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Maintaining occupation-based practice in Australian mental health services: A critical stance

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Abstract

Introduction: This paper explores the way dominant discourses, and their associated practice knowledge dimensions shape personal paradigms, and occupation-based practice in mental health workplaces.

Methods: Narrative inquiry methods and narrative thematic analysis was used to explore the career stories of nine occupational therapists who had worked in mental health practice for more than five years.

Findings: The main narrative themes to emerge were i) living with the biomedical practice knowledge discourse, ii) living with the psychological practice knowledge discourse, and ii) reflection as a strategy for maintaining occupation-based practice. These discourses created the need to reflect on practice and adopt strategies to avoid the marginalization of occupational perspectives, and occupation-based practice. The strategies used to cope with these discourses varied from acceptance and embracing of other discourses to resistance and rejection.

Conclusions: This paper demonstrates that in some mental health workplaces there is a danger that occupational perspectives and occupation-based practice can become marginalized. Making visible the different discourses in mental health practice allows occupational therapists to analyse, better understand and live with the tensions in their professional lives. This requires professional support strategies to be in place, to maintain occupation-based practices and retain practitioners in the workforce.

Introduction

Occupational therapists in mental health practice face challenges to their professional identity as they work alongside colleagues with differing perspectives of wellness (Ashby, Ryan et al. 2013). The influence of different perspectives often leads to difficulties in enacting occupation-based practices (Lloyd, King et al. 2007; Scanlan, Still et al. 2010). These difficulties create the need for further debate about ways to support practitioners in mental health practice to ensure the enactment of the professional paradigm and occupation-based practices (Gillen and Greber 2014).

This paper draws upon Foucault's (1980) concept of competing discourses to explore the impact of the competing biomedical, and psychological practice knowledge discourses on occupational therapists' personal paradigms and their practical actions in mental health practice. Foucault argued that discourses are the "languages, representations and practices that consist of a set of assumption that, although rarely consciously recognized, provide the basis for fields of knowledge" (Mackey 2007 p.97). This paper also considers the relationship between knowledge, power and practice associated with different disciplines and professions, and the power relationships within organisations. Foucault (1980) used the term 'power/knowledge' to connect knowledge and power with the identity configurations associated with disciplines and professions. He was particularly interested in historical analyses of the ways in which particular discourses become dominant, and the power dynamics operating, in these processes. Thus, the status and dominance of a discourse is the product of power relations. This stance acknowledges the ways socioecological influences, such as educational, social, policy and managerial discourses and their translation into service delivery methods may shape an individual's professional practice and identity (Ashby, 2013). In addition this approach shifts attention from perceived individual practitioner inadequacy to a broader perspective that distinguishes the impact of these discourses. This is a key step

because there has been little exploration of how occupational therapists' practice knowledge in personal paradigms and actions are shaped by these discourses (Kinsella and Whiteford 2009).

Within occupational therapy, Mackay (2007) has described the way Foucault's ideas can be utilised to challenge taken-for-granted assumptions about professional practice and the processes 'through which the dominant discourses about the occupational world come into play' (p. 97). In the current paper the occupational therapy profession's central assumption that wellness is shaped by a person's engagement in occupation is referred to as the *occupation perspective discourse* (Whiteford and Wilcock 2001). In turn, *occupational issues* arise when personal, or environmental factors restrict a person's engagement, or performance in their chosen and required occupations. For clarity within this paper the term ***occupation-based practice*** draws on Fisher (2013) and McLaughlin Gray's (1998) work on 'occupation as both a means and ends of enabling service-users to participate in the occupations, they need and want to do. Thus, *occupation-based practice in mental health settings* refers to practices where a practitioner uses occupation-based evaluation methods including 'performance and task analyses' and uses occupation as 'the therapeutic agent of change' (Fisher, 2013. p.164). While occupation-based evaluations may increase understanding of the performance components that impact on occupational performance, such as processing skills and other underlying personal factors, occupation-base practices involve engaging a service-user 'in-vivo', or real-world 'doing', with occupation as the principle therapeutic modality *which alongside environmental and occupational adaptations fosters the change in performance*.

