Occupational therapists’ use of occupation-focused practice in secure hospitals

Practice guideline
Second Edition

Royal College of Occupational Therapists
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Occupational therapists’ use of occupation-focused practice in secure hospitals

Practice guideline

Second Edition

Royal College of Occupational Therapists
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NICE has accredited the process used by the Royal College of Occupational Therapists to produce its practice guidelines. Accreditation is valid for five years from January 2013 and is applicable to guidance produced using the processes described in the Practice guideline development manual 3rd edition (2017). More information on NICE accreditation can be viewed at www.nice.org.uk/accreditation.
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Note: The guideline development group has consulted with patients involved in secure services and the term ‘patient’ is preferable, therefore the term ‘patient’ is used within this document to refer to individuals who are detained within the secure setting.

This guideline was developed using the processes defined within the *Practice guideline development manual* (College of Occupational Therapists [COT] 2017a).

Readers are referred to the manual to obtain further details of specific stages within the guideline development process.

The manual is available at: [www.rcot.co.uk/practice-resources/rcot-practice-guidelines](http://www.rcot.co.uk/practice-resources/rcot-practice-guidelines)
Foreword (2nd edition)

Being a patient in a secure hospital is not something one aspires to become. As human beings we all set out in life wanting to do well and be happy. Unfortunately some of us will develop mental health conditions, and some of those who do may in time commit criminal offences in the context of their illness.

If and when the story of your life reaches this tragic point and you find yourself detained under the Mental Health Act (MHA), in a secure psychiatric hospital, you are unlikely to feel good about either yourself or your situation. Many patients (and I was one of them) feel depressed and inferior, forgotten by society and lost in a system that all too often seems to view us as mere units of risk. Recovery is the only viable way forward: finding medication that helps you to manage the symptoms of your disorder, and sometimes psychological therapy which enables you to delineate and understand the various twists and turns in your thinking and life that led to your current situation. More often than not, you may feel hopeless, condemned to be viewed in a very negative way because of the markers you bear; the double whammy of being not just ‘bad’ but ‘mad’ as well.

As human beings we all need to feel needed and of positive use to others. Every patient has the potential to benefit from investment, in terms of care, treatment and occupation. What is meaningful to a given patient depends very much on their own specific needs, strengths and aspirations. No patient is a cookie-cutter copy of another; we all have our strengths and weaknesses and need to be seen and treated as the diverse individuals we are.

This is where occupational therapy (and occupational therapists) can have such a positive impact on a patient’s recovery and ultimately their life. Occupation-focused occupational therapy for adults in secure hospitals can literally transform a patient’s experience of their detention. Occupational deprivation is a concept patients in secure settings are only too well acquainted with. At times you feel forced into a state of utter dependency on staff; they are the (very busy) people whom you need to unlock the cleaner’s cupboard so you can access a fresh toilet roll, let you into the therapy kitchen so you can pour yourself a cup of cola from the 2 litre bottle which is banned from communal areas and patients’ rooms because of its size, or sign you out on your precious S17 leave. You do feel disempowered; treated like a child and sometimes utterly devalued and degraded.

The occupational therapist is the member of the multidisciplinary team (MDT) who has the training, skill and role-based licence to work with you to determine your activity needs. As a patient you may have certain, possibly illness-related areas of need. These can be considered and discussed with your occupational therapist in terms of forming a plan on how to manage and work to overcome or minimise them. The occupational therapist can also help you to reinforce and extend your skill and activity base, allowing you to feel a sense of re-empowerment, validation and the beginnings of hope.

The ‘recovery of ordinary lives’ concept is so important, guiding patients towards ways in which they can make their own decisions and take back their sense of self-responsibility and adulthood.
The practice guideline focuses on the importance of outcome-focused care and collaborative, strength-based care planning. Working with a patient in terms of utilising the Model of Human Occupation to craft a framework that allows a patient to move forward, address issues and gain confidence as goals are planned and achieved is the kind of support all patients need and benefit from.

In short, having positive purposeful activity is something everyone needs and enjoys – especially if you are a patient in a secure setting! In my experience, good occupation-focused practice can transform a patient’s experience of their situation and sense of self, both as a patient in recovery and as a whole human being. The occupational therapist can be key to a patient developing an understanding of the empowering and therapeutic effect of activity and how they can access this and establish themselves as valued members of the community – both in hospital and beyond.

Dr Sarah Markham
Department of Biostatistics, King's College
Department of Computer Science and Information Technology, Birkbeck College
Foreword (1st edition)

If the man (or woman) on the street were to visit a ward in a secure hospital, it would not be a surprise if they were to see a group of middle-aged men sitting passively whose only ‘occupation’ was to gaze vacantly at a television. This surprise might turn to anger if they were informed about the cost to him/her as a taxpayer of this activity (or lack of it). This concern is likely to be further augmented if s/he were told that the factor which is most protective against future offending when in the community is a meaningful occupation, but that the likelihood of such employment in those who leave secure services is only about ten per cent (Davies et al 2007).

It follows, therefore, that those who provide secure services will be increasingly challenged to produce meaningful activities that will aid a mentally disordered offender to gain recovery and desist from further offending. The service user as a consumer, and society more generally as the paymaster, is unlikely in the future to accept anything less. Occupational therapy (and occupational therapists) will have a key role in this extension of current service delivery as it is they who have the skills and competencies to make this happen. This sea change in attitude will not be easy to effect as they will face entrenched professional self-interest and challenges – particularly of threats to security – that such extensions necessarily entail.

Here the availability of evidence that has been rigorously collected and set out so that it can be implemented in a standardised manner will, I believe, be the greatest protection to a profession – and here I hope that this does not sound patronising from another profession – one that is at last beginning to find its feet. This practice guideline, that carefully and assiduously examines what evidence is available in the literature, marks an important first step in a profession that has come of age within secure mental health provision. The timing of its publication is opportune as it chimes with an emphasis on what individuals can achieve, rather than focusing on their deficits, on their recovery from, rather than on the recurrence of, mental disorder and, as such, will I feel be a major antidote to the stigma that for too long has cast its shadow over the mentally disordered offender. As well as congratulating Dr Cronin-Davis and her co-authors in its publication, I strongly commend it to as wide a readership as possible as it has much to teach all of us, both within and beyond the profession of occupational therapy.

Conor Duggan BSc, PhD, MD, FRCPsych, OBE
Emeritus Professor of Forensic Mental Health, University of Nottingham
Head of Research and Development, Partnerships in Care
Foreword (1st edition)

I would echo Professor Duggan’s remarks in recognising this publication as an important contribution to the occupational therapy profession. As a commissioner it can also be seen as a vehicle that will help steer secure services toward a better place, through a turbulent time of change, and in that respect, this practice guideline is both important and timely.

Significant changes are taking place across the NHS as it attempts to shift its commissioning focus to one that is much more service user and clinically driven, while driving through an agenda for providers that aims to shift their emphasis from the delivery of services to the delivery of outcomes. For secure services this will require a system change toward achieving outcomes that improve service user experience and reduce lengths of stay, hand in hand with the cultural changes required to place service users at the centre of their own care. This will be a formidable task, particularly across a secure system, which embeds change slowly and takes a measured pace toward practices that promote positive risk-taking. However, these changes are being introduced now and are evident in a number of national initiatives with system re-design in mind. The promotion of recovery-based approaches to care planning and the drive to introduce standardised outcomes across secure services through the ‘Shared Pathway’ is an example of this cultural shift, as is the introduction of Payment by Results, and the development of a national Clinical Reference Group for Forensic and Secure Services.

This practice guideline confirms the role of occupational therapy as an important player in a developing system. The emphasis placed on the engagement of service users in occupation-centred care that gives meaning and value, hope and aspiration, is core to a recovery-based approach. The recognition of the impact of environments and the restrictions that procedure and security place on individuals, and how these may be addressed will ensure true person-centred practice, and the feeling of being done with, rather than done to. Of equal importance is the focus throughout the guideline on the importance of outcome-focused care and collaborative, strength-based care planning. Utilising the Model of Human Occupation as a framework for this resonates with the national agenda, while articulating the role of occupational therapist firmly within the evidence base means it is difficult to ignore, providing an important resource for any clinical discipline working within secure environments.

I think the authors and contributors should be congratulated for drawing together the current thinking and innovative practice for this profession at a time when it can potentially have a significant role to play in engineering change for the benefit of service users. It would seem that there has never been a better time to be an occupational therapist.

Ged McCann  
Senior Mental Health Supplier Manager  
NHS England, Specialist Commissioning Team, Yorkshire and Humber Hub  
(Formerly Associate Director of Commissioning, North of England Specialist Commissioning Group)
The aim of this practice guideline is to provide specific recommendations to support the use of occupation-focused occupational therapy for adults (18 years and above) in secure hospitals. The recommendations are intended to be used alongside the occupational therapist’s clinical expertise and, as such, the clinician is ultimately responsible for the interpretation of this evidence-based guideline in the context of their specific circumstances, environment and patients’ needs.

Recommendation statements should not be taken in isolation and must be considered in conjunction with the contextual information provided in this document, together with the details on the strength and quality of the recommendations. The statements are graded based on the Grading of Recommendations Assessment, Development and Evaluation (GRADE) process (GRADE Working Group 2004) as described in the College of Occupational Therapists’ Practice guideline development manual (COT 2017a). The strength of the recommendations is identified via a scoring of 1 (strong) or 2 (conditional), and the quality of the supporting evidence via a grading on a scale of A (high) to D (very low). It is strongly advised that readers study section 10 to understand the guideline methodology, together with the evidence tables in Appendix 6, to be fully aware of the outcome of the literature search and overall available evidence.

The four recommendation categories: volition; habituation; performance capacity; and environmental considerations, reflect the concepts associated with the Model of Human Occupation (Kielhofner 2008), as currently this appears to be the most frequently used and cited model of practice in relation to forensic occupational therapy (Bennett and Manners 2012, O’Connell and Farnworth 2007). The use of this model is by no means prescriptive; however, it serves as a useful framework within which to categorise the recommendations.

Recommendations by category

The overall quality of evidence grade reflects the robustness or type of research supporting a recommendation, but not necessarily the recommendation’s significance to occupational therapy practice. The recommendations are not presented in any order of priority or relative importance.

‘It is recommended. . .’ benefits appear to outweigh the risks (or vice versa) for the majority of the target group; most patients would want or should receive this course of intervention or action.

‘It is suggested. . .’ risks and benefits are more closely balanced, or there is more uncertainty in likely patient values and preferences; the majority of patients would want this intervention but not all, and therefore they should be supported to arrive at a decision for intervention consistent with the benefits and their values and preferences.
This second edition of the guideline incorporates relevant literature published since 2012. There are no new recommendations; however, some of the 2012 recommendations have been refined to reflect more recent evidence or policy, while other statements remain unchanged but supported by further research findings, and are annotated to reflect these changes.

### Volition

<table>
<thead>
<tr>
<th>1. It is recommended</th>
<th>That occupational therapists always take into account the gender-specific needs of patients with whom they are working.</th>
<th>1C</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(Baker and McKay 2001 [C])</td>
<td></td>
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<tr>
<td>2. It is recommended</td>
<td>That occupational therapists consider the occupational life history of patients, including that at the time of the index offence, and its influences on occupational performance, life satisfaction and criminogenic lifestyle.</td>
<td>1B</td>
</tr>
<tr>
<td></td>
<td>(Lindstedt et al 2005 [B])</td>
<td></td>
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<tr>
<td>3. It is recommended</td>
<td>That occupational therapists establish, as part of their assessment, patients’ perspectives of their occupational performance and social participation, and work with those perceptions in planning care.</td>
<td>1B</td>
</tr>
<tr>
<td></td>
<td>(Lindstedt et al 2004 [B])</td>
<td></td>
</tr>
<tr>
<td>4. It is recommended</td>
<td>That occupational therapists work collaboratively with patients to identify and develop care pathways which are recovery-focused.</td>
<td>1C</td>
</tr>
<tr>
<td></td>
<td>(Clarke 2002 [C]; Walker et al 2013 [D])</td>
<td></td>
</tr>
<tr>
<td></td>
<td>[Statement amended, new evidence 2017]</td>
<td></td>
</tr>
<tr>
<td>5. It is recommended</td>
<td>That occupational therapists recognise the specific intrinsic value of occupation to individual patients.</td>
<td>1C</td>
</tr>
<tr>
<td></td>
<td>(Craik et al 2010 [C])</td>
<td></td>
</tr>
<tr>
<td>6. It is recommended</td>
<td>That occupational therapists facilitate meaningful occupational choices for patients.</td>
<td>1C</td>
</tr>
<tr>
<td></td>
<td>(Craik et al 2010 [C]; Cronin-Davis 2010 [C]; Mason and Adler 2012 [C]; Morris 2012 [C]; O’Connell et al 2010 [D]; Stewart and Craik 2007 [C])</td>
<td></td>
</tr>
<tr>
<td>7. It is recommended</td>
<td>That occupational therapists ascertain patients’ aspirations towards paid employment at the earliest opportunity, and during rehabilitation.</td>
<td>1C</td>
</tr>
<tr>
<td></td>
<td>(McQueen 2011 [C])</td>
<td></td>
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</tbody>
</table>
### Habituation

8. **It is recommended** that occupational therapists consider patients’ roles (past, present and future) within treatment planning and interventions.
   *(Schindler 2005 [C])*

9. **It is recommended** that occupational therapy facilitates a range of interventions that enable patients to engage in structured and constructive use of time throughout the week, including weekends and evenings.
   *(Bacon et al 2012 [D]; Castro et al 2002 [C]; Farnworth et al 2004 [C]; Jacques et al 2010 [D]; Stewart and Craik 2007 [C])*

### Performance capacity

10. **It is recommended** that occupational therapists routinely use standardised outcome measures to assess and demonstrate patients’ progress.
    *(Clarke 2003 [D]; Fan 2014 [D]; Fitzgerald 2011 [C]; Green et al 2011 [C]; Kottorp et al 2013 [C]; McQueen 2011 [C]; Williams and Chard 2016 [D])*  
    [New evidence 2017]

11. **It is recommended** that occupational therapists consider prevocational training, real work, or supported employment as part of occupation-based intervention opportunities for patients.
    *(Cox et al 2014 [D]; Garner 1995 [D]; McQueen 2011 [C]; Smith et al 2010 [D]; Völlm et al 2014 [D])*  
    [Statement amended, new evidence 2017]

12. **It is recommended** that occupational therapists consider the use of healthy living programmes and exercise as activity to benefit health and wellbeing.
    *(Bacon et al 2012 [D]; McQueen 2011 [C]; Prebble et al 2011[D]; Tetlie et al 2009 [C]; Tetlie et al 2008 [C]; Teychenne et al 2010 [C])*

13. **It is suggested** that occupational therapists include social inclusion programmes as part of their intervention to improve occupational functioning.
    *(Fitzgerald 2011 [C])*  

### Environmental considerations

14. **It is recommended** that occupational therapy staff fully value the therapeutic use of self as being integral to the positive engagement of patients in occupations.
    *(Evans et al 2012 [C]; Mason and Adler 2012 [C]; Tetlie et al 2009 [C])*  
    [Statement amended, new evidence 2017]

15. **It is recommended** that occupational therapists ensure that risk assessment is a dynamic process, in which judgements are made on an ongoing basis in collaboration with patients and members of the multidisciplinary team.
    *(Cordingley and Ryan 2009 [C])*

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**Royal College of Occupational Therapists 2017**
Key recommendations for implementation

<table>
<thead>
<tr>
<th>Recommendation</th>
<th>Description</th>
<th>Source(s)</th>
<th>Grade</th>
</tr>
</thead>
</table>
| 16.            | *It is suggested* that occupational therapists recognise the role and contribution of families and friends in the recovery of patients. *  
*Absalom et al 2010 [C]; Fitzgerald et al 2012 [D]*/  
[Statement amended 2017] |                                                   | 2C                               |
| 17.            | *It is recommended* that occupational therapists consider the impact of the environment on quality of life and occupational engagement.  
*Craik et al 2010 [C]; Fitzgerald et al 2011 [D]; Long et al 2011 [C]; Long et al 2008 [C]; Morris 2012 [C]* |                                                   | 1C                               |
| 18.            | *It is suggested* that occupational therapists liaise with a range of community services to facilitate replication of patients' pro-social behaviours developed during an inpatient stay.  
*Elbogen et al 2011 [D]; Lin et al 2009 [C]; Lindstedt et al 2011 [C]* |                                                   | 2C                               |
| 19.            | *It is recommended* that occupational therapists demonstrate their competencies (skills and training) to facilitate identified therapeutic groups, enhancing the confidence and participation of patients.  
*Mason and Adler 2012 [C]* |                                                   | 1C                               |
| 20.            | *It is recommended* that occupational therapists articulate, to patients and the multidisciplinary team, their role and the contribution of occupational therapy to the overall treatment programme.  
*Cronin-Davis 2010 [C]* |                                                   | 1C                               |

It is additionally recommended that occupational therapists use the audit tool that is available to support this guideline (see section 7) to undertake audit against the above recommendations.
1 Introduction

In secure environments, the opportunity and ability to engage in occupations of meaning and purpose can be impeded by patients’ mental health, personality disorder or learning disability; their perceived and actual risks to themselves or others; and institutional regulations, policies or legal restrictions. It may, for many patients, be a combination of all three. Their choice, opportunity for and ability to voluntarily or spontaneously engage in occupation can be severely limited. The impact of being detained in secure environments for some patients has been noted to lead to a sense of hopelessness and poor mental health.

Occupational deprivation is a concept by which patients are denied opportunities to engage in purposeful and meaningful occupations. Routines are highly structured so people cannot practise habits and routines that replicate outside life. There is a lack of choice and control that may impact negatively on the individual’s health and wellbeing, and over a prolonged period, skills can be lost. Whiteford (1997), reporting from a needs assessment project, suggested that there was occupational deprivation in a maximum secure prison. She found that rigid policies and practices contributed to an environment in which deprivation from occupation was the norm, and occupational deprivation was historically used as a form of punishment. Occupational deprivation could apply to secure hospitals where patients have limited access to certain or preferred occupations; they may be unable to go into the community due to their legal status or perceived risks, and decisions to grant such access may be dependent on the treatment team or the Ministry/Department of Justice in the case of restricted patients. This was explored further by Molineux and Whiteford (1999), who suggest that occupational enrichment is considered as an approach to better meet the needs of prisoners. Cronin-Davis et al (2004) have stated that occupational enrichment can be achieved by providing opportunities for patients to engage in a range of occupations either alone or within groups. It may also involve addressing wider systemic issues within forensic mental health services or institutions, such as policies on access to the community, employment programmes and family contact opportunities.

As well as the risks patients present, many lack typical occupational performance skills usually associated with successful community living. Long admissions may also lead to institutionalisation and subsequent de-skilling in activities of daily living and community living skills. Therefore, group or individual occupational therapy programmes often target basic living skills, self-care, vocational skills, adaptive coping strategies, creative arts and anger or stress management (Lloyd 1987–1988, Flood 1993, Taylor et al 1997). There is a reminder in the literature of how the environmental and equipment restrictions constrain the truest sense of occupational therapy practice (Taylor et al 1997, O’Connell and Farnworth 2007). A patient could be ready for and need a community assessment but due to his or her legal status, this will not take place.

The ultimate aim of occupational therapy is to enable patients to experience occupational enrichment and thus achieve optimal occupational participation to maintain health and wellbeing. It can, however, be extremely challenging within secure environments; therefore, occupational therapists devising treatment programmes with, and for, their patients require a more creative and versatile skill base (Cronin-Davis et al 2004). Occupational enrichment in forensic settings can be considered as both the goal
Introduction

Occupational therapists’ use of occupation focused practice in secure hospitals

and process of occupational therapy interventions. Implementation of the guideline recommendations, with their emphasis on meaningful occupation and personal recovery goals, can assist and have a positive impact on the patient’s recovery journey.

This practice guideline focuses on the core outcomes of occupation-focused practice, but it is important to stress that the occupational therapist’s clinical reasoning must take account of individual preferences and needs when implementing the recommendations.

1.1 Practice requirement for the guideline

Occupational therapy is an essential component of secure services, and it is therefore pertinent that evidence-based practice is supported by the development of a practice guideline.

The practice requirement for this guideline was supported by a survey of occupational therapists conducted at the national forensic occupational therapy conference in 2008. Out of a possible 120 delegates, 82 completed a questionnaire designed to capture demographic information related to forensic occupational therapy and the challenges these respondents faced in the workplace. The challenges cited were lack of practice guidelines and an evidence base to support occupational therapy; the fact that occupational therapy was misunderstood by other disciplines and the voice of occupational therapists was not ‘heard’ in the same way as other professionals in multidisciplinary teams. These respondents worked in high, medium and low secure hospitals (Cronin-Davis and Spybey 2011). There is no doubting the need for occupational therapists working in forensic mental health to strengthen their own evidence base (O’Connell and Farnworth 2007), a situation which is still pertinent at the time of this second edition of the guideline (Hitch et al 2016).

It has been well documented and debated that the occupational therapy profession needs to return to its philosophical roots and use occupation both as means of therapy intervention and as a desired end goal for those people using services. Historically, engagement in occupations was fundamental to the profession and certainly its founding premise. However, over time there have been well-documented paradigm shifts and influences regarding this principle (Kielhofner 2004). Influences such as medicine led the profession into more of a mechanistic framework, leaving behind the core concept of using occupation to improve health (Cronin-Davis 2010). There is a strong move to restore and reintegrate occupation to the core of occupational therapy practice; to recognise and establish that a strong relationship exists between occupation, health and wellbeing (Creek and Hughes 2008).

This guideline aims to address some of these challenges. It provides an encouraging and emerging evidence base and specific recommendations for staff on occupation-focused occupational therapy. The latter is its specific remit. The publication is also intended to enable other professionals to have a better understanding of occupational therapy interventions in secure hospitals.

1.2 Topic identification process

Occupation-focused practice was identified by the Forensic Forum, a clinical forum of the College of Occupational Therapists’ Specialist Section – Mental Health, as a topic on which a guideline could be developed. The topic emerged from information and the challenges experienced by occupational therapists in the survey conducted in 2008 (Cronin-Davis and Spybey 2011), in addition to the call for occupational therapists who
work in forensic mental health services to conduct relevant research and contribute to the evidence base (O’Connell and Farnworth 2007).

A guideline development project proposal was subsequently approved by the College of Occupational Therapists’ Practice Publications Group in March 2011.

1.3 National context of secure services

Secure services refer to those that provide care and treatment for patients with mental illness, personality disorder and neurodevelopmental disorders, including learning disabilities. Individuals typically have complex mental disorders, co-morbid difficulties of substance misuse and/or personality disorder, which are linked to offending or seriously irresponsible behaviour (NHS England 2013a). Those admitted to a secure care setting are detained under a section of the relevant/country-specific mental health legislation. The majority of these patients will have been in contact with the criminal justice system as a consequence of their offending behaviour. There are a minority of patients in secure settings who are admitted due to the severity of their behaviour that cannot be contained or managed within local mental health units.

The typical population in a secure unit tends to be younger men (88%) (Rutherford and Duggan 2007, p8). Rutherford and Duggan (2007, p9) have also previously highlighted that statistics indicate there is an over-representation of ethnic minorities in the prison and secure services.

For the purposes of this guideline, ‘secure services’ refers to high secure hospitals, medium secure units and low secure units (which may include psychiatric intensive care (PIC)). ‘Secure’ relates to those physical, relational and procedural measures in place to enable treatment to be delivered in a safe and secure environment. Depending on their individual needs, patients may go through an integrated care and treatment pathway that spans one or more of the high, medium or low levels of care. Community occupational therapy may also form an important part of the secure care pathway, but is not specifically addressed within this guideline.

