young person's mental health diagnosis, where one had been given. The notion of a systemic understanding, be that family, occupational, friendship or daily routine was also used. As discussed earlier in the chapter, this medical and systemic constructions contributed to the teams' discourse through which they understand children and young people.

This chapter section, an occupational therapy case, has illustrated how a labelled mental health condition did not solely define the suitability of a young person to receive occupational

therapy. An occupational therapy case required the added dimension of a difficulty in everyday life. This profession-specific referral criterion was disconnected from the mainstream medical and psychological referral and treatment pathways of The Orchards' team. Julie used the clinical discussion meetings as a forum to demonstrate how she was working with occupational therapy cases; conversely, individual supervision structures at The Orchards endeavoured to maintain the influence of psychology and psychotherapy on her practice. The next section of this chapter builds on the idea of an occupational therapy case by drawing attention to the way in which Julie maintained an occupational point of view when working with young people.

An Occupational Point of View

Julie used the phrase *"occupational point of view"* (Interview) to describe her way of viewing and thinking about a young person's difficulties:

(...) I am trying to use things like Model of Human Occupation tools with most young people I used to get that you know to help me think and frame it from an occupational point of view erm, ...so most people I try and think about what they are doing in their day, try and think about areas of occupation (...) (Interview).

Establishing this point of view was founded in the referral of an occupational therapy case, as discussed in the previous section of this chapter. To help maintain this point of view or lens, when thinking about young people, Julie used the Model of Human Occupation, the Canadian Model of Occupational Performance and Engagement and the person-environment-occupation as conceptual models of occupation, as described here in her interview:

I worked in adult mental health, so that has probably informed a lot of the way I worked with adults and older people. So we have used the Model of Human Occupation quite a lot erm and also things like the Canadian Model of Occupational Performance and Engagement as well, erm so those are ideas of the person within their environment. I very much think about that kind of erm child-activity, or child-occupation-and environment kind of triad that fit, that informed my thinking quite a lot in the way that I approach something. How does this impact on the child how does the environment impact on the child and what they are able to do and erm, so sort of Model of Human Occupation kind of approaches but also it is not an OT approach very much, a cognitive-behavioural way of thinking. Because I think as an OT you are looking at what a person does and the impact of how they have approached that activity you know what I mean, how have they perceived their experiences impacts on what they do so I kind of use those ideas, but I don't practice as a cognitive behavioural therapy therapist (...) (Interview).

As well as using conceptual models of occupation to inform her point of view, Julie also described the use of a cognitive-behavioural way of thinking. While Julie was quick to affirm that she did not work as a cognitive-behavioural therapist, there was a suggestion that, at times, her occupational point of view could include or have tensions with other points of view, or ways of thinking. This tension is explored further later in the chapter, when considering her generic practice. To complement the use of models of occupation Julie used assessment tools to understand a young person's occupational world. Firstly, Julie used a departmental non-standardised occupational therapy initial assessment. Julie had developed this assessment tool herself to reflect the constructs of the Model of Human Occupation. Conducting an occupational therapy assessment commonly included a detailed analysis of a young person's daily routine and occupational participation, as described here by Julie:

(...) I really go into detail about a typical day, what they would do and how they would do it, yeah, erm and that is what I try and explain when I meet with people as well. I try and explain what is an OT, why they are seeing me as an OT, erm and I try and sort of explain it in a way, you know that we look at all the things that you do in your day-to-day life from getting up in the morning to going to bed and how does some of the struggles you are having at the moment impact on you being able to do these things or the things you have to do or want to do in the course of your day. (Interview).

Secondly, Julie used a range of standardised Model of Human Occupation assessments tools such as the Occupational Circumstances Assessment Interview and Rating Scale (Forsyth et al., 2005) and the Child Occupational Self-Assessment (Kramer et al., 2014). See Table 15 for a list of standardised occupational therapy assessments used at The Orchards.

- Child Occupational Self-Assessment (Kramer et al., 2014)
- Occupational Circumstances Assessment and Interview Rating Scale (Forsyth et al., 2005).
- Model of Human Occupation Screening Tool (Parkinson, Forsyth, & Kielhofner, 2006).
- Short Child Occupational Profile (Bowyer et al., 2008).
- Canadian Occupational Performance Measure (Law et al., 2014)
- Learn to Play (Stagnitti, 2009).
- Sensory Profile 2 (Dunn, 2014).

Table 15 Standardised Occupational Therapy Assessments

The profession-specific assessment tools used by Julie provided her with a theoretical lens, language and symbols through which to maintain an occupational point of view. This point of view was seen by Julie as being different to the view or lens taken by other members of The Orchards' team, as described here in her interview:

Sometimes I think it is maybe a little bit different. You know I think about things like, if I am drawing up in our general Child and Adolescent Mental Health Services assessment we have to do finding out about the family tree, finding who is there, the support networks... for example if I was doing a family tree with somebody I would get a big piece of paper and I would get the young person to draw their family tree, whereas when I have done it with other people the attention you might give to something is different. I get them to say right you know so how is, you know you and your brother there, what do you and your brother like doing together, who are you closest to, who do you go to for hugs. I get them to try and think about the roles within their family and erm and what would I see, you know if I was a fly in the wall in your house what would I see you all doing as a family and so I might go into different details I might ask things in a different way...erm...Yeah and I do a lot of things like you know a get a child to draw their world and the things they like doing in their world and I frame it from an OT point of view thinking about who is who in the family, friends, what you all like doing together what is your favourite food, and yeah I do you know we often do think about your typical day that is what I would do in a Child and Adolescent Mental Health Services assessment often think about you know... (Interview).

Julie defined her different point of view in assessments as being rooted in a young person's doing. She went on to describe how the differences in the way in which professions approached and thought about young people during assessments were often subtle:

(...) it is just very hard to define how you work that is specifically different to say a nurse or social worker because you know a lot of the time when you are working with children or young people when talking is not always the easiest medium you use a lot of play, drawing so we use similar mediums to help young people express themselves erm I suppose some of the things that I might do some for the activities I might do may have a different focus or a different direction you know I might be focused...I might look at somebody err, for instance if I am working with teenager and doing a bit of exploration about how they see themselves I might you know do something on their self-image and their identity as a teenager, the thing they like doing and erm things that they feel makes them as a teenager and erm so I very much think from a

doing point of view, what do you do, what do you do that defines you, erm... (Interview).

Julie suggested that her point of view that “*what you do defines you*” (Interview) resonated with young people and families. She described how, when conducting assessments, her occupational point of view enabled her to understand or ‘get’ (Interview) what families were experiencing:

(...) I have had feedback from families they have found it really helpful because it is the only assessment that has been done with them that really looks at how it really impacts on their day-to-day and understanding their day; their life experience. That is some of the experience I have had from families you know, sometimes they quite like that because they feel that you understand where they are coming from. I had a young girl I worked with who had benign joint hypermobility and I think that she was struggling with people understanding how difficult it was for her. I did a Child Occupational Self-Assessment with her and her mum. We kind of did it and her mum contributed too and was able to say how she observes her in the day to day, you know. The girl was able to comment on the unpredictability of the condition how impacts on her and the variety, you know. I am not sure if variety is the right word but the different ways it impacts so someday she can be perfectly fine and people look at her and think there’s nothing wrong and then other days it has a huge effect and I think the feedback I got from her and her mum was that it really summarised what they were going through, which I don’t think they had had before. So you get I get quite a lot of positives from that point of view because you really do get it sometimes. (Interview).

Whilst Julie reported positive experiences from families of her occupational point of view, she also identified how this perspective was not always what families were expecting from a mental health clinician. This excerpt from an interview with Julie highlights how some families had expected a psychologist to help their child:

(...) families come sometimes with an expectation and they think you know, a psychologist, they would like to see a psychologist, because a psychologist might be able to sort out their child’s problems more, you know. So I suppose it is peoples understanding of Child and Adolescent Mental Health Services and how they work. We do get a lot of that, you know. They want their child to see a psychologist or psychiatrist and when I work with people I have had that well you are not a psychologist so how do you know... (Interview).

An expectation from some families of a psychological or medical explanation of their child's difficulties could reflect the authority of these professions at The Orchards, and wider society. An occupational point of view was valued by those who received occupational therapy, but was not always understood by families.

To summarise this section, an occupational point of view is the lens through which Julie viewed and understood young people. Julie's occupational point of view was informed by models of occupation, although this perspective was challenged by psychological ways of thinking. An occupational point of view was enhanced through the use of occupational therapy assessment tools that had a theoretical coherence. An occupational point of view could be seen as part of Julie's resistance of the systemic-medical culture of practice at The Orchards. The next section of this chapter builds on the notions of an occupational case and occupational point of view to examine Julie's use of occupation in her interventions.

Occupation as an Intervention

This section draws attention to the ways in which Julie enacted her occupational practice interventions with young people. Julie's interventions addressed a range of occupational issues with young people, including taking up voluntary work, walking the dog, completing homework and going to school. Julie used occupation as an intervention in three different ways: using occupation as a tool of engagement, talking about doing occupation, and doing occupation. Within each of these intervention approaches Julie used a number of techniques and skills, which are summarised in Table 16, and discussed in more detail next.

Intervention	Strategy
Occupation as a tool of engagement	Sustaining attention Develop therapeutic relationship
Talking about doing occupation	Occupational questioning Problem solving Roles and routines Suggesting occupations Grading complexity Pacing participation
Doing occupation	Grading Doing with Modelling Feedback

Table 16 Occupation as an Intervention

Occupation as a Tool of Engagement

Julie used occupations during therapy as a way to engage with young people, for example drawing, playing board games, playing pool and playing on the PlayStation. These occupations were not carried out in natural contexts, rather they were used in therapy rooms at The Orchards. Her use of occupation as an engagement tool could be seen when she was working with Paul when she used drawing, and when working with Mike when she used the PlayStation. These were not occupations that Paul or Mike had identified as being difficult for them; rather these were occupations used in therapy to foster a therapeutic relationship. Julie used the occupation of playing the PlayStation with Mike to keep him engaged and focused. Mike had difficulties with sustaining attention as a symptom of his attention deficit hyperactivity disorder. Julie was not seeing Mike to address his symptoms rather she was addressing difficulties at school; the use of the PlayStation assisted Mike to sustain attention in the session. Julie used creative occupations to engage Paul in therapy, but also as a way for him to try out a new occupation. Julie was keen for him to attend a creative arts centre in the town; the use of creative occupations in therapy was a way for him to try this occupation. Both Mike and Paul were young people that were described as being difficult to engage in any sort of mental health therapy. Julie's use of occupation as a tool of engagement was therefore a non-threatening intervention that did not require them to talk about thoughts or feelings. The use of occupation as a tool for therapeutic engagement could be described as being the most basic use of occupation as an intervention. It also provided Julie and the young person with a strong foundation from which to build more complex interventions that used talking about occupation or doing of occupations in vivo.

Talking About Doing

Julie's second intervention approach was to talk with young people about engaging in occupations. This intervention commonly focused on occupations that young people were going to do, rather than the doing of any occupations during occupational therapy itself. There was a synergy between this intervention and Julie's occupational therapy assessments (see An Occupational Point of View on page 191) which included a detailed analysis of a young person's daily routine and occupational participation. When Julie talked about occupations with young people she would use a questioning style that focused on doing in everyday life; I have termed this strategy 'occupational questioning'. Julie used occupational questioning to keep her occupational therapy sessions focused on occupation, rather than other issues such as feelings or medical symptoms. Presented here are some of the occupational questions that Julie used with young people:

"What kind of things do you do at home?"

"What do you like to do with your friends?"

"What did you do on holiday?"

"What do you do that makes you happy?"

"How's your routine?"

"What have you been doing?"

"What are you good at?"

"What do you want to do in life?"

"Apart from playing on the play station, what else do you do?" (Field notes)

The use of occupational questioning was a cognitive problem solving strategy that Julie used to get children and young people to logically think thorough occupations, identifying where difficulties might arise, and how to overcome them. An example could be seen when Julie was working with Paul to try and establish a morning routine, she discussed with him reasons to get up or not get up and strategies to help with getting up. As a component of problem solving Julie would also set challenges as a way to promote a sense of their own agency and abilities. These could be as small goals for the child or young person to do before they met again, for example with Angela goals regarding walking and using an exercise DVD and *"getting up each day at 8.30am and doing homework in 30 minute chunks"* (Field notes).

The focus of Julie's talk about occupation would often be on a young person's routine; this could have been a daily or weekly routine. To support and reinforce talking about routines, Julie would give young people a printed weekly timetable with space to fill in and schedule activities. Talking about establishing and maintaining a daily routine, such as getting up, attending school and sleeping was an occupational therapy intervention used to aid a young person's recovery. An example can be seen when Julie was working with Angela:

Julie: "How's your routine?"

Angela: "Getting up is much better but I am not sleeping well"

Julie: "How are you managing to balance everything? Going to college, doing course work"

Angela: "I am getting over being a perfectionist as I don't have enough time to do it all"

Julie: What else have you been up to?"

Angela: "Photography, physiotherapy walk – I walked next door on my own"

Julie talked to Angela about making sure she had some restful time as well as some doing time. Angela spoke of how she was busy all of the time with college, dealing with the dog, course work and that she had exams coming up. Julie listened and suggested that Angela needed to pace her activities throughout the day adding:

Julie: "You are a person who needs to balance your time (...) Have you been doing a timetable or structure for the week?"

Julie had ready prepared some printed weekly schedules for Angela to fill in, she asked her "what could you do realistically?" Angela talked of wanting to go out for a walk but that she worried that people would say as ill people don't go out for a walk. Angela talked of possible indoor activities such as the cross-trainer, yoga, Pilates, exercise DVDs or the Wii Fit. Julie thought they were all good suggestions but that Angela needed to start off slowly, "Can you set some goals for each day?" Julie suggested that getting up by 8.30am each day would be a good start and then doing something each day to make you feel more tired. (Field notes).

In addition to establishing routines, Julie used talking about occupations to reengage young people in specific occupations. These were often leisure occupations, but attending school was also an expected occupation for some young people. Julie suggested a range of occupations to young people including walking, playing on the Wii, yoga, youth parliament, rugby, swimming, martial arts, trampolining, basketball, art, photography, poetry and dog walking. To help a young person engage in a specific occupation, or establish a routine, Julie used a range of techniques; these included grading the complexity of the occupation, pacing the level of engagement, or adapting the way the occupation was done. Bina described how Julie had instructed her to grade therapy when working with a young person with chronic fatigue:

Yeah, yeah I am actually working with somebody at the moment which is quite useful so I can reflect on that. My understanding erm of that young person, first I would kind of look at what the nature of their referral is, and if it something like chronic fatigue syndrome then we would kind of go and see the young person and build up that relationship and then it would mean to take very tiny steps for instance because ...if the young person gets very very tired and is looking very pale and only a short amount of work. If that means a walk from A to B for about 20 minutes and then going for a coffee the next day that child possibly would be washed out and be very drained, so my understanding would be that I would have to take very very tiny steps in

understanding what the tiredness is about what the nature of it is, what are the underlying factors, what other things are going on things like study stress erm... so I would have to grade that very carefully (...) (Interview).

Julie talked about routines and specific occupations with the aim of enabling young people to achieve meaningful overarching occupational roles, such as student. Julie talked at length with Paul about his role as son and his dad's role as father. She discovered an absence of joint father-son occupations, such as playing sports together or having days out. Julie suggested to Paul that this could have contributed to his anger and relationship difficulties with his dad and recommended occupation as a way to establish roles and relationships: *"Could you suggest to your dad that you do something together?"* (Field notes). Julie also talked with Paul and Mike, who were excluded from school, about their roles as students. Paul and Mike both spoke of missing their role of student and friend and how this had affected their mood and self-esteem.

Using talking about doing an occupation as an intervention required the young person to engage in the activity themselves in the future, usually without Julie or a support worker present. Julie used this intervention approach when a young person had already begun to reengage in daily life, and needed less support. Julie also used a further intervention approach with Angela that involved her participation in occupations within naturalistic settings. This final intervention strategy will be explored next.

Doing Occupation

Julie used a doing approach to intervention, meaning that some occupational therapy sessions involved young people engaging in an occupation, within a real-life context. Julie's use of doing occupation was reflected in the significant amount of time she spent out of the office visiting young people at home or in community settings. Julie reported that it was important to her that young people are seen in their own environments. Julie also believed that engaging in doing was often better than talking about doing, as demonstrated in her statement to Paul: *"If we went to find out things to do rather than sitting here would that be better?"* (Field notes). Seeing young people in community settings was not unique to Julie, but the way that she used the setting was different. Some members of the Orchards' team would visit young people at home or at school to carry out a talking therapy session; however, Julie used the community setting and its associated occupations as the intervention. Julie used the grading of occupations to build a young person's ability to engage successfully with an occupation. For example, with Angela, Julie had worked with her to go out for short walks and to talk with neighbours and friends. This was used as building blocks towards going out for a coffee and looking at voluntary work:

We met Angela at her house and immediately left by car for the volunteer service in a nearby town. Angela appeared a little anxious about the trip and Julie distracted her by talking about her exams, course work, walks and photography. Julie did ask Angela how she was and she replied "tired".

