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The implementation of evidence-based change in practice settings is complex and far reaching, but only limited research has been undertaken in this area. This participatory action research study investigated the implementation of the Model of Human Occupation (MOHO) across a mental health occupational therapy service.

Method: The study involved preparatory workshops and 12 months of team-based, monthly group reflective supervision sessions, facilitated by a colleague from academia, with follow-up contact for a further 12 months.

Findings: The main findings emphasise the importance of developing a critical learning space, or 'community of practice', and identify that barriers to theory implementation can be overcome by collective effort with a shared dialectic. The successful development of a community of practice required the careful consideration of a number of interconnected influences, including those of self, peer and facilitator, and contextual and theoretical relationships.

Conclusion: The study concluded that the community of practice was central in supporting the effective implementation of MOHO and its associated assessment tools. A key output of the study is a Participatory Change Process, which illustrates the key steps undertaken and interrelated factors affecting theory uptake. The process requires further testing, but has potential to guide theory implementation in other settings.

Introduction

Government policy over the past 10 years has focused on specifying the capabilities required of all mental health workers (Sainsbury Centre for Mental Health 2001, Department of Health [DH] 2004), rather than the specific contributions of individual professions. The Mental Capacity Act (DH 2005a) and Mental Health Act (DH 2007) have created more permeable boundaries between psychiatry and the allied health professions (DH 2005b, 2007). Although such policy and legislation provides new opportunities for occupational therapy, it also requires greater competence and confidence of practitioners. Contemporary practice is fluid and challenging, requiring practitioners to work with heavy caseloads, in complex and indeterminate situations (Higgs et al 2004). On top of these demands, practitioners must articulate their specific contribution and make explicit their professional knowledge (Higgs et al 2004, Richardson et al 2004, Pettican and Bryant 2007).

A 10-year strategy developed for mental health, *Recovering Ordinary Lives* (ROL) (College of Occupational Therapists [COT] 2006), seeks to keep occupational therapy abreast of new policy and situated at the heart of modern

mental health services. This document calls for development in several areas, including a focus on occupation and adding value to occupational therapy (COT 2006).

Literature review

Occupational therapy literature acknowledges that the profession has some way to go in achieving the vision outlined in ROL. For example, some occupational therapists have abandoned the delivery of profession-specific services, adopting evidence-based techniques from outside the profession in order to receive funding and status (Layard 2004). Elsewhere, practitioners have been viewed as 'gap fillers,' accepting an identity imposed upon them by their workplace (Fortune 2000, p229). Furthermore, significant tension revolves around the appropriate balance of generic skills and profession-specific practice, especially within community mental health teams where consensus regarding the optimal type of casework for occupational therapists has not been reached (see Craik et al 1998, Brown et al 2000, Hughes 2001, Parker 2001, Dunrose and Leeson 2002, Forsyth and Summerfield Mann 2002, Harries and Gilhooly 2003, Pettican and Bryant 2007).

Since the 1980s, conceptual models have been developed to define more clearly and support occupational therapy practice and to generate evidence concerning its value. It is recognised that these models can strengthen practice (Hagedorn 1997, McColl 2003, Forsyth et al 2005), yet practitioners often struggle with, or fail to see, their relevance (Duncan 2006). The demands and constraints of the practice setting, along with therapists' attitudes, are consistently identified in research as major barriers to implementing theory (Van Duesen-Fox 1981, Barris and Kielhofner 1986, Law and McColl 1989, Javetz and Katz 1989, Storch et al 1995, Oxman et al 1995, Dunning et al 1998, Haglund et al 2000, Wye and McClenahan 2000, Walker et al 2000, Metcalf et al 2001, Elliott et al 2002, McCluskey 2003, Brown et al 2005, Lee et al 2008). However, these studies have not investigated in depth or over time what actually happens when therapists are involved in a supported process of incorporating a practice model.