![Figure 1 Pathways through criminal justice and mental health services](image-url)
The policy, service structure, commissioning and legislation relating to services in secure settings services are not the same for each of the four UK countries. This guideline does not attempt to provide details of all the country-specific features, which can be complex and are better obtained direct from source documents. However, while it is fully acknowledged that variations exist, Figure 1 provides a useful indicative overview of the range of services available for adults with mental health needs, set in the context of level of risk.

1.3.1 Secure service provision

High secure services in the UK are provided by four high secure hospitals and are all National Health Service (NHS) facilities.

Three of the hospitals, namely Ashworth, Broadmoor and Rampton, are located in England. Approximately 795 beds were commissioned by NHS England for England and Wales in 2014/15 (NHS England 2013a). Rampton includes the national services for women, deaf men, and men with a learning disability.

The State Hospital, located in Scotland, provides the national service for Scotland and Northern Ireland and provides 140 beds for male patients, 12 of which are specifically for patients with a learning disability.

These hospitals are for detained patients considered to be an immediate, grave and serious danger to the public and who require a significant period of treatment. The average length of stay is recommended to be 5–7 years, but while the stay for many patients is shorter, some patients will remain in the high secure hospital for a significantly longer period of time.

Sourcing current data on the number of medium and low secure beds across the four countries of the UK has improved; however, there is no comprehensive database of services. It is acknowledged that the information provided in this section is indicative of secure service provision, but unlikely to be all-inclusive.

Medium secure services are provided by the NHS or the independent sector. Many patients will have a history of offending and some will have been transferred from prison or from court to receive inpatient treatment. Typically, patients will remain in treatment between two and five years. Patients detained in a medium secure unit are said to represent a significant danger to the public.

Low secure services are for people detained under a section of the relevant/country-specific mental health legislation, who, because of the level of risk or challenge they present, cannot be treated in open mental health settings. Services are provided by a range of independent sector organisations and NHS trusts or health boards. Patients may have a history of offending and may have been transferred from prison or courts to receive inpatient treatment.

In England there were approximately 3,192 medium secure commissioned beds, and approximately 3,732 low security beds, commissioned in 2014/15 (NHS England 2013a).

An inpatient bed census in Scotland in 2014 identified the number of mental health and learning disability patients within secure settings as 127 medium secure and 285 low secure (Scottish Government 2014). Medium secure facilities are provided in Scotland by three regions, with low secure facilities provided by local health boards (Forensic Network Scotland 2016). The Forensic Mental Health Services Managed Care Network is
key to Scotland’s approach to forensic mental health and learning disabilities (Walker et al 2015).

In Northern Ireland, the first medium secure unit, with 34 beds, opened in 2005. Low secure provision (defined as psychiatric intensive care units or long stay on locked/lockable wards) was reported as 144 beds at the time of the Bamford Review (McClelland 2006, p64), with results from a subsequent assessment of need for low secure care providing an indicative figure of 105 beds with which to inform the commissioning of low secure services (Campbell and Bell 2015). In 2014 there were three newly refurbished low secure facilities in use (Department of Health, Social Services and Public Safety 2014).

The All Wales Mental Health and Learning Disability Collaborative Commissioning Group advise the Welsh Health Specialised Services Committee on issues related to the development of secure mental health services for Wales (Welsh Health Specialised Services Committee 2016). There are NHS medium secure units and independent sector providers; however, a significant proportion of provision for patients from Wales is provided in England. Growth in provision of low secure inpatient facilities is within the independent sector but again placements are often outside Wales (Welsh Assembly Government 2009).

A number of secure units provide specific services and resources for those with a learning disability. A survey involving data from NHS trusts and independent sector hospitals in England, conducted by the faculty of psychiatry of intellectual disability of the Royal College of Psychiatrists, identified a total of 2,393 beds comprising 48 high secure, 604 medium secure and 1,741 low secure, although the uneven distribution means that individuals may be in a secure setting far from away from their home (Royal College of Psychiatrists 2013, p33). Policy evidence has led to the development of standards for people with learning disabilities in medium secure care (Phillips 2010). These address issues such as health action plans, a sensory integration profile and communication skills included within assessment, accessible information and care plans, and attention within the environment to sensory needs. The faculty of psychiatry of intellectual disability has also set out forensic care pathways for people with intellectual disability, together with recommendations and good practice guidance (Royal College of Psychiatrists 2013). The importance of good commissioning of specialist forensic services for people with intellectual disability has been highlighted, particularly in the context of poor practice exposed at the Winterbourne View hospital, and the anticipated reduction in beds (DH 2012a).

NHS England has introduced ‘Care and Treatment Reviews‘ (NHS England 2015a) to improve the care and treatment of people with learning disabilities, with the aim of reducing admissions and lengthy stays in hospitals. This includes those patients detained in specialist units, such as secure services, ensuring the focus of attention is on early identification of outcomes and transferring patients back into the community. The aim is to reduce the overall bed numbers of patients with learning disabilities detained in secure care. An overall reduction of 25–40 per cent is anticipated for beds commissioned by NHS England, with the majority of that change in secure care expected to occur in low secure provision (NHS England 2015b, p6).

An Offender Personality Disorder Pathway Strategy is also in place in England which includes secure hospital provision within three medium secure units and high secure hospitals. This takes a whole systems pathway approach across the criminal justice system and the NHS and, as such, reflects ‘the various stages of an offender’s journey...
from sentence through prison and/or NHS detention to community-based supervision and resettlement’ (NHS England, National Offender Management Service 2015, p2).

Some patients will have been admitted to secure settings as transfers from the prison estate or directed from the court, whereas others may be transferred from other mental health units.

The length of admission to a secure hospital or unit can vary greatly, and depends on a number of factors including risk, responsiveness to assessment and treatment, and discharge planning. Community forensic services are available to facilitate the transition from secure care back to the community, and there is a drive to provide more secure care in the least restrictive setting, with ‘step-down’ help in the form of residential rehabilitation, supported housing and forensic or assertive outreach teams (Mental Health Taskforce 2016).

The focus of this guideline is on the secure hospital setting, but occupational therapy services may be involved at any of the stages along the pathway.

1.3.2 Mental health legislation
Patients admitted to secure facilities are detained under the mental health legislation applicable to the country, and many, but not all, will be convicted offenders. All the UK parliaments have mental health law that permits the detention and treatment of mentally disordered offenders. They are as follows:

- Northern Ireland: The Mental Health (Northern Ireland) Order 1986 (Great Britain. Parliament 1986). (The Mental Capacity Act (Northern Ireland) 2016 was given Royal Assent in May 2016; however, at time of publication of the guideline the date the new Act comes into effect could not be confirmed.)

The Acts/Order legislate for all people requiring care and treatment for a mental health problem, and included in each there is a ‘forensic’ or ‘criminal’ section. Due to the complex nature of mental health law, readers are directed to undertake further reading about the specific sections. All of the legislation makes provision for:

- Assessment in hospital prior to trial or conviction.
- Treatment in hospital prior to trial or conviction.
- Further assessment and treatment following conviction.
- Compulsory treatment in hospital.
- Compulsory treatment in hospital with restrictions.
- Transfer from prison to hospital for compulsory treatment.
- Provision for treatment to continue once criminal sentence expires.
- Provision for compulsory treatment in the community.

In forensic mental health it is, therefore, vital that occupational therapists understand and appreciate the legal implications for those patients detained under mental health legislation.
Occupational therapists will also need to be familiar with the relevant restrictions imposed by the Ministry of Justice (England and Wales), the Department of Justice (Northern Ireland) or the Scottish Justice Directorate.

The complexity of the wider mental health and criminal justice systems has been highlighted in the report *Blurring the boundaries* (Rutherford 2010). The report focuses on the convergence that has been taking place between mental health and criminal justice legislation, policy, systems and practice, highlighting the benefits and risks of that convergence. Rutherford suggests that ‘there are more and more instances in which the health and justice systems are having to work together for the care, support, rehabilitation and punishment of people with mental health problems who have, or are suspected of having, offended’ (Rutherford 2010, p8). The document provides a useful resource including literature, policy and legislative analysis of recent and current examples of convergence. While focused on England and Wales, the issues raised and implications for the future undoubtedly have parallels across the UK.

### 1.3.3 The recovery approach

Services provided within secure hospitals/units should reflect evidence for best practice within nationally agreed standards, frameworks and legislation. Standards have been developed for medium and low secure care and these provide a ‘robust assurance framework for services to drive quality improvement both locally and nationally’ (Royal College of Psychiatrists, Quality Network for Forensic Mental Health Services 2016, p5).

Fundamental to the delivery of services is the recovery approach whose key principles include hope, control and opportunity (Drennan et al 2014, p3).

The challenges associated with the application of recovery principles within secure settings have been explored, and five key areas have been identified which it is considered can ‘contribute to the creation of an environment in which recovery processes can take root’: supporting recovery along the care pathway; quality of relationships; risk and safety; meaningful occupation; and peer support (Drennan et al 2014, p7).

The recovery approach and a focus on individualised outcomes are embodied in the ‘My Shared Pathway’ initiative which identifies eight outcome areas: my mental health recovery; stopping my problem behaviours; getting insight; recovery from drug and alcohol problems; making feasible plans; staying healthy; my life skills; and my relationships (Joint Commissioning Panel for Mental Health 2013). It is also suggested that personalised approaches using tools such as the Recovery Star Secure™, with its domains which include meaningful activities, social skills and trust and hope (Triangle 2015), may be ‘useful complements in helping the person to identify personal goals with a clear structured approach’ (Drennan et al 2014, p7).

In England, in addition to contractual service specifications, The Commissioning for Quality and Innovation (CQUIN) payment framework enables commissioners to reward excellence, by making a proportion of the providers’ income conditional on the achievement of ambitious quality improvement goals and innovations. These are developed annually. In 2016/17 the focus for secure settings was the structured implementation and evaluation of ‘sense of community’ interventions in high secure wards; recovery colleges for medium and low secure patients; and reducing restrictive practices within adult low and medium secure services (NHS England 2016).
A clear synergy exists between the occupational therapist's role in promoting and enabling recovery and independence, and the secure care standard which states that patients should have clear personalised outcomes in relevant key recovery areas such as mental health recovery, insight, independent living skills and physical health (Royal College of Psychiatrists, Quality Network for Forensic Mental Health Services 2016, p19).
The occupational therapy role

Occupational therapy is acknowledged as a core part of service provision within secure services, identifying specifically a role within assessment and intervention for ‘daily living, educational and occupational needs’ (NHS England 2013b). It is also recognised that occupational therapists in forensic services should have relevant clinical experience (DH 2002a).

The low and medium secure standards, developed by the Quality Network for Forensic Mental Health Services, personify key principles of occupational therapy in the following standard:

*Patients have a personalised plan of therapeutic and skill-developing activity that is directly related to their outcomes plan. Patients can see the connection between activities they are undertaking and the achievement of recovery goals.*

(Royal College of Psychiatrists, Quality Network for Forensic Mental Health Services 2016, p20)

Guidance associated with the standard includes that: therapeutic and skills development interventions are evidence based and ‘prescribed’ by need; there is a proactive approach to promoting relevant vocational skills and opportunities; activities and therapy are planned over seven days and not restricted to conventional working hours; and there are personalised timetables in which an individual’s activities and therapies are planned.

2.1 Occupational therapy in mental health

Occupational therapy in any mental health setting is concerned with helping people to recover ordinary lives that have been affected by mental ill health (COT 2006a, p20).

“The ‘recovery of ordinary lives’ concept is important, and supporting patients to feel empowered to make decisions is key. Just as important is the need to constantly signpost relevance of activity and engagement to recovery, because it is the connection between activity and recovery goals that patients struggle with. And throughout my visits around secure hospitals great work is being done but there is a great lack of understanding of activity relevance to the individual. This could be better reinforced, measured, shared and acknowledged when progress is made.”

Patient consultation feedback

Occupational therapists believe fundamentally in the importance of productive occupation to health, self-esteem and wellbeing (COT 2006a, McQueen 2011). The core skills, role and contribution of occupational therapists in forensic mental health should be no different in many respects to that of an occupational therapist working in general mental health or any other health and social care settings.

*Occupational therapy enables people to achieve health, wellbeing and life satisfaction through participation in occupation* (WFOT 2013, p48). *‘Occupation’ refers to practical*
Occupational therapists’ use of occupation focused practice in secure hospitals

and purposeful activities that allow people to live independently and have a sense of identity. This could be essential day-to-day tasks such as self-care, work or leisure.

(COT 2016)

The primary function is to enable people to maximise their independence in productivity, self-care and leisure through the medium of occupation, either as a means to an end or a desired outcome. It is important, however, to acknowledge that due to the longer-term nature of forensic mental health admissions and patients’ mental health, there is an impact on their quality of life. This is particularly relevant to their living situation, leisure activities, social relations and health (Long et al 2008).

Within secure settings there is by necessity a greater emphasis on risk assessment, risk management and positive risk-taking. There is, however, a growing interest in, and evidence for, protective factors in relation to the risk of violence and recidivism, with key areas addressed by occupational therapists (for example work, leisure activities, financial management, life goals, social network and living circumstances) being considered in formal assessment tools, such as the Structured Assessment of PROtective Factors (SAPROF) for violence risk (SAPROF 2016).

Occupational therapy unquestionably lends itself to contributing to the aim of assisting patients in the secure care pathway ‘to lead personally meaningful, purposeful lives, creating positive sense of identity which reduces the risk of recidivism on discharge or readmission to services’ (Cronin-Davis 2017).

2.2 History of occupational therapy in forensic mental health services

Occupational therapy was introduced into secure and prison units on a small scale in the 1980s (Farnworth et al 1987, Taylor et al 1997). It is alleged that since the 1990s there has been an increasing demand for occupational therapists to work with mentally disordered offenders or patients detained in secure hospital settings (Taylor et al 1997, Crawford 2003), and the specific contribution of the profession has been equally recognised and documented (Chacksfield 1997, Flood 1997, Baker and McKay 2001, Farnworth et al 2004, Humphreys 2005). However, what explicitly determined the need for occupational therapists in forensic mental health in the UK was the Reed Report (Department of Health and Home Office 1992).

The Reed Report (Department of Health and Home Office 1992) made clear recommendations for the care and services required for mentally disordered offenders, with a strong emphasis on rehabilitation and independence. It emphasised that high-quality care was to be provided with due attention to patients’ individual needs and wherever possible patients should be cared for in the community. Security levels should be proportionate to the identified risk of the patient, and finally, patients should be cared for as close as possible to their own home and family.

Occupational therapy was considered to be very much part of the rehabilitation process for mentally disordered offenders. A number of key areas were highlighted relating to the needs of the profession following this report: the need for more trained (i.e. Health and Care Professions Council registered) occupational therapists; a structure for support and supervision; a broader career structure; and the need to ensure that support staff numbers increase proportionally with qualified staff (Flood 1993).
Flood, in 1997, identified the distribution of occupational therapists working in secure settings. Out of 86 occupational therapists surveyed by Flood, 55 per cent were working in medium security, 15 per cent in private secure hospitals, 12 per cent in low secure units and 8 per cent in maximum (now referred to as high) security. Unfortunately, there are no current figures in the UK with which to compare figures quoted by Flood. However, from the personal knowledge of the National Executive Committee of the College of Occupational Therapists’ Specialist Section – Mental Health, Forensic Forum, attendance at the annual national forensic occupational therapy conference had reached approximately 140 (the majority of the delegates being registered occupational therapists). There is to date no means to account for the range and exact number of occupational therapy support and technical instructor staff in forensic mental health. It is important, however, that all members of the multidisciplinary team acknowledge that these staff contribute significantly to the assessment and treatment of forensic mental health patients (Blom-Cooper et al 1996, p63).

2.3 Occupational therapy intervention

Occupational therapists focus on patients’ daily living skills (Davies et al 2006), but are not necessarily limited to this aspect of the care and treatment of patients in secure settings. The role of occupational therapy in forensic settings has been defined as helping people to engage in occupations which give their lives meaning and value, and mitigate alienation and anti-social behaviour (Couldrick 2003, p13). Duncan (2008, p516) additionally suggested that occupational therapy should assist people to develop their interpersonal capacity, pro-social values, their personal identity and skills for life participation. Crawford and Mee (1994) identified that the occupational therapy process in forensic mental health is the same as in other mental health settings. Occupational therapists have a contribution to make in all forensic contexts and in every part of a patient’s journey, from pre-admission assessments, ongoing assessment and intervention through to discharge. Occupational therapists have an important role in identifying those occupations associated with, or leading up to, offending behaviour. Equally, within the recovery approach occupational therapy plays a part in supporting and instilling hope for patients’ goals and aspirations (COT 2006a).

Occupational therapists have multifactorial roles within the secure setting and it is important to remember that although rehabilitation and programme planning are important, rehabilitation should not be limited to teaching patients skills for domestic tasks (Blackburn 1993). O’Connell and Farnworth (2007) suggested that the focus for occupational therapists in secure settings should be on daily living skills with an emphasis on community reintegration. The drive for vocational rehabilitation should be considered in forensic settings (McQueen 2011); occupational therapists play an important role in supporting patients to ‘establish meaningful and productive roles’ (Dunn and Seymour 2008, p450).

The secure environment in which occupational therapy is provided demands a balance between therapy and security, while still maintaining the validity of occupation for patients. The restrictive features of a secure environment, which are in place to protect people and society from the identified risk posed by a patient, combined with the complex and demanding needs of patients, present challenges to providing the therapeutic opportunities usually taken for granted in a less secure and disturbed environment (Watson et al 2004). Despite this, the relationships between safety and containment, relational security and therapeutic risk-taking can lead to change and progress, aptly depicted by Watson et al as a continuum (Figure 2).
Chugg and Craik (2002) noted that patients’ occupational choices and experiences can be greatly influenced by the environment; it is this environment that either offers opportunities and choices or imposes constraints and demands. Patients detained in secure units may have additional restrictions placed on them by a section of the relevant/country-specific mental health legislation and/or Ministry/Department of Justice restrictions. The secure environment, the patient’s legal status and local policies can have an impact on, and restrict, the range of occupations that can be offered and provided by occupational therapists. A crucial skill of the occupational therapist is, therefore, in grading and adapting the occupation or environment to meet the security demands without losing the value and potential of the intervention (Cronin-Davis et al 2004).

It has long been recognised that it is imperative that occupational therapists appreciate legal issues associated with the environment and the complicated legal procedures related to the patient group (Farnworth et al 1987, Chacksfield 1997, Forward et al 1999). Risk assessment and risk management are high priorities; there is a professional obligation not only to assist and treat the patients but also to protect the public. Part of the occupational therapy assessment and intervention is to positively manage patients’ identified risks in controlled environments.

Detained patients do not necessarily have the same access to community facilities, and multi-agency public protection and safeguarding arrangements may impact on the interventions that can be offered. Occupational therapists, therefore, need to be aware of this when planning inpatient occupational therapy programmes, particularly those supporting social inclusion. Such programmes might include community meetings, outings, cooking, supportive group-work, psycho-education, adult education and vocational rehabilitation (Alred 2003). The environment and legal restrictions inherent within forensic settings can be limiting in terms of patient choice and severely impact on what is considered true person-centred practice.

Occupational therapists should be aware that there are contradictory opinions about occupational therapy in secure settings. One view is that occupational therapy should not focus on treating criminal behaviour, but should assist patients to acquire knowledge competencies and skills related to self-esteem, sense of control and decision making (Farnworth et al 1987, Hood 1998). There is, however, a counterview that the impact of a patient’s forensic pathology must be acknowledged, and consequently occupational therapists must be proactive in addressing how patients’ criminogenic and anti-social occupations impact their lifestyle and wellbeing, whether that is in the past, present or future (Cronin-Davis et al 2004, Twinley and Addidle 2012). Addressing that impact of occupation on lifestyle and wellbeing is the unique contribution of occupational therapy within this clinical speciality.
3 Objective of the guideline

The guideline objective:

*To provide specific recommendations to support the use of occupation-focused occupational therapy in secure hospitals.*

This guideline is relevant to occupational therapy staff working in high, medium and low secure hospitals and provides explicit recommendations for occupation-focused occupational therapy practice, based on the available evidence.

It is acknowledged that there are other influences on occupational therapy practice, such as the recovery and social inclusion agendas and, additionally, consideration of future possible employment for patients in forensic mental health.

The guideline recommendations are, therefore, intended to be used alongside the occupational therapist’s clinical expertise and, as such, clinicians are ultimately responsible for the interpretation of this evidence-based guideline in the context of their specific circumstances and patients’ individual needs.

These evidence-based recommendations should be used in conjunction with the current versions of the following professional practice requirements, of which knowledge and adherence is assumed:

- *Standards of conduct, performance and ethics* (Health and Care Professions Council 2016)
- *Standards of proficiency – occupational therapists* (Health and Care Professions Council 2013)
- *Code of ethics and professional conduct* (COT 2015)

Additionally, the following guidance should also be considered:

- *Standards for forensic mental health services: low and medium secure care* (Royal College of Psychiatrists, Quality Network for Forensic Mental Health Services 2016)
- *Standards for people with learning disabilities in medium secure care* (Phillips 2010)
- *Guidance for commissioners of forensic mental health services* (Joint Commissioning Panel for Mental Health 2013)
- *Service user experience in adult mental health services* NICE Quality Standard 14 (National Institute for Health and Care Excellence 2011).
4 Guideline scope

4.1 Clinical question

The key question covered by this guideline is:

*What evidence is there to support the use of occupation in occupational therapy in secure hospitals with patients over the age of 18?*

Occupation-focused practice may incorporate a number of dimensions:

- Occupational therapy assessment and interventions.
- Risk assessment and management, specific to occupational therapy.
- Community-based interventions if relevant to the patient in a secure hospital.
- Management and adaptation of therapeutic environment.
- The principles of recovery, motivation and social inclusion.
- Vocational rehabilitation and real work opportunities.
- Education/further education.

Key areas not covered in this guideline are specific index offence interventions, e.g. anger management, sex offender treatment. These interventions require additional and specialised training for practitioners and are not always occupation-focused, although they may link directly to patients’ occupational performance areas.

The guideline development group was fully aware of, and endorsed, the fact that many occupational therapists are involved in these interventions in secure hospitals; however, the specific remit of this guideline was to address occupation-focused occupational therapy.

The guideline development group, from their knowledge of the evidence base and their own clinical expertise, also identified some key outcomes of occupational therapy practice:

- The occupational needs and strengths of patients in secure settings are identified through assessment using occupation-based assessments.
- Patients are offered and receive occupation-focused interventions that are relevant and consistent with the demands and constraints of secure environments, and are meaningful to patients.
- Occupations will be used as both means and goals of intervention and contribute to pro-social behaviour.
- Engagement in pro-social occupations will contribute to the health and wellbeing of patients in secure settings.
- Patients will benefit from occupational therapy that focuses on developing, maintaining and enhancing their skills in the following areas:
  - Self-care
  - Productivity (e.g. paid work, volunteerism, work within the hospital, committee membership)
Guideline scope

- Social and leisure occupations
- Relationships
- Rest.

It can be difficult to determine the importance of specific outcomes to individual patients, particularly as in occupation-focused practice, those outcomes are frequently interdependent. The guideline development group decided, therefore, not to make any judgements on the relative importance of the outcomes identified above.

During the consultation of this guideline, one patient did, however, comment on the five areas of skills development outlined above, and expressed the following view of their importance. Productivity (demonstration of respect, responsibility and social connections) and relationships with staff (trust was stated as important) were rated highly. Social and leisure occupations were also rated high, followed by self-care and rest, and subsequently relationships with patients. This provided a valuable insight into a patient’s perceptions of these specific outcome areas.

4.2 Target population

This practice guideline relates to adults who are patients within a secure setting.

To further define the target population:

- Adults are defined as any person (man or woman) aged 18 years and over.
- There are no restrictions/limitations on gender, ethnicity or cultural background.
- Patients are admitted to secure settings (high, medium or low secure).