We parked the car in the street and walked the short distance to the volunteer service. When we arrived the coordinator was with someone else and asked us to return in half an hour. Julie suggested that we go to a local café. In the café Angela became quiet and nervous. Julie modelled how to buy a drink and Angela copied. We all sat in the café and Julie led the conversation, concentrating mostly on Angela's photography A-Level, this led to a discussion about summer holidays. Angela seemed to relax and began to engage in discussion, it almost became like a café visit with friends.

After finishing our drinks we returned to the volunteer centre where Julie introduced Angela to the coordinator and then took a backseat while Angela began discussing volunteering opportunities. Various forms were filled in and printed out and Angela left with several leads to follow up. (Field notes).

When Julie was with Angela she used three intervention strategies: doing with, modelling and giving feedback. An example of doing with was going to the café with Angela, she modelled when she demonstrated how to choose, order and pay for the drink. Angela was given feedback in the car, on the way home. Julie gave her positive praise for how she carried out the occupation. The use of an occupation in context was the most complex intervention type that Julie used; it was used as a progression from talking about, and as a way to support a young person towards their occupational goals.

This section of the chapter has focused on the interventions strategies that Julie use in her individual occupational therapy with children and young people. These interventions took place with cases that had been referred to occupational therapy, and had an occupational problem. Julie's approach to intervention was underpinned by her occupational point of view, discussed earlier in the chapter, which was informed by models of occupation. Julie described this part of her role as being a 'real' (Interview) occupational therapist:

(...) I am trying to use things like Model of Human Occupation tools with most young people I used to get that you know to help me think and frame it from an occupational point of view erm, ...so most people I try and think about what they are doing in their day, try and think about areas of occupation erm, I am trying to think how to answer that by saying this is a real occupational therapists role here (...) (Interview).

Julie's role of being a 'real' occupational therapist could be described as enacting the occupational practice discourse, which included discursive constructions such as language, structures, culture and practice that embodied occupation in her practice. Julie brought discursive constructions associated with her role of being a 'real' occupational therapist and the occupational practice discourse to her generic work with the team. This raised tensions with the dominant systemic-medical discourse, which is discussed next.

Negotiating the Discourse

Professional practice at The Orchards was influenced by a systemic-medical discourse; for medical doctors, clinical psychologists and psychotherapists this discourse embodied their own professional practice. Julie's practice as an occupational therapist, however, encompassed discursive constructions which reflected her own occupational practice discourse; this has been interpreted to include profession-specific practices, which included the use of the language, symbols and practice of occupation, and assessments and interventions specific to the profession of occupational therapy. In her day-to-day practice Julie had to negotiate using systemic-medical practice and occupational practice. As systemic-medical practice was associated with the dominant discourse it often sought to suppress her occupational practice. An example of this suppression could be seen when Julie was expected to conduct generic team work, such as medical diagnostic assessments for autism spectrum condition and attention deficit hyperactivity disorder. To resist the dominance of systemic-medical practice Julie used practice associated with being a 'real' occupational therapist as a form of resistance. For example: *"We all do generic work, but we [occupational therapists] bring a different angle about what do you do in life" (Interview)*. The different angle referred to the notion of bringing occupational practice to the systemic-medically informed generic work. Julie spoke further about how her occupational practice informed her work in generic assessment clinics:

Rob: So which, which assessment clinics do you go into?

Julie: I go into the autism assessment, well I have been going into the autism assessment clinic (...) I think OTs have a lot to offer there because they can really look at the environment the child is in. So I think yeah, so I have been in that one the autism clinic, and also because I was in there because I quite enjoy it I have kind of a bit of an interest in the sort of children who have a more neurodevelopmental, erm I have also contributed as part of the attention deficit hyperactivity disorder team as well. Again it is on a neurodevelopmental erm perspective but there is nothing stopping me from having an OT you could have an OT in the eating disorders team here. I think I could have a lot to offer you could look at you know a person's self-image how they

are, their relationship with food from practical point of view, erm lots of things really, looking at how the routines and roles. (Interview)

A further example of occupational practice informing Julie's generic work could be seen when she conducted an assessment using the Autism Diagnostic Observations Schedule. The Autism Diagnostic Observations Schedule is a semi-structured interview of communication, social interaction and play and is used when a young person is suspected of having an autism spectrum condition diagnosis. The Autism Diagnostic Observations Schedule had a set of standard activities carried out with the child which aimed to elicit behaviours that are concurrent with the features of autism spectrum condition. The field notes excerpt below illustrates how Julie brought the idea of "(...) *what do you do in life*" (*Field notes*) to the Autism Diagnostic Observations Schedule:

Matt was seen with his mum. The Autism Diagnostic Observations Schedule assessment was conducted by Julie and a paediatrician at the Orchards, in a treatment room on the second floor. Julie introduced the session as some time to play and do some activities and that mum and the paediatrician would be watching. Matt seemed happy with the explanation and was keen to get going. Julie and Matt sat on low chairs opposite each other round a small table.

Julie started with a warm-up shape activity, then she asked Matt what kind of things he does at home; Matt replied "Wii and video games". Matt was not very talkative and quickly became disinterested in the shape game so Julie brought out a set of small play items and asked "can you make a story with these?" Julie demonstrated playing with the small items on the table and making up a story. Matt was not really interested in the story and said that they would not normally play with things like that at home. Julie seemed un-phased and carried on talking to Matt.

Julie: "Apart from playing on the play station, what else do you like to do at home?"

Matt: "Riding my bike"

Julie: "Do you have a best friend?"

Matt: "No, but I have some friends"

Julie: "What do you like to do with your friends?"

Matt thought about this for a few seconds but found the question hard to answer, seeing that Matt was struggling Julie moved onto the next play activity.

Julie: "Now we are going to do some pretending, let's pretend we need to teach an alien how to brush its teeth and wash its face".

Matt engaged somewhat with the pretending activity, but copied Julie rather than coming up with his own pretending. Julie brought out a recognition activity, while completing this she asked Matt about his family holidays, what he did on his past holiday and what he would like to do on his next holiday...

...Julie described the next activity as a special book called Tuesday that had pictures but no words "you have to make up the story". Julie began telling the story then asked Matt to take over and finish the story. Julie assisted Matt with the story by asking questions such as "where are we now?" or "what's happening here?" After the story Julie talked about the silly things people say, such as "it's raining cats and dogs, pull your socks up, or pigs might fly" she asked Matt about what these things meant. Matt knew these things weren't real but wasn't sure what they were.

Julie: "What makes you happy?"

Matt thought about this for a while and then said "my guitar"

Julie: "How does it feel when you are happy? Matt didn't know

Julie asked a number of other questions about feelings including being afraid, angry and sad. Matt struggled to describe how any of these would feel. Next Julie suggested a break and gave Matt some pencils and paper to draw. While he drew she talked to him about his favourite books, films, school and sports. After a short while Julie asked Matt to put the pencils away, which he did and the assessment resumed.

Julie: "Why do people get married?" Matt had no idea.

Julie: "Do you ever get lonely?"

Matt: "Sometimes, I try and find something to do".

The final activity was to make up a story using some small non-play items such as a piece of sting and a bit of wood. Julie demonstrated what to do and made up a story of a queen sitting on a throne who was bored and wanted something else to do. The queen called for the footmen to take her away to do something new and she is taken to the circus where she becomes a tight rope walker. Matt was asked to make up his own story and he mostly repeated the example from Julie.

Julie thanked Matt for taking part in the activities and the session ended (Field notes)

The field note illustrated how Matt's occupation or 'doing' was drawn out in the assessment by Julie asking him what he likes to do at home and what does he do with his friends. 'Doing' is also evident in the make-believe story where Julie talks of someone who has nothing to do.

Whilst Julie imperceptibly negotiated systemic-medical practice and occupational practice she was also challenged by the traditions of occupational therapy practice at The Orchards' team. Julie managed a tension between staying true to being a 'real' occupational therapist and being the occupational therapist her team wanted, or expected. This tension could be seen in her use of play. Julie reported how occupational therapists at The Orchards had historically been involved in play work with children and young people. Julie described how she used play in therapy as play itself, rather than as a medium through which to understand a young person's deeper, more unconscious thoughts and feelings:

Julie reported using play, but not as play therapy. When I asked her to expand on this she described assessing play itself, for example the play skills of a child with autism, or using play if she want to get to know a child rather than using play to analyse deeper meanings as perhaps a psychotherapist of play therapists might (Field notes).

The above description of play as play itself can be contrasted with her use of play with John. When working with John, Julie used a therapeutic approach called Theraplay; she described this as "a range of play activities that work on underlying relationship and emotional skills of the young person and parent" (Field notes). This use of Theraplay as in intervention to address relationships and emotions suggested a tension between her ideas about using play as play itself; the use of Theraplay was a historical role of the occupational therapists in the team. This was not to say that Julie resented conducting Theraplay, rather that it represented a culture of expected practice in the team. Julie identified sensory work as a further historical tension in occupational therapy practice at The Orchards. In this interview passage Julie talks of the historical role of the occupational therapist in sensory work at The Orchards:

(...) at the time the consultant in that team really wanted an OT because the previous OT worked here used to do that type of work, erm I went into the autism clinic very much from a sensory perspective, I could offer some advice and input there to look at the sensory aspects, but I have found through doing that, you know I have not just been the sensory OT I have been someone who can do other stuff, I can go and I have done play-based assessments looking at how a child is an their imagination from a functional point of view, how they play and you know and going in to do observations in schools I think OTs have a lot to offer. (Interview).

Julie described how she has sought to develop her occupational therapy role into one that was more than that of being the “sensory OT” (Interview). Her use of play as an occupation was an idea that held for her a greater fidelity with the notion of being a ‘real’ occupational therapist and enacting occupational practice. Julie also suggested that the sensory role of the occupational therapists in children and young people’s mental health was a wider professional tradition:

I think in Child and Adolescent Mental Health Services traditionally OTs have very much been seen as people who do sensory work, traditionally I have picked up cases for children with autism where you know they think there could be some sensory issues which might be helpful from an OTs point of view and... (Interview).

As well as the actions of therapy revealing Julie’s occupational practice, the use of language was an important part of reinforcing this as her dominant discourse. She adopted the use of the systemic-medical language associated with the teams’ dominant discourse, but also used a variety of terms to describe her own role, her theoretical perspective and her occupational therapy to colleagues and to children and young people. The language, or discursive formation, that she used frequently included a reference to her addressing everyday life and practical things. For example: “I work in a very practical way” (Interview), “the practical way that you are looking at a person” (Interview) and “I very much think from a doing point of view” (Interview). Despite her job title of occupational therapist, her use of the word ‘occupation’ was absent when she talked about her role. Julie did use the word occupation when speaking to the researcher, who was an occupational therapist. Her modification of language may have been a way of making occupation or occupational therapy understandable to others. It could also have reflected the pervasive influence of medicine and psychotherapy, which acted to inhibit the use of the language of occupational therapy. There was some incongruity between Julie’s use of spoken and written language. In Julie’s written occupational therapy reports she used the Model of Human Occupation to structure her writing, such as the use of report headings, volition (motivation for occupation), interests (leisure occupations) and habituation (occupational roles and routines). Her reports could be viewed as an opportunity to resist the language associated with the systemic-medical discourse, which pervaded many other aspects of her work. Julie’s differentiation of language, with different people and in different settings, was further revealed in her professional practice, which is discussed in the next section of this chapter.

In summary, Julie had to negotiate professional practices that reflected different discourses. Being a ‘real’ occupational therapist and enacting the occupational practice discourse included profession-specific assessments and interventions. This was challenged by systemic-medical

practice, such as assessments for attention deficit hyperactivity disorder and autism spectrum condition, which represented the dominant systemic-medical discourse of the team. There were tensions between these two practices with the dominant discourse often foregrounding Julie's occupational therapy; she sought to resist this marginalisation by bringing occupation into generic work.

Chapter Summary

This chapter has presented a description and analysis of The Orchards and the occupational practice of Julie. The analysis has described the relationship between the structures and functions of the team and Julie's occupational practice. The Orchards had a systemic-medical discourse that offered the team a common framework for understanding children, young people, families and mental health. A medical discourse was revealed through the use of medical diagnosis to label young people's mental health difficulties, for example in assessment clinics for attention deficit hyperactivity disorder and autism spectrum condition. A systemic discourse situated young people within family relationships or systems, an approach that was used during clinical discussions.

The systemic-medical discourse informed Julie's practice as an occupational therapist, such as a cognitive-behavioural way of thinking and taking part in generic team work, such as assessments for autism spectrum condition. In this way it acted to suppress Julie's occupational practice. Julie resisted the systemic-medical discourse through the use of occupational practice, which she described as being a 'real' occupational therapist. Her occupational practice was underpinned by a profession-specific point of view that was informed by the Model of Human Occupation. There was some tension between Julie's occupational practice and that of generic team work, which was often medically orientated. Julie sought to reconcile this tension through a nuanced practice that brought occupation, systemic and medical practice together. Despite her ability to blur the boundaries between these practices it did suggest that medical and systemic practice had a prevailing authority within The Orchards' team.

Julie's occupational practice interventions were characterised by referrals for occupational needs and assessments and interventions that focused on those needs. Julie used occupation as a way to engage young people, to talk about doing occupation and to do occupations. A number of strategies were used by Julie during her interventions including problem solving, grading, doing with and modelling; these formed discursive constructions of the occupational practice discourse.

The purpose of the next chapter is to present a description and conceptual analysis of the ethnographies. Subsequently, the final chapter of this thesis will bring the findings from the survey and ethnographies together to consider their contributions to knowledge and implications for theory and practice.

Chapter Nine: Discussion and Conceptual Development of the Ethnographic Findings

Introduction

This chapter of the thesis has brought together the findings from the ethnographic phase of the study into a critical discussion. To build this conceptual development three main ideas will be presented; first, drawing on the work of Foucault (2001, 2002, & 2003) the notions of archaeology, discourse and power are used to examine the dominance of medicine and psychology and the marginalising of occupational therapy, before going further to consider the resistive strategies used to manage this suppression. Subsequently, Goffman's (1959) dramatological idea of backstage and frontstage performances are employed as a way to explain occupational practice as generic and profession-specific performances. Finally, attention is given to occupational practice; using the structure of the Occupational Practice Model and the work of Fisher (2013) the use of theory, perspective and intervention is used to delineate occupational practice; this has been conceptualised into the Occupational Practice Model for Children and Young People's Mental Health. The post hoc use of these theorists has been used to drive a deeper interrogation and understanding of occupational therapy and occupational practice. The ideas are considered separately; nevertheless, jointly they articulate a macro, meso and micro analysis of occupational practice in children and young people's mental health.

A Foucauldian Analysis

The Foucauldian ideas of archaeology, discourse and power (Foucault, 2001; Foucault, 2003) were introduced in Chapter Two of this thesis as tools for interrogating the languages, representations, practices and common assumptions that are the basis for fields of knowledge within healthcare settings (Cheek & Porter, 1997; Fadyl, Nicholls & McPherson, 2012). In this section consideration will be given to the processes which have shaped a dominant medical-psychological discourse, the discursive constructions that have served to maintain this dominance, how this dominance marginalised occupational therapy, and in what ways occupational practice was used as a resistive strategy.

Foucault described archaeology as the history and processes that shape the conditions of possibility for an emergent discourse at a given time (Foucault, 2002; Kendall & Wickham, 1999; Schirato et al., 2012). Foucault (2006) reported an in-depth historical archaeology of psychiatry. A historical lineage of children and young people's mental health has been

presented in Chapter Three of this thesis; however, this is not a Foucauldian archaeology. Such an archaeological analysis could serve to enlighten otherwise veiled discursive elements in the field; nonetheless, this was not the focus of this study. The discussion in this section does focus on the discursive constructions currently shaping children and young people's mental health.