The literature suggests that certain *approaches* might be more effective. For instance, Chard (2000, 2004, 2006) identified the importance of a team or whole systems approach to the implementation and adoption of new knowledge. Descriptions of efforts to support occupational therapy practitioners (Reeves and Summerfield Mann 2004, Forsyth et al 2005, Wimpenny et al 2006, Boniface et al 2008) acknowledge that such team approaches can be effective. Nonetheless, an in-depth study of the processes involved in supporting mental health occupational therapists to adopt a conceptual model has yet to be reported.

The present study is situated in a journey that began in June 2003. An occupational therapy service manager, keen to improve the evidence base and theoretical knowledge of the occupational therapists working across a mental

health trust, organised a study day. Key concepts and assessment tools of the Model of Human Occupation (MOHO) (Kielhofner 2008) were presented and discussed. An evaluation questionnaire completed by all participating therapists indicated that the day had been received positively. Some therapists were already using MOHO; consequently, the therapy manager decided that this would be the model of choice across the service.

It was recognised that implementing MOHO would require an extended professional development effort. What evolved was a collaboration of practitioners, a manager and an educator/researcher working together (IIott and White 2001, Forsyth et al 2005). This study, which was facilitated by the latter, was designed both to support and to examine the process of the implementation of MOHO across the service.

Aims of the study

This study sought to provide evidence of how to achieve an effective partnership between practitioners and academics. Specific questions were:

- How can barriers to theory integration be removed?
- What is the role of an educator/researcher in facilitating practice development?
- What is the impact of MOHO upon therapists' perception of their role and on their practice?

Method

Study design

This inquiry was undertaken as a discovery process, which aimed to enhance practice, to identify factors that enabled success and to document its impact. Participatory action research (PAR) (Reason 1994, Kemmis and McTaggart 2005) was selected as the research methodology because it is uniquely suited to conducting research in the midst of creating change. Ideally, a PAR approach would not impose a model such as MOHO; however, in this situation the participants were aware of the practice issues to be addressed and how MOHO might support this, and were open to the use of action change processes.

PAR is conducted *with* people as opposed to *on* people (Heron and Reason 2001). Participants are encouraged to act as co-researchers, with shared objectives and decision-making powers alongside a primary researcher. The latter's role is to facilitate the group in its work (Reason 1994) and to create opportunities for dialogue (Kidd and Kral 2005). The facilitator must be skilled, supportive and resourceful to assure that power is shared when shaping the vision of the inquiry, its aims, methods and actions (Wimpenny 2010).

The participants within the study were therapists working within the acute, community and older adult services, along with the occupational therapy service manager and the occupational therapy academic, who took the role of primary researcher (referred to hereafter as the facilitator). The number of therapists varied over the course of the study. On average, 15 therapists at a time were involved.

The research methods

The research took place over 2 years, with the facilitator and participants involved in a series of monthly group reflection and action cycles (36 sessions) and a further 12-month period of follow-up. The group meetings focused on addressing barriers to adopting MOHO, re-examining practice in the light of theoretical constructs of MOHO and considering and piloting a range of MOHO assessment tools. These monthly sessions were the only form of *profession-specific* supervision that the therapists received. In addition, each therapist was offered the opportunity to meet with the facilitator at 6-monthly intervals to enable focus on individual perspectives. Furthermore, individual supervision was provided by senior (non-OT) colleagues within the respective teams. This strategy was intended to separate individual management issues from those of professional competency (Sweeney et al 2001).

The PAR process within the monthly meetings involved a cyclical process identified in the PAR literature (McTaggart 1997, Kemmis and McTaggart 2005). Illustrated in Fig. 1, this cycle involves planning, acting, observing and reflecting upon the processes and consequences of change.