Patients who are admitted to secure services are usually diagnosed with severe mental illness, personality disorder or learning disability. They may have a combination of these diagnostic categories and some patients equally have substance misuse problems. This guideline will, therefore, cover all aspects of severe mental illness, personality disorder and learning disability. This will include diagnoses such as schizophrenia, psychosis, bi-polar affective disorder, personality disorder; however, diagnoses are not the specific focus of this guideline.

Diagnostic terminology has been deliberately avoided in general because of the number of possible ‘diagnostic groups’ and the fact that the broader terms used above are much more appropriate to occupational therapy practice. Occupational therapists need to consider the occupational performance strengths and needs of those for whom they provide intervention. It is important that occupational therapy staff understand the possible impacts and prognosis of certain mental disorders on patients’ occupational performance; however, this is not the primary focus for intervention. Occupational therapists should also take into account potential health inequalities and any social determinants of health that may be appropriate to the provision of services (Marmot 2010, p15).

Child and adolescent groups detained in medium or low secure settings are not included due to their specific developmental and educational needs. However, it is anticipated that some aspects of this guideline will be relevant to these groups.
4.3 Target audience

This guideline will be primarily relevant to occupational therapists and occupational therapy staff working in secure hospitals/settings. The guideline may also be valuable in informing the development and delivery of occupational therapy services in prisons.

In addition to occupational therapy staff, it is suggested that this practice guideline is relevant to:

- Commissioners and managers of secure services.
- Patients in high, medium and low secure hospitals.
- Families and friends of patients in high, medium and low secure hospitals.
- Multidisciplinary team members who work in secure hospitals (forensic psychiatrists, psychiatrists, clinical and forensic psychologists, nurses, social workers, education and support staff).
- Health, social care and occupational therapy students, educators, academics and researchers.
- Specialist commissioning groups for forensic mental health services.
- Care regulators:
  - Care Quality Commission (England)
  - Care Inspectorate (Scotland)
  - Healthcare Inspectorate Wales
  - Regulation and Quality Improvement Authority (Northern Ireland).
- Mental Health/Mental Welfare Commissions.

It is intended that this guideline provides a comprehensive, practical resource for occupational therapists working with adults in secure settings, as well as for the wider audience identified above.
5 Recommendations and supporting evidence

The guideline recommendations are presented under categories that reflect the Model of Human Occupation (MOHO). This model (O'Connell and Farnworth 2007, Bennett and Manners 2012) and its associated assessments (Cassidy and Garrick 2012) are the most frequently cited to date in texts and research related to forensic occupational therapy. The model was initially developed in the 1980s by Professor Gary Kielhofner and had subsequent revisions and collaborations until its last published version in 2008 (Kielhofner and Burke 1980, Kielhofner 2008).

MOHO recognises that human occupation is motivated, patterned and performed. Humans are conceptualised as three interrelated components: volition, habituation and performance capacity.

Volition denotes the motivation for occupation; habituation is the process by which occupation is organised into patterns or routines; and performance capacity refers to the physical and mental components, and the subjective experience, that assist the ability to do things. There is a requirement within the model to understand the physical and social environments in which an individual's occupation takes place (Kielhofner 2008). MOHO assists the understanding of occupation(s) and problems of occupation that occur in terms of volition, habituation, performance capacity and environmental context (MOHO Clearinghouse 2017a).

Essentially a system-based model, it incorporates a number of well-recognised assessments: observational, self-report and interview schedules. These range from tools that explore one aspect of the model, for example volition, to more in-depth, holistic assessments which consider all aspects of a person's occupational performance and life history narratives (Kielhofner 1998). One of the advantages of this model is that its use is extensively supported by research in mental health settings; there is a forensic version of one of the assessment tools, the Occupational Circumstances Assessment and Interview and Rating Scale (MOHO Clearinghouse 2017b).

The guideline recommendations themselves do not prescribe any particular model, or standardised assessment/outcome measures, and full recognition is given to the fact that occupational therapists may find other tools valuable to support their practice. The use of MOHO is, therefore, by no means intended to be prescriptive; however, it serves as a useful framework within which to categorise the recommendations. It is suggested that while each guideline recommendation has been categorised within one of the MOHO concepts, there is undoubtedly some overlap and a recommendation may not be discrete to one area.
Recommendations grading

Recommendations are graded B (moderate), C (low) or D (very low) to indicate the quality of the evidence. Following critical appraisal there was no evidence assigned an A (high) grade.

The scoring of 1 (strong) or 2 (conditional) indicates the strength of the recommendation (sections 10.4 and 10.5).

Each statement starts with either ‘It is recommended’, or ‘It is suggested’.

‘It is recommended . . .’ means that most patients would want, or should receive, this course of intervention or action.

‘It is suggested . . .’ means that the majority of patients would want this intervention but not all, and therefore they should be supported to arrive at a decision for intervention consistent with the benefits, and their values and preferences.

Additional details on individual studies (for example, on recruitment numbers and statistically significant p values) can be accessed in the evidence tables (Appendix 6).

This guideline addresses occupational therapists’ use of occupation-focused practice within the context of the secure hospital environment. As such, the intervention is specifically occupational therapy, and alternative management options have, therefore, not been explicitly reviewed or discussed. This is in line with the clinical question, which indicates that there was no comparator intervention. Risks associated with implementing the recommendations in this guideline are central to the overall context within which occupational therapy is provided within secure settings. Benefits and any specific risks have been integrally incorporated within the discussion of the evidence.

5.1 Volition

Evidence overview – Volition
The evidence identified that life history is a factor that influences occupational performance and life satisfaction. Patients expressed a wish to be involved in decision making about their care; determining the patient’s perspectives, and aspirations, is highlighted as being important in this respect. A body of evidence was particularly noted in the proportion of time being spent by patients in passive leisure and rest occupations. Occupational therapists have a key role in facilitating occupational choices that are meaningful to the patient.

5.1.1 Introduction
Volition relates to people’s motivation to engage in occupations combined with their self-belief and capacity to succeed (personal causation). Motivation and personal causation can be affected by a patient’s mental health (e.g. depression, schizophrenia, personality disorder), or their perception of the reason and need for their admission to a forensic mental health setting. Sheldon and Tennant (2011, p46) opined that there are certain ‘internal’ factors for patients with personality disorder that can impede their engagement and motivation for treatment. These include ‘affective’ factors such as embarrassment; ‘cognitive’ factors such as self-doubt in one’s own abilities; and ‘volitional’ factors such as pursuing goals other than treatment. They recommend that it is important to establish the patient’s own goals to ensure treatment readiness.
Despite the quest for meaningful and purposeful occupational activities in forensic environments, some patients lack the motivation to engage and resent being incarcerated against their will, describing admission as ‘doing time’ or being ‘nutted off’. These patients can view the environment as a barrier to participation in usual activities (Farnworth et al 2004), and lack of engagement can impact negatively on the patient's mental health and wellbeing. Patients often have complex occupational histories, which are situated within social tensions related to their anti-social or criminal occupations.

Patients admitted under a section of the relevant mental health legislation (see section 1.3.2), and when against their will, can be unwilling or unmotivated to engage in occupational therapy or any interventions. Patients’ desire for discharge into the community or to settings of lesser security is very evident in secure settings. Occupational therapists have the skills and expertise to assess and engage people in those occupations that they find interesting, meaningful and motivating. This requires a careful understanding and appreciation of what underlies the motivation and creating occupational opportunities. Occupational therapists also help people to identify and achieve their own hopes and aspirations; vocational rehabilitation and work skills are key occupational therapy interventions (McQueen 2011).

‘Recovery is what people experience themselves as they become empowered to manage their lives in a manner that allows them to achieve a fulfilling, meaningful life and a contributing positive sense of belonging in their communities’ (National Institute for Mental Health in England (NIHME) 2005, p20). Recovery-focused practice is at the centre of patient treatment pathways. NHS England’s Recovery College Commissioning for Quality and Innovation (CQUIN) Scheme 2016–2017 is anticipated to promote the principles of recovery and ensure that patients, detained or otherwise, have access to opportunities to empower their learning and recovery pathways (NHS England 2016). Occupational therapists must demonstrate that their practice is recovery-focused and developed collaboratively with patients.

Personal causation and choices can be influenced by gender. Gender-specific ways of working should be the remit and within the capabilities of all staff, and this applies no less in forensic mental health. Newton et al (2000) produced a report that indicated that women in high and medium secure care are detained for different reasons to men, and have different needs. There are significantly fewer women than men admitted to forensic units, with only 14 per cent women in the high secure patient population and 16 per cent in medium secure units (Bartlett and Hassell 2001, DH 2002b). In 1999, a Centre for Reviews and Dissemination report highlighted that less than a fifth of the population in secure services are women, and they are a heterogeneous group with a wide range of personal, mental health and forensic histories (Lart et al 1999). These women are less likely to have committed serious criminal offences compared with men, yet more likely to have had previous admissions for mental health problems. Patterns of diagnoses differ between the two groups: in high secure hospitals, women are more likely to have a diagnosis of personality disorder, and in particular borderline personality disorder, whereas men are usually classified with mental illness. There are further elements of clinical differences; it would appear that the prevalence of self-harm is greater for women, and this is often the focus of risk management within secure settings; however, men are more likely to exhibit aggressive behaviour to others (Lart et al 1999, Bartlett and Hassell 2001, DH 2002b, Bowers 2002). Men are less likely to have convictions for fire-setting and criminal damage than women patients, who often have a significant history of abuse from others.
Volitional difficulties experienced by patients are likely to be highly relevant in the secure setting, manifesting in a decrease in personal causation, difficulty identifying or having unrealistic goals, and an inability to find meaning or interest in activities.

5.1.2 Evidence

<table>
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<tr>
<td>1. It is recommended that occupational therapists always take into account the gender-specific needs of patients with whom they are working. (Baker and McKay 2001 [C])</td>
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Baker and McKay (2001) conducted a survey of the needs of women in medium secure environments. This did not include women patients but the perspectives of occupational therapists (n=62) who responded to the survey. Results indicated that occupational therapists were cognisant of the gender-specific needs of the women patients; moreover they tried to tailor appropriate interventions accordingly within the constraints of a secure environment. Sessions provided included education, assertiveness, sexual health, and fashion and beauty sessions. These related particularly to self-esteem. Additionally, the respondents recognised the need for women-only sessions due to potential intimidation by men in the unit. Particular attention was necessary to address women patients’ roles such as mothering and relationships. This was a useful survey, which highlighted aspects of occupational therapy practice, but also suggested that service provision did not satisfactorily meet the needs of women in secure care. It was acknowledged that the study was limited as it did not address the patients’ own perspectives, an important area for future research.

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<tr>
<td>2. It is recommended that occupational therapists consider the occupational life history of patients, including that at the time of the index offence, and its influences on occupational performance, life satisfaction and criminogenic lifestyle. (Lindstedt et al 2005 [B])</td>
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It is vital that occupational therapists collect and consider the contextual occupational histories of patients as these have an impact on past, present and future occupational performance areas. Lindstedt et al (2005) reported on a cohort study in which 75 patients from an eligible sample of 161 agreed to participate. In total, 55 of the patients completed all the relevant assessment measures, including the Karolinska Scales of Personality. The study found that patients with psychopathy/personality disorder differed from other groups: they were more likely to have conduct disorder prior to age 15; have less involvement with welfare agencies and come from disadvantaged backgrounds. Certain characteristics such as poor socialisation were associated with a life history lacking in positive interpersonal relationships, empathy and satisfaction. Anxiety proneness was also noted and considered an important factor in treatment planning. The authors highlighted the heterogeneous nature of the forensic population, and that occupational performance and life satisfaction are not simple concepts. A conclusion from the findings was that life history was an important factor that influences occupational performance and life satisfaction.

While not identified within the evidence, it is important to highlight that some patients may find sharing their life history difficult. Patients with learning disabilities, for example, may require support from carers or family members.
3. **It is recommended** that occupational therapists establish, as part of their assessment, the patients’ perspectives of their occupational performance and social participation, and work with those perceptions in planning care.  

*(Lindstedt et al 2004 [B])*

Lindstedt and colleagues, using the same cohort, also conducted a cross-sectional comparative multi-method study *(Lindstedt et al 2004)*. The aim was to describe occupational performance and social participation of mentally disordered offenders and compare professionals’ and patients’ appraisals of these abilities. Data collection included patients’ self-report measures, professionals’ observation of occupational performance and register data. One critique of the study is that data were collected in different formats for the professionals and patients. The patients reported some disability in performing occupations and participating in community life. However, they were satisfied with their performance and participation, implying limited awareness of their disabilities. The professionals judged the patients as having problems with social participation, and major, longstanding disabemlents in several areas. This potential for variance between patients and staff in the perceptions of performance should be determined if the patient and occupational therapist are to work effectively towards common goals.

4. **It is recommended** that occupational therapists work collaboratively with patients to identify and develop care pathways which are recovery focused.  

*(Clarke 2002 [C]; Walker et al 2013 [D])*  

[Statement amended, new evidence 2017]

The need to work collaboratively with patients was identified in Clarke's *(2002)* ethnographic research study. This aimed to determine the extent to which forensic mental health patients were involved in decisions regarding their care, and their desire to be involved in the decision-making process. The research took place in a medium and low secure unit in the UK with ten patients and ten staff. Observational analysis suggested that a medical culture dominated in the secure unit, and little was observed in terms of patients' involvement in decision making. Analysis from the interviews with patients indicated that patients wished to be more involved in decision making and that they perceived staff to be the decision-makers in their care. Low staff numbers were reported to inhibit patient involvement, but there were also inconsistencies in practice related to patients' involvement in decision making. Although a small study, the results have some level of transferability and reinforce the importance of a person-centred approach to address a patient's volitional needs.

Walker et al *(2013)* carried out a study on a secure intensive rehabilitation unit in Australia to investigate the understanding of male patients (n=9) and staff (n=10) regarding community day leave (CDL). Escorted CDLs were observed and interviews carried out. While staff and patients had a similar overall understanding of the function of CDLs, the style of interaction and decisions/actions of staff providing the escort significantly impacted on the potential benefits of CDL. The study reported the ways the escorting members of staff facilitated the aims of rehabilitation and fostered recovery. The findings indicated that preparation and planning regarding the purpose of community leave, and its relevance to the individual care treatment plan, was required, and should be negotiated between the patient and staff member before the leave
Recommendations and supporting evidence

commences. The importance of collaborative goals and objective-setting based on recovery principles and concepts was identified, and that those concepts such as installing hope, empowerment, and connection to others need to be embedded in the leave to maximise the rehabilitative outcomes. The authors identified that there were no guidelines addressing the implementation of leaves from a functional rather than a risk assessment perspective, and that guidelines on how to facilitate CDLs from a recovery perspective were necessary.

5. **It is recommended** that occupational therapists recognise the specific intrinsic value of occupation to individual patients.

   *(Craik et al 2010 [C]*)

6. **It is recommended** that occupational therapists facilitate meaningful occupational choices for patients.

   *(Craik et al 2010 [C]; Cronin-Davis 2010 [C]; Mason and Adler 2012 [C]; Morris 2012 [C]; O’Connell et al 2010 [D]; Stewart and Craik 2007 [C]*)

A number of studies recommended that occupational therapists should facilitate meaningful occupational choices for forensic mental health patients (Stewart and Craik 2007, Craik et al 2010, Cronin-Davis 2010, O’Connell et al 2010, Mason and Adler 2012, Morris 2012).

The qualitative ethnographic study reported by **Craik et al (2010)** involved 26 patients in medium or low secure units in five focus groups, one of which was specifically for women. Participants expressed how they valued engaging in meaningful occupation as it gave them a sense of achievement and promoted their health. They also indicated that life skills and vocational rehabilitation were highly important. Participants identified a lack of both resources and willing staff, among other factors, as barriers to their current occupations. This was a useful study but potentially limited by the use of focus groups, which may have resulted in the loss of valuable information from those who did not wish to participate or felt that their voice could not be heard in a group environment. The emphasis on occupation being meaningful highlights the importance of recognising that the specific intrinsic value of an occupation is unique to each individual.

Qualitative doctoral research conducted with eight patients in secure hospitals (four high secure and four medium secure) used interpretative phenomenological analysis to interpret and communicate the patient’s views and perceptions of being involved in occupational therapy (**Cronin-Davis 2010**). These participants valued their occupational therapy sessions and could identify what they gained from certain occupations; there was evidence to suggest that these patients were able choose what was meaningful to them. One patient indicated that he was motivated to use occupational therapy as a way of relaxing and having time out from other therapies. Some patients in the study did not realise that occupational therapy was a legitimate therapy or were unaware that they had an occupational therapy treatment plan. This was another small-scale study with patients from four different sites. Further research was recommended, as were the implications for clinical practice training and pre-registration training, to ensure that occupational therapists are able to communicate explicitly to patients the nature and purpose of occupational therapy interventions.

**Mason and Adler (2012)** reported on a qualitative study that explored factors that influenced 11 men’s engagement in therapeutic group-work within a high-security
hospital environment. The most significant and far-reaching theme of influence was found to be the culture of the environment, closely linked to the concepts of choice, which stem from and are greatly influenced by culture. Participants highlighted additional motivational areas of influence: relationships, trust, motivation, group-work content and expected outcomes.

A time use study (O’Connell et al 2010) of two patients who transferred from a prison to a medium secure service indicated that sleeping, together with passive and leisure occupations, dominated at both sites. Changes to occupations were noted when the patients transferred to the secure unit. One slept more while the other slept less; and there was/were less delusional-driven behaviour/occupations in the secure unit. The data indicated that the secure unit offered more in terms of an optimum level of occupational engagement than the prison. O’Connell et al suggested that occupational choices are influenced by past occupational roles, and that current illness symptomatology also has an impact on occupational engagement. Limiting or eliminating delusional-driven activity can, however, lead to other occupations (such as excessive sleeping), raising the question as to whether delusional occupations can facilitate health when they are meaningful and enjoyable for the person, even though they are delusional in nature.

Stewart and Craik (2007) undertook mixed methodology research to explore how people with schizophrenia experience occupational engagement in forensic medium secure units, and the impact of detention on performing occupations. This was a small-scale time use and interview research project, which had some difficulties recruiting participants. However, the findings suggested that the five participants spent the majority of their waking hours resting and engaging in recreation. Self-initiated occupations accounted for 73 per cent of the time. The overall time use, when considered in four occupational domains, identified 15 per cent in daily living tasks, 8 per cent in work-related occupations, 23 per cent in recreation and 15 per cent resting. The other 39 per cent of time was spent sleeping. Therefore, time use was characterised mainly by engagement in passive leisure and rest occupations. Themes from interviews in this research included motivation for occupation; the value of occupations; choice and autonomy; and pattern of occupation.

There were correlations between competence and enjoyment, and value and enjoyment; and occupations chosen were based on expectations, namely of enjoyment, success, and their association with independence and normality. Research has additionally suggested patients use occupation as a means of ‘escape’ (Stewart and Craik 2007, Cronin-Davis 2010).

Morris (2012) investigated the value placed on occupation and how that changed over a year for five men in a regional secure unit. In this qualitative study, the importance of meaningful activity was reflected in the ‘irritation’ expressed by the men when therapeutic programmes/occupations were not considered interesting or relevant. The provision of specific activity projects with clear purpose and timescales was suggested as being more meaningful than those weekly creative sessions where there was no apparent extrinsic purpose. Meaningfulness was demonstrated by increased motivation, attendance and participation. Morris identified that a lack of availability of preferred occupations also contributed to boredom. In the conceptual framework developed as part of the study, Morris suggests that ‘Occupational engagement is a fluctuating state influenced by complex and multiple internal and external factors’, additionally highlighting the significance of ‘personal value and perceived consequence to participation’ (Morris 2012, p251).
7. **It is recommended** that occupational therapists ascertain patients’ aspirations towards paid employment at the earliest opportunity, and during rehabilitation.

*(McQueen 2011 [C])*

In a review to the Scottish Government of vocational rehabilitation in forensic mental health services, **McQueen (2011)** highlights the importance of including the ‘work question’ when looking at the wider recovery goals for those with mental health needs, including those in secure settings. The report recommends that patients should be assisted to identify their work aspirations as soon as possible during their admission to a secure service. Ten patients who took part in in-depth interviews and focus groups indicated that the positive impact of work facilitated self-belief, satisfaction, achievement, feeling useful and increased confidence. Those involved in the research suggested that being given early opportunities to be involved in work-related occupations was important to their rehabilitation (McQueen 2011, p15).

**Volition – patient perspectives**

“Direct consideration of what interests and enthuses me is important, as it also allows for a good initial relationship and discussion to be individualised. What MIGHT interest me is also important as hospital can be a place to discover new interests...”

“Aspirations’ could more specifically relate to a person’s outlook generally rather than only to paid employment.”

“Meaningful – Yes, but also relevant to their ‘recovery needs’. Activity and progress should be time framed and phased, so progress and skill development can be measured and to ensure things don’t drift, lose meaning and focus. Sometimes activities are done to aid independent living skills but repetition leads to boredom and disinterest.”

Patient consultation feedback

5.2 **Habituation**

**Evidence overview – Habituation**

Meaningful structured activity is a recommended quality standard which is supported by the evidence. A number of studies identified that a range of interventions should be made available for patients, to include weekends and evenings, not just within traditional working hours. Consideration of past, present and future roles is important when planning individualised interventions.

5.2.1 **Introduction**

The concept of habituation refers to a person’s internalised roles and patterns of behaviour consistent with a person’s lifestyle. It is the process which enables people to appreciate and co-operate with their environments to do routine tasks automatically and effectively (Kielhofner and Forsyth 2002). Roles are those associated with personal identity, occupations and activities of daily life, and extraordinary occupations. Internalised pro-social roles may be missing for some offender patients, with their daily routines and occupations more consistent with criminal lifestyles.
An aim of interventions in secure environments is to enable patients to consider pro-social roles and occupations in an effort to live within society without resorting to previous criminal or new anti-social behaviours. The imposed legal and security restrictions in secure environments can mean that patients are unable to participate in their habitual or chosen occupations; this may be because such occupations are anti-social, or due to lack of resources, facilities or particular environments being available in secure settings. Often patients benefit from the structure, stability and consistency of admission.

The importance of structured activity was previously recognised in Best practice guidance for adult medium secure services (DH 2007, p24) and by the Royal College of Psychiatrists' Quality Network for Forensic Mental Health Services (Tucker and Reeve-Hoyland 2010), stating that there ‘will be a minimum of 25 hours a week per patient of structured activity’ (DH 2007, p24). This has been further defined in the NHS England contracts for high, medium and low secure mental health services as a minimum of 25 hours a week: ‘access to social, educational and occupational opportunities that is meaningful and supports rehabilitation and recovery’ (NHS England 2013a, 2013b).

Achieving the recommended 25 hours a week per patient structured activity is not, however, without its challenges. Rani and Mulholland (2014) undertook a study in Ireland to identify if patients (n=93) were receiving this quality standard. The survey relied heavily on researchers reviewing documentation, and findings indicated that 61 per cent of service users (n=57) fully met the criteria, although the meaningfulness of the activities was not captured. Barriers to participation in meaningful occupation or activities were greater in high secure units, where engagement was found to be lower than for those in medium or low secure environments, reflecting, in part, risk management strategies in place.

Given the diversity of the population within secure settings not only in terms of age, ethnicity and culture, finding the ‘right’ occupations that are culturally relevant, risk managed and appropriate to the ‘typical’ forensic population creates its own challenges for occupational therapists. Technological advances have had an impact on the range of occupations that occupational therapy is able to offer, extending to the inclusion, for example, of contemporary videogames (Gooch and Living 2004) and Nintendo® Wii™ (Bacon et al 2012), in addition to actual sports.