Background

Björklund (1999) argued the formation of a personal paradigm is shaped, not only by the occupational therapy professional paradigm but also through the interplay of practice knowledge and social contexts encountered during careers. Thus, the presence of competing discourses in workplaces is likely to shape personal paradigms practice if practitioners draw on associated sources of knowledge (Kinsella and Whiteford 2009). In addition, when practitioners advocate occupational perspective discourses of wellness and the enactment of occupation-based practices this stance may be at odds with more prevailing discourses. Indeed, an earlier study of Canadian occupational therapists working in community mental health day program services found that practitioners 'good intentions' to enact occupation-based practices are overwhelmed by dominant discourses (Townsend 1998). There are also issues facing minority professions in community-based interprofessional teams as they encounter the greatest challenges to their professional identity (Larkin and Callaghan 2005). This is because they have limited professional socialisation, which is a protective factor in maintaining professional resilience and professional identity (Scanlan, Still et al. 2010; Ashby, Ryan et al. 2013). This of concern because the majority of occupational therapists in Australian mental health practice are employed in community-based interprofessional services (Ceramidas 2010).

Within Australia, mental health services are biomedically-oriented with service delivery methods reinforced through the enactment of various Mental Health Acts (Rickwood 2004). Rickwood argues the dominance of biomedical-oriented services in Australia has created problems in the implementation of recovery discourses despite its support by policy and legislation (Australian Health Ministers 2003; Rickwood 2004). This is reflected in the experiences of Australian occupational therapists who

face simultaneous demands to integrate biomedically-oriented practices into case management, along with discipline-based occupational perspectives (Lloyd, King et al. 2004). In addition, previous studies indicate occupational therapists draw on psychological practice knowledge discourses and adopt therapies and techniques in their mental health practice (Bartlow and Hartwig 1989; Haglund, Ekbaldh et al. 2000). However, there is little critical evaluation of ways adoption of these forms of practice knowledge shape occupation-based practices.

This paper aims to explore the practice knowledge discourses practitioners live with in their practice and their influence on occupational-based practices within mental health settings. In doing so it draws on findings from a larger study that sought to understand what shaped the theoretical knowledge valued and used by occupational therapists in mental health practice (Ashby 2013).

Methodology

Recruitment of Participants

Formal ethical approval for the study was granted from the local Area Health Human Ethics Committee and the University's Human Ethics Research Committee.

In this study, purposeful sampling was used to recruit participants from a regional health area in Australia. On receipt of approval from the two ethics committees, the first author sought the assistance from the Professional Leader in Mental Health Occupational Therapy to identify appropriate occupational therapists. The inclusion criteria for recruitment were: Occupational therapists with more than two years' experience in mental health and who had worked in more than one workplace. The rationale for these criteria was to identify practitioners who had consolidated and developed theoretical and skills-based knowledge for mental health occupational therapy practice (Hodgetts, Hollis et al. 2007). It was assumed having experience in more than one workplace would allow participants to compare and

contrast the influence of different workplaces on what theoretical knowledge was valued and used.

Of the 42 occupational therapists employed in the health area at the time of the study 18 occupational therapists met the inclusion criteria. The Professional Leader in Mental Health then provided this list of names and contact workplace email addresses to the first author. All of these practitioners were sent an information statement about the research. Of these 18 practitioners, 9 participated in the study. Prior to data collection, written informed consent to participate in the study was obtained.

Data Collection

The data collected for the larger study were gathered in two rounds of interviews. These interviews involved asking participants for explanations of, and stories about, their professional journeys. The interviewing techniques and questioning style employed were strongly influenced by a single narrative interview question based upon a biographical-narrative style (Wengraf 2001). The intention of these interviews was to provide a forum that encouraged and invited participants' personalized understanding of the topic under study (Holloway and Freshwater 2007). The interviews were audio recorded and verbatim transcripts prepared. Each participant chose or was allocated a pseudonym to maintain anonymity. After each interview, a copy of the transcript was sent to each participant to check the accuracy of the transcript as one method of member checking

Stage One Interviews.

In the first interview, each participant was asked to describe the story of their professional journey; the knowledge used and valued in practice; and to describe what factors influenced how this knowledge was used and valued in different jobs. It also included questions about case-studies to obtain descriptions of the participants'

use of theoretical knowledge and if different workplace conditions had impacted upon this.