Fig. 1. Representation of the action and reflection cycle.
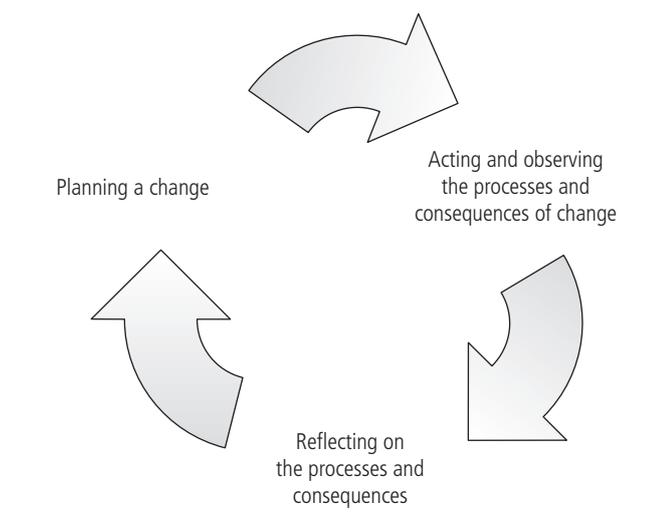
This cycle provided a space for critical discourse, which led to *consciousness raising* or 'conscientisation', a term used by Friere (1970) to denote the ability of participants to use knowledge for their own active efforts. The following exemplifies this process. The community adult occupational therapists were reviewing their assessment processes in light of MOHO. One cycle of reflection and action focused on the initial assessment. The team members first highlighted and reflected upon the assessment methods and styles that were in use. A MOHO assessment tool, the Occupational Circumstances Assessment – Interview and Rating Scale (OCAIRS) (Haglund et al 2001), which can be used as an initial assessment, was introduced by the facilitator. Over subsequent sessions, the tool was considered

and piloted by the therapists, who were supported to reflect in action as described by Schön (1983). Within monthly meetings, therapists shared assessment outcomes and case formulations following their use of the tool. They reflected upon how the assessment was conducted, how ratings were scored, how long it took, how assessment outcomes were shared and how therapy goals were recorded. Those who started using the tool and found it beneficial supported those who were less sure. The outcome of this inquiry cycle led to all the therapists agreeing to use the OCAIRS as one of their initial assessment tools of choice.

Data collection

A variety of qualitative data was collected during the study. With consent, the monthly sessions were recorded and written up reflectively (summary of the session content) and reflexively (acknowledging personal perspective) by the facilitator. The therapists similarly documented their personal reflections of the experience and the data from the individual meetings were transcribed and returned to the participants for annotation.