5.2.2 Evidence

| 8. It is recommended that occupational therapists consider patients’ roles (past, present and future) within treatment planning and interventions. | 1C |
| Schindler 2005 [C] |

In an American study, Schindler (2005) explored the area of social roles and the skills involved in these roles. She conducted pre- and post-test research to examine whether adults diagnosed with schizophrenia demonstrated improved task skills, interpersonal skills and social roles when involved in an individualised intervention based on a role development programme (RDP). The comparative intervention was based on a multi-department activity programme (control). There were 42 participants in both the treatment and control groups, all of whom were men aged 18–55 years. The findings indicated significant differences in interpersonal ability between the groups. The RDP group demonstrated greater improvements in social roles than the control at 4, 8 and 12 weeks. The research concluded that individuals with schizophrenia are willing and able to develop roles and underlying skills.
Recommendations and supporting evidence

9. **It is recommended** that occupational therapy facilitates a range of interventions that enable patients to engage in structured and constructive use of time throughout the week, including weekends and evenings. *(Bacon et al 2012 [D]; Castro et al 2002 [C]; Farnworth et al 2004 [C]; Jacques et al 2010 [D]; Stewart and Craik 2007 [C])

A retrospective evaluation conducted by Castro et al (2002) examined the effects of socio-demographic, behavioural and treatment variables on discharge and independent living at six-month follow-up for patients in medium secure provision. There was no specific intervention for the focus of the study, with data collection for the study being dependent on what was available in reports/notes and obtained via telephone interview at six months after discharge. Patients’ participation in specific interventions (occupational therapy and psychology) was highlighted in the results. The main indicators of success at follow-up included constructive use of time since discharge, including: work; education; day hospital; leisure centre; therapy; or maintenance of a social life. A useful predictor of progress after discharge appeared to be employment status. Engagement in psychological therapies and/or group activities was directly related to length of stay, general progress and improvement in mental state. Participation in therapy was not found to be directly related to subsequent involvement in community services or general success in independent living at follow-up; however, levels of participation were not measured. This study was limited to one unit with a small follow-up group, with limitations in generalisability, particularly as more than 85 per cent of patients were discharged within nine months. For engagement in therapy this is considered relatively short term.

A naturalistic inquiry into time use in the context of the occupational histories and current environment of a group of patients in a secure forensic psychiatric setting in Australia was carried out using a mixed methodology *(Farnworth et al 2004)*. Quantitative data were collected using a time use diaries approach, qualitative interviews used the Occupational Performance History Interview (OPHI-II), and field notes were also recorded. Participants were eight men on two wards (medium and low secure) aged 24–48 years; seven were diagnosed with schizophrenia and one with co-morbid poly-substance abuse. Findings suggested that personal care predominated on weekdays (50% of time), followed by recreation and leisure (40%). At the weekends participants spent 96 per cent of time on personal care, recreation and leisure, and 89 per cent of personal care time was spent sleeping. Themes from the interviews implied that these participants felt that they were ‘killing and passing the time’, ‘doing groups’ while trying to ‘make the most of’ the time. They wanted creative challenges; however, there were barriers to exploiting occupational opportunities and every day felt the same. These findings suggest that a range of interventions should be provided over the seven-day week to increase patients’ engagement in constructive and personally satisfying occupations, which also provide temporal adaptation.

An audit/evaluation to review the needs of the men in a medium secure service who had been inpatients for more than five years was conducted in one medium secure unit in the UK *(Jacques et al 2010)*. Demographic details were collated and patients’ nurses were interviewed to collect data using the forensic version of the Camberwell Assessment of Need. Twenty-one patients were included in the study, 95 per cent of whom had occupational therapy as part of their overall programme. Only 19 per cent attended their entire programme. The group were rated by the nursing staff and 81 per cent were identified as requiring support to structure the day/occupy their time. The
evaluation concluded that a significant population of men in this particular medium secure service had been inpatients for more than five years (21% had been longer than the three-year intended stay). This group had different needs from those who progress at a faster rate through medium security, and it was therefore suggested that services should be tailored to meet these needs. Additionally, this audit suggests that patients are difficult to engage in the therapeutic activities on offer, and that the need to consider flexible and alternative activities for this cohort must be emphasised.

Bacon et al (2012) identified within an exploratory study that age-appropriate activity, when enjoyable and meaningful, could impact positively on a patient’s daily exercise habits. Two case studies demonstrated that the use of a Nintendo® Wii Fit™ could increase the amount of weekly engagement in physical activity. The use of virtual technology can provide a novel environment and motivating forum for those in a secure setting.

Finally, in an exploration of time use by five patients with mental illness in forensic units, Stewart and Craik (2007) demonstrated that participants were more likely to engage in occupations late in the afternoon and at the end of the day. The authors suggest that occupational opportunities during the evening may better suit levels of arousal. The implication of this is that occupational therapists may have to relinquish nine-to-five working hours in favour of flexible working hours to provide occupations at the time patients have better levels of temporal arousal. Albeit a small qualitative study, the participants indicated that occupations were of value and enjoyable, thereby proving the benefit of occupation.

**Habituation – patient perspectives**

“It’s really important to help us identify the patterns and history of our engagement and why this is relevant. Consider productivity according to past and present – asking patient why this may have differed in order to help us understand the relevance and importance of changed behaviour/engagement. Consideration of habituation formed as a result of medication, and/or sleep pattern. Help needed to support patients to work on identifying these patterns in their daily routine and collaborate on how these can be overcome and WHY breaking them is beneficial to the Patient and their Recovery. This is currently a huge issue!”

Patient consultation feedback

### 5.3 Performance capacity

**Evidence overview – Performance capacity**

A number of studies considered the use of standardised outcome measures, and demonstrated their importance in assessing a patient’s progress and identifying ongoing needs through a dynamic process. A range of measures were demonstrated as being feasible to apply within the secure hospital setting.

A case was made in the evidence for prevocational training, real work, or supported employment, with recognition of the importance of work for mental health and future opportunities. The positive contribution of exercise-focused activities in relation to health and wellbeing was the subject of a number of studies, with encouraging evidence also noted for a social inclusion programme.
5.3.1 Introduction

According to the Model of Human Occupation, performance capacity is related to a person's adaptive interaction with the environment, and the ability to do things provided by underlying objective physical and mental components and the associated subjective experience (Kielhofner 2008). Many patients, due to their illness or disorder, may not have the prerequisite occupational performance skills for accomplished daily living, or these skills may have been eroded due to long-term institutionalisation. Alternatively, these performance skills have not been acquired or learnt during the transition from child to adult. Occupational therapists in secure environments have a major role to play in helping patients to develop, maintain or acquire new skills for successful community reintegration or transition to less secure settings, particularly in the area of vocational rehabilitation. Occupational therapists can help patients to identify which vocational areas may be possible; for example, study/education, voluntary or paid employment. It is important that these options are considered carefully, with a realistic appraisal of what might be available to the patients given their mental health and any convictions that might prevent some areas of work/study. Interventions should address specific prevocational needs. Some patients may not work again and therefore other pro-social, productive and meaningful occupations need to be established.

The social inclusion agenda, with the requirement of reducing discrimination and social exclusion for mental health service users, has been dominant in mental health provision in the UK (Fitzgerald 2011). It is a key component of the College of Occupational Therapists' document, Recovering ordinary lives: the strategy for occupational therapy in mental health services 2007–2017, a vision for the next ten years (COT 2006a), and its relevance to forensic mental health services has been highlighted by the Royal College of Psychiatrists (Royal College of Psychiatrists, Faculty of Rehabilitation and Social Psychiatry 2009).

Occupational therapists consider the impact of engaging in occupations on a person's health and wellbeing and this should be no different in secure settings. Patients often have complex mental health/emotional problems; and often co-morbid physical health problems. Patients' propensity for weight gain in secure settings due to side effects of psychotropic medication is well documented (Bacon et al 2012). Such side effects can adversely affect patients' health, wellbeing, occupational performance and general quality of life, and occupational therapy staff are often involved with interventions designed to promote a healthy lifestyle.

What is important is that both patients and occupational therapists recognise which occupational performance skills require intervention and why. These must be routinely measured to demonstrate change and progress, using recognised outcome measures.

5.3.2 Evidence

10. It is recommended that occupational therapists routinely use standardised outcome measures to assess and demonstrate patients' progress.

(Clarke 2003 [D]; Fan 2014 [D]; Fitzgerald 2011 [C]; Green et al 2011 [C]; Kottorp et al 2013 [C]; McQueen 2011 [C]; Williams and Chard 2016 [D])

[New evidence 2017]
Assessment tools and outcome measures may take many forms, including those completed by the occupational therapist, and those that are patient reported.

A UK mixed methodology study undertaken by Green et al (2011) aimed to develop a brief and simple questionnaire, the Recovery Journey Questionnaire (RJQ). The RJQ was designed to measure medium secure unit patients’ experience of recovery over their inpatient journey, and to be reliable and feasible for use in forensic mental health services. Sixty-nine participants responded to the questionnaire; two focus groups and four in-depth interviews were held. The questionnaire required individuals to indicate the extent (0–100%) to which they felt the following recovery principles were being met: working together; support and preparation; providing good role models; and things to do. Of the included participants, 78 per cent (n=54) reported that the tool/assessment was very useful. The authors conclude that this would be a useful measure to administer at regular intervals; for example, before Care Programme Approach meetings. It assesses patients’ subjective experiences of recovery in a forensic setting, but requires further study of other variables associated with inpatient stay. The study had limited involvement of women and the researchers additionally identified the need for further validation of the RJQ in relation to quality of life and other clinically relevant factors.

Clarke (2003) reported on the use of the Canadian Model of Occupational Performance (CMOP) within a forensic rehabilitation hostel. While this was not a research study, the description of the application of the model within a forensic setting provides some useful perceptions. CMOP, as in the RJQ reported in Green et al (2011), includes the residents’ self-perception, in this case of occupational performance. Clarke suggested that CMOP was easy to use in a forensic hostel with certain advantages, namely its emphasis on client-centred practice; the focus on occupational performance; and its use in evaluating the effectiveness of intervention. While supporting data are not provided, the author indicated that the residents in the forensic hostel expressed feelings of increased empowerment, autonomy and satisfaction, and had shown increased levels of motivation, treatment compliance and engagement in therapeutic interventions.

In a UK study, Fitzgerald (2011) demonstrated the utility of using the Model of Human Occupation Screening Tool (MOHOST) in a low secure rehabilitation unit. This was a pre-test and post-test, between-group comparison evaluative study. The overall aim of the study was to provide evidence for the role of occupational therapy related to a social inclusion programme (SIP) in the rehabilitation of mentally disordered offenders. Twenty-four patients attended a SIP, with a comparative 19 attending treatment as usual (TAU). Of the total participants in the study, 84 per cent were men (SIP group n=21, TAU group n=15) and 16 per cent women (SIP group n=3, TAU group n=4). MOHOST indicated statistical differences post-intervention for the SIP group in the following subscales: motivation for occupation; pattern of occupation; motor skills (decrease); and environment. The intervention group demonstrated improved occupational functioning as measured by MOHOST scores. This research is indicative of
MOHOST providing a useful outcome measure for detecting changes in patients’ occupational performance.

Retrospective analysis of data sets from low and medium secure units, in six mental health trusts in England, were analysed by Fan (2014). The objective was to examine patients’ occupational profiles and their occupational participation over time. Measures used to collect the data were the Model of Human Occupation Screening Tool (MOHOST), Health of the Nation Outcome Scales (HoNOS) and Historical, Clinical Risk Management (HCR-20). All patients had received occupational therapy and the MOHOST scores had been recorded by the treating occupational therapists at six-month intervals. Analysis identified that the patients in the low secure units (n=163) had more positive and active occupational participation than those in the medium secure setting (n=326). Occupational participation, measured across six subdomains (motivation for occupation; pattern of occupation; communication and interaction skills; process skills; motor skills; and environment) were found to be influenced, often with statistical significance, by risk and factors such as relational instability, employment problems, substance misuse problems, major mental illness, psychopathy, cognitive problems and activities of daily living problems. Analysis implied that overall occupational participation, identified by MOHOST scores, had improved over the two-year period during which the information was collected. However, due to the multifactorial treatments necessary for patients in secure settings, it was not possible to attribute this directly to occupational therapy. The study demonstrates the value of a valid and reliable outcome measure, such as MOHOST, in assessing and measuring a patient’s progress, and identifying ongoing and dynamic needs.

Kottorp et al (2013) explored activities of daily living (ADL) using data from 35 patients in a Swedish forensic psychiatry evaluation unit. The Assessment of Motor and Process Skills (AMPS) and the Assessment of Awareness of Ability (A³) were used to determine motor and process abilities, and awareness of abilities, respectively. Rasch analysis of the findings indicated that participants demonstrated lower functioning in ADL compared with a normal population, and a limited awareness of their problems with regard to ADL. A moderate and significant relationship existed between awareness of ability and motor ability, while that between awareness and process ability was strong and significant. The findings indicated that ADL ability should be considered when occupational therapists are working with people in forensic psychiatry, and that AMPS and A³ are suitable measures to identify limitations in ADL functioning and awareness.

A practice analysis explored the potential of the Evaluation of Social Interaction (ESI) standardised assessment tool for routine use in an inpatient low secure forensic unit (Williams and Chard 2016). Baseline observations using the ESI identified specific social interaction skills that either supported, or limited, the competent quality of social interaction of six male patients in the unit. Discussion of their ESI assessments enabled the patients to gain a better understanding of why they had social interaction difficulties, and to subsequently engage in the development of intervention plans based on their individual occupational goals. The ESI post-intervention scores facilitated the identification of progress in relation to the patient’s quality of social interaction, and the use of the occupation-based assessment and intervention elicited positive responses from both patients and staff.

A report on a national scoping exercise with allied health professions formed part of a review to the Scottish Government on vocational rehabilitation (McQueen 2011). The questionnaire included a question about models and approaches used in security settings. The Model of Human Occupation was the most frequently used, with the Canadian Model of Occupational Performance or the Individual Placement and Support
Model also used in a number of services. The report recommends the use of activity checklists to inform treatment programmes, particularly for those patients whose goals ‘are not work related’, and evaluation using standardised outcome measures (McQueen 2011, p4). It also suggests that work-related outcomes should be indicative of quality forensic mental health care.

McQueen’s review also recommended that all forensic mental health patients should be routinely asked about their employment aspirations and a collaborative vocational rehabilitation plan written. The report suggests that supported employment may be more effective than prevocational training but recognised that much of the research has taken place outside of the forensic setting, or has consisted of opinion pieces or descriptive accounts.

One of the studies referred to within the McQueen review is that conducted by Smith et al (2010). This provides a reflective and descriptive account of a work-based learning programme designed for a forensic learning disability patient group in the UK. The programme was a partnership between the secure hospital, a workplace in the community and a local further education institution. The views of partner organisations, together with four programme participants, were sought via interviews. Smith et al suggest that there was an increase in transferable skills such as social skills and work skills, literacy and numeracy, and self-esteem. They concluded that the workplace provided a realistic environmental context, which enabled patients to increase their self-confidence, motivation and a sense of achievement. Smith et al recommended research into the use of the Occupational Therapy Task Observation Scale (OTTOS) as a potential outcome measure to strengthen the subjective views obtained in their evaluation.

Although dated, Garner (1995) likewise provides a useful descriptive account of a prevocational training course for mentally disordered offenders from a medium secure unit on return to the community. Twenty patients (four women, sixteen men) aged 20–51 years took part in the course. Of the 20 patients who joined the programme, two did not complete. Eighteen completed a personal development plan; six registered for in-house City and Guilds programmes; and eight planned to move on to part-time training or education as a result of the programme. Garner reported almost 100 per cent attendance, with 12 of the patients progressing to other forms of vocational training or education. She noted that the programme helped with confidence and patients’ ability to compete in mainstream provision (although this was not measured). Programme membership assisted towards discharge.

High attendance was a finding also reported in the evaluation of a ‘Real Work Opportunities’ vocational rehabilitation programme delivered within a forensic intellectual disability service (Cox et al 2014). The programme job roles, carried out by participants for one hour a week over a 12-week period, included trained kitchen cleaner, animal care assistant and gym orderly. ‘Real work’ was simulated throughout the process of advertisement and recruitment through to appointing the successful candidates. The level of support provided by the occupational therapy staff to individuals during the process, for example via workshops, mock interviews and interview feedback, was recognised as more extensive than that likely to be offered by a ‘real’ employer. Outcomes were not formally measured; however, the development of a range of work skills, motivation and commitment was observed. The authors recommend that ‘Real Work Opportunities’ can be used as the first part of a graded pathway, working towards community-based programmes, following reduction in patient risk.
A desire for more ‘real work’ opportunities in vocational rehabilitation was confirmed in a survey of patients and staff carried out in a high secure setting (Völlm et al 2014). The self-reported views of 150 patients and 65 staff confirmed that there is a need for opportunities to maintain and develop work-related skills, which staff in particular considered can be lost during admission. There was recognition by the majority of both staff and patients of the importance of work for mental health and its prevention of reoffending.

12. **It is recommended** that occupational therapists consider the use of healthy living programmes and exercise as activity to benefit health and wellbeing. (Bacon et al 2012 [D]; McQueen 2011 [C]; Prebble et al 2011 [D]; Tetlie et al 2009 [C]; Tetlie et al 2008 [C]; Teychenne et al 2010 [C])

In the context of occupational performance, a small number of studies considered the area of physical health and wellbeing.

A descriptive case study carried out in New Zealand by Prebble et al (2011) set out to establish how health professionals and patients initiated and maintained a healthy living programme in a medium secure unit, and also in a voluntary programme in a pre-discharge medium secure unit. They invited patients and staff to participate, with 16 out of 32 and 17 out of 20 participating, respectively. The first programme was compulsory while the second engaged patients in a health promotion approach. They analysed patients’ notes and minutes of meetings, and used the following health status measures: body mass index; glucose tolerance tests; blood pressure; and use of medication. It was reported that success required a flexible multidisciplinary approach, and that it was important to understand the physical and psychological contexts in which such programmes are established, as these affect the style of a programme.

Two Norwegian studies published by Tetlie et al (2008, 2009) demonstrated the use of exercise programmes in secure settings and the impact on patients’ health and wellbeing. The first (2008) was reported as a before and after study to test if exercise in a regional secure unit, offered as part of routine treatment, would affect psychological and physical health. All patients admitted to the unit over a 14-month period were invited to participate; this resulted in three women and ten men, with a mean age of 32.5 years, participating in the eight-week group programme. Findings demonstrated statistically significant improvement in resting heart rate and systolic blood pressure post-treadmill test. There were no statistically significant changes in body mass index. Participants reported statistically significant changes in feelings of wellbeing and safety. Tetlie et al (2008) concluded that exercise had a positive impact on physical health, and provide useful evidence for this health-promoting intervention. Healthy living programmes were also endorsed by McQueen (2011), who recommended that patients should be aware of the benefits of physical health and wellbeing.

In the second qualitative phenomenological study, Tetlie et al (2009) explored how nursing staff used exercise as a compulsory group-based intervention for patients with severe mental illness in a regional secure unit. Fifteen patients were interviewed, and five staff were interviewed and participated in a focus group. Themes that emerged from the findings included that positive reinforcement was a key ingredient to a successful outcome; that the mandatory nature of the intervention provided certain challenges; and that the therapeutic relationship with exercise staff was fundamental. This second study provides useful information regarding the nature of exercise.
programmes and what needs to be considered for successful patient engagement and participation.

A literature review undertaken by Teychenne et al (2010) investigated the effect of sedentary behaviour on the risk of depression in adults. Many patients in medium secure units demonstrate sedentary behaviour, often present with depression as a major mental illness or co-morbid diagnoses. Seven observational and four intervention studies (including two randomised controlled trials) were included in this review. Positive associations were identified between sedentary behaviour and the risk of depression in the observational studies, although this should be noted with caution as the intervention studies contradicted these results. These authors opine that physical activity could attenuate the association between sedentary behaviour and depression.

Bacon et al (2012) reported on a mixed methods exploratory study, which aimed to evaluate the use of the Nintendo® Wii Fit™ to change engagement in physical activity for patients at risk of obesity at a secure hospital in Australia. Two participants used a Wii Fit™ for eight weeks in individual or group sessions. Participants’ use of the Wii Fit™ was compared with their attitudes towards it (reported during interviews) and their daily physical activity levels (measured using an accelerometer). Researcher field notes were also used to gather contextual data. The findings showed that the two participants played Wii Fit™ up to four times a week in sessions ranging from 7 to 127 minutes. When using the Wii Fit™, participants increased their overall time spent actively moving their bodies in physical activity, as measured by the accelerometer. Using the Wii Fit™ also changed participants’ attitudes towards exercise as they realised that it could be ‘fun’ and ‘challenging’, especially if staff members also participated.

Bacon et al concluded that use of the Wii Fit™ was a meaningful occupational intervention for a secure setting; it encouraged patients to attempt physical activities and to learn about their own bodily response to exercise. Limitations of this research included the exploratory nature of the study and that it was conducted within a limited timeframe. This affects the generalisability of the results, which are nevertheless encouraging.

13. **It is suggested** that occupational therapists include social inclusion programmes as part of their intervention to improve occupational functioning.

(Fitzgerald 2011 [C])

Fitzgerald’s study (2011), described earlier in the context of the use of MOHOST as an outcome tool, also demonstrated how an additional occupational therapy-led SIP (n=24 self-selected patients) benefited participants compared to those only receiving TAU (n=19). The SIP included interventions of leisure; literacy; college; work; and stepping-stone education.

The overall mean MOHOST score for the SIP group increased from pre-intervention to post-intervention, while the TAU group showed a lower post-intervention score compared with that at pre-intervention. That pattern continued for the subscale scores of motivation for occupation, communication and interaction skills, and process skills. The pattern of occupation and environment subscale scores improved for both groups but the SIP group had a larger increase. The Model of Human Occupational Screening Tool (MOHO, Clearinghouse 2017c) subscales indicated statistical differences post-intervention for the SIP group: motivation for occupation; pattern of occupation; motor
Occupational therapists’ use of occupation focused practice in secure hospitals

Skills (decrease); and environment. The intervention group demonstrated improved occupational functioning as measured by MOHOST scores, indicative of positive outcomes of the social inclusion intervention. Although a fairly small sample, this study has encouraging results which attest to the value of a SIP facilitated by occupational therapists.

**Performance capacity – patient perspectives**

“Work needed in initial admittance on patients’ fears and anxieties . . . this is overlooked by staff and in my experience is a barrier for the majority of patients. Once this understanding is established with individuals, steps can be taken to overcome them before and alongside activity, rather than fear being the ongoing shackle along the way that doesn’t get identified and dealt with.”

“Collaboration with patients to identify methods best used to help them understand/learn/ and identify their own progress are important, i.e. learning styles visual, kinaesthetic etc. Consideration of barriers to learning also – language/cultural preferences. This is important in order to best facilitate understanding and engagement.”

“Key for me . . . and not enough attention paid to [this] in secure care is the identification and appreciation of an individual’s past and present skills and qualities. This would help to avoid deskilling and lack of confidence in doing things we used to be very competent at. A great starting point to develop confidence in staff and interactions generally as well as ensuring engagement. It is often the fear of engagement and perceived failure that overwhelms us!”

“Narratives . . . the importance of these is desperately underestimated. Narratives of all kinds but especially those with peers and with others in the community. Involvement in vocational activity and volunteering is often a pivotal point in recovery. So working out in advance what a narrative could be for your circumstances is crucial. There is nothing worse than confidence knocked because you’re not prepared for inquisitive yet friendly interaction/questions . . . being confident in your own story is vital and should be practiced in activity settings.”

**Patient consultation feedback**

**5.4 Environmental considerations**

**Evidence overview – Environmental considerations**

The evidence in relation to environmental considerations indicated a number of areas for consideration by occupational therapists. These included risk assessment, the role of families and friends, impact of the environment per se, and transition from the secure setting to the community.