The interviews lasted between 120-160 minutes. Participants were asked to reflect on the content prior to the second interview. The data analysis and interpretation began at this stage. The coding of the first round interview led to emerging themes. These themes were discussed and explored further in the stage two interviews.

Stage Two Interviews.

The second interview with each participant sought to clarify and further develop information and data gathered and coded from the first interview. To begin participants reviewed the timeline of their professional journey and commented on their personal reflections. They recounted any changes that had occurred since their previous interview. The interview was an opportunity to use member checking, with participants asked to comment on the accuracy and comprehensiveness of the themes identified from the analysis of the first interviews. The participants were asked to consider the various explanations posited by the researcher. This second interview ranged from 90 to 160 minutes.

Data Analysis

The data analysis began with the completion of the first interview. A computer-assisted data analysis package – N*Vivo9 (QSR) assisted in the storage of the data and in the coding process (Bazeley 2007). Preliminary analysis of data from the first interview formed the basis of the second interview. The data analysis for the broader study considered what had shaped each participant's professional journeys and their use of different forms of theoretical knowledge (Holloway and Freshwater 2007). The analysis of the narrative focused on what was 'told' or reports of events and experiences rather than on aspects of 'the telling' (Mischler 1986). Within the

broader study each episode and mention of theoretical knowledge was coded by the first author. Further interpretation led to coding examples of when power relationships had influenced the valuing and use of theoretical knowledge, or the use of occupation-based practices. Throughout the analysis process the primary author (SA) consulted with the other researchers and this led to using Foucault's (1980) work on power/knowledge to delineate between discourses and to consider power/knowledge relationships. Additional data triangulation about these interpretations of the narratives occurred during the member checking process with participants being asked if they agreed with the initial analysis and interpretation of all the data.

To ensure the trustworthiness and rigour of the study strategies outlined by Lincoln and Guba (1985) were employed these included: prolonged engagement with participants (the engagement with the nine participants extended over a two-year period); and participants' validation of findings through member checks. It also included peer debriefing and audit trails to ensure that the interpretation of data was clear. As noted, after each of the two interviews, each participant received a copy of their transcript for member checking, to verify its accuracy and during the second interview, each participants was asked to comment on the analysis and interpretation of the themes which had emerged from the first interviews

Findings

The description of the findings begins with a description of the participants and progresses to a description of the main narrative themes which emerged from participants' stories which were i) living with the biomedical practice knowledge discourse, ii) living with the psychological practice knowledge discourse, and ii) reflection as a strategy for maintaining occupation-based practice.

Description of Participants

To preserve the anonymity of the nine participants only generic demographic information is included in this paper. As noted in the methodology each person chose or was allocated a pseudonym and this was used to assign ownership of the quotations used in the findings. At the time of the study, the participants who had volunteered for the study worked in a range of work places. This information is described in table 1

Table 1: Participants' mental health settings

Pseudonym	Current service-user group and setting
Alex	Adults – inpatient rehabilitation services
Anna	Adults – community team
Bronwyn	Children and Adolescents - community
Diana	Adults – community mental health team
Eliza	Management – community mental health service
Liam	Adults - –community rehabilitation services
Maria	Adults – , acute in-patient mental health
Megan	Adults – community rehabilitation services
Sarah	Children and Adolescents – community mental health team

Although the criteria had stated a minimum of two years' experience the mean number of years worked in mental health practice was 14.3 years, with a range of 5 – 35 years. As a group, the collective post-graduation experience was 129 years, and they had worked in over 58 work places which contributed to the richness of the data. Six of the participants began their careers in acute in-patient units. Of the nine participants two were male. Each participant held a Bachelor of Applied Science in Occupational Therapy, or a Bachelor of Occupational Therapy from an Australian University but did not have post-graduate qualifications in occupational therapy. Three of the participants had worked overseas since graduation.

It became clear from the data that encounters with the competing practice knowledge discourses of biomedicine and psychology had shaped the participants'

experiences of the mental health workforce. These experiences are described below. The identification of the tensions created by these dominant discourses in mental health practice resonated with all the participants.