Data analysis

In PAR, the core of data analysis involves an ongoing scrutiny, debate and discussion by all participants regarding what was experienced as it occurred (Reason 1994). The facilitator took responsibility for documenting ongoing insights and eventually for writing up the findings, but all participants played a role in the data analysis.
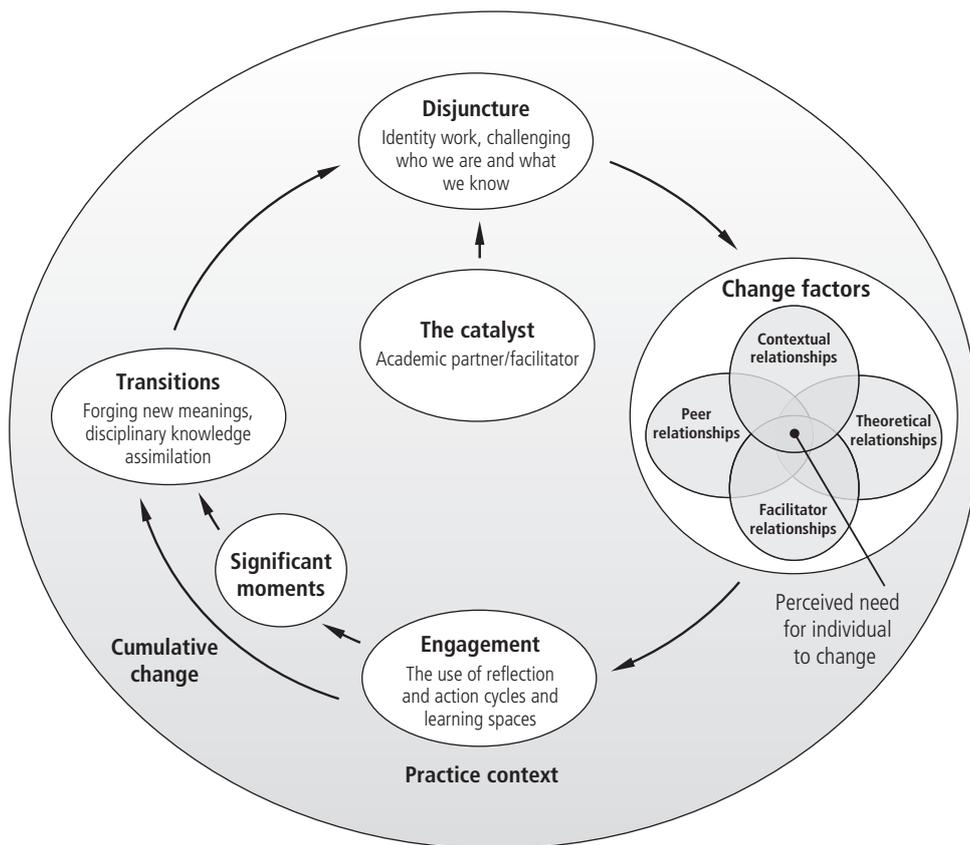
The analytical process involved four phases of reflection and action (Reason 1994, Heron and Reason 2001). Phase one was primarily 'propositional knowing', where the therapists explored their practice in the light of MOHO concepts and their theories-in-use (Argyris and Schön 1974). In phase two, they engaged in action, examining how their practice was or was not illuminated by MOHO theory and also learned from the practice of others. Phase three, identified as the 'touchstone of the inquiry method' (Reason 1994, p43), involved participants shifting their understandings and attitudes; for example, therapists who had previously viewed MOHO as too complex and/or not practical experienced greater understanding. In the final phase, participants considered their original perspectives in light of their experience; many therapists felt a sense of increased confidence in their practice.

Finally, as a means of drawing together the outcomes from the PAR process, and making team-based analysis more explicit, a workshop was organised at the end of the formal period of group sessions. Here, all the therapists were invited to present their individual and team-based perspectives regarding the experience.

Validity procedures

The validity of PAR requires *authentic* engagement by all participants. This means creating a process that both facilitates and protects participants (Cousin 2009, p18). Maintaining integrity for all was considered throughout

Fig. 2. A Participatory Change Process (Wimpenny 2009).

Practice context and external partnerships

The support of the therapy service manager, who viewed the adoption of MOHO as vital in raising the occupational therapy service profile, was important to the initiation of the process. The partnership between education and practice and the situation of the inquiry within the practice setting were key contextual factors, providing the participants with an awareness that genuine efforts were being made to support their practice.

Although there were challenges connected with the involvement of an academic facilitator, this role provided a number of benefits. For example, not being immersed in day-to-day practice issues enabled a more detached perspective from which to observe, reflect upon and structure the ongoing process. The facilitator used strategies developed within one team to support another team's efforts.

by paying attention to the dignity and sensitivities of the therapists, acknowledging the presence of unequal power structures and assuring confidentiality. It was also important that the research process engaged the occupational therapists as active participants and resulted in practical outcomes related to their work (McTaggart 1997).

Ethical approval

The PAR project gained approval from the NHS Trust Research Ethics Board (Ref: CREC 046/03/04).

Findings

The first two questions of this study sought to understand how to remove barriers to theory integration and to illuminate the role of an academic partner in facilitating practice development. The third question asked what kinds of outcome using theory would have. The major findings are the identification of a Participatory Change Process (Wimpenny 2009, illustrated in Fig. 2). This process, grounded in a professional knowledge base (MOHO), allowed participants to rethink and renegotiate their professional identity and to enhance their practice. It required space and time, and involved a number of interconnected relationships and influences. The key features of this change cycle are presented and discussed.