Chapter Three of this thesis described current intervention trends shaping children and young people's mental health services, such as cognitive behavioural therapy, family therapy and pharmacological therapies; these can be understood as discursive objects and theoretical choices (Hodges et al., 2014) that have been made possible through medical-psychological discourses. Such discourses have been further supported by government policies, such as 'No Health Without Mental Health' (Department of Health, 2011), which have served to focus services on psychological 'talking-style' therapies, for example through the implementation of Children and Young People's Improving Access to Psychological Therapies and Targeted Mental Health in Schools. It can be argued that these practices, policies and services form part of the embodied knowledge that has shaped and reinforced the medical-psychological discourses as an accepted regime of truth, and therefore dominant in children and young people's mental health services. This discourse could also resemble the effects of a cultural hegemony (Jones, 2006; Mokuolu, 2013), whereby the professions of medicine and psychology have exerted power and dominance over children and young people's mental health services, and society more generally. Indeed, the issue of medical hegemony has been given some attention in the healthcare literature (Coombs & Ersser, 2004; Whitehead & Davis, 2001; Wilding, 2011). However, Jones (2006) has argued that the notion of hegemony has an awkward relationship with Foucault's notion of possessive power. A medical and psychological hegemony implies the wielding of possessed power; Foucault suggested that rather than power being situated with specific institutions it was everywhere, and acted through cerebral dominance to shape the behaviours of others (Freundlieb, 1999; Mokuolu, 2013). Foucault's (1995) idea of the panopticon could offer an alternative solution; the panopticon is used by Foucault as a metaphor for understanding the relationship between social control and power. The application of this metaphor to this study positions medical-psychological discourses as controlling mechanisms which have shaped subordinate groups in society to encourage them to accept their inferiority. Such coercive powers have been reported in the literature to influence the actions and attitudes of individuals in society, as well as healthcare professionals, to recognise medicine in particular as the reality of health surveillance and healthcare (Miers, 1999; Whitehead & Davis, 2001; Wilding, 2011).

The discussion of interventions, policies and services has made explicit some of the current discursive constructions within society that have created the conditions of possibility for

medical and psychological discourses to emerge as dominant. The scope of this study was nonetheless to bring greater attention to two specific children and young people's mental health teams, which are examined next. Before this examination it is important to note that Foucault did not contend, nor does this thesis, that medical and psychological discourses should be excluded, or are wrong, but that they should be recognised as being the dominant discourses (Foucault, 2001; Kendall & Wickham, 1999).

In this study, the medical-psychological discourses emerged as dominant through the use of shared practice frameworks, albeit in different guises. The philosophy and structure of the mentalisation approach was particularly persistent at The Gateway, and a systemic-medical approach prevailed at The Orchards. In her work about Foucault's concept of discourse Mills (1997, 2003) has proposed that discursive theories can become dominant when they offer a "...systematicity of ideas, opinions, concepts, ways of thinking and behaving" (p. 17). Such systematicity was observed at both study settings; the medical and psychological discourses had become embodied through an organised series of objects through which the team's reality had become perceived. This study has revealed these discursive objects in a number of forms; for example, specific offices and treatment rooms for medical and psychological practitioners, the design of clinical paper work to focus on medical diagnosis and psychological formulations, and the format of team meetings and formal clinical discussions which emphasised systemic understandings. As well as discursive objects, discursive constructions were also represented through individual and group behaviours at The Gateway and The Orchards. For example, conducting medical assessments for attention deficit hyperactivity disorder and autism spectrum condition, the prescription of medication, the delivery of interventions such as cognitive behavioural therapy and psychotherapy, and supervision arrangements which saw clinical psychologists and psychotherapists overseeing other professions. Whilst the emergence of such objects and behaviours were an observed reality, they signified the rules or conditions (see Freundlieb, 1999) which had enabled medicine and psychology to systematically emerge as dominant in the study settings. This dominance was not only seen within the team but had also pervaded societal expectation. Julie reported such expectations when families expected to see a clinical psychologist not an occupational therapist, and questioned how she would be able to help.

As a postmodernist thinker, Foucault considered power to be held everywhere in society, pervading thoughts and actions to construct our subjectivity (Mackey, 2007; Peterson & Bunton, 2000; Schirato et al., 2012). Reflecting this idea, I would contend that the dominant discourses at The Orchards and The Gateway held a pervasive power over the ideas and practices of their teams. This idea draws on the work of Opie (2000) who described the pervasiveness of power associated with dominant discourses in healthcare as being

“everywhere” (p. 255). This inextricable relationship between discourse and power has also been reported in the occupational therapy literature (see Estes & Pierce, 2012; Mackey, 2007). Pervasive power in this study appeared to determine what was perceived by The Gateway and The Orchards’ teams as legitimate knowledge, which reinforced, regulated and controlled the dominant discourses. The use of shared practice frameworks, which were grounded in medicine and psychology, was a mechanism at both study settings for introducing pervasive power over the use of language and formulations. A further example of pervasive power was comprehended through the use of the criteria in the Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association, 2013) as a system to diagnose young people’s mental health difficulties; this power was reinforced at The Orchards through autism spectrum condition diagnostic clinics, the expectation of staff to be involved in diagnostic assessments, rooms to conduct such assessments and the Autism Diagnostic Observations Schedule assessment tool. The power of medical discourse was also acutely evident at The Gateway, where medical staff assumed the role of leader for the daily team meeting, acted as gatekeepers to hospital inpatient services, rejected the role of case-coordinator and provided clinical leadership.

The inequalities in power and hierarchy between medicine and other healthcare professionals have begun to be documented (Ellingson, 2005; Hart, 2015; Hughes, 1988; Lewin & Reeves, 2011; Nugus, Greenfield, Travaglia, Westbrook & Braithwaite, 2010; Opie, 1997a; Opie, 1997b; Porter, 1993). Opie (1997a) has suggested that the dominance and power of medicine in healthcare teams can cause frustration and resentment by allied health professionals. Findings from the field supported these claims, whereby Amanda and Julie did not overtly report frustration in front of their teams; however, both were observed negotiating discourses and power within their practice, such as at team meetings and case discussions. Such ideas suggest that in this study Amanda and Julie managed a tension between discourses, a notion supported by Creek (2009) who has proposed that imposed power and authority can be continually challenged by other discourses.

The idea of discursive tension is also supported by Ashby et al. (2015) in their study of occupational therapists working in adult mental health. These authors used Foucault’s analytical tools to explore the use of occupation in occupational therapy practice; the findings of Ashby et al. (2015) are echoed in the results of this study. Ashby et al. (2015) suggested that occupational therapists managed a tension between their own discourse and that of medicine and psychology; the study participants described these discourses as complementary, but that it was easy to get “sucked into the system” (p. 434) of medical practice. The study presented in this thesis also contends that the dominant medical-psychological discourses acted as a tool to support medical and psychological practice and

suppress occupational practice. Ashby et al. (2015) also indicated that occupational therapists were resisting the dominant discourses, suggesting the use of reflective practice as a resistive strategy; occupational practice has been found in this study to be a resistive strategy, this notion is presented later in this chapter.

A more nuanced view of managing power in healthcare teams was proposed in the literature by Nugus et al. (2010), who discussed the idea of negotiated power. This notion explained how different healthcare professionals could exercise agency and resist the power structures of medicine, yet these power structures themselves provided the conditions under which that agency could be made. The idea of negotiated power holds some resonance with the findings of this study; both Amanda and Julie held roles as case-coordinators, meaning they were responsible for the overall care of patients, a role that would have historically, and legally, been assumed by a medical practitioner (Ellingson, 2005; Opie, 1997a). To adapt to such a change in the boundaries of practice, the medical practitioners at both study sites sought to maintain the authority of medicine by acting as gatekeepers to medication and hospital admission. This idea of maintaining authority is supported by Ellingson (2005), who described how medical practitioners sought to marginalise less powerful professions, and that power was exerted through a combination of language, knowledge, institutional power and disempowerment; such suppression of occupational therapy is discussed next.

The Marginalising of Occupational Therapy

The discursive constructions presented in this study, which led to the dominance of medical and psychological discourse, acted as a tool to marginalise the ideas, knowledge and practices associated with occupational therapy. The idea of marginalisation draws on the work of Cheek and Porter (1997) who suggested that marginalising can explain why some views of health seem common whilst others “remain just that – other” (p. 109). I would suggest that an occupational therapy view of the world within this study could be described as being an ‘other’ perspective. As an alternative knowledge about health, occupational therapy was not given the same status as medical and psychological knowledge; this maintained the status quo, preserving the dominance of medical and psychological discourses. The idea of the marginalisation of occupational therapy is supported by Creek (1997). Creek argued that occupational therapy is better understood through a postmodernist perspective that accepts complexity and does not adhere to the scientific endeavour of medicine. However, medicine and its goal towards understanding causes of disease, finding a cure and eradicating disease from the world are more highly valued than helping someone to be able to get dressed again. Whilst I would not suggest that in this study there was a conscious marginalisation of occupational therapy, any occupational therapy statements appeared to be judged as being

a truth based on their accord with other statements that had been given authority. For example, Amanda, when discussing a case at the team meeting, had her suggestions about the young person's daily occupations challenged and reframed by a clinical psychology colleague as issues relating to attachment. Similarly, Amanda needed to keep repeating in the formulation meeting the idea of using cake decorating as a young person's coping strategy; this suggestion was side-lined over mentalisation and psychotherapy understandings. Further marginalising was observed at The Gateway and The Orchards through the absence of a defined referral pathway for occupational therapy, suggesting that the legitimacy of occupational therapy was questioned.

The marginalising of occupational therapy was compounded by the actions of the occupational therapists themselves. Julie and Amanda both used strategies to translate or explain occupation to colleagues as 'doing'. This interpretation resulted in colleagues reporting that they did understand what occupational therapists did; such reporting could of course also be interpreted as a means of further marginalising occupational therapy. The idea of occupational therapy language being suppressed has also been reported by Creek (2009) who has suggested that occupational therapists implicitly accept medical ideas without challenge. Creek (2009) went further to propose that when occupational therapists used the language of occupation other healthcare professions ignored or made fun of them. The translation of language by occupational therapists in this study could be described as a self-limiting behaviour; similar self-limiting behaviours by occupational therapists have also been reported by Wilding (2011) who suggested that the conformist behaviours of occupational therapists could contribute to medical hegemony.

To summarise this point; the use of Foucault's social theories as critical analysis tools has enabled me to draw attention to discursive constructions which led to the conditions of possibility for the dominance of medical and psychological discourses, the notion of discursive tensions, and the marginalising of occupational therapy. Despite the influence of discourses on social actors, Foucault believed that people were free agents, but were influenced by context. I propose in this thesis that the occupational therapists in this study were able to make choices about their work, act to resist the dominant discourses and experience their own occupational practice discourse. The occupational practice discourse can be described as the unique knowledge, language and practice of occupational therapy (Mackey, 2007). Occupational practice has been further developed in this thesis as a specific discourse, within occupational therapy, that reflects the theoretical notions of humans as occupation beings and health through occupation, and the practice ideas of being occupation-centred, occupation-based and occupation-focused; it is presented next in this thesis as a form of resistive discourse.

Resistive Discourse

This section will build a picture of how occupational practice was utilised by Amanda and Julie in the ethnographic phase of this study to resist the dominance of medicine and psychology. This postmodernist perspective will challenge the legitimacy of the dominant discourse and deconstruct the power associated with it (Peerson, 1995; Wilkinson, 1999). The possibility of resistance has been conceptualised by Armstrong and Murphy (2011) as being complex, flexible, nuanced and at both a behavioural and conceptual level. In accordance with this the focus of the resistive strategy discussed in this section will be on the use of occupational practice of Amanda and Julie during team work activities, such as team meetings and generic assessments. My interpretation of the study findings has led to the conclusion that enacting occupational practice as a resistive discourse was a fine balance for Amanda and Julie. Colluding in the dominant discourse contributed towards them being seen as 'one of the team', enacting resistance could be interpreted as disrupting the team performance (Ellingson, 2005; Nugus et al., 2010). Morag, the Trust lead for occupational therapy at The Gateway, described that occupational practice as a resistance should be enough to make colleagues (in medicine and psychology) feel uncomfortable. The challenge for Amanda and Julie was to enact a degree of resistance that demonstrated agency and challenged the dominant discourse, but not exert a level of resistance that would risk their social role of being one of the team.

To enact a resistive discourse and manage discursive tension Julie described bringing a different angle to her team activities at The Gateway, and Amanda explained how her work at The Orchards took a more practical, here and now approach. The use of these 'different angles' as a resistive strategy was unconscious, subtle and would often present as a perspective in the emphasis of language. The use of language associated with occupation, such as self-care, leisure and school as taxonomies of occupation, was used by Julie and Amanda to both describe what they were doing and to create an understanding of their social reality; however, such language was disconnected from that of their team. Nicholls (2012) has suggested that such a change in a social actor's language could be due to the influence of competing powerful discourses. Amanda and Julie's change in language was a way to construct an understanding of reality conversant with occupational therapy, and resist the reality of medicine and psychology. The specific use of the language of the Model of Human Occupation at both settings was observed to be a tool of resistance. Julie used concepts associated with the Model of Human Occupation, such as volition and habituation, to structure her written occupational therapy reports. The content of these reports was not overtly silenced by colleagues, although whether they were read and accepted as a version of the truth is not known. Further examples of the use of language, that purported occupation as the social reality of young people, and as a resistive approach use can be drawn from case discussions.

During Amanda's case discussion at the daily meeting she described the young person in the context of what they were, or were not doing in their daily life, rather than initiating a discussion with the language of symptoms or aetiology. Similarly, Julie introduced her case at the clinical discussion meeting as having difficulties with school and friendships; the medical diagnosis of social anxiety was labelled and presented secondary. The issue here was that, as discussed earlier in this chapter, when Amanda and Julie presented such resistive practices there were attempts by clinical psychologists and psychotherapists to silence such ideas with alternative explanations that embodied the dominant discourses.

I have previously argued that the shared practice frameworks, mentalisation and systemic-medical, acted as discursive tools to marginalise occupational practice. Whilst such marginalisation may have been imperceptible to Amanda or Julie, they both sought to resist the effects of these theoretical frameworks on their practice. Amanda described her use of a shared framework as a theoretical middle ground and that she was prepared to resist this by fighting for occupational therapy. An example of resistance to mentalisation as a shared practice framework could be observed in Amanda's development of a document that described a way of integrating the components of the mentalisation approach with the Model of Human Occupation. Similarly, Julie had modified the psychological concept of systemic to mean systems of doing or occupation in a young person's life, suggesting that she had developed a strategy to resist her team's overarching philosophy. The shared practice frameworks also promulgated the use of medical diagnosis and psychological formulations to explain a young person's mental health difficulties; Amanda and Julie used the idea of an occupational therapy case or an occupational formulation as a way to resist this dominance and provide an alternative understanding of a young person's reality. Amanda saw occupational formulations as offering a specialist understanding of reality and therefore giving her a specialist role. The medical and psychological reconceptualisation of cases by Amanda at team meetings suggested that her team challenged this reality and role. Similarly, Ashby et al. (2015) contended that occupational therapists in mental health can face challenges when working alongside colleagues from different professions, some of which hold a discourse with a greater status. Such a challenge was observed during Julie's joint autism spectrum condition assessment with a paediatrician. Here Julie became part of the prevailing medical discourse but used occupational practice to modify the assessment to focus on the occupations in the young person's life. Through this approach she was still able to elicit symptoms of autism spectrum condition, thereby maintaining her social role of being one of the assessment team, but also enact occupational practice which resisted the dominant discourse.

Amanda and Julie also presented resistance to the dominant discourse by surrounding themselves with symbols associated with occupational therapy. Amanda and Julie's office

desks, shelves and filing cabinets were filled with books and articles about occupational therapy, such as the *British Journal of Occupational Therapy* and *Creek's Occupational Therapy in Mental Health*. They both also had resources relevant to engaging young people in occupations, such as leaflets about volunteering opportunities, employment and leisure activities. The presence of such profession-specific resources appeared to be an act of presenting a resistance to the dominant discourse.

To summarise this section of the chapter, the use of Foucault's social theories has enabled a consideration of the discursive constructions that have provided the conditions of possibility for medicine and psychology to emerge as dominant discourses in children and young people's mental health. A range of discursive theories and objects have been identified which have served to maintain the dominant discourse, and examples of how this has marginalised occupational therapy practice have been offered. The occupational practice discourse has been discussed as a way in which Amanda and Julie resisted the dominant discourses. This analysis has brought to light tensions previously unexplored in the literature and has offered a new way of explaining occupational therapy practice as occupational practice in this field. To provide further analysis of occupational practice this thesis will now go on to use Goffman's (1959) notion of frontstage and backstage theory.