Living with the Biomedical Practice Knowledge Discourse

Each participant regarded the biomedicine practice knowledge discourse as necessary for effective assessment of risk and symptom management. Liam described this discourse as “value-added knowledge for case management roles”, when incorporated into practice it underpinned the assessment of risk, symptom management, and treatment. Thus, it often served as a complementary discourse for case management and generic multidisciplinary team membership. As Bronwyn noted:

We work in alliance with the medical model sometimes. The way the service is with community treatment orders [determined by the NSW Mental Health Act] we have to be monitoring people's medication. There's no way around it. We're working with a medical model framework in those instances. But it doesn't mean that's all that you're doing and that's the end of your contact with the person. You might be using something from a number of different frameworks. But that's part of being a health professional, which is part of being an OT.

However, as Alex said, when the emphasis was on the biomedical aspects of service provision it was important to maintain professional identity and valuing of occupational perspectives:

I think the medical model is the opposite [of occupational therapy], it reinforces that the medication is the most important thing – without that everything falls down but I've seen some really unwell people continue to live in the community, but I haven't seen well people without living skills survive very long in the community.

The influence of the biomedicine practice knowledge discourse on occupation-based practices and professional identity was greatest in acute inpatient facilities and community mental health team settings. In these settings, participants

identified that the focus was on the reduction of service-users' symptoms through pharmaceutical interventions. In these settings, while the occupational therapy program and a practitioner's role were appreciated, participants perceived these were devalued and marginalised when prioritised against medical interventions. This resulted in interruptions to occupational interventions, which was perceived as a lack of respect from colleagues. Indeed, these interruptions were described using metaphors of battle and war – as acts of 'sabotage'. As Bronwyn noted:

In the acute unit...there was lots of opportunity to use activity or use occupation and modify the environment and all those sorts of skills...but there was a very biomedical focus in the team overall and I felt like occupational therapy was tacked on.

The six participants who had worked in this environment as their first job noted that the dominance of the biomedical model which was experienced as interruptions to programs along with a perceived lack of respect for occupational perspectives which challenged their professional identity. This reduced their confidence in the use of valued discipline-specific theoretical knowledge and occupation-based practice initiatives.

Maria suggested that new graduates were challenged in this environment because occupational therapists are educated to:

Think creatively, and view a person holistically...by looking at all aspects of that person's being from a psychosocial perspective, an occupational perspective, which doesn't always gel with the medical model.

According to Bronwyn, the main danger to enactment of occupation-based practice in these settings, came because "It's easy for occupational therapists to get sucked into the system". While dual roles as a case manager and occupational therapist created demands on participants, Diana described that she gained more validation from others for her case management work than in engaging in occupation-focused practice. She enjoyed the importance of being central to the management of service-users' symptoms. However, Diana also acknowledged that:

I was doing things differently to other people, so there was definitely an OT focus from me, whether I thought it or not.

In community-based mental health teams Diana described that it was easy for the needs of acutely unwell community-dwelling service-users to be prioritized over rehabilitation oriented, community-based occupation-focused appointments. These genuine needs could cause the postponement of appointments with other service users who needed occupation-based interventions. As Diana noted occupation-based practices could:

Become a bit of a secondary goal a lot of the time. As soon as your caseload increases or the urgency of acuteness of some of the clients increases, then they are the first things to drop off, unfortunately.

Participants noted that community-based interventions took longer to implement than clinic-based appointments because they usually occurred in the community, as they involved engagement and participation in vivo. However, Diana enjoyed working in a community mental health team because she enjoyed the work and the balance of the occupational discourse with the use of biomedical and psychological discourses.

In acute in-patient units, where the biomedicine practice knowledge discourse was at its greatest, the strategy most commonly used by occupational therapists was to move on from the job when another became available. Indeed only Maria had remained in this setting for more than two years because she enjoyed the work and could deal with the tensions, which existed in the workplace. The transitory nature of positions in this challenging setting was often viewed as what Sarah described as “a stepping-stone into community work” where they sought more opportunities for occupation-based practice. In contrast with participants who worked in acute in-patients units as a first job episode, Maria had entered acute inpatient mental health after ten years’ experience of working in a large rehabilitation-focused hospital. Although she reported the same frustrations as the other participants, Maria relished

the battle and had shaped her role to include more time to work on service-users' occupational issues by negotiating for ongoing therapeutic and occupational engagement with service users in the community. She remained in the midst of an acute inpatient unit, resisting the dominant discourse and was prepared "to do battle every day" because she could live with these tensions.