Disjuncture

Disjuncture refers to the 'troublesomeness' of new learning (Savin-Baden 2008, p104). Disjuncture occurred when therapists were challenged to reflect on their identities, considering who they were and what they knew. Even those therapists who appeared positive about the venture at the outset experienced personal and environmental barriers, which had an impact upon their intentions to act. For example, one therapist initially experienced MOHO theory and evidence-based tools as stifling her own and her colleagues' professional creativity:

> I think I don't like being told exactly what to do and what I mustn't do and I'm quite wary of doing that with MOHO because I feel as a clinician I should have reasonable choice.

Another source of disjuncture was the discontinuity between what therapists were learning about MOHO within monthly group supervision and their practice within their teams. For example, therapists who were expected to be generic workers struggled to work out how to use MOHO. As one therapist noted:

> Back in the workplace it was less clear, more isolating, it gets lost somehow.

The process also had the effect of disrupting therapists' working lives. For example, they were not accustomed to having to review and defend their current practice in front of one another. This elicited some negative reactions, such as the following:

> I think some of the initial monthly meetings we had … I didn't find those positive particularly because I wasn't getting to grips with it and I sort of dreaded going until the OCAIRS was introduced and then I started thinking 'well this is what I do anyway' and I got to learn more about the tool – So the beginning ones I didn't find positive.

With time, however, this initial sense of disruption was replaced with new experience; this therapist goes on to note:

> I used to find it a bit intrusive actually to my other proper work, whereas now it feels like it has become my proper work.

As this example illustrated, integrating MOHO initially created a sense of upheaval, yet the disruption served as a catalyst, opening up possibilities to effect change.

Change factors

The PAR process provides a means of problem posing and problem solving that leads to change (McTaggart 1997). In this study, this process focused on the blocks and barriers towards integrating MOHO. Several factors had an impact on that process: self-efficacy and personal agency beliefs, peer relationships, facilitator influences, contextual circumstances and therapists' relationship with MOHO.

Self-efficacy and personal agency beliefs

When undertaking a PAR process, participants' resistance to change can be related to both the complexity of the learning process and to each participant's life and personal 'story' (Savin-Baden 2008, p102). In this study, each participant brought his or her own particular skills, attributes and personal motivations to the process. The individual's response towards implementing MOHO was often linked to previous experience and encounters with theory application. For example, one therapist recalled:

> As a newly qualified OT I worked in departments which were very under staffed and we had lots of agency OTs or OTs that had trained in different cultures and they had quite different theory bases and ways of working and I picked up a lot of that without realising it.

Bandura (1997) maintained that self-efficacy beliefs provide the foundation for change processes. In this study, therapists' self-efficacy beliefs were reflected in how prepared they were to engage in the learning opportunity, including the amount of effort required; many struggled with the process:

> I've actually felt really negative over the past 2 or 3 [sessions] it has been hard. Oh, the last one I nearly didn't come. It is a learning process isn't it. It's not all going to be easy and I do feel the model [MOHO] is beneficial and will work within the teams. It's just getting it going. I've just felt like I've been

whinging all the time. It's how I felt and it's been really difficult to be positive about it.

It was also evident that therapists' self-efficacy changed over time. It was common that participants experienced dissatisfaction and disjunction in applying MOHO before progressing to more positive responses. For example, another therapist noted:

> It wasn't easy at first and I thought people where doing more than me. And they are full time as well and I'm not. So I think I felt quite isolated. But because I am happier with the tools I am finding it easier to contribute now. I certainly didn't feel like that before though, so I was a bit reluctant to feed back my work because I wasn't confident about my goals.

Peer relationships

PAR aims to open up a space for participants to communicate and share mutual understandings. However, this happens only if participants want and feel able to share their views. Developing a new perspective was not a comfortable process and most therapists felt unease and discomfort in having to confront their own practice publicly with colleagues. Developing a dialogue between participants was both a challenge to and an opportunity for change, as has been previously asserted by Savin-Baden and Wimpenny (2007). In this study, dialogue was encouraged by constantly reflecting on and adjusting the structure, purpose and value attached to supervision, illustrated below:

> The challenges of group supervision are that now it's more structured and we've identified what we are going to do. So when I've said I'm going to do something, it's a case of I can't be generic, I've got to do my part. In a way it's making me more of an OT. That's good.