The Frontstage-Backstage of Occupational Practice

The idea of a frontstage and backstage performance draws on the work of the sociologist Goffman, and his book *The Presentation of Self in Everyday Life* (1959). Goffman proposed that individuals play roles in society that are represented through a composition of performances (Burns, 1992; Ellingson, 2005). These performances adopt certain characteristics and behaviours which represent a specific social position, in this case as an occupational therapist. Goffman proposed that performances can be observed as if acting on a stage, whereby different frontstage and backstage performances represent different roles and therefore have different characteristics and behaviours (Goffman, 1959; Smith, 2006). The ideas of performances and stages have been described by Goffman as the dramatological perspective. Goffman's frontstage and backstage theory has traditionally been used in the literature to describe professional and non-professional identities and performances (for example, Day, Kington, Stobart & Sammons, 2006; Goldie, 2012). The occupational therapists in this study did have a truly backstage role when they were away from their work setting; however, this was not the focus of this study. This thesis has employed a novel use of the frontstage and backstage theory as a tool to examine the performance of occupational therapy in two Child and Adolescent Mental Health Services settings; this analysis can be described as being at the meso level. The use of Goffman's dramatological perspective has

been reported by a number of healthcare researchers as a framework to understand practice and relationships in healthcare teams (Cain, 2012; Ellingson, 2003; Ellingson, 2005; Hindmarsh & Pilnick, 2002; Lewin & Reeves, 2011; Riley & Manias, 2005; Tanner & Timmons, 2000). These studies predominantly focused on the performances of nursing and medical teams, within hospital wards and in operating theatres. The use of Goffman’s dramatological perspective to understand occupational therapy practice within any healthcare setting appears to have been overlooked; this study therefore offers new insights.

I propose that the occupational therapy role of Amanda and Julie, in children and young people’s mental health, can be conceptualised as having frontstage and backstage performances; these have been conceptualised in Figure 24, and will be explained in the next paragraph.

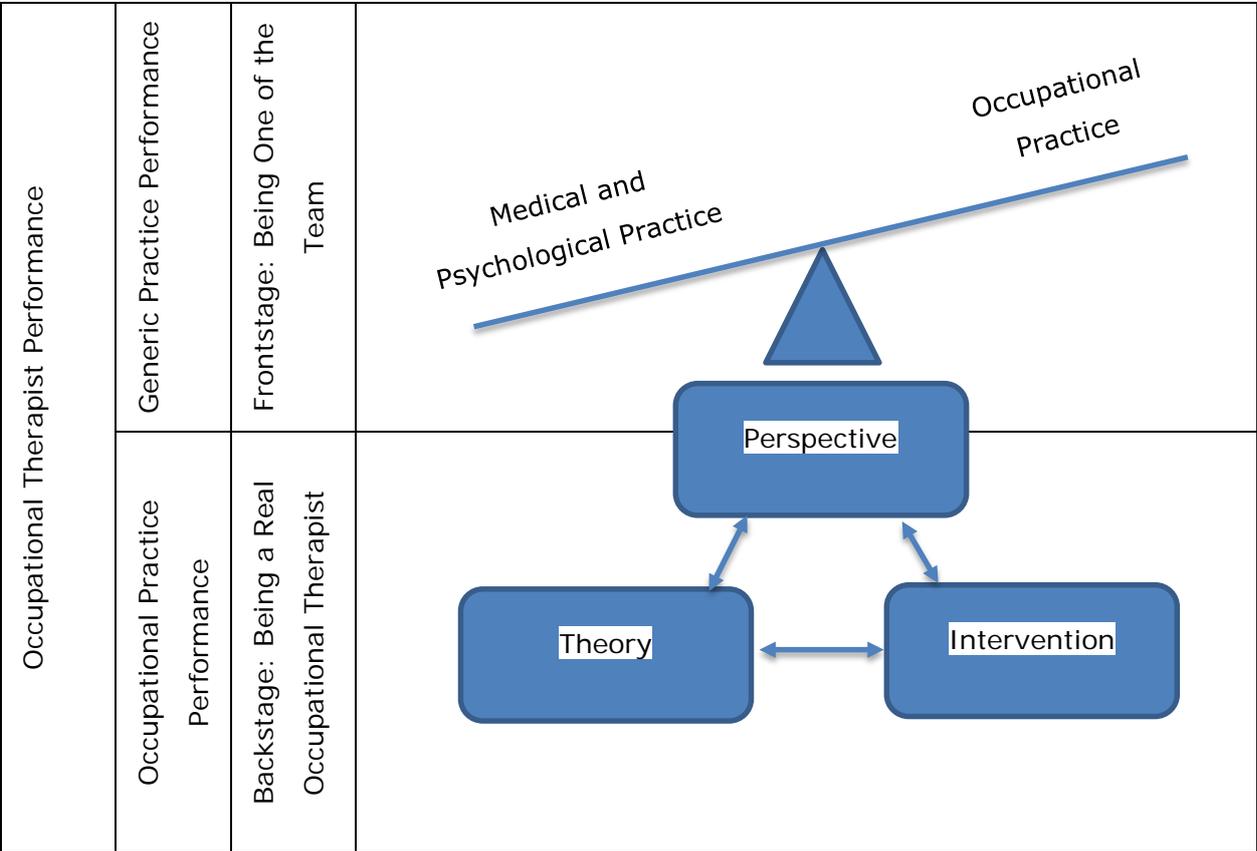


Figure 24 The Frontstage-Backstage of Occupational Practice

The strength of the conceptualisation lies in its grounding in the observation of Amanda and Julie within the context of their teams; this has drawn attention to the challenges and frictions in their clinical settings. Figure 24 situates the frontstage performances as those which the occupational therapist as the actor performed in front of colleagues, such as being in the team

office or a clinical discussion group. Backstage performances are those that the occupational therapist performed with children and young people, for example in therapy rooms or at young people's homes. It should be noted that performances can be viewed by different audiences, depending on the actor's position. Indeed, 'being a real occupational therapist' could be viewed as the frontstage of Amanda and Julie's work and 'being one of the team' the backstage. Alternative positions such as the frontstage of the children and young people could also be considered.

Figure 24 illustrates how collectively the frontstage and backstage performances conducted by Amanda and Julie formed their social role and performance of being an occupational therapist. This overall performance was a composite of two different performances: a generic practice performance and an occupational practice performance, on two different stages: frontstage and backstage. Their frontstage and backstage performances were not mutually exclusive; the occupational therapists concurrently negotiated their professional practice, which saw them fluctuate between performances and stages indiscernibly. The frontstage generic practice performance was characterised by practices more commonly associated with medicine and psychology, such as assessments for autism spectrum condition and the use of mentalisation. These performances usually took place when the audience included other healthcare professionals. This frontstage performance was however influenced and informed by the backstage occupational practice performance, therefore the generic practice performance is depicted as the balancing of practice associated with medicine and psychology and occupational practice. Frontstage performances were used by Amanda and Julie as an instrument to achieve the social role of being 'one of the team' in children and young people's mental health. Backstage performances included practices that were aligned to occupational practice. Occupational practice has been illustrated in Figure 24 as comprising a perspective, theory and intervention; these replicate the structure of the Occupational Practice Model (see Chapter Two) and they are detailed and developed further for application to children and young people's mental health in Figure 25 (see page 222). Backstage performances commonly took place when the occupational therapist was working alone with a child or young person and could be described, using a term conveyed by Amanda, as adopting the social role of a 'real occupational therapist'. To explore the idea of a frontstage and backstage dynamic of occupational therapy practice further the following sections of this chapter will develop its core dimensions.

Frontstage Performance: Generic Practice

The frontstage, in the context of this study, was the children and young people's mental health services at The Gateway and The Orchards. The occupational therapists in this study

performed a number of frontstage practices which they described as generic work, meaning such work was not profession-specific, and contributed to the overall functioning of their team. Julie, for example, was involved in diagnostic clinics for autism spectrum condition; Amanda was a case-coordinator and would see urgent cases of self-harm. The performance of such generic work appeared to be an expectation from their team. The performance of generic work nonetheless served a purpose for Amanda and Julie, it was a way to attain the social position of 'being one of the team'. Being accepted as one of the team was a valuable social position, as this appeared to give them permission from their team to enact an alternative backstage performance. This finding is supported by that reported by Henderson et al. (2015), where conducting generic work was related to fitting into the team.

The reporting of occupational therapists being involved in generic work, in children and young people's mental health, is not new (Fortune, 2000; Hardaker et al., 2011; Harrison & Forsyth, 2005; Henderson et al., 2015; Lougher, 2001). Indeed, occupational therapists have been praised by other professions for their contribution to such work (Henderson et al., 2015). The reasons for engaging in generic work have been less forthcoming in the literature; Fortune (2000) described occupational therapists in children and young people's mental health as gap-filling, meaning that they filled generic roles in the absence of a clearly defined professional role. The reporting of gap-filling may still be a valid description of some occupational therapy practice in children and young people's mental health, as identified in the survey results of this study (see Chapter Four). The occupational therapy practice of the participants in Fortune's (2000) study was also described as being void of occupation; however, this was not the case for Amanda and Julie. Amanda and Julie were purposefully selected for this study because they reported using occupation in their practice, yet they still engaged in generic practices. The idea of gap-filling is therefore challenged in this study and is reconceptualised as the idea of being a frontstage performance that represents 'being one of the team' (Goffman, 1959; Ellingson, 2005; Smith, 2006). This idea is further supported by Goffman's (1959) notion of idealisation. Idealisation occurs when performances are moulded and modified to fit into the understandings and expectations of the society in which it is presented; the performance is socialised (Burns, 1992; Smith 2006). The Gateway and The Orchards were informed by and valued medical and psychological thinking, which informed the shared theoretical frameworks that they used. Amanda and Julie adopted a frontstage performance that was valued by their teams, it was also idealised so that their performance would meet their teams' expectations.

Goffman (1959) wrote further about how team work requires the cooperation of a number of individuals, all with different performances. He used the term 'performance team' to refer to a group of individuals who cooperate to stage a single routine; The Gateway and The Orchards

could be described as 'performance teams'. The routine of the performance teams, in the context of this study, included observable practice with young people, such as an autism spectrum condition assessment, and implicit team working such as discussions at team meetings and supervision. Such routines relied on a synchronised performance that was not disrupted; Goffman described this reliance on each other as a "bond of reciprocal dependence..." (p. 88). I would argue that the use of idealised frontstage performances by Amanda and Julie, during team performances, showed they were 'on the same page' as colleagues. Being cooperative fostered a positive team relationship, and their acceptance as one of the team. This finding again echoes that of Henderson et al. (2015) who reported that the contribution of occupational therapists to generic work furthered team cohesiveness and fitting in.

The frontstage practice in this study almost always took place at The Gateway and The Orchards' buildings. These were purposefully built physical structures designed for the delivery of mental health services. The frontstage included waiting areas and treatment rooms where the assessments or interventions with young people and families took place (Cain, 2012). The frontstage was not limited to formal spaces for interaction with patients; Julie for example would talk about cases with colleagues in the corridors and offices of The Orchards; Amanda engaged in office talk at The Gateway team office. More formal case discussions were held at both sites in meeting rooms, laid out with the chairs and tables required for the job in hand. The frontstage performances by Julie and Amanda were shaped by the spatial constraints of the frontstage itself, which echoes the findings of studies of healthcare teams by Lewin and Reeves (2011) and Ellingson (2003). The spatial constraints at The Gateway and The Orchards included profession-specific spaces, whereby professional groups took ownership of frontstage areas, such as clinic rooms, psychotherapy rooms and family therapy suites. This room ownership excluded occupational therapists, who needed to ask permission to be allowed to use some rooms.

To summarise to this point, the occupational therapists in this study are presented as enacting frontstage performance that was characterised by idealised generic work, which was an expectation of their teams, was shaped by the physical context and which contributed to the social role of 'being one of the team'. The discussion now continues with a consideration of the backstage performance.

Backstage Performance: Occupational Practice

Goffman (1959) described the backstage as where an alternative and sometimes suppressed performance takes place. Backstage the performer can relax, drop the front, change the props and step out of character. Backstage can be a safe place to hide, where work done cannot be

seen. In Chapter Seven Amanda was described as creating a physical and theoretical space for occupation; I interpret this as the space for this backstage performance. Goffman (1959) proposed that when the performer moves between the frontstage and backstage regions there is a “putting on and taking off of character” (p. 123). Frontstage and backstage can be physically separated and in this study the majority of backstage performance took place in community settings, such as in children and young people’s homes. The occupational practice detailed in this section is described as taking place backstage as it occurred away from the therapist’s team; however, this could also be interpreted as the frontstage for Amanda and Julie as this is where they performed their occupational practice, which included their individual assessments and interventions. The backstage performance was a key component of the occupational practice discourse, which has been described as a resistive strategy earlier in this chapter. The backstage performance of Amanda and Julie has been conceptualised in this thesis as The Occupational Practice Model for Children and Young People’s Mental Health; this is presented next as the final micro-level conceptual development of the ethnographic findings.

Occupational Practice Model for Children and Young People’s Mental Health

Occupational practice is situated in Figure 25 (on page 222) as a backstage performance which includes a multidirectional cycle of theory, perspective and intervention. This cycle has been lifted from Figure 25 to form Figure 26 where it has been developed in this thesis into the Occupational Practice Model for Children and Young People’s Mental Health; it has foundations in the Occupational Practice Model developed in Chapter Two (see Figure 3 on page 36) but has been informed by the findings from this study; it is used to provide a framework to detail Julie and Amanda’s occupational practice with children, young people and families. The strengths of the model lie in its grounding in the observations of occupational therapists that used occupation in their practice, together with the conceptualisations of occupation-centred, occupation-based and occupation-focused practice (Fisher, 2013); it offers practice-based evidence (Barkham & Mellor-Clark, 2003; Bergstrom, 2008). It also has strengths in its use of the language and constructs of occupation which make it accessible to occupational therapists. The next sections of this chapter will discuss and develop the core dimensions of the model: theory, perspective and intervention as a backstage performance and relate these to current literature.

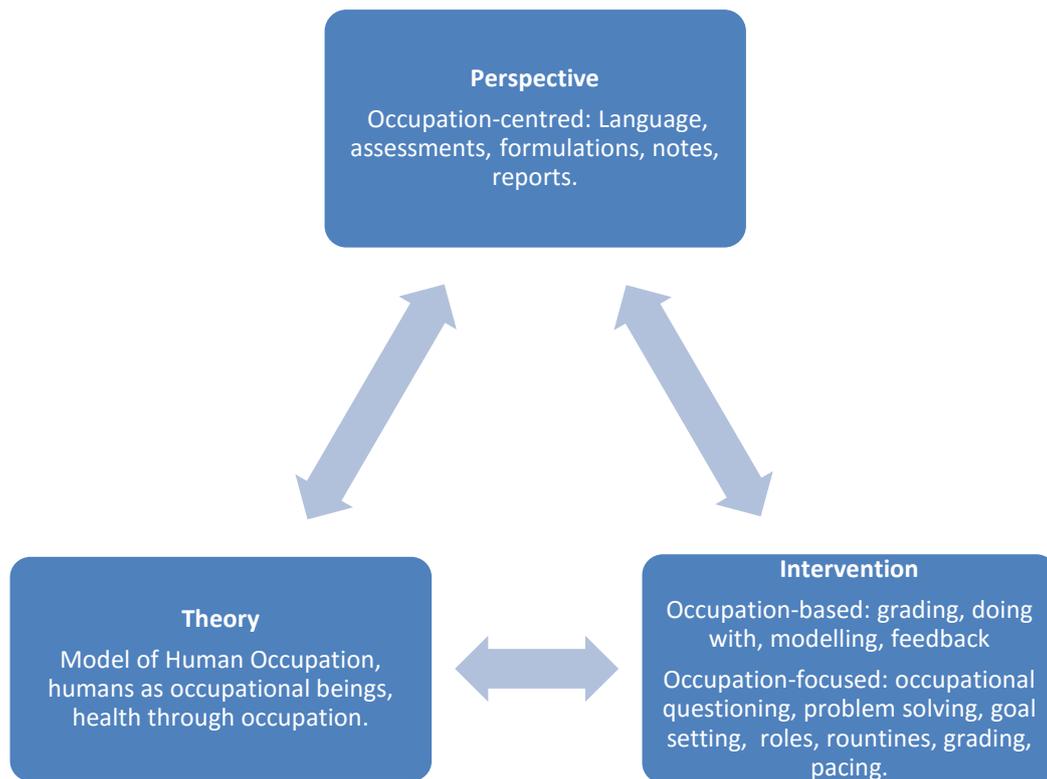


Figure 25 Occupational Practice Model for Children and Young People's Mental Health.