A key feature of the evidence was the need for occupational therapy staff to fully recognise their therapeutic use of self, how a patient’s perceptions may impact on their engagement, and the need to ensure that patients, and members of the multidisciplinary team, understand the contribution of occupational therapy to the overall treatment programme.
5.4.1 Introduction

Patients can be denied access into their own complex occupational worlds due to the physical isolation brought about by institutionalisation; that is, because they are cut off from the rest of society they are unable to do the activities they would like to do (Whiteford 2004, p237). There are studies which highlight that for people with mental illness, the environment has a strong influence over occupational choices and experience (Rebeiro and Allen 1998, Nagle et al 2002). Moreover, the environment can provide opportunities, constraints and demands when people perform occupations (Kielhofner 2002). Studies have shown that patients in secure environments spend much of their time in passive leisure, personal care and rest occupations (Helbig and McKay 2003, Farnworth et al 2004, Stewart and Craik 2007); and occupational therapists are instrumental in helping people engage in, or develop, occupations of their choice. This is, however, restricted by the legal implications and the security procedures.

The forensic mental health environment can be dominated by physical, relational and procedural security measures, thus making the opportunities for spontaneous occupations difficult. Many patients will not be allowed to leave hospital without the permission of the UK Home Secretary or Home Office due to their restricted section under mental health law. The ability to provide spontaneous opportunities for patients is hampered by rigorous security procedures that often mean the patients can lose interest as occupational therapists locate and count equipment to use in the associated occupation. Often, occupational therapists facilitate the exploration of new or unknown occupations as some patients may have limited exposure or positive life experiences.

Clarke and Ndegwa (2006) reported the lessons learnt from a dangerous and severe personality disorder (DSPD) unit in London making certain suggestions for practice and environmental considerations, which included the number of patients with behavioural dysregulation; the diagnostic mix; offering patients information prior to admission; setting limits; staff supervision and support; and the need for a structured day.

The College of Occupational Therapists' document, Recovering ordinary lives: the strategy for occupational therapy in mental health services 2007–2017, a vision for the next ten years, stresses the necessity to work in partnership with patients, families and friends and to ensure that occupational therapy is accessible and timely to those who need interventions (COT 2006a). Service user involvement groups are working towards developing admission leaflets and, for example, in the Yorkshire and Humber Region the 'Chat Net' internet facility enables patients to view videos of other units. It has been reported that the level of carer support and involvement in forensic mental health services is variable (Canning et al 2009). Carer support and involvement is, however, vital to patients’ recovery in mental health settings, and it has been, and remains, an integral part of the mental health agenda (Worthington and Rooney 2010).

Risk assessment and management is the core business of forensic units; this may include risk to self, others or property, sexual aggression, arson, vulnerability, escape or abscondion. Security in secure health settings has been identified as having three distinct, but interrelated aspects: procedural security, physical security and relational security (Royal College of Psychiatrists, Quality Network for Forensic Mental Health Services 2015). The Department of Health guidance, Your guide to relational security: see, think, act (Royal College of Psychiatrists, Quality Network for Forensic Mental Health Services 2015), states that the balance between these three dynamics often shifts, resulting in the need to modify plans to ensure the needs of a particular patient group or situation are met. It also suggests that all three should be in place at all times.
The Royal College of Occupational Therapists has its own guidance for occupational therapy risk management, risk assessment being an integral component (COT 2006b). The challenge for occupational therapists is to be mindful of the risks posed by individual patients while at the same time facilitating occupational engagement in assessment or treatment. This requires a creative and resourceful approach relevant to the identified risks (Cronin-Davis et al 2004) and often in high-risk environments such as kitchens, workshops and, when possible, the community. In these secure environments the occupational therapists’ skills involve adapting and grading the environment to manage the presenting risk and provide opportunities for positive risk-taking to enable engagement in preferred occupations.

Occupational therapists can provide vital observations and feedback to the multidisciplinary team regarding patients’ presentations in differing environmental contexts such as group, individual and project-based occupations. There has been a recommendation that a profession-specific assessment is developed (Duncan et al 2003), whereas others have argued that occupational therapists can make contributions to the multidisciplinary risk assessment due to their assessments and observations in different situations (Chacksfield and Forshaw 1997). Clinical risk assessments conducted by various disciplines (nurses, doctors, occupational therapy, social work and others) in 64 out of 67 forensic mental health units in the UK indicated no uniformity in the type of risk assessments used and inadequately developed tools, thus potentially causing a lack of continuity in care through the system (McGregor Kettle et al 2003).

A core skill of occupational therapists is to run groups and engage patients in them. However, these are not always appreciated by patients and therefore need to be considered carefully as a valued therapeutic intervention. In a study by Farnworth et al (2004), participants reported that groups were boring and a waste of time; additionally they acknowledged that many attended groups in order to gain leave or to ‘keep the staff happy’ (Farnworth et al 2004, p435). Patients are also known to learn criminal or maladaptive behaviours in forensic settings due to the opportunities to mix with others.

In the seminal book related to forensic occupational therapy (Couldrick and Alred 2003), a number of other interventions are cited; for example, cognitive behavioural group-work, forensic addictions and sex offender work. Many specialist interventions are provided in conjunction with other members of the multidisciplinary team. Occupational therapists need to be creative in providing patients with choice, autonomy and opportunities to engage in occupations of relevance. This can mean working with and sharing skills and expertise with other members of the multidisciplinary team and applying their therapeutic use of self to engage patients in relevant interventions. It is essential that occupational therapy staff work alongside their colleagues in the multidisciplinary team, in accordance with local service arrangements, to ensure that the needs of patients are met and that person-centred care is delivered.

5.4.2 Evidence

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<td>Recommendation (Evans et al 2012 [C]; Mason and Adler 2012 [C]; Tetlie et al 2009 [C])</td>
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(Statement amended, new evidence 2017)
Mason and Adler's (2012) research with 11 patient participants in a high secure hospital confirmed the importance of staff maintaining therapeutic rapport, to promote autonomy, choice and engagement in occupations. Choice and trust also featured as concepts. However, the constraints of security requirements and the pervasive nature of the culture within the environment impacted on goal attainment and autonomy. The importance of therapeutic relationships was also endorsed by research in Norway (Tetlie et al 2009).

A qualitative research study (Evans et al 2012) explored the formation and development of therapeutic relationships between patients and support staff, namely occupational therapy support workers (n=3) and nursing assistants (n=7), in two medium secure units. The perspectives of staff provided three main themes which consisted of: the development of relationships with patients ('Building Bridges'); seeing the person and managing risk ('You do forget what they've done'); and maintaining boundaries ('Playing your cards close to your chest'). Engaging in activities with patients was highlighted as a ‘building block’ that helped to create and develop a relationship. The authors suggest that support staff need to be aware of a patient’s attachment style, as well as the factors that impact on their own style of interaction.

15. It is recommended that occupational therapists ensure that risk assessment is a dynamic process, in which judgements are made on an ongoing basis in collaboration with patients and members of the multidisciplinary team. (Cordingley and Ryan 2009 [C])

Research published by Cordingley and Ryan (2009) investigated forensic occupational therapists’ ideas about risk assessment and what risks they assess. A qualitative approach, which used three focus groups of therapists working in different forensic settings, provided data. Analysis of the data found that four themes emerged: risk perceptions and interpretations; fundamental information; risk behaviours and occupations; and environments. Cordingley and Ryan suggest that the findings support a number of aspects of risk assessment in the forensic occupational therapy literature and could be categorised under the components of the person, the environment and occupational performance and participation. They noted limited evidence in the literature and in their own study about the risks associated with occupations and about client-centred approaches to risk assessment. They recommended further research related to a comparison between forensic occupational therapy risk assessment and multidisciplinary risk assessment.

16. It is suggested that occupational therapists recognise the role and contribution of families and friends in the recovery of patients. (Absalom et al 2010 [C]; Fitzgerald et al 2012 [D])

[Statement amended 2017]

Qualitative UK research by Absalom et al (2010) demonstrated that forensic patients needed family interventions. The needs of 137 patients identified were assessed by key nurses, and 318 staff from low, medium and high secure settings completed a training needs questionnaire. Absalom et al concluded that there was considerable unmet patient need which could be addressed by family intervention. Some of the staff lacked the required skills to deliver family interventions and there may be specific barriers to delivery in forensic services. There was no data or assessment of the families’ perceived needs.
A reflective practice analysis published by Fitzgerald et al (2012) demonstrated how occupational therapists could contribute to such family interventions. The case study described family intervention led by occupational therapy, the authors purporting that occupational therapists are well placed to provide family work because of their unique skills in environmental modification and behavioural management. They also suggest that family work can assist in the successful discharge of a patient to the home environment.

17. It is recommended that occupational therapists consider the impact of the environment on quality of life and occupational engagement. (Craik et al 2010 [C]; Fitzgerald et al 2011 [D]; Long et al 2011 [C]; Long et al 2008 [C]; Morris 2012 [C])

Occupational therapists are uniquely placed to consider the impact of patients’ quality of life and engagement in occupations in secure settings. Research by Craik et al (2010) and Fitzgerald (2011) have both demonstrated this. Fitzgerald et al used a ‘serious game format’ to engage patients in a low secure unit to assist in the design, layout and refurbishment of the unit. The patient participants were able to raise their objections regarding a change in medication management that resulted in a proposal not going ahead. The negative impact of the environment was highlighted in the study by Craik et al; ward staff were identified by patients as gatekeepers, with a lack of interest, reluctant to change, and actively preventing their participation. There was no meaningful choice in occupations and patients’ attendance at sessions was viewed as being linked to discharge. Occupational therapists need to focus on the environmental impact and patients’ occupational choices to ensure meaningful rehabilitation.

A UK cohort study conducted by Long et al (2008) assessed the quality of life in detained mental health patients (n=100). They also identified the characteristics of satisfied and less satisfied patients to make recommendations for service improvements. Sixty per cent of participants were perceived to be mostly satisfied with life in general. There was also an association between high quality of life and lower levels of anxiety, depression and hostility symptoms. The authors concluded that interventions that enhance patients’ perceptions of control and mastery are critical. In addition, attitudes, as well as the working practices of staff, are likely to be an important determinant of quality of life. For long-stay patients detained in secure conditions, the findings highlight the importance of maximising the therapeutic, social and rehabilitative aspects of the physical or built environment.

Occupational therapists recognise the value and impact of the environment. A further evaluative study by Long et al (2011) attested to the value of involving patients when making changes within the secure unit environment. They investigated the factors that influenced the design of a purpose-built medium secure unit. Nine patients and 16 staff from one UK medium secure unit took part in the study, which used the Ward Atmosphere Scale (WAS) before and after a move to a new unit. Staff judged the new unit to have more homely features than the old unit; patients were satisfied with the new unit generally, and significantly, in terms of physical environment. Patient symptomatology was noted to reduce following the move. However, there were no significant differences in the levels of aggression when comparing wards. The authors suggest that the reduction in overall symptomatology, anxiety and guilt (Brief Psychiatric Rating Scale) may reflect the effect of a more satisfactory ‘homely’ physical environment or time in treatment.
The impact of the environment on perceptions of empowerment and freedom was identified in the qualitative research by Morris (2012). Facilities in the regional secure unit where the five participating men were patients ranged from acute to pre-discharge, reflecting a change in the level of staff control and the ability of patients to manage their environment. Morris suggested that there was a close relationship between disempowerment and compliance, with disempowerment associated with negative feelings and occupational restrictions. Compliance was a route used by some towards empowerment. Obtaining leave and being in pre-discharge were associated with a sense of freedom and being trusted by staff. Compliance was influenced by the value placed on achieving lower levels of observation and leave.

18. **It is suggested** that occupational therapists liaise with a range of community services to facilitate replication of patients’ pro-social behaviours developed during an inpatient stay.

(Elbogen et al 2011 [D]; Lin et al 2009 [C]; Lindstedt et al 2011 [C])

Occupational therapists need to ensure that patients have the relevant occupational performance skills to assist their reintegration into the community. A review written by Elbogen et al (2011) indicated that improving money management can enable individuals to gain more knowledge about disability benefits, improve basic financial skills and reduce vulnerability to financial exploitation in the community. They also suggested that money management needs to be incorporated into rehabilitation programmes to address skills that can be used in living, working and social environments to enhance consumer choice and promote recovery. Although not directly involving forensic patients, this descriptive article may have some useful information for consideration.

It is imperative that occupational therapists ensure that community facilities are accessible and available to patients when they make the transition to the community. A Canadian qualitative study explored the meaning of occupational engagement for forensic patients living in the community (Lin et al 2009). Ten participants took part in interviews, all of whom had been supported in the community. Their ability to engage in occupations provided consistency and a sense of coherence to time; many sought and engaged in positive and meaningful occupation. Participants in this study considered it important to ‘do the right thing’ and connect with others. They reported challenges to occupational engagement and recognised the importance of freedom and responsibility. Participants engaged in occupations which they chose and enjoyed, but they also felt a need to demonstrate to authorities that they were doing well in their occupations.

Participatory action research in Sweden examined patients’ life conditions and daily occupations one year after standard forensic mental health interventions in four high secure, seven medium secure and six general mental health units (Lindstedt et al 2011). One year after admission 61 per cent of the original sample were still hospitalised, 18 per cent were cared for on conditional release, 16 per cent relocated and 5 per cent were discharged from care. Participants’ satisfaction with their occupational performance and social satisfaction improved after one year. However, frequency of occupational performance deteriorated over one year. The authors questioned how patients are prepared for community life. They recommended early, goal-directed interventions in occupational performance and social satisfaction for alterations in daily occupations, together with more jointly planned daily occupations and interventions to support housing in the community.
The three studies by Elbogen et al (2011), Lin et al (2009) and Lindstedt et al (2011), while focusing on different issues, highlight the importance of thinking of occupational needs beyond the secure setting. Intervention with patients needs to include developing the skills and occupational performance that enhance an individual’s successful transition to the community.

19. **It is recommended** that occupational therapists demonstrate their competencies (skills and training) to facilitate identified therapeutic groups, enhancing the confidence and participation of patients.

(Mason and Adler 2012 [C])

The study by Mason and Adler (2012) within a high secure unit highlighted the importance of the distinction between skills-based group interventions and those groups where there was a focus on issues that were personal or criminogenic. Such issues were felt by most participants to be better dealt with on an individual basis. The research suggests that occupational therapists need to be aware of how any previous negative experiences of group work, and patient perceptions of the group-work facilitator’s skills and competency, could impact on engagement.

20. **It is recommended** that occupational therapists articulate, to patients and the multidisciplinary team, their role and the contribution of occupational therapy to the overall treatment programme.

(Cronin-Davis 2010 [C])

Occupational therapists need to be able to articulate the role and contribution of occupational therapy in patients’ interventions. Exploratory research with eight patients with a diagnosis of personality disorder in secure settings revealed that they were unaware of the occupational therapy assessments or treatment plans and how occupational therapy fitted in with the overall multidisciplinary treatment plan (Cronin-Davis 2010); ‘patients should be able to recognise and acknowledge the benefits and outcomes of their involvement in occupational therapy interventions’ (p213). Occupational therapists need to be able to likewise communicate benefits and outcomes to colleagues, managers and commissioners.

**Environmental considerations – patient perspectives**

“Risk assessment: ‘should be geared towards ultimately empowering patients to take responsibility for their risk and therefore the risk assessment. Therefore that should be the goal in preparation for independent living or life outside of hospital. Encourage patients to work towards driving this and not just being a partner in it!’”

“Articulating the role of occupational therapy: ‘The work achieved by OT with patients is so important but this work can be progressed during the time between sessions with other staff . . . sharing OT knowledge with other front line staff is important for patient recovery . . . OT work should not happen in isolation or in silos but be work that can be progressed and developed by other staff with improved insight. Shared understanding is key. Better introductions required by OTs when meeting patients for the first time . . . big misunderstanding of OT role for patients . . . and a lot of staff. This could be better signposted to all.’”

Patient consultation feedback
5.5 Potential impact of the recommendations

5.5.1 Desired outcomes
Implementation of the recommendations has the potential to deliver some key outcomes for patients and services, most notably:

• Patients report being collaboratively involved in the planning of their care, during which the occupational therapist takes account of their roles and aspirations.

• Patients participate in meaningful social, educational and occupational opportunities which support rehabilitation and recovery.

• Prevocational training, real work, supported employment, exercise-based activity, and social inclusion programmes are available as part of a recovery-based approach.

• The patient's and occupational therapist's assessment of progress is informed by information from standardised outcome measures.

“With these recommendations being aspired to for all patients I think there is real potential to engage patients sooner in their recovery and just as important is sustaining a momentum of engagement, but there must be a focus on consistency and the importance of continually signposting activity to recovery goals. Ultimately I do believe these have the power to improve quality of life and reduce patients’ length of stay!”

Patient consultation feedback

5.5.2 Risk management
Implementation of the guideline recommendations must be in the context of effective risk assessment and dynamic risk management, which is inherent within the context of a secure setting. Occupational therapists should support the provision of individualised therapeutic intervention within the least restrictive environment while being cognisant of risks posed by individual patients.

5.5.3 Generalisability
The studies supporting the recommendations were often conducted with a small sample and within one level of security. This variation has been taken into account in the development of the recommendations, to ensure that findings have not been overgeneralised.

5.5.4 Social determinants of health
The recommendations for considering the patient's life history and gender-specific needs are important in the context of developing care plans with patients that take into account their background and any issues associated with, for example, social inclusion.
6 Patient perspectives of the guideline

The core target audience of this practice guideline is occupational therapy staff, but the guideline development group also intended that the document would have some relevance to patients in high, medium and low secure hospitals (section 4.3).

6.1 Patient consultation 2012

A small number of patients were alerted to the guideline development by the occupational therapy services involved in their treatment, and invited to share their views as part of the consultation. Five individuals in total volunteered to contribute. One patient provided feedback on the scope, and four other patients reviewed the draft guideline document, with the support of unit staff.

Comments with respect to both the scope and the draft guideline document reaffirmed the value placed on occupational opportunities outside of traditional Monday–Friday working hours (recommendation 9). Any reduction in the occupational therapy programme was viewed by one patient as limiting opportunities for engagement in occupational therapy groups and learning new skills. In relation to the availability of occupational opportunities, another patient reported that it was a struggle at weekends on the ward.

One patient suggested that recommendation 12, relating to healthy living activities, should be a ‘recommendation’ rather than a ‘suggestion’. The view here was that this was applicable to everyone, in that it assisted with looking after one’s self, to be healthy and to give purpose to life. The guideline development group reviewed this recommendation and it was agreed by consensus that this should be amended to a grade 1 statement.

The impact of the environment was also reinforced by one patient, indicating that a homely environment was desired (Long et al 2011).

A preference for one-to-one occupational therapy sessions, with the importance of the occupational therapists in relation to motivation being highlighted, was also expressed by one patient in the context of group work (recommendation 19).

A key feature of the feedback was that the full guideline document, while considered by one patient as being clearly structured and explained, was felt by three of the four patients to include language that was difficult to understand and required explanation. A comment was made that it was too academic.

The comments received from patients will have been influenced by their own expectations, experiences and personal circumstances, and, therefore, cannot be said to be representative of the population of patients in secure hospitals. However, the consultation provided some invaluable insights into the perceptions of those patients, views which have influenced the final practice guideline.

It is important to acknowledge that in the context of obtaining the views of patients in secure settings, a vital contribution is provided by the strong qualitative nature of the
published evidence, which both informs, and underpins, many of the guideline recommendations.

6.2 Patient consultation 2016

The guideline review process, taking place during 2016, provided the opportunity to build on the earlier patient consultation activity.

Two guideline review group members co-ordinated the opportunities for patients to read and comment on the full draft second edition, or a shorter Quick reference guide / Recommendations and evidence summary document. Views were provided from a total of 15 individuals either via email or in face-to-face discussions.

Feedback on the accessibility of the guideline or the summary document varied quite markedly among patients, highlighting the diversity of the population.

Comments included that the document provides a good explanation of secure care and what the guideline is for and hopes to achieve. One comment was that the concise ‘evidence overview’ at the end of each section was the most useful part to read, but could be more helpfully placed at the start of each section. This suggestion has been incorporated into this version of the guideline to improve readability.

A common perspective, however, related to the ‘technical’ nature of the language and the concepts (such as the Model of Human Occupation) used within the guideline. This was especially the case for those patients with a learning disability. The translation of the information into simpler words and images that convey the impact of the guideline on day-to-day care was felt to be needed.

Comments provided during the consultation, many of which were detailed, have been included within the text wherever possible to maximise the patient perspective in the context of the evidence-based recommendations.

The section of the guideline addressing the role of occupational therapy was considered by one patient to be ‘very interesting and insightful’, another stating that ‘[I] agree with everything that is said about the role of the OT in secure services and what they try to achieve, this matched with my personal experience of OT’. There was also a suggestion that to enhance patient understanding of the occupational therapy role, case studies on the recovery journey would be useful to demonstrate the potential impact of the guideline recommendations.

A significant point made in reflecting on the potential value of the guideline was, however, that the role of occupational therapists is often misunderstood. While the document was considered as ‘providing good guidelines for OTs themselves’, it was also suggested that ‘this document should be shared with other clinicians and professionals’.

A specific patient version of this guideline was not part of the guideline development project brief given the target audience is primarily occupational therapists. However, the difficulty for many patients in accessing even a brief summary document, and the depth of feedback received, have stimulated the Royal College of Occupational Therapists’ Specialist Section – Mental Health, Forensic Forum to make a commitment to the development of a patient document or leaflet, and to ring-fence resources to take this forward during 2017 via a service user project.
The outputs from such a project could support occupational therapists to implement the recommendations, and in particular, ‘to articulate the role and contribution of occupational therapy’ to patients, and assist in enhancing shared decision-making discussions between the patient and his or her occupational therapist along the individual’s recovery-focused care pathway, as conveyed by one patient in their feedback:

“Perhaps a sideline to this set of guidelines could be an introductory leaflet on the key elements of the OT role and what part they will play in helping a patient in their recovery. Drawing more on potential for recovery goals being achieved and possibilities for me engaging with someone who can help empowers me to regain skills and find new ones for hope into the future, rather than being a mere escort on a grounds walk!”

Patient consultation feedback
7 Implementation of the guideline

This practice guideline aims to provide specific recommendations to support the use of occupation-focused occupational therapy in secure hospitals and the recovery journey of patients.

Familiarity with the guideline document will be an important first step for both individual practitioners and their managers. It is, therefore, imperative that occupational therapists and managers working in this clinical area take responsibility to review the guideline recommendations within the context of their practice.

Bringing the guideline to the attention of colleagues within the multidisciplinary team and service commissioners should also be a priority.

A further action to facilitate implementation must be for lead therapists to consider the ‘levers’ and ‘barriers’ within their local organisation and culture that may have an impact on any changes that may be necessary to practice. Section 7.2 identifies some potential barriers that may be applicable, while section 7.3 provides details of resources to facilitate implementation.

7.1 Dissemination and promotion

Awareness and implementation of this practice guideline are important if it is to influence and have an impact on occupational therapy practice, and is therefore important, not only for current practitioners, but for occupational therapy students who are the future workforce.

Following publication, the full practice guideline has been made available to download freely from the Royal College of Occupational Therapists’ website.

The guideline has been promoted to its key target audience of occupational therapists and to relevant others using professional networks and publications, internet and social media channels.

7.2 Organisational and financial barriers

The recommendations stated within this guideline document are intended to help occupational therapists to deliver occupation-focused practice. It is recognised, however, that there will be potential barriers, both organisational and financial, which may influence application of the recommendations. It is important that occupational therapists take these into account when implementing this guideline. The most likely barriers, described below, were identified via consensus agreement of the clinical experts in the guideline development and review groups.

The recommendations are varied but potential issues impacting on implementation that may be present across all recommendations include:

- Culture of secure units with preconceived ideas about patients and occupational therapy interventions.
Implementation of the guideline

• Security issues and high-risk management requirements of secure units; and a lack of understanding regarding how occupational therapists have the skills and expertise (e.g. grading and adapting occupations and environments) for positively managing risk.