It was also imperative to establish a non-judgemental peer-group environment where an honest range of views could be shared. However, feelings and dynamics aroused in the groups were complex where there were multiple layers of relationships, in concurrence with Winship's and Hardy's (1999) and Finlay's (1993) observations. Facilitating dialogue was a gradual process. There were no short-cut solutions.

In time, the monthly group sessions came to be viewed as an important means of support. A number of individuals acknowledged that without the monthly meetings, their commitment to the venture would have 'fizzled'. Furthermore, it was evident that observing others engage led to personal decisions to act. As reflected in the following comment by one therapist, peer relationships served to keep up group momentum:

> I think we all egg each other on. I think we all have mixed feelings at different times, someone will be quite positive about MOHO and there will be others for whom it's not going well or it doesn't seem as relevant …

A final indicator of the value of peer relationships was that a number of therapists began meeting on their own outside monthly sessions.

Facilitator influences

An important responsibility of the facilitator was achieving the right balance between incorporating and imposing knowledge. This required respect for the therapist's professional knowledge and ensuring that the monthly sessions were not purely pedagogical and centred around a predefined set of activities. The facilitator needed to be mindful to empower *participants* in the decision-making process. For instance in the discussions, everyone's practice was under the spotlight and it was possible for therapists to feel vulnerable. Thus, she had to walk a fine line to move the agenda forward while supporting therapists. The complexity of this process is illustrated in the following reflexive field note:

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

It was also important that the facilitator did not push participants to 'learn too fast', as Cousin (2006, p143) cautioned. For example, it was easy to become disheartened when individuals agreed to do something but did not follow through. Thus, a more circumspect consideration of individuals' behaviours was required. Often, therapists would become discouraged or reluctant for very real reasons. The following reflection by one therapist illustrates how complex the process was:

> I think it's the naturalness of when you first use the assessment and I feel that it can prevent you building up your rapport with the person you are working with. So I thought about using the tool more flexibly and I did the OCAIRS with a young guy and I transferred all the questions onto cards so it was more user friendly, it didn't look complicated, and I asked the questions from the cards; I explained it to him and that was fine. He was very responsive to the questions, though the outcome was that really he didn't want to change and I think that kind of put me off again.

In this instance, the therapist developed a creative way to administer the OCAIRS, but perceived the process as a failure because the assessment revealed the client's reluctance to change. In this case, it was important to validate the therapist's reaction, while also working through the idea that the point of the assessment was to discover where the client was; the client's reluctance to change was therefore an important outcome and such information could be very useful to treatment planning. Taking the time to sort out such issues with therapists was a key role of the facilitator.

Contextual circumstances

The influence of context was substantial. Therapists, who already felt burdened with competing agendas, initially viewed MOHO as yet another pressure. Sometimes the demands of using MOHO conflicted with therapists' role definitions. For example, adopting MOHO challenged the generic practices of those working as case managers. To some extent, MOHO required everyone to reconsider their professional identity and question their own commitment to professional values, as reflected in the following therapist's musings:

> I didn't really have anything to tell me that I wasn't acting as an OT before … now at meetings I sit there catching myself thinking well we wouldn't have done that, we won't sign up to that, that's not in line with MOHO thinking … now I would sit there and say well obviously that needs developing but it's not within our role to do it.

It was vital that the organisational difficulties that the therapists experienced were heard by the facilitator and discussed as a context for change, as recommended by Hunter and Blair (1999).

Therapists' relationship with MOHO

Reactions to theory are always influenced by the congruence of the theoretical concepts with assumptions and values that one already holds (Richardson et al 2004). Some therapists initially viewed MOHO as alien and conceptually difficult to understand. As Meyer and Lands (2006) noted this is often the reaction to new concepts. Some viewed MOHO concepts as belonging to the world of 'the academy', rather than useful in their day-to-day work, a reaction that Usher et al (1997, p122) have also commented on. Even therapists who found MOHO useful sometimes felt ambivalent toward it:

> My reactions to MOHO are mixed really. I think it is a good idea that can improve practice. I think it can support me in justifying what I do and give me a professional language and make me work more professionally. That's on the positive side. I suppose on the other side I think it is very time consuming and just occasionally I think that I'm really not sure about it all. Sometimes I've felt we were just making too much of it.