Living with the Psychological Practice Knowledge Discourse

All participants described the dominance of the psychological practice knowledge dimension in their mental health practice. They regarded the dominance of psychology as more of a threat to occupation-based practical actions because the associated therapies offered alternative ways of solving service-users' issues and shaped therapy. In some workplaces psychological discourses determined the therapy used with service-users and practitioners were expected to adhere to particular psychological therapies - this was the case for Sarah and Anna.

The main reason identified by all the participants for the dominance of psychological discourses was the success of the psychology profession in generating a broad research evidence-base, greater than that of occupational therapy. Along with the research base, the adoption of structured therapies also created a more dominant and highly regarded position for psychologists. The pressure to adopt therapies from the psychological discourses came from team members and other occupational therapists. Although these therapies were seen as useful, Diana suggested "the talking therapies can take the 'doing' away from practice".

Participants, such as Bronwyn reflected that a lack of strategies to cope with this incursion could result in the displacement of occupation-based practice. While all the participants noted that they valued evidence-based practice, for the reasons outlined, they often indicated occupational discourses were undermined due to the relative lack of evidence for occupation-based strategies.

The dominance of psychology in professional practice was reflected by occupational therapy professional supervisors' suggesting participants should attend training courses, or adopt these therapies into their practice. In some ways, participants noted it was more difficult to resist adopting psychological discourses when the pressure to use them came from occupational therapy colleagues, especially those in senior positions. The pressure and encouragement from other occupational therapists to use psychological therapies resulted in some participants adopting these to direct and inform their practical actions. This was used at a conceptual level for the analysis and understanding of a service-user's issues and more concretely in consequent practical actions. Sarah noted the pressure was often greatest early in careers:

You know, how sometimes a client on a ward might want to do showering, dressing or something and a colleague says, Can you go and do distress tolerance instead? And, a new inexperienced OT is likely to say, Yeah, yeah okay.

All participants identified that working in community mental health teams often resulted in clinic-based physical environments, which restricted the spaces available for group and individual occupation-focused work. This, along with high caseloads, encourages practitioners to adopting clinic-based psychologically-based therapies over occupation-based practices. Thus, time and space issues created barriers to community-based in vivo activity-based therapies, and other forms of more time consuming occupation-based practice.

Not all the participants had adopted psychology practice knowledge discourses with Alex, Liam and Eliza consciously resisting their use in favour of occupation-based practices. Over time participants, such as Bronwyn and Diana had reflected on their experiences and realised the adoption of psychological theories, particularly when newly qualified, had been to the detriment and neglect of occupational issues. Their adoption had resulted in more talking rather than doing. It was only the increased clinical experiences, and for some, the time to reflect during

the research interviews, that allowed participants to recognise the need for psychological therapies to be adapted more judiciously to ensure they resulted in occupation-based practice.

Participants reflected that these psychological therapies required adaptation to ensure occupation-based practice. However, when they were newly qualified, they had adopted them to the detriment and neglect of occupational issues. Megan noted “We dilute our skills because we’re actually trying to do our job and a range of other people’s jobs at the same time”. This linked with Alex’s assertion that the adoption of psychological theories by occupational therapists required more critical review by practitioners, and the broader occupational therapy profession.

Reflection as a Strategy for Maintaining Occupation-based Practice: A

Strategy for Coping with Competing Discourses

The research interviews offered time and opportunity for participants to reflect on the strategies they had used during their careers to remaining in the workforce.