• A patient’s fluctuating mental health and possible ongoing personality disorder difficulties.

• A patient’s lack of motivation or perceived choice when offered a prescription of available interventions, rather than occupations specifically identified to meet their requirements or choices.

• Varying occupational therapy staff resources and staff recruitment or vacancies.

• Challenges associated with embedding the routine searching for evidence by occupational therapists to inform their practice.

• Limited/lack of specific forensic training opportunities for occupational therapists to further develop their expertise.

• Mostly low and medium secure units in the included studies – some recommendations may have additional issues if implemented within high secure environments (e.g. higher risks, longer lengths of stay or no discharge at all, greater environmental security).

• Mental health legislative restrictions (e.g. patients unable to leave the secure setting except for emergency treatment or court attendance).

• Lack of opportunities for meaningful, individualised occupational choices for patients.

• Long-term seclusion or segregation.

• Physical environment and resources.

The underpinning critical resource required to implement these guideline recommendations is undoubtedly the availability of occupational therapy personnel within the multidisciplinary team. Staffing resources will, therefore, be important in enabling implementation, particularly where consideration may be given to providing services throughout the week, including weekends and evenings, within an ongoing climate of cost efficiencies.

A valuable way of identifying organisational and financial barriers is to carry out a baseline audit using the College’s audit form. An audit facilitates exploration, identification and discussion of local resource issues and other barriers which may have an impact on implementation.

Occupational therapists are in a position to embrace these challenges, and this practice guideline is one way of facilitating the occupational therapy process to become more standardised across secure units. The varying nature of occupational therapy practice means that it can be perceived by other disciplines to lack clarity, and the role of the occupational therapist is not always fully recognised. The merits of occupational therapists using the same language and being able to validate their interventions should impact positively on the profession.
7.3 Implementation resources

Three core implementation resources are available to support this practice guideline.

7.3.1 Quick reference guide
The quick reference guide lists the recommendations and indicates their strength and the quality of the evidence leading to their development.

This is intended to be used by practitioners as an easily accessible reminder of the recommendations for intervention. It should ideally be used once the practitioner has read the full guideline document. This is important to ensure an appreciation and understanding of how the recommendations were developed and their context.

The quick reference guide includes the following:
- Introduction.
- List of the recommendations, their strength, and the quality of the evidence leading to their development.
- Evidence overview.
- Outline of context and occupational therapy role.

7.3.2 Audit form
It is recommended that occupational therapists use the Royal College of Occupational Therapists’ audit tool that supports this guideline.

The audit form for this guideline provides a template for individual occupational therapists or services to audit and review their current interventions against the recommendations. The aim is to encourage a reflection on current practice and to consider, where this does not follow the recommendations, the clinical reasoning in place to support decisions.

A baseline assessment conducted using the audit tool can be repeated to enable review of progress on actions identified from the audit. It can be useful to undertake a routine audit every one or two years to monitor ongoing compliance.

The audit form, while initially providing a tool for use within an individual/service context, offers the potential for future benchmarking and wider comparative analysis.

A practice example of the use of the audit form can be found in OTnews magazine: Aitchison S (2015) Auditing for success. Occupational Therapy News, 23(8), 32–33.

7.3.3 Continuing professional development/knowledge transfer resource
The continuing professional development resource is interactive and can be tailored for local use. The session can be used for group or self-directed learning, or for raising awareness of the guideline at multidisciplinary meetings, study days or events.

A feedback form is also available to provide comment on the guideline and implementation resources to the Royal College of Occupational Therapists.
7.3.4 Other associated resources
Additional resources available include:

- Occupational therapy evidence fact sheet.
- Implementation tips.

**Accessing the implementation resources**
The quick reference guide, audit form and continuing professional development session resources are available as separate documents.

These can be downloaded, together with the full guideline document, from the RCOT publications section (Practice guidelines) of the Royal College of Occupational Therapists’ website: [http://www.rcot.co.uk/publications/practice-guidelines](http://www.rcot.co.uk/publications/practice-guidelines)

The resources can also be accessed via the webpages of the Royal College of Occupational Therapists’ Specialist Section – Mental Health, Forensic Forum.
8 Recommendations for future research

The review of the evidence identified a lack of primary occupational therapy research in the area of forensic practice, and a need particularly for interventional studies.

The effectiveness of occupation-focused interventions continues to be the major priority identified by occupational therapists for research activity.

(COT 2007, p12)

Establishing effectiveness is closely linked to the use of standardised assessments and outcome measures in the provision of services, and to cost-effectiveness studies which support the commissioning of occupation-focused services (COT 2013).

In the context of mental health, personality disorder and learning disability, the ‘recovery’ agenda should be considered a priority focus for research:

• The impact and outcomes of integrating recovery principles into secure care delivery. [New 2017]

Additional key areas identified for research:

• Determining the validity and reliability of assessments for specific use in secure settings. [New 2017]

• The effectiveness and specific contribution of occupational therapy interventions determined using pre- and post-outcome measures, ideally with both control and intervention groups.

• The impact of the environment on time use, occupational performance and quality of life using robust measures.

• The use of occupational therapy models in forensic mental health, e.g. the Model of Human Occupation, the KAWA model, Creative Ability Model, PEOP (Person, Environment, Occupation, Performance), the Canadian Model of Occupational Performance and Engagement and the Individual Placement and Support Model.

• Impact of occupation, and evidence for protective factors, in relation to the risk of violence and recidivism. [Amended 2017]

• Impact of patient transitions from different levels of security, including step-down and step-up.

• Meeting the specific occupational needs of people with learning disabilities in the secure setting.

• The effect of past, present and future occupational risk factors, such as alienation, deprivation and disruption.

• Comparing effectiveness and impact of forensic occupational therapy risk assessment and multidisciplinary risk assessment.
• The role of occupational therapy for patients in seclusion or those being cared for in longer-term segregation.
• Preparation for community living including vocational activities/work.
• Impact of the social environment in addition to the occupational environment.
• Gender-specific occupational needs of women in secure settings.
• The occupational implications of the positive behaviour support (PBS) model of care and its contribution to the management of challenging behaviour in secure settings. [New 2017]
• The applicability of the CORE-OM as a potential patient-reported outcome measure (PROM) in secure settings. [New 2017]
• Empowerment of patients to understand the association of activity and recovery goals. [New 2017]
• Habituation/institutionalisation and how this can be overcome. [New 2017]
• What role occupational therapists play in creating a safe community within hospitals that reflect the wider community. [New 2017]
• Preparation for discharge that empowers patients to survive in community (‘collaboration with recently discharged patients to understand the hurdles big and small that will need to be overcome when discharged so patients feel better equipped to cope and not panic!’). [New 2017]

In addition to suggestions for further research, which are included above, the patient consultation also highlighted the importance of providing information about how patients can get involved in research.
9 Guideline development process

Sections 9 and 10 provide the details of the development process and methodology for the first edition of the guideline. Section 11 outlines the various elements of the process for the review and update for this second edition. Detailed information on the steps of the guideline development and review processes can be found in the Practice guideline development manual (COT 2017a).

9.1 The guideline development group

The membership of the core guideline development group (see Appendix 1 for full list) comprised five occupational therapists with expertise and experience in the field of forensic practice. It was determined that, given the very specific occupational therapy nature of the guideline, the core group would be profession based, and expertise required from other stakeholders and patients would be most effectively obtained outside of core group meetings, via a reference group and consultation.

Four group members were practising occupational therapists and the fifth was working as an educator/researcher. Guideline development work was undertaken mainly in their private time, with support from employers to attend meetings. To facilitate the progress of the guideline development, much of the liaison and activity undertaken by group members was therefore carried out at a distance, using email correspondence to effect communications.

The guideline development group co-opted three people for specific activities: two to undertake the screening of the literature search findings, and one to provide assistance with critical appraisal of the evidence, together with editorial support.

9.2 Stakeholder involvement

Stakeholders with a potential interest in the guideline development were identified by the core group membership at the preliminary guideline meeting. Specific attention was given to identifying professional colleagues who may be working as part of the multidisciplinary team, and national voluntary organisations that may represent patients or their families and friends.

A range of stakeholders (126 individuals/groups in total) were subsequently contacted and invited to comment on a draft scope. This included healthcare professionals; service provider and commissioning representatives; patient representative and families and friends groups/charities; and other professional bodies. Valuable feedback was received from the small number of stakeholders who responded to the invitation, although these in the main represented occupational therapy clinical expertise, and forensic services (located in Scotland, England and Wales). All comments were reviewed and, where indicated, incorporated into the final scope document, which was then submitted to the College of Occupational Therapists’ Practice Publications Group for approval.

To encourage involvement from organisations representing patients or families and friends, and from professional bodies, a more targeted approach was used to seek views
on the full draft guideline document. A smaller group of individuals/organisations were approached and responses were received from a representative of WISH (a national, user-led charity working with women with mental health needs in prison, hospital and the community), together with clinical experts from forensic mental health services, learning disabilities and education.

Details of the stakeholders consulted at each level can be found within Appendix 2.

9.3 Patient involvement

The guideline development group identified that obtaining patient perspectives was vital to the project, but it was immediately highlighted that the nature of the patient group meant that opportunities would be potentially limited. Arranging meetings outside of the secure unit/hospital which patients can attend is difficult due to their detained status under a section of the relevant/country-specific mental health legislation. Feedback on the scope was, therefore, obtained from a patient known to a member of the guideline development group.

Four patients also volunteered to review the full draft guideline. Their involvement provided views from both high and medium secure facilities, men and women, and included a patient with learning disabilities. Support was available from the occupational therapy staff working within those units as required to facilitate the review process. None of those staff were members of the guideline development group.

A summary of those patients’ perspectives is provided in section 6.

9.4 External peer review and consultation

Two independent peer reviewers were identified by the guideline development group to review a draft of the full guideline document. Reviewers were selected for their clinical expertise in the field, and/or their guideline development experience or knowledge.

A one-month consultation period was established to enable members of the College of Occupational Therapists’ Specialist Section – Mental Health, Forensic Forum (guideline end users) to comment on a draft of the full guideline. This consultation was also open to all members of the British Association of Occupational Therapists via the College’s website.

The guideline development group considered the feedback received from all stakeholders, patients, peer reviewers and end users when finalising the recommendations and guideline document.

9.5 Conflict of interest

All guideline development group members (core group and co-opted), stakeholders and external peer reviewers were asked to declare any pecuniary or non-pecuniary conflict of interest, in line with the guideline development procedures (COT 2017a).

The nature of the potential or actual conflicts, made in the declarations (see Appendix 3), were not determined as being a risk to the transparency or impartiality of the guideline development.
9.6 Declaration of funding for the guideline development

This practice guideline for *Occupational therapists’ use of occupation-focused practice in secure hospitals* was developed by a group led by a Specialist Section of the College of Occupational Therapists. Specialist Sections are official branches of the College with specialist or regional interests, who, through their membership, are able to engage expert practitioners, educators and researchers in the development of guidelines, and access the required clinical and research expertise.

As a membership organisation, the major source of funding for the Royal College of Occupational Therapists and its Specialist Sections is obtained from membership. Other sources of income are primarily from advertising and events.

The development and publication of this practice guideline was funded by the College of Occupational Therapists and the College of Occupational Therapists’ Specialist Section – Mental Health.

The College of Occupational Therapists provided specific resources to cover travel expenses, literature search, editorial and publication support.

Funding was also allocated and approved by the National Executive Committee of the College of Occupational Therapists’ Specialist Section – Mental Health to cover costs associated with sourcing copies of published articles, administration and promotional costs for the guideline development and its dissemination.

There were no external sources of funding.

Although one of the editorial leads was a member of staff at the College of Occupational Therapists, the recommendation decisions were made by the guideline development group, and the views of the College of Occupational Therapists have, therefore, not influenced the final recommendations within this guideline.

9.7 Appraisal and ratification process

The guideline proposal, scope and final document were all reviewed and subsequently ratified by the College of Occupational Therapists’ Practice Publications Group, in line with the requirements of the *Practice guidelines development manual* (COT 2011).

The first edition of this guideline was approved by the Practice Publications Group in July 2012.

The guideline review process commenced in October 2015, and the second edition was approved by the Practice Publications Group in January 2017.
10 Guideline methodology

10.1 Guideline question

*What evidence is there to support the use of occupation in occupational therapy in secure hospitals with patients over the age of 18?*

The PICO framework (Richardson et al 1995) was used to assist in developing the practice question further (see Table 1). PICO describes the specific care group or condition being studied, and the nature of the intervention to be investigated. A comparative treatment can be defined, where applicable, together with the anticipated outcomes (the desired/undesired or expected results of the intervention). This level of specificity is important in developing the question so that it addresses the requirements of the scope (COT 2017a).

### Table 1: PICO framework

<table>
<thead>
<tr>
<th>Patient (service user), Population or Problem/circumstance</th>
<th>Adults, 18 years and over who are residing in a secure hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intervention under investigation or action</td>
<td>Occupational therapy</td>
</tr>
<tr>
<td>Comparison, which is an alternative intervention or action</td>
<td>None</td>
</tr>
<tr>
<td>Outcome desire</td>
<td>Occupation-focused assessment and treatment interventions. Patient engagement in a range of occupations which include self-care, productivity (e.g. paid work, volunteerism, work within the hospital, committee membership), social and leisure, and rest.</td>
</tr>
</tbody>
</table>

10.2 Literature search strategy and outcomes

The literature search was carried out by a College of Occupational Therapists’ librarian using a search strategy defined following discussion and agreement with the guideline development group.

The varied clinical and academic experience of the guideline development group meant that there was prior knowledge that the occupational therapy specific evidence was likely to be limited. On the basis of this, the search covered a wide remit to ensure that there was adequate sensitivity to locating any relevant articles of which the group may not be aware (for example, the NOT operator was not used with ‘child*’ by the librarian to avoid losing any potential relevant hits related to younger adults).
10.2.1 Key terms
The strategy involved combining groups of key words. Five key categories or concepts and their related terms were identified: forensic; occupation; mental health; occupational therapy; and setting (Appendix 4 Table A1).

10.2.2 Databases
The databases searched reflected the most likely sources of evidence for occupational therapy and secure hospitals. Six core databases were searched from their commencement period to the search date, as detailed in Table 2.

Table 2: Database searches

<table>
<thead>
<tr>
<th>Core databases</th>
<th>Period of search</th>
</tr>
</thead>
<tbody>
<tr>
<td>CINAHL</td>
<td>1981 to 03/08/11</td>
</tr>
<tr>
<td>Medline</td>
<td>1966 to 08/08/11</td>
</tr>
<tr>
<td>Allied and Complementary Medicine (AMED)</td>
<td>1985 to 08/08/11</td>
</tr>
<tr>
<td>PsycINFO</td>
<td>1806 to 08/08/11</td>
</tr>
<tr>
<td>Social Policy and Practice</td>
<td>1980 to 08/08/11</td>
</tr>
<tr>
<td>Health Management Information Consortium (HMIC)</td>
<td>1979 to 08/08/11</td>
</tr>
</tbody>
</table>

Specialist databases were also searched: College of Occupational Therapists specialist library catalogue; OTDBASE; OT Search; OTseeker; National Institute for Health and Care Excellence; and the Scottish Intercollegiate Guideline Network.

In the majority of cases, title, subject heading and abstracts were searched. Where the search term combinations were more general, some limitations were then applied to provide a stronger focus on relevance. Specific search fields, data ranges and search ‘hits’ are detailed in Appendix 4 (Tables A2 and A3).

Full search histories are available on request from the Royal College of Occupational Therapists.

10.2.3 Search results
The searches identified a total of 4,028 results.

These were scrutinised for duplicates by the guideline development group project lead, both within-database searches and cross-database search returns.

The unique findings were provisionally screened against five preliminary exclusion criteria:
- Children/under 18 years of age.
- Pre-1990 (publications before 1990 were only considered where there was an exceptional reason for inclusion, e.g. excellent research with robust outcomes).
- Book reviews.
Guideline methodology

• Language other than English (due to lack of resources for translation).
• Books or book chapters with no reference to occupational therapy.

As a result of this preliminary screening to remove duplicates and any search result that met one or more of the exclusion criteria, 1,386 findings were excluded.

10.3 Criteria for inclusion and exclusion of evidence

The resultant 2,642 search findings (title, keywords and abstracts) were screened by two members of the guideline development group, with support from two co-opted occupational therapists. An eligibility checklist defined core inclusion criteria:
• Topic relevant to a secure or forensic setting, i.e. high/medium/low secure hospitals.
• Refers to occupations or activities for patients/service users.
• Refers to occupational therapy in a secure or forensic setting.
• Is research-based.

Additional key features that were noted included whether the publication referred to occupational therapy models or to occupational therapy outcome measures.

Reference to any additional relevant background or context was noted where applicable.

This process enabled the identification of abstracts that would be potentially relevant to the guideline and should therefore be included within the critical appraisal process.

Following the screening, a total of 2,592 items were excluded, resulting in a total of 50 items identified for full paper review and critical appraisal. Subsequent to the literature search by the College of Occupational Therapists' library, the guideline development group were alerted via their professional networks to four pertinent additional publications. These met the inclusion criteria and were critically appraised.

A total of 54 articles were, therefore, critically appraised and information compiled into evidence tables (section 10.4). From those critically appraised, 34 items of evidence were subsequently used to develop the recommendations (section 10.5).

An overview of the literature search outcomes is provided in Figure 3.
10.4 Strengths and limitations of body of evidence

The 54 articles identified as potential evidence were independently reviewed by two members of the guideline development group/co-opted members. Any discrepancy in grading was resolved by a third reviewer. Reviewers who were also authors of evidence identified did not appraise their own work.

The quality of the evidence was initially assessed using the McMaster Appraisal checklists (Law et al 1998, Letts et al 2007). Assessment took into account factors such as the appropriateness of the study design; sample justification; procedural rigour in data collection and rigour of analysis; potential biases; credibility; transferability; dependability; and confirmability.

A grade was then also assigned to the evidence within an individual article using the GRADE approach as defined within the Practice guideline development manual (COT...
2017a). The grading reflects the research design and the confidence in the research findings.

The initial grading was allocated as follows:

- Randomised trial/systematic review = High
- Observational study = Low
- Any other evidence = Very Low

Limitations in the design of a study or its implementation may, however, bias the estimates of the treatment effect. If there were serious limitations, then the downgrading of the quality of the evidence was considered, using the criteria shown in Table 3.

**Table 3: Grading evidence up or down (after GRADE Working Group 2004)**

<table>
<thead>
<tr>
<th>Decrease* grade if</th>
<th>Increase grade if</th>
</tr>
</thead>
<tbody>
<tr>
<td>*Each quality criterion can reduce the quality by one or, if very serious, by two levels</td>
<td></td>
</tr>
<tr>
<td>• Serious or very serious limitation to study quality.</td>
<td>• Magnitude of the treatment effect is very large and consistent.</td>
</tr>
<tr>
<td>• Important inconsistencies in results.</td>
<td>• Evidence of a large dose–response relation.</td>
</tr>
<tr>
<td>• Some or major uncertainty about directness of the evidence.</td>
<td>• All plausible confounders/biases would have decreased the magnitude of an apparent treatment effect.</td>
</tr>
<tr>
<td>• Imprecise or sparse data (relatively few participants and/or events).</td>
<td>Only studies with no major threats to validity should be upgraded.</td>
</tr>
<tr>
<td>• High probability of reporting bias.</td>
<td></td>
</tr>
</tbody>
</table>

A decision to increase or decrease the initial grade of the evidence was justified in the evidence table. The ‘moderate’ category came into play if there was a suggested change in the grading. Evidence was ultimately graded in one of four categories, as detailed in Table 4.

If there was no reason to up or downgrade the evidence, then the original grading remained.

**Table 4: GRADE quality of evidence grading (after GRADE Working Group 2004)**

<table>
<thead>
<tr>
<th>Quality of evidence</th>
<th>Grading</th>
<th>Characteristics</th>
<th>Confidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>High</td>
<td>Grade A</td>
<td>Based on consistent results from well-performed randomised controlled trials, or overwhelming evidence of an alternative source, e.g. well-executed observational studies with strong effects.</td>
<td>True effect lies close to that of the estimate of the effect. Further research is very unlikely to change confidence in the estimate of the effect.</td>
</tr>
</tbody>
</table>
Quality of evidence | Grading | Characteristics | Confidence |
--- | --- | --- | --- |
Moderate | Grade B | Based on randomised controlled trials where there are serious flaws in conduct, inconsistency, indirectness, imprecise estimates, reporting bias or some other combination of these limitations, or from other study designs with special strengths. | True effect likely to be close to the estimate of the effect but the possibility that there could be a substantial difference. Further research is likely to have an important impact on our confidence in the estimate of effect and may change the estimate. |
Low | Grade C | Based on observational evidence, or from controlled trials with several very serious limitations. | True effect may be substantially different from the estimate of the effect. Further research is very likely to have an important impact on confidence in the estimate of the effect and is likely to change the estimate. |
Very Low | Grade D | Based on case studies or expert opinion. | Any estimate of effect is very uncertain and may be far from the true effect. |

Once the methodological quality of each piece of evidence had been assessed, details for each item of evidence were collated, from the two independent appraisals, into an evidence table (Appendix 6).

10.5 Method used to arrive at recommendations

The evidence tables were used by the guideline development group as the basis to evaluate and judge each item’s potential contribution to the development of the guideline recommendations.

The core dimensions of occupation-focused practice identified within the scope (section 4.1), were used as the starting point, with identification of the relevant evidence in relation to these areas. Where supporting evidence was identified, this was reviewed. Each individual group member contributed their expert views to the discussion to develop recommendation options.

Where a number of items of evidence supported an identified recommendation, an overall quality of evidence rating was identified:

- Where the evidence outcomes pointed in different directions towards benefit and towards harm, the lowest quality of evidence determined the overall quality of evidence.
- Where the outcomes pointed in the same direction towards either benefit or harm, the highest quality of evidence was appropriate to recommend an intervention and determined the overall quality of evidence.
• In circumstances where the balance of benefits and harm was uncertain, the lowest grade of quality of evidence was assigned.

Strength of recommendation was the second element of the GRADE system applied using the College categories, strong or conditional, to reflect the strength (Table 5).

**Table 5: Strength of grade** (after Guyatt et al 2008)

<table>
<thead>
<tr>
<th>Strength</th>
<th>Grade</th>
<th>Benefits and risks</th>
<th>Implications</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Strong</strong></td>
<td>1 'It is recommended . . .'</td>
<td>Benefits appear to outweigh the risks (or vice versa) for the majority of the target group.</td>
<td>Most patients would want or should receive this course of intervention or action.</td>
</tr>
<tr>
<td><strong>Conditional</strong></td>
<td>2 'It is suggested . . .'</td>
<td>Risks and benefits are more closely balanced or there is more uncertainty in likely patient values and preferences.</td>
<td>The majority of patients would want this intervention, but not all, and therefore they should be supported to arrive at a decision for intervention consistent with the benefits and their values and preferences.</td>
</tr>
</tbody>
</table>

The development of the recommendations, including assignment of the overall quality and strength grading, was a consensus opinion obtained at the guideline development group meeting. There were no recommendations which were not agreed by all members, so that no formal voting system or use of the nominal group technique was required. Thirty-four items of evidence were used to develop the recommendations.

A recommendation decision form was completed for each recommendation developed, recording key information about the evidence used to form the basis of that recommendation, and the overall allocation of quality of evidence and strength of recommendation. The recommendation decision form facilitated discussion and recording of any specific or associated risks and benefits, and this was also highlighted in the final recommendation strength. Any judgement by the guideline development group was documented as part of this decision-making process (recommendation decision forms are available on request from the Royal College of Occupational Therapists).
The guideline review followed a scheduled review process as outlined in the Practice guideline development manual (COT 2017a, section 3.15); this commenced three years after publication of the guideline.