Despite initial misgivings, the therapists came to appreciate the relationship of theory to their practice. As noted by Guba (1990) and Roberts (2002), this process takes time and sustained effort. Therapists needed opportunity to identify, share and discuss their fundamental concerns. They needed to reflect upon their identity and beliefs.

Over time, MOHO came to be viewed as an indispensable resource, but the process of knowledge assimilation was complex. Although the aim of the process was for the therapists to master an understanding of the MOHO concepts and tools, what emerged was a kind of deconstruction and reconstruction of the theory. This allowed the therapists to personalise and integrate MOHO. The therapists needed to exercise autonomy to use MOHO knowledge as they deemed appropriate: to modify and adapt it in order to meet both their human and practice needs. This process of personalisation and integration has been noted by previous

authors (Higgs et al 2004, Richardson et al 2004). As Bandura's (1989) theory of self-efficacy suggests, practitioners who did not feel restricted by MOHO but were able to feel self-determined, had greater interest in expanding their knowledge of MOHO.

It was interesting to note this fusion of personal stance and MOHO. Although practice focuses on expert knowledge and professional competency, the way in which a practitioner delivers such practice is a highly personal art form (Andresen and Fredericks 2001). This need to personalise practice theory should not be underestimated.

Engagement

Being active learners who could explore and examine their practice critically was key to this process. At first, learning was primarily facilitated by the monthly group sessions. Over time, when therapists began to implement MOHO concepts and tools, the work setting became an important source of learning. As noted by one therapist:

> Getting to grips with the model needs to be considered during therapeutic decision making and that needs to be backed up by ongoing supervision and opportunities for us to talk to each other … you know, it's about developing a culture.

Learning to implement MOHO was not purely an individual cognitive task; it involved participation in *social practice*, as noted by Lave and Wenger (1991). MOHO and the assessment tools offered opportunity for the therapists to explore collectively and challenge their previous assumptions and practices. This questioning of the participants' therapeutic reasoning encouraged the kind of critical approach to theory and practice relationships advocated by Carr (1986).

Wenger (1998) asserted that the relationship between theory and practice is always complex and that practice is not a mere realisation of theory. Putting MOHO into practice was challenging, but was facilitated by the collective intelligence of the therapists working together. Attitudes and values towards professional theory became a collective issue addressed by the community.

Significant moments/cumulative change

As already noted, MOHO challenged therapists to rethink their identities and roles and the importance of occupation-focused practice. For many, this meant recognising that their previous practice was less than desirable, as identified within the following reflection:

> If there was someone off … and there will be 8 or 10 [service users] sitting by themselves I'll do a group and it's wrong in some ways. But I've always wanted to fit in. I think that's what's caused the problems. People see me as a generic team member because I haven't stuck up for OT. I am starting to question 'is it OT'? Is it occupation-based? Will it move my patients forward?' Things are starting to change, so I can go home at the end of the day and feel what I did was good, what I did was OT, as opposed to what I did was good but where was the occupation?

Some participants experienced significant moments that proved to be turning points. For example, in one of the group sessions, a therapist openly acknowledged how negative she had felt towards change. She realised that amongst other things, she had resisted changing because of her unstated fear that she lacked confidence in her clinical skills. After she faced this reality, she was able to refocus and use MOHO and the group process to improve her skills. Such moments are what Denzin might refer to as a transformational experience or an 'illuminative epiphany' (2001, p37).