Participants, such as Bronwyn, reflected that earlier in their careers they had allowed professional occupation-based practice to be lost because they enjoyed the validation of the generic, or psychology-based work they received from other team members. In contrast, Alex and Eliza had fought this and defended the time to implement their discipline-specific occupation-based duties and had not adopted psychological therapies. In acute community mental health settings, practice was a direct translation of mental health legislation and policies, which often directed the focus of practice at biomedical rather than occupational issues. Bronwyn explained:

In that more generic role, the way I formulated treatment plans in my head was always as an OT...but how do you apply new meaningful activities to someone being forced to have a depot injection.

Despite these issues, Bronwyn continued to fight to have occupational therapy accepted as a component of this mental health team because she believed in the efficacy of occupation-based practice.

Discussion

This study reveals the ways the biomedical and psychological practice knowledge discourses can marginalize the enactment of occupation-based practice in some Australian mental health practice. It builds on previous studies (Townsend and Wilcock 2004; Lloyd, King et al. 2007; Scanlan, Still et al. 2010) by highlighting how experiences in the workplace shape the use of theoretical knowledge, professional identities, professional resilience and consequently occupation-based practice.

Practice Knowledge Discourse Dimensions

The study extends the understanding of the ways competing practice knowledge dimensions of practice can shape an occupational therapist's personal paradigm and practical actions in mental health practice. Practice is shaped when occupational therapists consciously, or unconsciously adopt prevailing knowledge discourses and allow them to shape practical actions.

Practitioners appear to regard the integration of the biomedicine discourse, with its focus on symptom management through pharmaceutical interventions, as supplementary and necessary to enhance skills in case management. This corroborates Lloyd, King and McKenna's (2004) finding that occupational therapists in mental health practice value generic-knowledge from the biomedical discourse. However, the current study indicated that the generic duties of case management described by Lloyd et al. (2004b) often resulted in the prioritisation of more acutely unwell service-users' needs over those who would benefit from occupation-based interventions in the community. In this situation, the participant's discipline-specific work became overwhelmed.

The findings indicated that tensions between occupation-based philosophies and biomedical discourses appeared to be strongest when occupational therapists are working in practice contexts with service-users who are most unwell. Many practitioners begin their career in these acute inpatient environments (Duffy and Nolan 2005) where a focus on symptom management and risk highlights the need for graduates to learn more generic mental health knowledge, in greater depth than that included in entry-level programs.

The experiences of practitioners in their first jobs offer greater insight into why graduating occupational therapists may question their preparedness for practice (Gray, Clark et al. 2012). As graduates transition into mental health practice contexts they are often entering environments where different discourses may dominate and the occupational perspective is marginalized. In addition in these mental health environments there may also be pressures for practitioners to adopt psychological theories, and subjugate activity-based therapies for 'talking therapies.' This can undermine a belief in the efficacy of occupation-based therapies. While the participants in this study learnt to live with these tensions others may simply chose to leave the profession (Scanlan, Still et al. 2010), or cope by reducing their occupation-based practice. Thus, although the time taken by participants to deal with biomedical needs over occupational issues limited the opportunities for occupation-based therapy, it did not shape the content.

While recovery discourses are considered complementary to occupation-based practice (Gibson, D'Amico et al. 2011) the adoption of psychological discourses without judicious use can shape all aspects of practice. The current study extends the work of Haglund et al. (2000) by highlighting the multifactorial ways psychological discourses shape occupational therapists' practice. While it is known Australian practitioners adopt psychological practice knowledge discourses and associated therapies (Bartlow and Hartwig 1989) the participants' stories showed

that this could result in practical actions that were not occupation-based and which do not enhance service-users' occupational experiences.

The dominance of the psychological discourse can partly be attributed to its alignment with biomedicine through the importance placed on diagnosis and symptom identification (American Psychiatric Association 2013). However, the primary reason participants provided for the dominance of psychological discourses in practice was the perception that there was a larger research evidence-base for psychological therapies and techniques when compared with the existing research for occupation-based practices. This combined with, time pressures and lack of physical space for occupation-based practices influenced the adoption of psychological therapies and techniques. It appears that an unintentional consequence of the high regard of evidence-based practice by policy makers, managers and occupational therapists (Bennett, Tooth et al. 2003; Upton, Stephens et al. 2014) is that it reinforces the relative lack of empirical data regarding the efficacy of occupation-based interventions when compared to psychologically-based intervention. This parallels the use of these interventions by social workers with Sheldon (2000) noting the necessity to use evidence-based practice in health and social care has led to the privileging of professional discourses with larger researched evidence bases. This privileging increases practitioners' attraction to psychological therapies and extends understanding of why role blurring affect minority professions in mental health teams as they move towards adopting the practices of those around them (Larkin and Callaghan 2005; Nolan and Hewison 2008; Scanlan, Still et al. 2010).