Theory

The discussion begins with a consideration at the level of theory; in the Occupational Practice Model, presented in Chapter Two, this had formed the largest foundation component of the model. This study did find that the use of theory was fundamental to occupational practice as a backstage performance, but that it was weighted equally to the conceptual ideas of perspective and intervention, and that it influenced and was informed by these ideas. To reflect these findings, the Occupational Practice Model for Children and Young People's Mental Health has situated theory, perspective and intervention as being linked together and of equal order. During backstage performances the use of the theory of humans as occupational beings, health through occupation, occupational justice and occupational science was implicit in Amanda and Julie's practice. Both participants spoke of their understanding of theoretical concepts related to occupational therapy and occupational science but these were operationalised through their perspective and interventions, which are discussed later in this chapter. This finding confirms the suggestions from Durocher et al. (2014b), Hammell (2008) and Wilcock (2003) that further work is needed to translate aspects of the theory of occupation into practice. Nevertheless, this study did find the explicit use of the Model of Human Occupation theory. There is some historical evidence of Model of Human Occupation being used in children and young people's mental health (for example, Brennenman Baron,

1987; Sholle-Martin, 1987) and some evidence of its use in other areas of occupational therapy practice (for example, Lee & Kielhofner, 2010; Reeves & Mann, 2000; Wimpenny, Forsyth, Jones, Matheson & Colley, 2010). This study has corroborated with the findings of Lee et al. (2012) and Lee et al. (2008) that implementing the Model of Human Occupation in practice settings can enhance professional identity, which leads to a greater occupation-focus to practice. Melton et al. (2010) found that some occupational therapists using the Model of Human Occupation lacked an understanding of how to apply the theory to practice; the findings of this study suggest that the application of theory to practice may be implicit and that further qualitative research evaluation may be needed to explicate its application.

The ability to make use of theory in occupational practice by Amanda and Julie may have been influenced by their professional education and work experience. Julie had completed post-graduate qualifications, which had included university modules that considered contemporary theoretical perspectives of occupation in the profession. She had also worked in paediatrics before children and young people's mental health; this area of practice has seen significant developments in research and practice related to occupation (for example, Coster, 1998). Amanda had a Master's degree in occupational therapy and had previously worked in adult mental health, where she described the use of occupation in occupational therapy as being more widespread. Whilst the nature of this ethnographic study was not to establish a causal relationship, it supports the findings of Estes and Pierce (2012) that the use of the theory of occupation is supported by professional education and previous work experience.

Perspective

The Occupational Practice Model for Children and Young People's Mental Health positions perspective as spanning frontstage and backstage (see Figure 25); this represents its function as a tool of the occupational practice discourse, and how it also informs the generic practice performances of Amanda and Julie. The perspective in the model refers to the structures, functions and languages of occupational practice. This includes the design of occupational therapy services, referral processes, the occupational therapy process, reports and interactions with colleagues. The concept of perspective has drawn parallels with Fisher's (2013) notion of being occupation-centred, and the terms are used interchangeably in this section. Fisher (2013) described occupation-centred as having occupation at the centre of everything, or having an occupational lens on the world. In the context of this study, being occupation-centred or having an occupational perspective was revealed in the way in which Amanda and Julie thought about the world; similarly, Njelesani et al. (2014) have described the term occupational perspective as "...a way of looking at or thinking about human doing" (p. 226). In this study Amanda and Julie's ability to focus on human doing is interpreted to

represent their commitment to an occupational perspective as a component of occupational practice. An occupational perspective was revealed through their referral criteria, which required a child or young person to have an occupational difficulty as well as a mental health problem. It was also revealed in their use of language, such as that associated with the Model of Human Occupation, but also their focus on doing, such as school and leisure occupations. Occupational formulations were key to understanding and representing the child or young person's difficulties within an occupational perspective; these also acted as a form of resistance to the psychological formulations and medical diagnosis, as discussed earlier in this chapter. The constructs of the Model of Human Occupation (such as volition and habituation) (Kielhofner, 2008) were integral to Amanda and Julie's occupational perspective. The application of the Model of Human Occupation as an occupational perspective was reported in their use of Model of Human Occupation assessments, such as the Occupational Circumstances Assessment Interview and Rating Scale (Forsyth et al., 2005) and Occupational Self-Assessment (Baron, Kielhofner, Iyenger, Goldhammer, & Wolenski, 2006); these assessed the core constructs of the Model of Human Occupation. The use of the Model of Human Occupation as a model to maintain an occupational perspective is supported by Wong and Fisher (2015) who reported its use in occupational therapy practice as a way to focus on occupation.

Maintaining an occupational perspective was a key component of Amanda and Julie's backstage performance of occupational practice, this perspective also informed and supported their 'different angle' to frontstage generic work (see page 218). During their frontstage performance their occupational perspective was challenged by constructions associated with the medical and psychological discourse (see page 207). This challenge to maintain an occupational perspective has been reported by others (for example, Colianni & Provident, 2010; DeGrace, 2003; Polatajko & Davis, 2012; Wilding & Whiteford, 2009). In this study being occupation-centred was a key component of occupational practice as a resistive discourse to challenge and managing discursive tensions. An occupational perspective expressed the core tenets of the profession; it represents the social reality of occupational therapy, and more specifically occupational practice.

Interventions

The discussion continues with a consideration of the interventions used by Amanda and Julie during their backstage performance of occupational practice. The use of Fisher's (2013) categorisation of interventions that use occupation as either occupation-based or occupation-focused has been reflected in the findings of this study. Table 17 on page 225 presents a summary of the key intervention strategies delineated from the observations in this study.

Intervention	Strategy
Doing occupation (occupation-based):	Grading Doing with Modelling Feedback Challenge
Talking about doing (occupation-focused)	Adaptive occupations Goal setting Problem solving Grading Pacing

Table 17 Summary of Occupation-based and Occupation-focused Interventions

Occupation-based interventions, according to Fisher (2013), are when someone is engaged in the actual act of an occupation as an intervention. The use of occupation-based interventions in this study was limited. Julie did use an occupation-based intervention; she engaged Angela in vivo in the occupation of going for a coffee and attending a volunteering centre. She also spoke of directing the therapy assistant to work with a young person using photography as the intervention. In sessions with Paul and Mike, Julie used leisure/play occupations in the context of a clinic room rather than the true context of the occupation. Julie's different use of occupation as an intervention suggested that there could be further delineation of occupation-based practice; firstly, the doing of occupation as a tool of therapeutic engagement, and secondly as a therapeutic engagement strategy. There have been a number of debates surrounding how occupation should be used in therapy. Gray (1998) first contributed to the discussion by suggesting occupation should be the means and the ends of occupational therapy. She interpreted means as "the use of therapeutic occupation as the treatment modality to advance someone towards an occupational outcome" (p. 358). She clarified this further by stating that the means should involve doing, and be relevant to the person's life. Polatajko and Davis (2012) furthered the debate by calling for a re-interpretation of occupation-based; they cited the American Occupational Therapy Association definition of occupation-based, using occupations to match identified goals, as too specific. Polatajko and Davis suggested that occupation-based should not mean that the client has to engage in the occupation, rather the practice should enable performance or engagement in an occupation. Fisher (2013) has since suggested that occupation-based practice should reflect the profession's notion of occupations: that they are meaningful, purposeful and contextualised. If this current idea is adopted the first suggested delineation of Julie's practice

can no longer be defended, and the use of occupation as a tool of therapeutic engagement becomes an adaptive occupation, and therefore occupation-focused. Julie's use of meaningful occupation within a natural context is supported by the literature; a study by Skubik-Peplaski, Rowles and Hunter (2012) identified natural environments as supporting occupation-based practice and giving a clear and unique professional identity.

The presence of only one occupation-based intervention, going to the coffee shop and the volunteering centre, limits the ability to be able to confidently assert the strategies that constituted that intervention, although some tentative suggestions can be made. The strategies of occupation-based or focused interventions, for any population, reported in the literature have included: providing information (O'Toole et al., 2013), practice and feedback (Law et al., 2007; Hubbard, Parsons, Neilson & Carey, 2009), education (Lau, Stevens & Jia, 2013), action plans (Hirons, Rose & Burke, 2010), mentoring (Schindler, 2010), cognitive strategies (Dawson et al., 2013), coaching (Graham, Rodger & Ziviani, 2008) and doing with (Price & Miner, 2007). Julie's intervention with Angela was characterised by the use of 'doing with' and 'providing feedback'. Julie and Angela had a drink in a café together and at the end of the intervention Julie gave Angela feedback about her performance and engagement in the occupation. Julie also used a strategy that has been called 'modelling', she modelled to Angela how to carry out the occupation of getting a drink at a café. In addition, she used the strategy of providing a 'challenge', Julie did not go into the volunteering interview with Angela, they discussed what to expect prior to the appointment, and Julie challenged her to carry out this occupation independently. The idea of a 'challenge' has some similarities with the strategy 'pushing participation' observed by Price and Miner (2007); pushing participation was a way of encouraging, showing trust and increasing the expectation of the young person. Providing a 'challenge' in this study facilitated Angela to do something new and experience a sense of satisfaction and performance from doing this. The use of 'modelling' and a 'challenge' as strategies for occupation-based intervention in children and young people's mental health have not previously been reported; the transferability of these findings to other settings should, nevertheless, be considered cautiously. Amanda and Julie reported a number of reasons for the absence of occupation-based practice in their work, including time pressures for conducting in vivo work, the dominance of talking-style therapies and a lack of manualised or clearly defined occupation-based intervention strategies.

The use of occupation-focused practice was much more prevalent for Amanda and Julie, and they employed the use of this style of intervention in some similar ways. Fisher (2013) described occupation-focused as bringing occupation into focus during therapy; this means that our attention is on occupation, it is the nearest point of reference and the proximal intent of the intervention. In this study the emphasis of occupation-focused interventions was on

preparing for engaging in occupations, rather than actually carrying them out, or engaging in an adaptive occupation as a tool for therapeutic engagement.

The use of adaptive occupations to engage young people in therapy was an occupation-focused intervention strategy used by Julie. This type of therapeutic engagement was described as being on a different level to other colleagues. When this idea was defragmented further, it was the engagement about everyday life activities which was a different approach to colleagues. For example, Daniel, the clinical psychologist at The Gateway, described engaging with young people through talking (for example, using cognitive behavioural therapy). Conversely, Pam and Helen at The Gateway described Amanda as engaging young people about doing, which they felt was a powerful tool for hard to reach young people. The occupation in this context is not necessarily meaningful to the young person, or in context, and is therefore described as an adaptive occupation. Engagement in an adaptive occupation can therefore be considered as an intervention strategy of occupation-focused practice.

The use of occupation-focused interventions to prepare for the engagement in occupations started with an understanding of a person's occupational life history (Twinley & Morris, 2014). A similar narrative approach to understanding the occupational world of young people is proposed by Wicks and Whiteford (2003) who suggested that hearing stories about occupational lives underpinned occupational therapy. Amanda and Julie both described how they would talk with young people, such as Liz and Mike, about their occupational lives, and use this as a basis for their therapy goals and interventions.

This study has outlined how the occupational therapists used a number of strategies to prepare children and young study for engagement in occupations (see Table 17 on page 225). Some of these strategies show consistency with other studies. Firstly, considering the idea of goal setting as an intervention, for example, Amanda's use of goal setting intervention was observed when she used the goal of finding a leisure interest with Charlotte. The use of goal setting as an intervention is emerging in occupational therapy and children and young people's mental health literature. Cairns, Kavanagh, Dark & McPhail (2015) reported on the use of the Goal Attainment Scaling. The Goal Attainment Scaling is an occupational-performance outcome measure, which focuses on occupational goals. Cairn's et al. (2015) found that young people found the process of goal setting positive and that it led to cognitive problem solving and helped to maintain the focus of therapy. Amanda and Julie also used goal setting to facilitate a problem solving cognitive strategy, which could be observed through their use of occupational questioning. The use of problem solving as a cognitive intervention strategy has been reported in a range of occupational therapy studies, including brain injury (Dawson et al., 2013; Mastos, Miller, Eliasson, & Imms, 2007; Park, Maitra, & Martinez, 2015), oncology

(Lyons, Erickson, & Hegel, 2012) children with disabilities (Martini, Mandich & Green, 2014; Rodger & Vishram, 2010) and adult mental health (Meeson, 1998). The problem solving strategy observed in this study did not have a formal structure, such as the goal, plan, do check strategy reported by Ward and Rodger (2004), rather it developed as occupational questioning which encouraged the young person to explore their own solutions to overcome goals. Goal setting and problem solving are both strategies that are used in occupational performance coaching (Graham et al., 2008; Kessler & Graham, 2015). While the use of occupational performance coaching was not fully observed in this study, it is an emerging intervention strategy and is considered as an area for future study (see page 234).

The use of grading was also a specific intervention technique, whereby a young person's engagement in an occupation was broken down into smaller or simpler components. The use of grading in occupational therapy is not new, the terms 'activity adaptation' (Creek & Bullock, 2008) and 'structuring' (Kielhofner, 2008) have been used to describe similar concepts. Amanda and Julie used grading to increase or decrease the complexity of an occupation; for example, when working with Stacy, Amanda spoke of grading the task of cooking by making simple meals and getting support from her mum. The use of grading was also found by Price and Miner (2007) in their study of occupation-focused practice with children. A systematic review of interventions for the community participation for children and young people (Andrews, Falkmer & Girder, 2015) has also suggested that grading should be used to improve participation in leisure occupations. The idea of pacing as an intervention was to structure the return of a child or young person to occupational participation. The use of pacing has been reported in occupational therapy literature associated with pain management (Murphy, Lyden, Smith, Dong & Koliba, 2010; Van Huet, Innes & Stancliffe, 2013), where strategies such as preplanning occupations and alternating activity with rest are described. The use of pacing was described as common in occupational therapy practice, yet no studies were found to demonstrate any efficacy; the use of pacing in any mental health setting appears to be absent.

To summarise this section of the chapter, the Occupational Practice Model for Children and Young People's Mental Health has been presented as a new model for understanding occupational practice in children and young people's mental health, and as the backstage performance of Amanda and Julie. Using the structure of theory, practice and intervention the practice of Amanda and Julie has been delineated. The theory of occupation has been identified as being predominantly implicit in practice, although the use of the constructs of the Model of Human Occupation was central to practice. An occupational perspective that provides an occupational lens across the occupational therapy process has been suggested as a strategy to be occupation-centred and as a construction to manage discursive tensions during frontstage performances. Finally, the Occupational Practice Model for Children and

Young People's Mental Health has outlined a number of specific intervention strategies have been identified as being elements of occupation-based and occupation-focused practice.

Chapter Summary

This chapter has used Foucault's social theory of archaeology, discourse and power to explore the occupational therapy practice of Amanda and Julie at a macro level. This Foucauldian analysis has illuminated previously concealed ideas associated with the discursive constructions that have supported a dominant medical-psychological discourse in children and young people's mental health. It has also drawn attention to how these dominant discourses may have marginalised occupational therapy, and how Amanda and Julie used occupational practice to resist this side-lining. To provide a further analysis, Goffman's idea of frontstage and backstage performances has been used to illustrate how generic practice performances and occupational practice performances made up the occupational therapy role of Amanda and Julie. This analysis has provided an explanation of how occupational therapists may use stages as a way to enable them to enact profession-specific roles whilst maintaining a team role. Further attention has been given to the backstage occupational practice performance which has been conceptualised in this thesis into the Occupational Practice Model for Children and Young People's Mental Health. The Occupational Practice Model for Children and Young People's Mental Health has generated an understanding of how Amanda and Julie used theory, perspective and interventions during their occupational practice. The Occupational Practice Model for Children and Young People's Mental Health is the first model to delineate occupational therapy practice in child and young people's mental health.

Chapter Ten: Contributions to Knowledge and Implications for Theory, Research and Practice

Introduction

This final chapter brings the thesis to a conclusion. This chapter will draw together the findings and discussion from the survey and ethnographic phases of this study to consider the key contributions that have been made to knowledge, and how this knowledge may impact on theory, research and practice. This approach to considering the findings of the study as a whole is in accordance with the mixed methods research design described in Chapter Four. This chapter will end by identifying a strategy for dissemination and providing a final conclusion of the study. The aims of this study were to critically explore occupational therapy and occupational practice in children and young people's mental health. These aims have been met through the study objectives to conduct a survey and carry out an ethnography. Chapter Five of this thesis has presented the findings, and discussed the results of the survey which has scoped the practice of occupational therapists working in children and young people's mental health. Chapters Seven and Eight have reported the ethnographies of The Gateway and The Orchards respectively, and Chapter Nine has conceptualised the ethnographic findings. These ethnographic accounts have served to explore the meaning and implementation of occupational practice.

Key Contributions to Knowledge

This thesis has explored how occupational therapists have used occupation when working with children and young people with mental health difficulties. This has been achieved through a national survey of practice and an ethnographic approach to the study of two occupational therapists using occupational practice. The study presented in this thesis appears to be the first to have identified and focused on occupational practice in the field of children and young people's mental health in the United Kingdom. There are five key contributions to knowledge that have emerged from the thesis; these are detailed below.