For others, change was more cumulative. The cycles of reflection and action provided the participants opportunity to become increasingly aware of the constraints that prevented them from practicing in a more occupation focused and evidence-based way. MOHO came to be viewed as a means of problem solving practice dilemmas and mobilising and informing their decision-making:

> It's totally changed the way that I look at people now because I'm focussed on what's important to them but also how they've coped in the past. Now I use MOHO knowledge. There are a few issues that I wouldn't have picked up before. So I'm just thinking differently. My perspectives on practice have changed … since we started using the assessments. I feel more confident in having the theory and … more able to articulate things knowing I have got that knowledge behind me. I now feel more confident and I can actually go out and come back to the MDT and say I've been able to complete my assessment.

A combination of persevering to overcome practice barriers, coupled with seeing others connect with MOHO, prompted certain therapists to confront tensions surrounding their own practice. Although not easy situations for individuals to deal with, witnessing turning-points prompted each group member to re-evaluate their own sense of self, in terms of practice, beliefs, meanings and, ultimately, of their own professional identity.

Transitions

Shifts occurred as the therapists forged a new kind of practice. As one therapist noted, these shifts were not only in how therapists perceived themselves but also in how others saw them:

> There have been lots of shifts, for example the tools we use, definitely there is an OT focus now, which is very clear in our minds as an OT group. There is some shift from a multidisciplinary team perspective in having more respect for us and what we do. This has been evidenced in people's relationships and people's perceptions of OT. Within the medical team this has been evidenced in team meetings and requests for OT to have more input. There is also feedback in terms of our assessment, which has been very positively commented upon, they like the assessment process.

Uncovering, challenging and reconstructing the therapists' working knowledge for practice through MOHO was empowering. In addition to providing a renewed energy and focus for their work, it also provided them with a sense that

they had something valuable to offer that should be shared with others. For instance, one therapist noted:

> I took the flow chart in to the meeting as it showed how the [MOHO] assessments were all set out. None of the other wards or teams have anything like it and that was seen to be quite impressive.

> I am so much more able to say things; I've been really pleased that I know what I am talking about without stating that it was just a preference. I've thought that's so unexpected from an OT.

As therapists began to practise differently, they could see the impact of their change upon others (for example, service users and multidisciplinary colleagues). Thus, implementing MOHO theory into practice became an ongoing, self-reinforcing process.

Discussion

This study sought to shed light on how therapists could be supported to adopt a theory-based approach to practice and what the outcomes would be. The study findings were presented as a Participatory Change Process (Wimpenny 2009). The results suggest that a partnership involving practice management and academic research can effectively lead therapists to adopt theory and advance their practice. The findings also highlight that, while integrating MOHO into practice has certain challenges, it also has tangible and lasting benefits.

The findings also indicate that barriers to theory implementation can be overcome by a collective effort with a shared dialectic. It requires considerable commitment, care and persistence. In this study, there were peaks and troughs within the partnership and careful attention was required to assure that relationships among the involved parties prospered.

The study also highlighted how learning in a community enables knowledge to take on greater significance and be sustained. Such learning is a social process, aptly highlighted by McDermott (1999, p17):

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

Finally, the impetus for this study, to choose a service-wide model, was in part driven by the need for the profession to establish its identity and clarify its contribution in the current health care marketplace. The findings underscore the fact that advances in the profession sometimes require a more collective or corporate approach (Boniface et al 2008), in which professional members come to use a shared language along with a common toolbox of structured assessment tools and intervention resources.

Conclusion

Many of the findings of this study are likely to be transferable to other settings. Nevertheless, it is important to recognise that the study findings represent the process of a particular setting and the participants. Further research in other contexts will be needed to determine which aspects of the process described in the findings are universal.

Key findings

- A community of practice can support the implementation of professional theory such as MOHO.
- The development of a community of practice can provide a necessary learning space and opportunity for occupational therapists to critique and challenge their respective ideas and beliefs about professional perspectives.
- Participatory action research (PAR) strategies provide a powerful and evolving learning process and opportunities to change practice through collective wisdom.

What the study has added

Partnerships between occupational therapists working across education and practice are vital and need to progress in order to ensure a cross-fertilisation of ideas with regard to theory and practice relationships.

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