The guideline question, objective and scope were unchanged, as were the criteria for inclusion or exclusion of evidence. This section outlines the process followed and, where necessary, cross-references to the original development process and methodology.

**11.1 Guideline review group established**

The review group consisted of three members of the original guideline development group, and three new members, who were also members of the College of Occupational Therapists Specialist Section – Mental Health, Forensic Forum. All were occupational therapists with expertise and specialist interest in forensic services. Conflicts of interest were declared in line with the guideline development process requirements.

**11.2 Identification of new evidence**

A literature search was undertaken by the College Library. The scope was unchanged but the search strategy for the review was a refinement of the original strategy, as advised by the information specialists, in order to reduce the number of results which were inadvertently outside of the scope.

**11.2.1 Key search terms**

The strategy involved combining groups of search terms from six categories or concepts and their related terms: forensic and settings; condition; occupational therapy; occupational therapy related terms; forensic occupational therapy; and finance/value terms (Appendix 5 Table A4).

**11.2.2 Databases**

Core and specialist databases were searched from the earliest date of the guideline original search (1 August 2011) to October 2015.

The databases accessed were: EBSCOHOST platform (MEDLINE, CINAHL); OVID platform (AMED, HMIC, PsycINFO, Social Policy and Practice); OTseeker; OTDBASE; OT SEARCH; Cochrane Library; COT Library online catalogue; and hand searches of NICE and SIGN.

Details for the specific database searches (including period of search) are provided in Appendix 5 Tables A5 and A6.

**11.2.3 Search results**

The core and specialist searches produced a total of 518 results (EBSCOHOST platform n=288; Ovid platform n=149 and specialist databases n=81). These were scrutinised for duplicates and anomalies by a College Officer, both within-database and cross-database search findings. As a result of cleansing, 378 abstracts were returned for screening.
11.2.4 Screening and appraisal of evidence
Each of the 378 abstracts was screened by two members of the guideline review group, against criteria identified in the guideline development process (sections 10.2.3, 10.3). This resulted in 301 items being excluded, and 77 items of evidence being selected for independent appraisal by two group members. Four items subsequently screened in via publication alerts, between October 2015 and the guideline development group meeting held in April 2016, were also appraised.

An overview of the literature search outcomes is provided in Figure 4.

---

**Figure 4 Review literature search outcomes**
11.3 Assessment of update requirements

The review group discussions focused on:

- New evidence appraised.
- Consideration of any original material that was no longer appropriate and how this might need to be superseded or withdrawn.
- Consideration of any relevant feedback and comments received since the publication of the guideline.
- Development of recommendations where indicated by new evidence or knowledge.

The review group identified that there was limited new evidence that was directly relevant to the guideline scope.

A total of seven articles were agreed by consensus as being suitable for inclusion in an update of the guideline. These provided additional evidence to support four existing recommendation statements, and minor amendments to three of those existing recommendation statements. The evidence appraised did not support the development of any new recommendations.

Recommendation decision forms were completed and it was agreed, by consensus from group members, that the grading of the new items of evidence did not affect the strength or grade of the original recommendations.

The seven items of evidence were graded as either C (low) or D (very low).

11.4 External review

The limited additional evidence and subsequent minimal nature of the update to the guideline recommendations was reflected in the approach to engagement of stakeholders and service users, which focused on a consultation of the revised draft guideline for a month mid-September to mid-October 2016.

End users: the draft updated guideline was made available to occupational therapists, particularly members of the College's Specialist Section – Mental Health who received an individual email alert. All members of the College of Occupational Therapists were invited to contribute via information in the professional body's magazine OTnews and on the website.

Stakeholders: stakeholders who had been invited to participate in the original consultation were contacted and invited to provide any comments on the full updated version of the guideline.

Patients: a patient engagement activity was undertaken by two members of the guideline review group to engage patients in a variety of settings and contexts. Feedback was received from 12 patients from two medium secure units (which included people with a personality disorder, those with a learning disability, and one patient on a women's ward), one member of a Recovery and Outcomes Group, and two members of the Quality Network for Forensic Mental Health Services. Feedback was provided either by comments via email or through face-to-face discussion. Patient perspectives are detailed in section 6 and comments included where applicable within the core text of the guideline.
Peer review: the two peer reviewers who undertook the original guideline review agreed to carry out an independent peer review of the updated draft.

Those individuals or organisations who participated are listed in the acknowledgements in Appendix 2.

11.5 Appraisal and ratification process

The draft revised guideline was submitted to the College's Practice Publications Group for review and approval.

11.6 Overview of limitations and any potential bias of the guideline

The limitations and any potential bias of the guideline were reviewed as part of the update and amended where necessary to reflect the additional evidence included to support or amend the guideline recommendations.

The original and review literature searches identified a number of primary research studies involving occupational therapy within the secure setting. Evidence included published, peer-reviewed journal articles, theses and one report. It is, therefore, acknowledged that other potentially useful grey literature may not have been included. Relevant policy documents, where applicable, have been referenced within the contextual information.

Review of the literature for the original guideline development identified 34 items of evidence from which recommendations could be developed. The guideline review process identified a further seven items which either supported existing recommendations or indicated the need for minor amendment to an existing recommendation (see Table 6 for a summary of the evidence used to develop the recommendations). The majority of this evidence, 63.4 per cent, was assessed as Grade C (low) and consisted predominately of cohort and qualitative studies:

- Grade A = 0.0% (n=0)
- Grade B = 4.9% (n=2)
- Grade C = 63.4% (n=26)
- Grade D = 31.7% (n=13)

A potential limitation of this guideline is that in many cases, a recommendation has been developed on the basis of a single item of evidence, often of a low grade.
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<th>Year</th>
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<td>Craik et al</td>
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Guideline review process

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Details on specific limitations of individual studies are noted in the evidence tables in Appendix 6.

Evidence was not always occupational therapy specific research; and, reflecting the potential difficulties with research in the secure setting, frequently consisted of small-scale qualitative studies, often focused on staff perspectives, and not always obtaining views of patients.

Research specifically investigating the impact or outcome of therapeutic, occupation-focused intervention was found to be very limited. No evidence was identified that specifically addressed economic evaluation of occupation-focused practice.

Of the items of evidence reviewed, 63 per cent related to research carried out in the UK. Where evidence relating to research originating in other countries has been used, this is based on those aspects which are translatable cross-culture.

It is also pertinent to note that studies will have generally been undertaken in a setting of one level of security and within a single organisation. Nevertheless, the recommendations are considered to be applicable across all secure settings, both NHS and independent sector, and across the four UK countries. Occupational therapists will, however, need to consider local policies and circumstances when implementing the recommendations.

The potential difficulties of engaging patients and with undertaking large-scale trials in a secure setting should be considered in the context of the grading of the evidence. The evidence reported in two articles based on a cohort study undertaken in Sweden (which for this type of research involved a relatively large cohort), while identifying limitations, was upgraded to reflect the robustness of the research in the context of forensic mental
Guideline review process

health occupational therapy research. These were the only two items of evidence to be graded as moderate.

It is important to acknowledge that the majority of the evidence was related to mental health, and there were only two studies that specifically included people with learning disabilities (Smith et al 2010, Cox et al 2014). Occupational therapists working with people with learning disabilities in secure hospitals will, therefore, need to give due consideration to the specific needs of their patients when interpreting the recommendations.

The guideline development group did not identify any evidence which was specifically based on expert opinion obtained via a formal consensus activity (e.g. a Delphi survey). The members of the group could have potentially developed best practice statements, particularly in relation to staffing ratios, workload and skills maximisation; however, it was agreed that a larger-scale consensus activity would have been required to reliably underpin such statements.

It is, therefore, important to highlight that this guideline is based on the available evidence and consequently the recommendations are not able to explicitly address all clinical, health and social care areas identified within the scope.

The involvement of the College and the Specialist Section in the development, authoring and funding of this practice guideline is fully acknowledged (section 9.6). Involvement is inherent because of the organisational structure of the professional body and its relationship with its members. It should also be recognised that the practice area covered by this guideline is specialist, and that there are a limited number of experts within the field.

The potential for any bias in development and authoring was, however, minimised through the rigorous nature of the guideline development process. This was achieved through the systematic methodology adopted, the contributions of stakeholders and patients, the valued opinions of the independent peer reviewers and occupational therapy end users, and the judicious management of any potential or actual conflicts of interest.
12 Updating the guideline

The National Executive Committee of the Royal College of Occupational Therapists’ Specialist Section – Mental Health is responsible for monitoring new evidence over the next five-year period, and will provide a focal point for feedback received following publication of the guideline.

In line with College procedures, this reviewed guideline will be available until 2022; however, a review may be initiated before this time if there is significant new evidence identified which may impact on practice.

Further information about the Royal College of Occupational Therapists’ Specialist Section – Mental Health, Forensic Forum is available at: https://www.rcot.co.uk/publications.
Appendix 1: Guideline development and review groups

Guideline Development Group 2010–2012

Dr Jane Cronin-Davis PhD, MSc, BA, BA (Hons), BHSc (Hons), PGCAP, FHEA. (Project Lead)
• Senior Lecturer/ Head of Programme, Occupational Therapy, Faculty of Health and Life Sciences, York St John University
• COT-SS Mental Health – Forensic Forum: Chair

Amanda Lang MSc, BSc, DipCOT
• Head of Occupational Therapy, Stockton Hall, Partnerships in Care
• COT-SS Mental Health – Forensic Forum: Committee member

Louise Llewellyn BSc (Hons)
• Lead Occupational Therapist, Betsi Cadwaladr University Health Board, North Wales Forensic Psychiatric Service, Bryn Y Neuadd Hospital
• COT-SS Mental Health – Forensic Forum: Committee member

Rhona Macleod BSc (Hons)
• Lead Occupational Therapist, Forensic Services, Specialist Adult Services Directorate, Northumberland, Tyne and Wear NHS Foundation Trust
• COT-SS Mental Health – Forensic Forum: Committee member

Kathryn Mason MSc (Hons), BSc (OT)
• Consultant Forensic Occupational Therapist, South Staffordshire and Shropshire Healthcare NHS Foundation Trust
• COT-SS Mental Health – Forensic Forum: Committee member

Guideline Review Group 2015–2017

Dr Jane Cronin-Davis PhD, MSc, BA, BA (Hons), BHSc (Hons), PGCAP, FHEA (Project Lead)
• Senior Lecturer/ Head of Programme, Occupational Therapy, Faculty of Health and Life Sciences, York St John University
• COT-SS Mental Health – Forensic Forum: Committee member

Robin Blezard Dip H.E., BSc (Hons)
• Senior Occupational Therapist, Ashworth Hospital, Mersey Care NHS Foundation Trust
• COT-SS Mental Health – Forensic Forum: Member

Lucy Chambers MSc Occupational Therapy, BSc
• Lead Occupational Therapist, Ardenleigh Women’s Service & Foston Hall Cameo Service
• COT-SS Mental Health – Forensic Forum: Committee Member

Amanda Lang MSc, BSc, DipCOT
• Allied Health Professions Lead, Stockton Hall, Partnerships in Care
• COT-SS Mental Health – Forensic Forum: Committee member
Appendix 1: Guideline development and review groups

Rhona Macleod BSc (Hons)
• Lead AHP – Forensic & Specialist Services, Lead Occupational Therapist – Forensic Services, Specialist Adult Services Directorate, Specialist Care Group, Northumberland, Tyne and Wear NHS Foundation Trust
• COT-SS Mental Health – Forensic Forum: Chair

Cheryl McMorris BSc (Hons)
• Head Occupational Therapist, NHSGGC Directorate of Forensic Mental Health & Learning Disabilities
• COT-SS Mental Health – Chair; Forensic Forum member
Appendix 2: Acknowledgements

The guideline development group would like to thank all those who have contributed to the development and review of the practice guideline.

A2.1 Guideline development (1st edition 2012)

Stakeholder representatives

The following stakeholders commented on the draft guideline:

- Joe Ayres, Lead for Occupational Therapy, Arts Therapies and Activity Coordinators, MI Directorate, West London Mental Health Trust, Broadmoor CSU
- Jo Ball, Senior Occupational Therapist Solent NHS Trust and Chairperson of College of Occupational Therapists Specialist Section – People with Learning Disabilities
- Kevin Cordingley, Occupational Therapy Lecturer, Brunel University, London
- Hilary Lomas, Consultant Occupational Therapist, Mersey Care NHS Trust
- Dr Sarah Markham, Service Evaluation, WISH
- Cheryl McMorris, Head Occupational Therapist, Directorate of Forensic Mental Health & Learning Disabilities NHSGGC
- Genevieve Smyth, Professional Affairs Officer, Mental Health and Learning Disabilities, College of Occupational Therapists

The following stakeholders commented on the draft scope: Kathryn Davies; Associate Professor Louise Farnworth; Mark Featherston; Kevin Jamieson; Cheryl McMorris; Jean McQueen. The professional background of those responding was occupational therapy (5) and physiotherapy (1).

Patient representatives

The guideline development group would particularly like to acknowledge the insightful views received from the patient representatives who commented on the scope and draft guideline document. To maintain patient confidentiality, further details cannot be provided within the guideline document.

External peer reviewers

- Associate Professor Louise Farnworth, Head of Department of Occupational Therapy, Monash University, Australia
- Dr Elizabeth McKay, Reader and Director of Occupational Therapy, Brunel University, London

Co-opted group members

- Anita C Smith BSc(OT), Senior Occupational Therapist, Stockton Hall, Partnerships in Care
Appendix 2: Acknowledgements

• Guy Richardson MSc(OT), BSc(Hons), Occupational Therapist, Stockton Hall, Partnerships in Care

• Mandy Sainty MSc, DipCOT, Research and Development Manager, College of Occupational Therapists

Additional thanks

The guideline development group would also like to thank the following:

• Members of the British Association of Occupational Therapists and their colleagues who contributed views and comments on the draft guideline during the consultation period: John Chacksfield; Caty Connell; Lisa Jamieson; Karen Morris; Fiona Mulholland; Roisin O’Regan; Brendan Rooney; Laura Shepherd; Daire Tierney; Gill Urquhart.

• The College of Occupational Therapists’ Practice Publications Group and supporting officers Julia Roberts, Quality Programme Manager, and Tessa Fincham, Publications Manager.

• The College of Occupational Therapists Library Service, and Gail Owen, Librarian Technician, BCUHB Library & Learning Centre, Ysbyty Gwynedd, Bangor.

A2.2 Guideline review (2nd edition 2017)

Stakeholder representatives

• Joe Ayres, Clinical Specialist Occupational Therapist, Broadmoor High Secure Service, West London Mental Health Trust.

• Christopher Clark, Consultant in Forensic Psychiatry, on behalf of the Royal College of Psychiatrists

• Genevieve Smyth, Professional Advisor, Mental Health and Learning Disabilities, College of Occupational Therapists

• Bev Taylor-Wade, Chair, College of Occupational Therapy Specialist Section – People with Learning Disabilities

Patient representatives

The guideline review group was extremely grateful for the comments received from the individual patients who reviewed the guideline or summary document.

Thanks are also expressed to Birmingham and Solihull Mental Health NHS Foundation Trust; the Royal College of Psychiatrists who contacted patient representatives of the Quality Network for Forensic Mental Health Services; and to the Recovery and Outcomes West Midlands Group.

External peer reviewers

• Associate Professor Louise Farnworth, Head of Department of Occupational Therapy, Monash University, Australia

• Dr Elizabeth A McKay, Reader, Division of Occupational Therapy and Community Nursing, Brunel University London
Appendix 3: Conflicts of interest declarations

Declarations were made in line with the conflict of interest procedures (COT 2017a) during the original development, and during the guideline review process as follows:

- Membership of the Forensic Forum of the College of Occupational Therapists Specialist Section – Mental Health by all members of the core guideline development group and the review group.
- The position as an Officer of the College of Occupational Therapists by the co-opted critical appraiser and editorial support.
- A therapeutic relationship between a member of the guideline development group and the service user commenting on the scope.
- Three members of the guideline development group were authors of literature referenced, with two of these members authoring evidence used in the guideline recommendations. The guideline development group editorial lead was the author of an item of evidence and a number of references used in this guideline. Careful allocation of abstracts and articles for screening and critical appraisal, and the consensus approach taken in the guideline development meetings, meant that there was no undue bias from any authorship.
- A member of the guideline development group supervised students conducting undergraduate research referenced in the guideline.
- One member of the guideline development group was asked by her employer to provide the evidence for forensic occupational therapy during the guideline development.
- The position as an Officer of the College of Occupational Therapists by a stakeholder.
- A number of the stakeholders, and the two peer reviewers, were authors or co-authors of evidence or sources of information used within this guideline. This is reflective of the relatively small number of experts within the field.
- A number of the stakeholders were members of the College of Occupational Therapists’ Specialist Section – Mental Health.

The nature of declarations, made by all those involved in the guideline development or its review, was related to professional interests and expertise in clinical practice, education or research. There were nil patient conflicts of interest declared, other than personal experience of a secure hospital.

No commercial or financial interests were declared.

The adherence to the College of Occupational Therapists’ conflicts of interest policy, and the nature and management of the above declarations, together with the robust guideline development and review methodology, means that the potential for any bias has been taken into account and mitigated.
Appendix 4: Literature search strategy (1st edition 2012)

Table A1: Search terms and strings

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<th>Forensic and related terms</th>
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<td>Reed report OR</td>
<td></td>
<td>Prison* OR</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Vocational rehab* OR</td>
<td></td>
<td>Addictive behave* OR</td>
<td></td>
<td>Principles of recovery OR</td>
<td></td>
<td>Prison based OR</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Education OR</td>
<td></td>
<td>Offending behav* OR</td>
<td></td>
<td>Individual need* OR</td>
<td></td>
<td>Prison unit OR</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Further education OR</td>
<td></td>
<td>Substance misuse OR</td>
<td></td>
<td>Community care OR</td>
<td></td>
<td>Psychiatric unit OR</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Self-care OR</td>
<td></td>
<td>Criminogenic need* OR</td>
<td></td>
<td>Family OR</td>
<td></td>
<td>Psychiatric intensive care OR</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Productivity OR</td>
<td></td>
<td>Alienation OR</td>
<td></td>
<td>Families OR</td>
<td></td>
<td>Psychiatric inpatient OR</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Particip* OR</td>
<td></td>
<td>Anti-social OR</td>
<td></td>
<td>Meaning OR</td>
<td></td>
<td>Special hospital OR</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Pro-social behaviour* OR</td>
<td></td>
<td>Anti social OR</td>
<td></td>
<td>Value</td>
<td></td>
<td>Forensic ward OR</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Pro-social occupation OR</td>
<td></td>
<td>Helplessness OR</td>
<td></td>
<td></td>
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<td>Forensic unit OR</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Pro-social value OR</td>
<td></td>
<td>Occupational deprivation OR</td>
<td></td>
<td></td>
<td></td>
<td>Institutional environ* OR</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Interpersonal capacity OR</td>
<td></td>
<td>Social isolation OR</td>
<td></td>
<td></td>
<td></td>
<td>OR</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Skill* for life OR</td>
<td></td>
<td>Learning disab*</td>
<td></td>
<td></td>
<td></td>
<td>Regional secure unit OR</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Life task* OR</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Correctional facilit* OR</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Life skill* OR</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Correctional setting* OR</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Solitary activit* OR</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>OR</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Personal care OR</td>
<td></td>
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<td></td>
<td>Forensic psychiatric unit</td>
</tr>
<tr>
<td></td>
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<td>Passive leisure OR</td>
<td></td>
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</tr>
<tr>
<td></td>
<td></td>
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<td>Relevant occupation*</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note: Asterisks were used as a wild card symbol for truncation.
Database search strategy

The search strategy combinations were replicated across the six core databases. The numbers of findings per search is detailed in this table.

In each case terms were searched within the title, subject headings and abstract unless there was an indication to apply exceptions or modifications to improve sensitivity and relevance of the search for that particular database. Exceptions are detailed below.

Table A2: Database search strategy

<table>
<thead>
<tr>
<th>Search code</th>
<th>Columns of search terms</th>
<th>CINAHL</th>
<th>Medline</th>
<th>AMED</th>
<th>PsychINFO</th>
<th>Social Policy and Practice</th>
<th>HMIC</th>
</tr>
</thead>
<tbody>
<tr>
<td>S1</td>
<td>1 + 4</td>
<td>No. of results: 17</td>
<td>No. of results: 7</td>
<td>No. of results: 11</td>
<td>No. of results: 144</td>
<td>No. of results: 14</td>
<td>No. of results: 4</td>
</tr>
<tr>
<td>S2</td>
<td>1 + 2 and occupational therap*</td>
<td>No. of results: 23</td>
<td>No. of results: 3</td>
<td>No. of results: 14</td>
<td>No. of results: 163</td>
<td>No. of results: 12</td>
<td>No. of results: 4</td>
</tr>
<tr>
<td>S3</td>
<td>1 + 3 and occupational therap*</td>
<td>No. of results: 28</td>
<td>No. of results: 17</td>
<td>No. of results: 20</td>
<td>No. of results: 165</td>
<td>No. of results: 15</td>
<td>No. of results: 6</td>
</tr>
<tr>
<td>S4</td>
<td>1 + 3 + 5</td>
<td>No. of results: 146</td>
<td>No. of results: 323</td>
<td>No. of results: 2</td>
<td>No. of results: 68 and occupational therap*</td>
<td>No. of results: 171</td>
<td>No. of results: 72</td>
</tr>
<tr>
<td>S5</td>
<td>1 + 2 + 5</td>
<td>No. of results: 98</td>
<td>No. of results: 224</td>
<td>No. of results: 2</td>
<td>No. of results: 68 and occupational therap*</td>
<td>No. of results: 127</td>
<td>No. of results: 55</td>
</tr>
<tr>
<td>S6</td>
<td>1 + 2 + 3</td>
<td>No. of results: 31</td>
<td>No. of results: 54</td>
<td>No. of results: 8</td>
<td>No. of results: 82</td>
<td>No. of results: 14</td>
<td>No. of results: 5</td>
</tr>
<tr>
<td>S7</td>
<td>2 + 3 + 5</td>
<td>No. of results: 176</td>
<td>No. of results: 204</td>
<td>No. of results: 8</td>
<td>No. of results: 119</td>
<td>No. of results: 39</td>
<td>No. of results: 26</td>
</tr>
<tr>
<td>S8</td>
<td>1 + 2 + 3</td>
<td>No. of results: 71</td>
<td>No. of results: 556</td>
<td>No. of results: 11</td>
<td>No. of results: 193</td>
<td>No. of results: 47</td>
<td>No. of results: 11</td>
</tr>
</tbody>
</table>
### Table A3: Additional and specialist searches

<table>
<thead>
<tr>
<th>Search description</th>
<th>Search date</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medline and CINAHL – cross-database all-fields search of Medline and CINAHL using term ‘forensic’ in title field searched together with ‘occupational therapy’ in title field, no date range set</td>
<td>10/08/11</td>
<td>24</td>
</tr>
<tr>
<td>Medline and CINAHL – cross-database all-fields search of Medline and CINAHL for ‘forensic psychol*’ and column 2 or column 3 or column 4 or column 5, date range 1990</td>
<td>10/08/11</td>
<td>141</td>
</tr>
<tr>
<td>COT library catalogue – search for term ‘forensic’</td>
<td>10/08/11</td>
<td>12</td>
</tr>
<tr>
<td>NICE guidance and research</td>
<td>10/08/11</td>
<td>5</td>
</tr>
<tr>
<td>OTseeker – search using just the term ‘forensic’ (OTseeker does not allow for more complex searching)</td>
<td>10/08/11</td>
<td>4</td>
</tr>
<tr>
<td>OT Search – ‘forensic’ searched in all fields, date range not set. This database is not sophisticated enough to perform advanced searches; a search for the term ‘forensic’ yielded 78 results – items relating to mental health were extracted</td>
<td>10/08/11</td>
<td>44</td>
</tr>
<tr>
<td>OTDBASE – ‘forensic’ searched in abstract and title field, date range to 1980s. This database is not sophisticated enough to perform advanced searches</td>
<td>09/08/11</td>
<td>26</td>
</tr>
<tr>
<td>AMED (Allied and Complementary Medicine), HMIC (Health Management Information Consortium), PsycINFO, Social Policy and Practice. Cross-database all-fields search using term ‘forensic’ in title field searched together with ‘occupational therapy’ in title field, no date range set</td>
<td>10/08/11</td>
<td>22</td>
</tr>
<tr>
<td>AMED (Allied and Complementary Medicine) HMIC (Health Management Information Consortium), PsycINFO, Social Policy and Practice. Cross-database all-fields search for ‘forensic psychol*’ and column 2 or column 3 or column 4 or column 5, no date range set</td>
<td>10/08/11</td>
<td>72</td>
</tr>
</tbody>
</table>
## Appendix 5: Literature search strategy (2nd edition 2017)