First, the development of the Occupational Practice Model (Figure 3 on page 36) as an output of the literature review conducted for this study provides a new model for occupational therapists to conceptualise the use of occupation in practice. The term 'occupational practice' is offered as a new term which describes a subculture of occupational therapy practice, and that advances a previously fragmented approach to occupation-related taxonomies.

Second, a survey of occupational therapy practice in children and young people's mental health had not been conducted in the United Kingdom since 1984 (Jeffrey et al., 1984). The survey presented in Chapter Five of this thesis has provided a contemporary description of its participant's occupational therapy practice in children and young people's mental health. The low response rate limits the findings to a description of the study participants and its generalisation should be considered with caution. Overall, the survey has indicated that the demography of occupational therapists in this study was female, experienced and did not have post-graduate training specific to occupational therapy. The survey participants reported that their occupational therapy role was to focus on children and young people's everyday life and to enable wellbeing; this was supported by their use of the Model of Human Occupation. However, the assessments and interventions used did not always reflect this focus on occupation, indeed there was an emphasis on the use of sensory approaches and talking-style therapies.

Third, the ethnographic analysis in Chapters Seven and Eight has brought to light the explicit and implicit use of shared practice frameworks in the children and young people's mental health teams in this study, and the influence of these on practice. The use of a grounded theory approach to the ethnographic analysis has exposed new understandings of the culture of occupational practice within the context of the healthcare teams in this study, and also to the use of occupation in practice. The idea of an occupational formulation is a new concept that draws parallels with some existing ideas, but begins to develop the notion as a profession-specific practice. This study has identified specific strategies that the occupational therapist participants used when working with children and young people with mental health difficulties. 'Modelling' and a 'challenge' are presented as previously unreported interventions; others such as goal setting and problem solving confirm findings from other studies.

Fourth, Chapter Nine has brought new understandings to the dynamics of occupational therapy practice in the study settings. The use of Foucauldian tools has led me to propose a discourse that supported medicine and psychology as the dominant disciplines. The study revealed tensions that these may pose to occupational therapy, and introduces the idea of marginalising as an explanation as to why some occupational therapists may feel side-lined. Whilst other studies have also proffered tensions in practice this study is the first to offer occupational practice as a resistive strategy. Chapter Nine has also utilised Goffman's frontstage and backstage theory to provide a framework through which to make sense of occupational therapy practice. The use of Goffman's frontstage and backstage theory to explain occupational therapy practice is innovative and provides an insight into how occupational therapists in the study settings worked in children and young people's mental health teams. The notion of a backstage performance as 'one of the team' and a frontstage

performance that enacts 'real occupational therapy practice' provides an account of how occupational therapists may contribute to team work, be seen as one of the team but also maintain an allegiance to their profession. This provides a positive conceptualisation that challenges the previously reported role of being 'gap-fillers'.

Finally, the Occupational Practice Model for Children and Young People's Mental Health (Figure 25 on page 222) is offered as a specific framework for practice for those occupational therapists working in the field of children and young people's mental health. The strengths of this new model are in its incorporation of the structure of the Occupational Practice Model (Figure 3 on page 36), which was developed from the literature review, and the empirical findings from this study. The Occupational Practice Model for Children and Young People's Mental Health adds to the body of knowledge surrounding the use of occupation in occupational therapy practice. It has also identified intervention strategies that occupational therapists could use when working with children and young people with mental health difficulties.

Contribution to Methodology

The study reported in this thesis used a mixed methods approach, with the survey leading into the ethnography. The employment of this approach led to the use of critical realism as a philosophical position. Whilst critical realism has some history with social science research, its application to studies of occupational therapy is limited. The use of critical realism in this study has demonstrated how its use can help to reconcile studies that wish to combine quantitative and qualitative data collection. This is important for occupational therapy which situates occupations as socially constructed yet continues to work in medically oriented healthcare settings.

In Chapter Six I described how occupational therapy and ethnography have had shared domains of concern; this study has continued this relationship and demonstrated the value of ethnographic methods for occupational therapists to reveal and understand professional practice. Focused ethnography was introduced in Chapter Six as an emerging qualitative methodology. This study is one of the first to use such an approach in occupational therapy; as such it has shown the utility of focused ethnography to enable occupational therapists to conduct critical research in fields that they know. This study has also shown the advantage that focused ethnography can bring accessing the field and interrogating the research data.

Implications for Practice

The implications for practice can be considered in relation to management and commissioning of services, education providers, children and young people's mental health teams and

individual occupational therapists. Firstly, managers and commissioners of healthcare services could draw attention to the demographic aspects of the survey; the limitations of the small sample size must however be recognised. The survey participants reported that their occupational therapy practice in children and young people's mental health was dominated by more senior occupational therapy roles. This finding may be of relevance to those in healthcare management and commissioning roles to examine how more entry level occupational therapy posts could be established to ensure the profession's succession in this setting. The survey has also illustrated how participants had a lack of post-graduate training and qualifications specific to occupational therapy. This may well be noted by managers when they are considering the training of their staff; it could also be of significance to higher education institutions and other training providers, such as the College of Occupational Therapists. These providers might consider the development programmes of study that enhance the knowledge and skills of occupational therapists, and encourage occupational therapists to engage in research.

The ethnographic findings may be applicable to children and young people's mental healthcare teams to understand team dynamics and occupational therapy. Managers and leaders of these services could utilise the ethnographic analysis and conceptualisation to make sense of power and dominance that may cause tensions within teams. This could be of significance in the United Kingdom where Child and Adolescent Mental Health Services structures and delivery are being shaped into universal, targeted and specialist services. This study supports healthcare teams to understand the perspectives, theories and interventions that occupational therapists use in practice and how these may offer a different view of reality to other team members, particularly those from a medical and psychological background.

Occupational therapists working in the field may be reassured that the participants in this study did overall espouse the philosophy of the profession, to enable wellbeing and focus on the everyday life of children and young people. However, they should also note that there were a number of challenges reported to realising this philosophy in practice. This study suggests that occupational therapists could make more explicit their use of occupational therapy specific theory, language, therapy goals and outcomes; the use of the Occupational Practice Model for Children and Young People's Mental Health developed in the second phase of this study is proposed as a framework to do this. An understanding of how medicine and psychology can marginalise occupational therapy practice may also help occupational therapists to evaluate their roles in teams and their engagement in generic assessments and interventions. The tensions that exist between these different discourses do have the potential to be a barrier to the progression of occupational practice. Occupational therapists may need to evaluate how best to negotiate their generic and profession-specific practice. Such

evaluation runs the risk of alienating occupational therapy from children and young people's mental health teams as we may no longer be seen as team players. The study findings could also be used to support occupational therapists to resist dominant discourses through the use of the language, theory and practice of occupation. This study has suggested that occupational therapists should not adopt defensive positions, such as being paused or gap-filling, rather that they should understand occupational practice as a frontstage and backstage performance.

The specificity of occupational therapy interventions was limited in this study; clinicians in practice should aim to demonstrate and report these with children, young people, families and other team members. To support clinicians in making their practice explicit the use of the Occupational Practice Model for Children and Young People's Mental Health is suggested. The participants in this study used the theory and language of occupation including use of the Model of Human Occupation, had a profession-specific referral pathway, used occupational formulation, presented occupation as a powerful tool for engagement, and offered specific occupational therapy intervention strategies. Clinicians may wish to draw on these strategies to support the use of occupation in their practice.

Implications for Policy

This study has shown that the dominant disciplines in the arena of children and young people's mental health are medicine and psychology. It is these professions that have influenced current government policy, particularly the drive towards the use of psychological 'talking therapies' associated with cognitive behavioural therapy and family therapy (Department of Health, 2011; Department of Health, 2015). Whilst this study has presented a number of occupation-focused interventions and strategies that also used a talking-style of therapy, these do not yet offer sufficient evidence to challenge the use of psychologically informed therapies. The findings of this study would have greater power if they were combined with findings from other studies which have also addressed mental health and occupation. To do this it is suggested that the findings can be used to support the College of Occupational Therapists Mental Health Strategy (College of Occupational Therapists, 2006). This strategy is due for revision in 2017 and as a collective and professional body document may have greater influence on future United Kingdom Government policy.

The evidence reported in this strategy also could be used to inform programmes, such as the Targeted Mental Health in Schools and Children and Young Peoples Improving Access to Psychological Therapies, to adopt a wider interpretation of talking therapies which could include those informed by occupational therapy. The strategy could also be used to lobby for

developments in government policy that are currently serving to reinforce the dominance of medicine and psychology.

Future Research

This study has made a contribution to new knowledge which has value for practising occupational therapists, manager, educators and researchers. There has been a call to strengthen the use of occupation in occupational therapy practice (American Occupational Therapy Association, 2014a; Pierce, 2003; Forsyth et al., 2005; Kielhofner, 2008) and to bridge the gap between research and practice (Kielhofner, 2000; Pierce, 2001a; Pierce, 2003; Polatajko & Davis, 2012). A number of studies are suggested to further develop the findings of this study and to meet the call from the profession detailed above. First, a qualitative phenomenological study of the role of occupational therapy in children and young people's mental health would provide additional qualitative data to support the challenges and tensions identified in this study. Second, a Foucauldian analysis of the archaeology of children and young people's mental health is suggested to bring further light to historical implications that have shaped the field. Third, a systematic review of occupational therapy interventions and outcomes in children and young people's mental health is recommended. The findings of such a review could be combined with the findings of this study as a way to move towards the development and testing of specific intervention strategies. The application of the occupational performance coaching to children and young people with mental health difficulties is highlighted as a specific intervention that warrants further exploration.

Dissemination Strategy

For an effective research dissemination strategy, it is important to tailor the presentation to maximise the audience engagement and uptake of knowledge (Funk, Tornquist, & Champagne, 1989; Wilson, Petticrew, Calnan & Nazareth, 2010). The dissemination strategy for this study has therefore been developed to include a local and international audience of research occupational therapists, a research methodology audience and a practising occupational therapy audience. The dissemination strategy is presented in Table 18 on page 236.

Proposed publication	Format	Target audience
Survey of occupational therapy in children and young people's mental health	Journal article	College of Occupational Therapists CYPFSS Journal
An ethnographic study of occupational therapy practice in children and young people's mental health	Journal article	Scandinavian Journal of Occupational Therapy
The use of focused ethnography in healthcare research	Journal article	Qualitative Research Journal
Implementing occupation-based and occupation-focused interventions in children and young people's mental health	Journal article	Occupational Therapy in Mental Health Journal
PhD Thesis	Thesis	College of Occupational Therapists Library
Occupational practice in children and young people's mental health: The Occupational Practice Model for Children and Young People's Mental Health	Training/Workshop	College of Occupational Therapists.
The Occupation Practice Model: A tool for Occupational Therapy Practice	Book Chapter	Occupational Therapy and Physical Dysfunction or Creek's Occupational Therapy in Mental Health

Table 18 Dissemination Strategy

Study Conclusion

The purpose of this study was to explore current occupational therapy practice in children and young people's mental health, and to consider the meaning and implementation of

occupational practice in this setting. This mixed methods study has found that there are challenges and tensions for occupational therapists to maintain a focus on occupation. Overall, occupational therapists espouse the profession's philosophy to enhance health and wellbeing through occupation. In practice the ability to enact the philosophy is challenged by discursive constructs which support the dominance of medical and psychology discourse; this dominance has resulted in some occupational therapy practices being marginalised. To manage this dominance and marginalisation occupational therapists have adopted the use of generic practice and occupational practice. During generic practice they use concepts, language and practice from medicine and psychology; during occupational practice they use concepts, language and practice from occupation. Their engagement in generic practices enables them to be seen as one of the team. The use of occupational practice has been shown in this study to be a strategy to resist marginalising from other professions and maintain a profession-specific role. Through the use of an ethnographic approach this study has illuminated how occupational practice is comprised of profession-specific theory, perspective and intervention; these have been conceptualised into the Occupational Practice Model for Children and Young People's Mental Health. The Occupational Practice Model for Children and Young People's Mental Health can be used throughout the occupational therapy process as a means of maintaining a focus on occupation. It has specifically identified the use of the Model of Human Occupation as a strong theoretical base and a number of occupation-based and occupation-focused intervention strategies.

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Appendices

Appendix 1: Assent Form (Children)

Appendix 2: Consent Form

Appendix 3: Consent Form (Parent/carer for child)

Appendix 4: Participant Information Sheet (Children aged 5-10 years)

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Appendix 11: Survey of Occupational Therapy Practice in Child and Adolescent Mental Health

Appendix 12: College of Occupational Therapists CYPF Newsletter study recruitment letter

Appendix 13: OT News study recruitment letter

Appendix 2: Consent Form



Consent Form

Title of Project: A study of Occupation-based Practice in Child and Adolescent Mental health.

Name of researcher: Rob Brooks

Please initial box

1. I confirm that I have read and understood the information sheet for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.
2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, without my healthcare or legal rights being affected.
3. I agree to be audio recorded.
4. I agree to the use of anonymised quotes in publications.
5. I agree to take part in the above study.

<input type="checkbox"/>

Name	Date	Signature
Researcher	Date	Signature

If you wish to receive a copy of the research results, please provide contact details here:

When completed, 1 copy for patient, 1 copy for researcher file, 1 copy in healthcare notes

Appendix 3: Consent Form (Parent/carer for child)



Consent Form (parent/guardian for child)

Title of Project: A study of Occupation-based Practice in Child and Adolescent Mental health.

Name of researcher: Rob Brooks

Please initial box

- 1. I confirm that I have read and understood the information sheet for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.
- 2. I understand that my child’s participation is voluntary and that they are free to withdraw at any time, without giving any reason, without their healthcare or legal rights being affected.
- 3. I agree to my child being audio recorded.
- 4. I agree to the use of my child’s anonymised quotes in publications.
- 5. I agree for my child to take part in the above study.

Name Date Signature

Researcher Date Signature

If you wish to receive a copy of the research results, please provide contact details here:

When completed, 1 copy for patient, 1 copy for researcher file, 1 copy in healthcare notes

Appendix 4: Participant Information Sheet (Children aged 5-10 years)



Participant Information sheet (children aged 5-10 years)

Title

A study of Occupation-based practice in child and adolescent mental health.



What is research?

Research is a way we try to find out the answers to questions



Why have I been asked to take part?

You have been asked to take part because your occupational therapist is being watched when they see children. Other children have also been asked to take part in this research.



Did anyone check the research was OK to do?

This research has been checked by a group of experts at the university and hospital who have said that it is Ok to do.



Do I have to take part?

No. You can choose. You can talk to your parents or occupational therapist about whether to take part, no one will be cross if you say no.



Will anyone know what I said?

No. What you say might be written down but your name will be kept secret. The only time this rule may be broken is if you talk about being hurt. If this happens your occupational therapist or the researcher will talk with you about who needs to know this.

All information will be kept locked away for 5 years after the research has finished.



What if I have any worries?

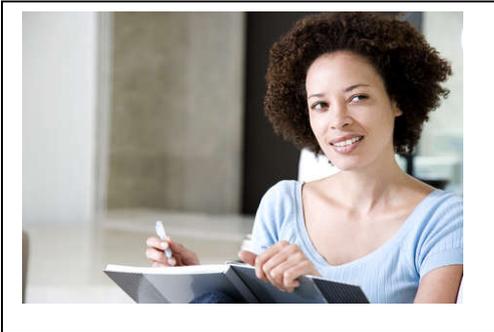
You should talk to your parents or occupational therapist who will do their best to answer your questions.



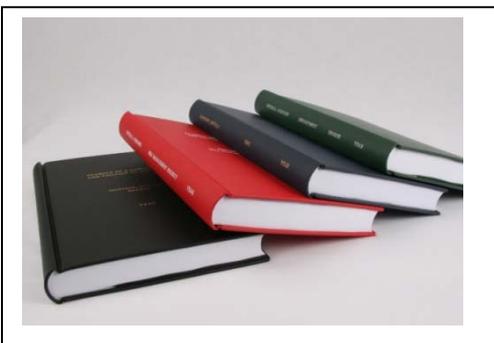
What will happen if I take part?



Next time you see your occupational therapist...



...a researcher will be in the room. They will listen to what your occupational says and does, will write things down and record what is being said...



...when the researcher has seen other children with their occupational therapist they will write a report. Your name will not be used and nobody will know you took part. You can have a copy of the report that you will understand.

Contact details: Rob Brooks, University of Huddersfield

U0871644@hud.ac.uk

Appendix 5: Participant Information Sheet (Young people aged over 15/parents/carers)



Participant Information Sheet (young people over 15/parents/carers)

We are asking if you would agree to take part in a research project to help us understand better what occupational therapists do to help children and young people and families. Before you decide it is important for you to understand why the research is being done and what it will involve for you. Ask if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

Thank you for reading this.