Living with Tensions

The current study supports (Björklund 1999) argument that daily contact with biomedical and psychological discourses can shape personal paradigms and diminish the enactment of occupation-based practice. If strategies to support

professional paradigms were not used the resulting tensions operating in professional lives influenced the career directions and choices of theoretical knowledge and practical actions of the study participants. This reinforces the need for practitioners' development of assertive stances to negotiate for occupation-based practices (Ashby, Ryan et al. 2013) and better communication to colleagues and clients of the occupational-perspectives underpinning their practice (Fortune and Fitzgerald 2009).

The findings indicate that practitioners utilise a range of strategies to cope with different practice knowledge discourses, which vary from acceptance and embracing other discourses to resistance and rejection. The participant accounts support the work of Mackey (2007) who also found that occupational therapists adopt different stances when confronted with these discourses.

The current study reinforced the need for practitioners to adopt strategies, which avoid the marginalization of occupational perspectives and broader recovery approach discourses. This included seeking opportunities to reflect on practice to identify when these discourses are influencing personal paradigms and fidelity to paradigm-dependent practice as described by Fortune (2000) and Molineux (2011).

While the focus of occupational therapy's professional literature is on how to preserve, or create dominance for an occupational perspective, as noted by Gillen and Greber (2014), it is important for the profession to consider how paradigm-specific occupation-based practice can be enacted within workplaces where there are power imbalances. The current study and others illustrate this power imbalance can be ameliorated by the validation of occupation-based practice and strategies supporting professional resilience (Lloyd, King et al. 2007; Scanlan, Still et al. 2010; Ashby, Ryan et al. 2013).

Study Limitations and Implications for Research

Although contextualized in one geographic area, the findings provide a deeper understanding of the challenges the participants faced as minority professions in the mental health workforce. Further research is required to identify if the challenges created by the two dominant dimensions identified in this study occur in the wider occupational therapy mental health community.

The findings extend the work of Townsend's (1998) analysis of medical, psychological and management discourses and their role in 'overruling' occupational discourses in mental health services by offering the presence of dominant discourses as a means of further explaining why retention of occupational therapists in the Australian mental health workforce can be problematic (Scanlan, Still et al.'s 2010), and why the retention in acute inpatient units is on average less than two years (Duffy and Nolan 2005). However, further research is required to explore the ways socioecological influences, such as educational, social, policy and managerial discourses shape professional practice and identity (Ashby, 2013).

reasons practitioners leave the profession.

Within education further directions for research include the role of curricula in establishing paradigm-specific paradigms, the formation of professional identity, and ability to reflect on, and deal with competing discourses and in the developing strategies to improve retention in the workforce.

Conclusion

This study illuminates the ways competing biomedical and psychological practice knowledge discourses influence occupational therapists' practice behaviours. This paper demonstrates that in some mental health workplaces there is a danger that occupational perspectives and occupation-based practice can become marginalized. To combat this marginalization practitioners are required to draw on their

professional resilience and develop a more assertive stance. If this issue is not tackled it can lessen the job satisfaction of occupational therapists in workplaces, where competing discourses dominate or when an occupation perspective is not validated. A greater understanding of the ways competing discourses shape personal paradigms allows educators, and managers to recognise and prepare strategies to support occupational therapists to live with these discourses and maintain occupation-based practices in the mental health workforce.

Key findings

- Personal paradigms are dynamic and shaped by competing practice knowledge discourses.
- Enactment of occupation-based practice can be diminished by competing dominant practice knowledge discourse.
- Strategies which enhance occupational perspectives of health and enactment of occupation-based practice contribute to professional resilience and identity.

What has study added

Making visible the different discourses that operate in mental health and sharing strategies allows occupational therapists to understand and live with the tensions operating in their professional lives.

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