Why are we doing this research?

The purpose of the study is to better understand what occupational therapists do to help child and young people and families.

The research is being completed as part of a PhD at the University of Huddersfield.

Why have I been asked to take part? And what do I have to do?

You have been asked to take part because the occupational therapist that sees you and/or your child is being observed to see what they do. You do not need to do anything differently but you will notice a researcher in the room when you see your occupational therapist. This person may take notes or record what goes on in the room. The researcher is primarily observing the occupational therapists, not you.

Do I have to take part?

It is up to you to decide whether or not to take part. You do not need to give a reason if you do not want to take part. If you do want to take part you will be given this information sheet to keep and be asked to sign a consent form. You are free to stop taking part at any time without giving a reason. Your decisions to take part or not take part will not influence the healthcare that you receive from your occupational therapist.

What are the risks and benefits of taking part?

There should be no risks to you if you chose to take part in the study. We cannot promise that the study will help you but the information we get might help other children and young people get better in the future.

Will my taking part in the study be kept confidential?

Yes, all information collected from you during this research will be kept secure and any identifying material will be removed in order to ensure anonymity of those participating. All data will be kept securely in a locked cabinet or stored on a password protected computer. Data collected from the questionnaire will only be accessed by Rob Brooks, Dr Sue Peckover and Dr Ruth Deery at the University of Huddersfield. All data will securely stored for a period of 5 years after the research study at the University of Huddersfield.

What will happen to the study results?

The overall results will form part of a PhD thesis which once finalised will be stored in the University of Huddersfield Library. It is anticipated that the results will be published in a journal or presented at a conference, your anonymity is still guaranteed. We will send you a summary of the results if you would like a copy.

Who has reviewed the study?

Before any research is allowed to happen it has to be checked by a group of experts called an Ethics Committee. They make sure that the research is OK to do. Your project has been checked by the University of Huddersfield and NHS Ethics Committee.

What if something goes wrong?

If you have any concerns about the study, please contact the researcher who will answer your questions. If you have any complaint about the way you have been dealt with during the study you can formally complain by contacting the Director of Centre for Health and Social Care Research, Professor Annie Topping on 01484 473 974 or a.e.topping@hud.ac.uk.

If you require further information about this study please contact the researcher on:

Rob Brooks U0871644@hud.ac.uk

Thank you for taking the time to read this information leaflet

Appendix 6: Participant Information Sheet (Occupational Therapists)



Participant Information Sheet (Occupational Therapists)

We are asking if you would agree to take part in a research project to help us understand better what occupational therapists do to help children and young people and families. Before you decide it is important for you to understand why the research is being done and what it will involve for you. Ask if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

Thank you for reading this.

Why are we doing this research?

The purpose of the study is to better understand what occupational therapists do to help child and young people and families. This study is specifically looking at occupation-based practice.

The research is being completed as part of a PhD at the University of Huddersfield.

Why have I been asked to take part? And what do I have to do?

You have been asked to take part because you expressed an interest in participating in this study. You do not need to do anything differently but a researcher will be with you when you see children and young people and when conducting other activities in your role as an occupational therapist, such as team meetings. This person will take notes and/or record what goes on. The researcher may wish to see departmental paperwork (that does not have patient identifiable data) such as, but not limited to policies, guidelines and report pro forma. The researcher will write up what they record and may want to discuss this with you.

Do I have to take part?

It is up to you to decide whether or not to take part. You do not need to give a reason if you do not want to take part. If you do want to take part you will be given this information sheet to keep and be asked to sign a consent form. You are free to stop taking part at any time without giving a reason.

What are the risks and benefits of taking part?

The research should help you and other occupational therapist to understand their clinical practice better. The risks are the anxiety of being observed and the observation of malpractice by the researcher. If this occurs this will be discussed with you and your manager and referred to the Health Professions Council if appropriate.

Will my taking part in the study be kept confidential?

Yes, all information collected from you during this research will be kept secure and any identifying material will be removed in order to ensure anonymity. All data will be kept securely in a locked cabinet or stored on a password protected computer. All data will be securely stored for a period of 5 years after the research study at the University of Huddersfield.

Child protection overrules confidentiality; the researcher would discuss this with you and your manager if this issue arose.

What will happen to the study results?

The overall results will form part of a PhD thesis which once finalised will be stored in the University of Huddersfield Library. It is anticipated that the results will be published in a journal or presented at a conference, your anonymity is still guaranteed. We will send you a summary of the results if you would like a copy.

Who has reviewed the study?

Before any research is allowed to happen it has to be checked by a group of experts called an Ethics Committee. They make sure that the research is OK to do. Your project has been checked by the University of Huddersfield and NHS Ethics Committee.

What if something goes wrong?

If you have any concerns about the study, please contact the researcher who will answer your questions. If you have any complaint about the way you have been dealt with during the study you can formally complain by contacting the Director of Centre for Health and Social Care Research, Professor Annie Topping on 01484 473 974 or a.e.topping@hud.ac.uk.

If you require further information about this study, please contact the researcher on:

Rob Brooks U0871644@hud.ac.uk

Appendix 7: Participant Information Sheet (Parental assent for 11-15 year olds)



Participant Information Sheet (Parental assent for young person 11-15yrs)

Your young person has given their consent to participate in a research study. Your young person is competent to make this decision on their own however to ensure everyone is informed we ask parents/carers to read the information about the study and give assent for their young person to participate in the study. Your young person can only take part in the study with your assent.

Thank you for reading this.

Why are we doing this research?

The purpose of the study is to better understand what occupational therapists do to help child and young people and families.

The research is being completed as part of a PhD at the University of Huddersfield.

Why has your young person been asked to take part? And what do they have to do?

Your young person has been asked to take part because their occupational therapist is being observed to see what they do. They do not need to do anything differently but will notice a researcher in the room when they see their occupational therapist. This person may take notes and/or tape record what goes on in the room. The researcher is primarily observing the occupational therapists, not your young person.

Do they have to take part?

Your young person has agreed to take part; it is up to you to decide whether or not you agree with this. You do not need to give a reason if you do not want them to take part. If you do want them to take part, you will be given this information sheet to keep and be asked to sign a consent form. Your young person is free to stop taking part at any time without giving a reason. The decision to take part or not take part will not influence the healthcare received from your occupational therapist.

What are the risks and benefits of taking part?

There should be no risks to your young person if agree they can take part in the study. We cannot promise that the study will help them but the information we get might help other children and young people get better in the future.

Will taking part in the study be kept confidential?

Yes, all information collected during this research will be kept secure and any identifying material will be removed in order to ensure anonymity of those participating. All data will be kept securely in a locked cabinet or stored on a password protected computer. Data collected from the questionnaire will only be accessed by Rob Brooks, Dr Sue Peckover and Dr Ruth Deery at the University of Huddersfield. All data securely stored for a period of 5 years after the research study at the University of Huddersfield.

What will happen to the study results?

The overall results will form part of a PhD thesis which once finalised will be stored in the University of Huddersfield Library. It is anticipated that the results will be published in a journal or presented at a conference, anonymity is still guaranteed. We will send you a summary of the results if you would like a copy.

Who has reviewed the study?

Before any research is allowed to happen it has to be checked by a group of experts called an Ethics Committee. They make sure that the research is OK to do. Your project has been checked by the University of Huddersfield and NHS Ethics Committee.

What if something goes wrong?

If you have any concerns about the study please contact the researcher who will do their best to answer your questions. If you have any complaint about the way you have been dealt with during the study you can formally complain by contacting the Director of Centre for Health and Social Care Research, Professor Annie Topping at a.e.topping@hud.ac.uk.

If you require further information about this study please contact the researcher on:

Rob Brooks U0871644@hud.ac.uk

Appendix 8: Participant Information Sheet (11-15 year olds)



Participant Information Sheet (Young People 11-15yrs)

We are asking if you would agree to take part in a research project to help us understand better what occupational therapists do to help children and young people. Before you decide it is important for you to understand why the research is being done and what it will involve for you. Please read the information on this sheet carefully. Talk about it with your family, friends or occupational therapist if you want to. If you want to take part we will also give your parents/carers information about the study and get them to agree that you can take part.

Title

A study of occupation-based practice in child and adolescent mental health



What is research?

Research is a careful study to help find an answer to an important question.



Why is this project being done?

This project is being done to help us know more about how occupational therapists help children and young people.



Why have I been invited to take part?

You have been asked to take part because your occupational therapist is being observed when they see children and young people. Other children and young people have also been asked to take part in this research.



What do I have to do?

You do not need to do anything differently but you will notice someone else is in the room when you see your occupational therapist. This person may take notes or tape record what goes on in the room. You may see the researcher once or several times depending on how often you see your occupational therapist. You will be told each time they will be present.





Did anyone else check the study is ok to do?



Before any research is allowed to happen it has to be checked by a group of people called an Ethics Committee. They make sure that the research is OK to do. Your project has been checked by the University of Huddersfield and NHS Ethics Committee.

Do I have to take part?



No. It is up to you to decide whether or not to take part. You do not need to give a reason if you do not want to take part and nobody will be cross with you.

Will joining in help me?

We cannot promise that the study will help you but the information we get might help other children and young people get better in the future.



Will my information be kept private?

No one will know that you are taking part and nobody else will know what you have said. The researcher will write things down or tape record what happens when you are seeing your occupational therapist but your name will be kept separate from this information. The only time this rule is broken is if you talk about being hurt, if this happens your occupational therapist or researcher will talk to you about who needs to know this.



What if something goes wrong?

If you have any worries you should speak to your parents/carer or occupational therapist, they will not be cross with you and will do their best to answer your questions. If you have any complaint you can contact the Director of Centre for Health and Social Care Research, Professor Annie Topping on 01484 473 974 or a.e.topping@hud.ac.uk.

Contact details

If you require further information about this study please contact the researcher on:

Rob Brooks

U0871644@hud.ac.uk



Appendix 9: Participant Information Sheet (Team members)



Participant Information Sheet (Team members)

We are asking if you would agree to take part in a research project to help us understand better what occupational therapists do to help children and young people and families. Before you decide it is important for you to understand why the research is being done and what it will involve for you. Ask if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part. Thank you for reading this.

Why are we doing this research?

The purpose of the study is to better understand what occupational therapists do to help child and young people and families. This study is specifically looking at occupation-based practice. The research is being completed as part of a PhD at the University of Huddersfield.

Why have I been asked to take part? And what do I have to do?

You have been asked to take part because an occupational therapist in your department has agreed to participate in the research. The researcher would like to understand what the occupational therapist does in all aspects of their work which could include you and other members of your team. You do not need to do anything differently but if you conduct any joint working with your occupational therapist the researcher will take notes and/or tape record what goes on. Consent will be gained from all children, young people and families. The researcher will also be present and take notes during other activities in your department such as team meetings but will not record any client identifiable data. The researcher is primarily observing the occupational therapist, not you.

Do I have to take part?

It is up to you to decide whether or not to take part. You do not need to give a reason if you do not want to take part. If you do want to take part, you will be given this information sheet to keep and be asked to sign a consent form. You are free to stop taking part at any time without giving a reason.

What are the risks and benefits of taking part?

The research should help you and others understand what occupational therapists do in their clinical practice to help children, young people and families. The only risk is the anxiety of being observed.

Will my taking part in the study be kept confidential?

Yes, all information collected during this research will be kept secure and any identifying material will be removed in order to ensure anonymity. All data will be kept securely in a locked cabinet or stored on a password protected computer. All data will securely stored for a period of 5 years after the research study at the University of Huddersfield. Child protection overrules confidentiality; the researcher would discuss this with you and your manager if this issue arose.

What will happen to the study results?

The overall results will form part of a PhD thesis which once finalised will be stored in the University of Huddersfield Library. It is anticipated that the results will be published in a journal or presented at a conference, your anonymity is still guaranteed. We will send you a summary of the results if you would like a copy.

Who has reviewed the study?

Before any research is allowed to happen it has to be checked by a group of experts called an Ethics Committee. They make sure that the research is OK to do. Your project has been checked by the University of Huddersfield and NHS Ethics Committee.

What if something goes wrong?

If you have any concerns about the study, please contact the researcher who will answer your questions. If you have any complaint about the way you have been dealt with during the study you can formally complain by contacting the Director of Centre for Health and Social Care Research, Professor Annie Topping at a.e.topping@hud.ac.uk.

If you require further information about this study, please contact the researcher on:

Rob Brooks U0871644@hud.ac.uk

**Appendix 10: National Research Ethics Service Approval
(11/YH/0181)**



National Research Ethics Service
NRES Committee Yorkshire & The Humber - Leeds East
Yorkshire and Humber REC Office
First Floor, Millside
Mill Pond Lane
Meanwood
Leeds
LS6 4RA

Telephone: 0113 3050122
Facsimile:

20 June 2011

Mr Rob Brooks
Senior Lecturer Occupational Therapy and Occupational Science
Leeds Metropolitan University
Faculty of Health and Social Sciences
City Campus
Room C602
Leeds
LS1 3HE

Dear Mr Brooks

Study title: A study of occupation-based practice in child and adolescent mental health
REC reference: 11/YH/0181
Protocol number: N/A

Thank you for your letter of 13 June 2011, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Chair.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised, subject to the conditions specified below.

Ethical review of research sites

NHS sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

This Research Ethics Committee is an advisory committee to the Yorkshire and The Humber Strategic Health Authority
The National Research Ethics Service (NRES) represents the NRES Directorate within
the National Patient Safety Agency and Research Ethics Committees in England

Management permission ("R&D approval") should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements.

Guidance on applying for NHS permission for research is available in the Integrated Research Application System or at <http://www.rdforum.nhs.uk>.

Where a NHS organisation's role in the study is limited to identifying and referring potential participants to research sites ("participant identification centre"), guidance should be sought from the R&D office on the information it requires to give permission for this activity.

For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.

Sponsors are not required to notify the Committee of approvals from host organisations

It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

Document	Version	Date
Covering Letter		09 May 2011
Evidence of insurance or indemnity		
Investigator CV		09 May 2011
Other: checklist		
Other: Supervisor CV		09 May 2011
Other: Assent form for children	1.0	13 June 2011
Other: Online survey	1.1	
Participant Consent Form: parent/guardian for child	1	09 May 2011
Participant Consent Form	1	09 May 2011
Participant Information Sheet: Children 5 - 10 years	1	09 May 2011
Participant Information Sheet: young people over 15/parents/carers	1	09 May 2011
Participant Information Sheet: occupational therapists	1	09 May 2011
Participant Information Sheet: parental assent for young person 11-15 years	1	09 May 2011
Participant Information Sheet: young people 11-15 years	1	09 May 2011
Participant Information Sheet: team members	1	09 May 2011
Protocol	1	09 May 2011
REC application		09 May 2011
Response to Request for Further Information		13 June 2011

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Now that you have completed the application process please visit the National Research

Ethics Service website > After Review

You are invited to give your view of the service that you have received from the National Research Ethics Service and the application procedure. If you wish to make your views known please use the feedback form available on the website.

The attached document "*After ethical review – guidance for researchers*" gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Progress and safety reports
- Notifying the end of the study

The NRES website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

We would also like to inform you that we consult regularly with stakeholders to improve our service. If you would like to join our Reference Group please email referencegroup@nres.npsa.nhs.uk.

11/YH/0181

Please quote this number on all correspondence

With the Committee's best wishes for the success of this project

Yours sincerely



CC
Dr Carol Chu
Chair

Email: Elaine.hazell@nhs.net

Enclosures:
Copy to:

"After ethical review – guidance for researchers"
Nigel King, University of Huddersfield

Ms Linda Dobrzanska, NHS Leeds Community Health Care

Appendix 11: Survey of Occupational Therapy Practice in Child and Adolescent Mental Health



Occupation-based Practice in Child and Adolescent Mental Health

Page 1: Welcome - A Survey of Occupational Therapy Practice in Child and Adolescent Mental Health

You are invited to take part in a research study. The research is being conducted using an online survey and should take you no more than 20 minutes to complete.

This survey should be completed by those registered with the Health Professions Council as an occupational therapist (even if you are not working in an occupational therapy specific post) and working with children and young people with mental health difficulties.

Before you decide whether to take part it is important for you to understand why the research is being done and what it will involve. Please take time to read the information on this and the next page carefully.

Ask if there is anything that is not clear or if you would like more information, contact details for the researcher are on the next page.

Please take time to decide whether or not you wish to take part.

Please only take this survey once. You are asked to complete all questions however there is the option to not to answer any question.

Page 2: Participant Information

What is the purpose of the study?The purpose of the study is to gain an understanding of occupational therapy practice in child and adolescent mental health in the United Kingdom.

The research is being completed as part of a PhD at the University of Huddersfield.

Why have I been invited to take part? And what do I have to do?There are several possible reasons why you may have been asked to take part: - All occupational therapists who are members of the College of Occupational Therapists Specialist Section for Children, Young People and Families and specialist section for Mental Health who have indicated they work in child and adolescent mental health have been invited to take part. - As not all occupational therapists are a member of a specialist section we have asked those that are to share this link with colleagues. - The link to this questionnaire has been advertised in OTNews.

Do I have to take part?It is up to you to decide whether or not to take part. You are free to withdraw at any time and without giving a reason. If you have completed the survey anonymously it will not be possible to remove your data from the research.

What are the risks and benefits of taking part?There should be no risks to you if you chose to take part in the study. The study will generate knowledge about the occupational therapy profession and influence future education, training and research. The results may assist personally in developing your own practice and planning future occupational therapy services to benefit children, young people and families.

Will my taking part in the study be kept confidential?You can participate in the survey without providing any contact details. If you wish to be considered for the second phase of the research or want to receive a copy of the study results you will need to provide contact information. Any contact information collected from you during this research will be kept secure and any identifying material will be separated from your responses in order to ensure your anonymity. All data will be kept securely in a locked cabinet or stored on a password protected computer. Data collected from the questionnaire will only be accessed by Rob Brooks, Dr Sue Peckover and Dr Ruth Deery at the University of Huddersfield. All data will be securely stored for 5 years after the end of the study at the University of Huddersfield.

What will happen to the study results?The overall results will form part of a PhD thesis which once finalised will be stored in the University of Huddersfield Library. It is anticipated that the results will be published in a journal or presented at a conference, your anonymity is still guaranteed. You can receive a summary of the results if you would like one.

Who has reviewed the study?The study has been reviewed and approved by the School of Research Ethics Panel at the University of Huddersfield and the NHS Research Ethics Committee.

What is there is a problem?If you have any concerns about the study please contact the researcher who will do their best to answer your questions. If you have any complaint about the way you have been dealt with during the study you can formally complain by contacting the Director of Centre for Health and Social Care Research, Professor Annie Topping on 01484 473 974 or a.e.topping@hud.ac.uk.

Contact detailsIf you require further information about this study please contact the researcher:Rob BrooksSchool of Human and Health SciencesUniversity of HuddersfieldQueensgateHuddersfieldHD1 3DHU0871644@hud.ac.uk07790272750

Page 3: Consent

Please read and answer all questions before continuing with the survey.

1 I confirm that I have read and understood the participant information. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.

- Yes
- No

2 I understand that my participation is voluntary and that I am free to withdraw at any time, without giving reason.

- Yes
- No

3 I agree to the use of anonymised quotes in publications

- Yes
- No

4 I agree to take part in the study

- Yes
- No

Page 4: Information about you

Note that once you have clicked on the CONTINUE button your answers are submitted and you can not return to review or amend that page

5 What gender are you?

Female

Male

Prefer not to answer

6 Is the name occupational therapist in your job title? If no please select other and state your job title (e.g. CAMHS practitioner)

Yes

Prefer not to answer

Other

6.a If you selected Other, please specify:

7 What Agenda for Change banding are you? If you are not under Agenda for Change please select other.

7.a If you selected Other, please specify:

8 How many years have you been qualified as an occupational therapist?

9 What area do you work in?

CAMHS Tier 2

CAMHS Tier 3

CAMHS Tier 4

- Prefer not to answer
- Other

9.a If you selected Other, please specify:

10 What occupational therapy qualifications do you have?

- Diploma
- Degree
- Pre registration masters
- Post graduate diploma
- Post graduate masters
- Doctorate/PhD
- Prefer not to answer
- Other

10.a If you selected Other, please specify:

11 What additional specialist qualifications do you have? (such as a post graduate diploma or masters)

- None
- Play therapy
- Family therapy
- Cognitive behavioural therapy
- Prefer not to answer
- Other

11.a If you selected Other, please specify:

12 What additional training do you have? (such as short courses or training)

- None
- Theraplay
- CO-OP
- EMDR
- CBT
- Sensory integration therapy
- Learn to play
- Prefer not to answer
- Other

12.a If you selected Other, please specify:

Page 5: Information about your practice

13 Can referrers (GP's, colleagues etc) specifically refer for occupational therapy in your service?

Yes

No

Prefer not to answer

13.a Please provide further details.

14 What frames of references/models/theories do you use to help guide your practice?

- Model of Human Occupation (MOHO)
- Generic CAMHS
- Canadian Model of Occupational Performance (CMOP)
- Psychodynamic frame of reference
- Cognitive behavioural frame of reference
- Lifestyle Performance Model
- Neurodevelopmental
- Sensory Integration
- Occupational Performance Model
- Rehabilitation
- Kawa (River) Model
- Person-Environment-Occupation Performance Model (PEOP)
- I do not use any
- Prefer not to answer
- Other

14.a If you selected Other, please specify:

15 What assessment tools do you use? (regularly means with most clients and occasionally means with some clients)

	Do not use	Use occasionally	Use regularly	Prefer not to answer	Other	If you selected Other, please specify:
Conners Rating Scales	<input type="radio"/>	<input type="text"/>				
Movement ABC	<input type="radio"/>	<input type="text"/>				
Sensory Profile	<input type="radio"/>	<input type="text"/>				
Occupational Self-Assessment (OSA)	<input type="radio"/>	<input type="text"/>				
Child Occupational Self-Assessment (COSA)	<input type="radio"/>	<input type="text"/>				
Vineland Adaptive Behaviour Scales	<input type="radio"/>	<input type="text"/>				
Canadian Occupational Performance Measure (COPM)	<input type="radio"/>	<input type="text"/>				
Child Initiated Pretend Play Assessment (ChIPPA)	<input type="radio"/>	<input type="text"/>				
Becks Depression Inventory	<input type="radio"/>	<input type="text"/>				
Perceived Efficacy and Goal Setting System (PEGS)	<input type="radio"/>	<input type="text"/>				
Children's Global Assessment Scale (CGAS)	<input type="radio"/>	<input type="text"/>				
Strengths and Difficulties Questionnaire	<input type="radio"/>	<input type="text"/>				

Occ. Circumstances Assessment Interview Rating Scale	<input type="radio"/>	<input type="text"/>				
Other	<input type="radio"/>	<input type="text"/>				

16 What interventions do you use with children, young people and families? (regularly means with most clients and occasionally means with some clients)

	Do not use	Use occasionally	Use regularly	Prefer not to answer	Other	If you selected Other, please specify:
Play therapy	<input type="checkbox"/>	<input type="text"/>				
Non-directive play	<input type="checkbox"/>	<input type="text"/>				
Cognitive behavioural therapy	<input type="checkbox"/>	<input type="text"/>				
Talking therapy	<input type="checkbox"/>	<input type="text"/>				
Family therapy	<input type="checkbox"/>	<input type="text"/>				
Sensory integration therapy	<input type="checkbox"/>	<input type="text"/>				

Cognitive Orientation to Daily Occupational Performance	<input type="checkbox"/>					
Psycho-educational	<input type="checkbox"/>					
Lifestyle Redesign	<input type="checkbox"/>					
Coaching	<input type="checkbox"/>					
Relaxation	<input type="checkbox"/>					
Eye Movement Desensitisation and Reprocessing (EMDR)	<input type="checkbox"/>					
Group work, please specify types/names of groups	<input type="checkbox"/>					
Other	<input type="checkbox"/>					

17 Please give two examples of a common/frequent aim or goal to your therapeutic work? Please leave blank if you prefer not to answer

[+ More info](#)

18 Occupational therapists often get asked what they do. How would you describe your role to someone new to your team? Please leave blank if you prefer not to answer.

Page 6: Survey results and future research

This results of this survey will be used to understand what occupational therapists working in child and adolescent mental health do. There is a second stage to the study; the researcher will be examining clinical practice in more depth with a limited number of occupational therapists. This would involve the researcher spending time with you and your team. This part of the research has also been approved by the NHS ethics committee. Please indicate below whether you would like to be contacted to discuss being involved in the second stage of the study. If you agree please supply contact details. Your contact details and answers to this survey will be kept separate.

If you would like to receive a copy of the results of this survey please indicate this in question 20 and provide your email or mailing address.

19 Do you consent to being contacted to participate in the second stage of the study?

- Yes
- No

19.a If yes, please provide contact details (email, phone number or address)

20 Do you want to receive a copy of the survey results? If yes please provide your email or mailing address.

- Yes
- No

20.a Contact details

Appendix 12: College of Occupational Therapists Specialist Section for Children, Young People and Families Newsletter study recruitment letter



Child and Adolescent Mental Health - Survey of OT Practice

I am an occupational therapist completing my PhD at the University of Huddersfield and I would like to invite you to participate in an online survey of clinical practice.

The survey is for occupational therapists working with children and young people (5-18yrs) with mental health difficulties. It is hoped that the survey will help us to better understand what occupational therapists are doing and how we help the children, young people and families that we see.

The survey is confidential and anonymous and has NHS ethical approval.

You have been asked to take part because you are a member of the COTSS CYPF. I would like as many OT's as possible to complete the survey so that the outcome is useful to our work as occupational therapists; please forward the survey details onto your colleagues so that they can take part too.

For full details and to access the survey please go to: www.survey.bris.ac.uk/hud/otcamhs

To ensure no cost to your organisation you are requested to complete your survey in non-salaried time.

With thanks in advance
Rob Brooks



Research Opportunities

British Academy of Childhood Disability – Strategic Research Group membership

The British Academy of Childhood Disability has a Strategic Research Group which aims "to encourage debate and promote research into the many outstanding questions in childhood disability". The Strategic Research Group (SRG) was formed with the following aims:

- To identify and encourage high quality clinical research in childhood disability in Britain; in particular collaborative multi-disciplinary projects.
- To encourage and assist people in the field, including families, young people and clinicians, to identify research priorities.
- To facilitate and support the development of major research applications to Wellcome, Medical Research Council, National Institute for Health Research and national charitable funding bodies.
- To encourage young clinicians, with research aptitude, to pursue an academic career path.

An opportunity has become available for an occupational therapist to join the strategic research group which meets three times a year at different locations. If you are interested please contact: Terry.Pountney@nhs.net

www.bacdids.org.uk

WANTED

The COTSS CYPF, currently have vacancies for

CLINICAL ADVISORS

This is an exciting CPD opportunity for individuals to directly contribute to the future of our profession and the client group we work with. Commitment is variable with 1 to 2 meetings per year and we are looking for advisors with a range of skills including:

Cerebral Palsy, Learning disability, DCD, Sensory Processing, ASD, Community, Acute, Early Years, Neurology, ABI, CAMHS and Neonatology.

Input is varied and can include the following:

Roles relating to COT & the SS

- To promote the work of CYPF, linking with OT's locally and regionally working within the same clinical field;
- Support individual members by responding to enquiries (via clinical practice sub-group)
- Act as a respected voice within the profession;
- Act as expert (this is taken as read if you are an approved advisor) but be clear of limits of knowledge/expertise;
- Link with the clinical forums coordinator and regional groups coordinator regarding training opportunities;
- Communicate with COT regarding service developments and priorities in collaboration with the specialist section.

Roles relating to Government and Policy

- Contribute to Government consultations in collaboration with the specialist section. Clinical advisors may be involved in responding to consultations at the request of the specialist section or relevant COT officers. The appropriate NEC officer will coordinate the responses and production of the final specialist section response in collaboration with the clinical advisor.
- Be proactive in influencing the development of Government and other organisations' policy.
- Influence service development, workforce development, clinical effectiveness and R&D;
- Represent the profession on national bodies and act as a respected voice.

Roles relating to Research & Development

- Keep up to date and develop a wide knowledge of evidence based practice within your area of practice/expertise.
- Support the Education & Practice subgroup in introducing evidence based practice through for example, the dissemination of information, writing in the Journal, and identifying training needs for the profession;
- Link with R&D developments both within OT and more generally within the field;
- Influence the SS - Children Young People and Families, R&D agenda.

For further discussion please contact our Clinical Advisors Link - Amanda Davie
info@scvof.co.uk

Appendix 13: OT News Recruitment

RECRUITMENT OPPORTUNITIES

Survey of OT practice

I am an OT completing my PhD at the University of Huddersfield and I would like to invite OTs working with children and young people, aged five to 18 years old with mental health difficulties, to participate in an online survey of clinical practice.

It is hoped that the survey will help us to better understand what OTs are doing and how we help the children, young people and families that we see.

The survey is confidential and has NHS ethical approval. For full details and to access the survey please go to: www.survey.bris.ac.uk/hud/otcamhs. If you have completed the survey through your COT specialist section, you do not need to complete it again.

The survey will be open until 1 July 2012. Rob Brooks, email: U0871644@hud.ac.uk

Regarding the use of lycra garments for children with Cerebral Palsy

I am interested to know what assessments are made prior to recommendation of a lycra garment. Are there particular groups of children who would be recommended? What firms do therapists use? Who funds the garments? Is there any research showing evidence of benefits?

Contact Paula Rothwell, advanced paediatric OT by email: paula.rothwell@sept.nhs.uk or tel: 01234 310278.



Literature scope

Dr Priscilla Harries, as part of a team at Brunel University, has been awarded a Joseph Rountree Foundation Grant to scope the literature related to 'Risk, trust and relationships in an ageing society' (March to June 2013).

With the development of 'personalised' services, the boundaries between formal, semi-formal and informal relationships may become blurred. New semi-formal and informal roles and relationships are being established between people who need care and those who provide it.

The boundaries between roles may become opaque, with possible attendant risks of abuse or exploitation as opposed to the expected goals of satisfaction and fulfilment. It is important to understand what facilitates trust, confidence and kindness in caring community relationships.

As one way of scoping the grey literature, the team would be very pleased to hear of any local projects or initiatives that focus on trust, risk, community support of wellbeing, within the context of semi-formal and informal caring relationships. Please email: priscilla.harries@brunel.ac.uk with any suggestions.

The use of vocational assessments in OT

We are a team of OTs working in Northern Ireland. We are seeking to compile a database of vocational assessments that would be useful for our clients. Referrals to the condition management programme mainly comprise of mental health, cardiovascular and musculoskeletal conditions.

We are already using several assessment tools relevant to our client group, however we are continually keen to improve our knowledge within this area. We

Interested in FES in spinal cord injury?

Researchers at Southampton and Bournemouth Universities are interested in your views on the benefits, use and barriers to using functional electrical stimulation (FES) in spinal cord injury.

The research is funded by Inspire, a leading spinal cord injury charity. The researchers have carried out focused in-depth research to gain the views of people with spinal cord injury, healthcare professionals and researchers to inform the content of a national questionnaire.

We would like to invite OTs to contribute their views. The findings of the research will be used to inform national research and service development. If you would like to take part in this research the questionnaire (which takes around 15 minutes) can be completed online at: www.soton.ac.uk/fes/ or via post or by telephone. For further details please contact Dr Caroline Ellis-Hill by email: cel111@bournemouth.ac.uk, or tel: 012 02 962173, Dr Maggie Donovan-Hall by email: mh699@soton.ac.uk, or tel: 023 80 598880, or Lisa Tedesco Triccas by email: lt1109@soton.ac.uk

OTs working in children's hospices

We have been recruited to Shooting Star CHASE, a local children's hospice service and a charity supporting families living in western London, Surrey and West Sussex with a child or teenager with a life-limiting condition.

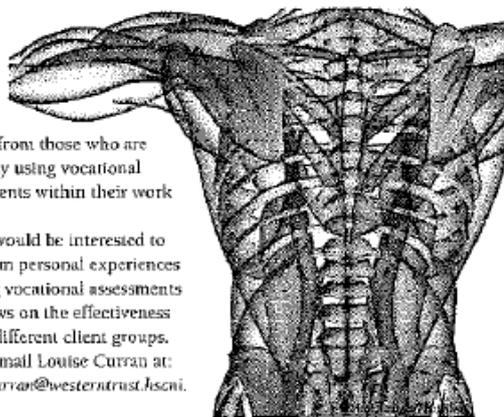
We are keen to build up professional networks in order to share relevant information such as articles, courses, professional opinions, pathways etc. We would be very interested to make contact with any OTs who work within a children's hospice environment, within children's palliative care services, or feel that they have any information and experience that we might be able to share together and learn from, in order to further develop this specialist clinical area.

Contact Kate T El Bizanti by tel: 020 8783 2142 or email: kate.elbizanti@shootingstarhospice.org.uk, or Michelle Watson by tel: 01483 230960 or email: michelle.watson@shootingstarhospice.org.uk



would be grateful to hear from those who are currently using vocational assessments within their work setting.

We would be interested to hear from personal experiences of using vocational assessments and views on the effectiveness within different client groups. Please email Louise Curran at: louise.curran@westerntrust.hscni.net



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