### Table A4: Search terms and strings

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Correctional facil* OR Forensic OR Forensic mental health OR Forensic psychiatri* OR Forensic setting* OR High securit* OR Medium securit* OR Low securit* OR Maximum securit* OR High-securit* OR Medium-securit* OR Low-securit* OR Maximum-securit* OR High secure OR Medium secure OR Low secure OR Maximum secure OR High-secure OR Low-secure OR Medium-secure OR Maximum-secure OR Offend* OR Secure environment* OR Secure hospital* OR Secure service* OR Secure setting* OR Secure unit* OR Psychiatric intensive care</td>
<td>Mental health OR Mental ill* OR Psychiatr* OR Schizophreni* OR Bi-polar OR Bipolar OR Depress* OR Mental disorder* OR Psychosis OR Psychoses OR Psychot* OR Addict* OR Substance misuse OR Substance abuse OR Personality disorder OR Anti-social behaviour* OR Asperger* OR Autis* OR Learning disabilit* OR Learning difficult*</td>
<td>Occupational therap*</td>
<td>Rehabilit* OR Recover* OR Assessment* OR Therapeutic OR Occupation* OR Activit* OR Activities of daily living OR ADL OR IADL OR Instrumental activities of daily living OR Daily living skills OR Life skills OR Personal care OR Self care OR Self-care OR Psychiatric rehabilit* OR Vocational rehabilit* OR Work rehabilit* OR Participat* OR Engage OR Engaged OR Engaging OR Engagement</td>
<td>Forensic occupational therap*</td>
<td>Econom* OR Cost* OR Financ* OR Money OR Monies OR Saving* OR Resource* OR Staff*</td>
</tr>
</tbody>
</table>

*Note: Asterisks were used as a wild card symbol for truncation.*
Appendix 5: Literature search strategy (2nd edition 2017)

Table A5: Core platforms and databases

<table>
<thead>
<tr>
<th>Database or platform and search date</th>
<th>EBSCO 01/10/15</th>
<th>Ovid 02/10/15</th>
</tr>
</thead>
<tbody>
<tr>
<td>Search term strings (below) and fields searched (right)</td>
<td>TI, AB, SU</td>
<td>ti, ab, de</td>
</tr>
<tr>
<td>Strings: 1 AND 3</td>
<td>43</td>
<td>39</td>
</tr>
<tr>
<td>Strings: 1 AND 2 AND 3</td>
<td>24</td>
<td>33</td>
</tr>
<tr>
<td>Strings: 1 AND 3 AND 4</td>
<td>43</td>
<td>39</td>
</tr>
<tr>
<td>Strings: 5</td>
<td>7</td>
<td>5</td>
</tr>
<tr>
<td>Strings: 1 AND 3 AND 6</td>
<td>8</td>
<td>11</td>
</tr>
<tr>
<td>Strings: 5 AND 6</td>
<td>8</td>
<td>1</td>
</tr>
<tr>
<td>Strings: 1 AND 2 AND 6</td>
<td>121</td>
<td>82</td>
</tr>
<tr>
<td>Strings: 1 AND 4 AND 6</td>
<td>212</td>
<td>36</td>
</tr>
<tr>
<td>Total results</td>
<td>466</td>
<td>246</td>
</tr>
<tr>
<td>Removed via platform de-duping and/or filter options</td>
<td>178</td>
<td>97</td>
</tr>
<tr>
<td>Total for cleansing within and across databases</td>
<td>288</td>
<td>149</td>
</tr>
</tbody>
</table>

Medline, CINAHL – accessed via EBSCOHOST platform
AMED, HMIC, PsycINFO, Social Policy and Practice – accessed via Ovid platform

Table A6: Specialist databases

<table>
<thead>
<tr>
<th>Database or platform</th>
<th>Fields</th>
<th>Terms</th>
<th>Number transferred</th>
<th>Date of search</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cochrane ti, ab, kw</td>
<td>Strings 1 AND 4 AND 6</td>
<td>4</td>
<td>05/10/15</td>
<td></td>
</tr>
<tr>
<td>OT Search ti id OR phrase</td>
<td>String 1 String 5</td>
<td>10</td>
<td>08/10/15</td>
<td></td>
</tr>
<tr>
<td>OTSeeker All fields</td>
<td>String 1</td>
<td>24</td>
<td>05/10/15</td>
<td></td>
</tr>
<tr>
<td>OTDBASE Topic search ti</td>
<td>String 1</td>
<td>14</td>
<td>05/10/15</td>
<td></td>
</tr>
<tr>
<td>NICE Hand search String 5 Forensic setting terms</td>
<td>14</td>
<td>06/10/15</td>
<td></td>
<td></td>
</tr>
<tr>
<td>COT Library All fields String 1 String 5</td>
<td>15</td>
<td>06/10/15</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Key:
ab = abstract de = descriptors hw = heading words id = key words
kw = keyword sh = subject heading su = subject ti = title
### Appendix 6: Evidence tables

<table>
<thead>
<tr>
<th>Source</th>
<th>Design and participants</th>
<th>Intervention</th>
<th>Outcomes</th>
<th>Results</th>
<th>Quality and comment</th>
</tr>
</thead>
</table>
| Absalom et al (2010) | Qualitative study                                                                       | No specific intervention tested | Measures used:  
- Camberwell Assessment of Need Forensic Short Version (CANFOR-S)  
- The Social Behavioural Scale  
- In-house 49-item questionnaire for staff to identify psychological needs  
- In-house training questionnaire for staff  
- National Minimum Standards (DH) used to develop a questionnaire to see if ward managers could provide evidence of family intervention. | 72% had contact with family (n=99)  
56% of relatives involved in discharge planning (n=77)  
Family contact between 69% and 79% across the wards  
Staff return rate of 87% (318)  
22 (7%) staff had specific skills in family intervention. Less than half of these got supervision for the intervention  
Two wards offered family intervention (18%)  
Conclusions that considerable unmet patient needs could be addressed by family intervention. Some lack of staff skills to deliver family interventions and may be specific barriers to delivery in forensic services. | Grade C – Low  
Limitations:  
- Patients assessed by primary nurse – potential bias  
- Relatives’ perceived needs not assessed  
- Ward sampling limited. Only 16 out of 27 possible forensic units took part – restricts generalisation  
- Specific focus on schizophrenia  
- Standards don’t relate to high secure  
- Not enough description of the in-house measures. |
|                 | Aims to:                                                                                 |              |          |                                                                         |                     |
|                 |  
- Demonstrate forensic patients will need family intervention  
- Assess current staff skills/knowledge to deliver family intervention. |              |          |                                                                         |                     |
|                 | Opportunistic sampling  
Patients n=137  
Mean age 38 years  
Male:female ratio = 118:19  
Low secure = 78  
Medium secure = 45  
High secure = 14  
Clinical staff: n=318  
Low secure = 152  
Medium secure = 141  
High secure = 25  
Included 13 occupational therapists  
United Kingdom.  
Structured questionnaires and interviews  
Procedure: Key nurses administered the observer measures on patient need  
Clinical staff completed training questionnaire  
Ward managers asked to provide evidence they met standards. |              |          |                                                                         |                     |
<table>
<thead>
<tr>
<th>Source</th>
<th>Design and participants</th>
<th>Intervention</th>
<th>Outcomes</th>
<th>Results</th>
<th>Quality and comment</th>
</tr>
</thead>
</table>
| Bacon et al (2012) | Exploratory study – two case studies  
Aim: evaluation of use of Nintendo® Wii Fit™ in changing the engagement of patients at risk of obesity  
Secure hospital  
Body mass index 25–31, indicative of obesity risk  
Number of patients engaged in Wii Fit™ but some transferred during study and only two consented from those still at the hospital – one man (28 years old), one woman (43 years old)  
Australia. | Participation in Wii Fit™ activities – either in group or individually. | Measures used:  
• Actical accelerometers (physical activity, estimated energy expenditure)  
• Wii Fit™ records of time spent playing  
• Semi-structured interviews exploring experiences and attitudes post-intervention  
• Field notes – researcher’s engagement. | • Active movement in Wii Fit™ can help patients increase overall daily energy expenditure and time spent in physical activity  
• Wii Fit™ can supplement but does not replace authentic physical activity  
• The male participant increased his physical activity by 61.6 minutes/week, while the female participant increased her physical activity by 114 minutes/week  
• Changed attitude to exercise – fun, challenging, social interaction, motivating, enjoyable  
• Accessible, motivating, meaningful tool in secure environment  
• Importance of staff – impact on behaviour/attitude – participants tended to play when researchers present. | Potential of Wii Fit™ as effective intervention.  
Grade D – Very Low  
Well-conducted study  
Limitations:  
• Small numbers  
• Exploratory study  
• Impact of presence of the researcher. |
<table>
<thead>
<tr>
<th>Source</th>
<th>Design and participants</th>
<th>Intervention</th>
<th>Outcomes</th>
<th>Results</th>
<th>Quality and comment</th>
</tr>
</thead>
</table>
| Baker and McKay (2001) | Quantitative, descriptive study | Interventions offered by occupational therapists identified: • Functional life skills • Social skills • Assertiveness training • Stress management • Problem solving • Gender-specific issues • Work-related practice • Recreational skills • Community skills. | A Likert scale analysis of four statements (derived from the literature) relating to the needs of women in secure settings. | Themes related to: • Environmental issues, i.e. the need for the women to have a safe environment • Gender-sensitive care, i.e. the need for women on the staff • Access to appropriate meaningful intervention, i.e. women-only sessions • Education, sexual health, self-esteem and assertiveness; and relationship issues, i.e. mothering role and limited opportunities to engage in positive relationships. Majority of occupational therapists felt current services didn’t adequately meet needs of women who were mentally disordered offenders. | Grade C – Low
<p>|                 |                         |              |          |         | Limitations: • Postal questionnaire restricts opportunities for further clarification • Limited discussion of the data analysis and how any bias may have been mitigated. |</p>
<table>
<thead>
<tr>
<th>Source</th>
<th>Design and participants</th>
<th>Intervention</th>
<th>Outcomes</th>
<th>Results</th>
<th>Quality and comment</th>
</tr>
</thead>
</table>
| Castro et al (2002)     | Retrospective evaluation                                                                                                                                                                                                                                                             | No intervention for the focus of the study, but patients’ participation in specific interventions (occupational therapy and psychology) was highlighted in the results | Data collected on admission, discharge and follow-up using records  
- Ratings of progress in therapy programmes  
- Ratings of improvement in mental state  
- Length of stay. | The main indicators of success at follow-up included:  
- Constructive use of time since discharge including work, education, day hospital, leisure centre, therapy or maintenance of a social life  
- A useful predictor of progress after discharge appears to be employment status.  
Engagement in psychological therapies and/or group activities was positively related to length of stay (p<0.0001, \( r=0.348 \)), and overall improvement in mental state (p<0.0001, \( r=0.555 \))  
Participation in therapy was not found to be directly related to subsequent involvement in community services or general success in independent living at follow-up, but levels of participation were not measured. | Grade C – Low  
Limitations:  
- One unit only involved  
- Small follow-up group  
- Over 85% of patients discharged within nine months; for engagement in therapy this is considered relatively short term  
- Data collection dependent on what was available in reports/notes. |
<table>
<thead>
<tr>
<th>Source</th>
<th>Design and participants</th>
<th>Intervention</th>
<th>Outcomes</th>
<th>Results</th>
<th>Quality and comment</th>
</tr>
</thead>
</table>
| Clarke (2003) | Descriptive article evaluating practice  
Aim: to demonstrate and critically evaluate the use of the Canadian Model of Occupational Performance (CMOP) in a forensic rehabilitation hostel  
Single case study of hostel described  
Subjects were men in a forensic community hostel providing intensive rehabilitation for those previously detained in secure hospitals and close to discharge  
United Kingdom. | CMOP suggested as offering four main advantages, namely its emphasis on client-centred practice, focus on occupational performance, provision of assessment and evaluation tools and ease of use in practice. | No pre- and post-CMOP scores  
No interviews with hostel residents or staff. | Author advocating the pros and cons of using CMOP  
Highlighted benefits of CMOP to guide practice, has promoted the effectiveness and unique contribution of the profession; evaluated how model can be used to strengthen service provision  
Indicates residents have stated feelings of increased empowerment, autonomy and satisfaction and have shown increased levels of motivation, treatment compliance and engagement in therapeutic interventions  
For residents living in secure environments the CMOP offers an alternative and more positive collaborative approach to intervention. | Grade D – Very Low  
Limitations:  
• No data collection to substantiate perceptions  
• No reference to number of residents, or analysis of needs identified as a result of assessment  
• No evidence how strengths and limitations were formulated. |
<table>
<thead>
<tr>
<th>Source</th>
<th>Design and participants</th>
<th>Intervention</th>
<th>Outcomes</th>
<th>Results</th>
<th>Quality and comment</th>
</tr>
</thead>
</table>
| Clarke (2002)     | Ethnographic approach Aim: to determine the extent to which forensic mental health patients were involved in decisions regarding their care, and their desire to be involved in the decision-making process Regional forensic service – medium and low secure Convenience/criterion sampling: ten patients and ten staff United Kingdom. | No specific intervention.                  | Semi-structured interviews and 16 days of fieldwork observations Care plan review for patients Perceived level of involvement in decisions regarding care.                                               | Observational analysis included:  
• Medical culture, and little observed in terms of patients’ involvement in decision making.  
Interviews with patients and staff included:  
• Differing perspectives  
• Patients wished to be more involved in decision making and perceived staff to be the decision-makers in their care  
• Low staff numbers inhibited patient involvement  
• Inconsistencies in practice related to patients’ involvement in decision making.  
Care plan analysis included:  
• Medical culture dominated formal documentation, little evidence to suggest patient involvement in care planning.                                                  | Grade C – Low Limitations:  
• Influence of researcher as known to most participants  
• One service – not necessarily transferable  
• Not necessarily representative but provides insight to user involvement  
• Snapshot view only. |
<table>
<thead>
<tr>
<th>Source</th>
<th>Design and participants</th>
<th>Intervention</th>
<th>Outcomes</th>
<th>Results</th>
<th>Quality and comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cordingley and Ryan (2009)</td>
<td>Qualitative study</td>
<td>Three focus groups asked specific questions</td>
<td>Questioning route:</td>
<td>Four themes emerged:</td>
<td>Grade C – Low</td>
</tr>
<tr>
<td></td>
<td>Aim: ascertain forensic occupational therapists’ perspectives on their beliefs and considerations informing their risk assessments</td>
<td>Groups videotaped.</td>
<td>• Introductory question (regarding experience or use of risk assessment)</td>
<td>1. Risk perceptions and interpretation: dynamic nature of risk, contextual factors and professional differences in risk assessment</td>
<td>Limitations:</td>
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<td></td>
<td>Three focus groups</td>
<td></td>
<td>• Transition questions (characteristics of risk assessments used/seen, and associations with word ‘risk’)</td>
<td>2. Fundamental information: clinical information taken from multidisciplinary team; current and historical</td>
<td>• Small group numbers</td>
</tr>
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<td></td>
<td>Occupational therapists recruited from first author’s place of work and an occupational therapy research group</td>
<td></td>
<td>• Key questions (additional risks for forensic occupational therapy).</td>
<td>3. Risk behaviours and occupations: harm to others, self-harm, self-neglect, cognition, substance misuse, social behaviour and coping strategies</td>
<td>• Experience levels of group</td>
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<tr>
<td></td>
<td>n=8</td>
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<td>4. Environment: occupational demands, opportunities and restrictions.</td>
<td>• High secure and learning disability not included</td>
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<td></td>
<td>Occupational therapists practised in low and medium secure units, young offender institution and Category A prison</td>
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<td>Study suggests risk assessment is a dynamic process that requires occupational therapists to make ongoing judgements in collaboration with colleagues.</td>
<td>• Potential for researcher bias but likely mitigated by peer checking.</td>
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<td>Length of professional qualification 2.5–20 years</td>
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| Cox et al (2014)       | Reflective practice description                                                        | A Real Work Opportunity Programme                                             | No formal outcomes measured                  | High attendance rate maintained over time                                                  | Grade D – Very Low Limitations:  
| [New evidence 2017]    | Aims of vocational training programme:                                                  | Roles offered included three ward-based kitchen cleaners, a gym orderly and   | Observation of range of work-related skills. | Initial trial ‘well received’                                                              |  
|                        | - Accessible job roles simulating real work experience                                 | an animal care assistant (n=5)                                                |                                               | Two sets of successful candidates                                                          |  
|                        | - Approach adapted to intellectual disability with realistic replication of employment | Vocational pathway including: role advertisement, application form, interview  |                                               | Observation of skills development:                                                          |  
|                        | process                                                                       | workshop, mock interview, interview, feedback, training given, and support    |                                               | • General work-based skills                                                                 |  
|                        | - Development of practical working and interpersonal skills                          | given                                                                          |                                               | • Punctuality and time management                                                           |  
|                        | - Increased self-esteem and confidence.                                                | One hour a week commitment and hold role for 12 weeks                         |                                               | • Managing duties                                                                          |  
| Forensic intellectual  |                                                                                       | Weekly supervision and feedback                                               |                                               | • Responsibility and accountability                                                         |  
| disability service,    |                                                                                       | Primarily delivered by occupational therapists.                               |                                               | • Specific role-related skills                                                              |  
| multiple co-morbid     |                                                                                       |                                                                               |                                               | • Interpersonal skills                                                                      |  
| diagnoses              |                                                                                       |                                                                               |                                               | • Personal presentation                                                                     |  
| 19 participants        |                                                                                       |                                                                               |                                               | • Working relationships with supervisors.                                                   |  
| Participant characteristics not described (age, gender) |                                                                                       |                                                                               |                                               | Need to expand roles in number and complexity, and                                        |  
| United Kingdom.         |                                                                                       |                                                                               |                                               | research the vocational and therapeutic outcomes                                           |  
|                        |                                                                                       |                                                                               |                                               | Programmes recommended as part of a graded pathway,                                        |  
|                        |                                                                                       |                                                                               |                                               | working towards community-based programmes, following reduction in patient risk.            |  
|                        |                                                                                       |                                                                               |                                               |                                                                                             |  
|                        |                                                                                       |                                                                               |                                               |                                                                                             |  

Limitations:  
- Non-experimental design  
- No discussion of outcome measures – assessments pre- or post-intervention.
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</table>
| Craik et al (2010) | Qualitative ethnographic  
Aim: to determine what engagement in occupation means to patients in forensic units – identifying needs to inform service development  
Low and medium secure  
n=26  
Range of ages and ethnicities represented  
Male:female ratio = 21:5  
Five focus groups, one group specifically for women  
Participants paid small cash fee  
United Kingdom. | Focus groups exploring occupational engagement. | Audio recorded and transcribed verbatim  
Each group lasted one hour  
Additional optional demographic form completed. Field notes also recorded  
Two researchers facilitated the groups  
Five local occupational therapists (co-authors) involved in the data analysis  
Questioning route asking about:  
• Experiences  
• Hopes  
• Suggestions for improvement. | Findings highlighted:  
• Previous occupations: comparison with prison, other services, lack sense of community  
• Current occupations: range of occupations, ward-based versus structured. Barriers: the nature of the occupation; other patients; staff (‘gatekeepers’); medication levels  
No meaningful choice as attendance viewed as linked to discharge  
Life skills and vocational rehabilitation highly valued  
Motivators to engage included to avoid boredom.  
• Future occupations: more education; more access to existing service; work rehabilitation. Timing preference for afternoons, evenings and weekends and contact outside hospital.  
Engaging in meaningful occupation gives sense of achievement, promotes health. | Grade C – Low  
Limitations:  
• All came from one practice area  
No information on:  
• Diagnosis  
• Methodology was focus group – potential problem for those patients who can’t engage in groups as no alternatives identified. |
### Appendix 6: Evidence tables

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<tr>
<th>Source</th>
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<tr>
<td>Cronin-Davis (2010)</td>
<td>Qualitative study: Interpretive phenomenological analysis</td>
<td>Individual in-depth interviews, on the ward/in office/meeting room.</td>
<td>Views of patients, managers and occupational therapists</td>
<td>Themes that emerged: Patients: diagnostic implications, occupational therapy, therapeutic relationships and what gained from occupations. Most valued occupational therapy interventions and engagement in occupations. Needed more information about role of occupational therapy</td>
<td>Grade C – Low Limitations: • Composition and size of participant groups • Single interview • Participant–researcher interaction and influence.</td>
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<td></td>
<td>Aim: to explore occupational therapy practice with men who were forensic patients (high and medium), focusing on the views and perceptions of the patients, managers and occupational therapists</td>
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<td>Interview protocol ‘Grand Tour’ question</td>
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<td>Recruitment: contacted known sites with specialist units for personality disorder patients. Two high and two medium secure</td>
<td>Iterative probing and content-mining questions</td>
<td>Research diary used after each interview to capture tone, non-verbal, etc.</td>
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<td>Patients with diagnosis of personality disorder n=8</td>
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<td>All men, age range 21 to 53 years</td>
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<td>Occupational therapy managers n=4</td>
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<td>Occupational therapists n=7</td>
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Occupational therapists' use of occupation focused practice in secure hospitals
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<tr>
<td>Elbogen et al (2011)</td>
<td>Review&lt;br&gt;Reviewed the issues of money management and mental health among people with psychiatric illnesses and proposed a recovery-orientated approach to increase community functioning&lt;br&gt;United States of America.</td>
<td>Money management programmes – included some published literature, case examples, financial literature.</td>
<td>For those with psychiatric disabilities:&lt;br&gt;• Superior quality of life&lt;br&gt;• Fewer hospitalisations&lt;br&gt;• Greater self-efficacy&lt;br&gt;• Budgeting skills&lt;br&gt;• Staying out of debt.</td>
<td>Suggested improving money management can enable individuals to:&lt;br&gt;• Gain more knowledge about disability benefits&lt;br&gt;• Improve basic financial skills&lt;br&gt;• Reduce vulnerability to financial exploitation.&lt;br&gt;Indicated need to incorporate money management into rehabilitation programmes to address skills that can be used in living, working and social environments to enhance consumer choice and promote recovery.</td>
<td>Grade D – Very Low&lt;br&gt;Limitations:&lt;br&gt;• Descriptive article provides some case examples as illustrations&lt;br&gt;• Minimal analysis&lt;br&gt;• Relates to non-forensic population and community based.</td>
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Aim: to understand how therapeutic relationships are formed and developed between support staff and patients in secure mental health services  
Two medium secure units  
Recruitment of support staff, directly working with patients, via self-selection response to a study advert  
Ten participants:  
Three occupational therapy support workers and 7 nursing assistants  
Mean age = 36 years (range 22–60 years)  
Male:female ratio = 3:7  
United Kingdom. | Interviews – semi-structured, recorded, at participant’s place of work  
45–90 minutes  
Examined factors which enhance and maintain relationships, and barriers which prevent relationships from forming or result in deterioration. | Interview schedules flexible:  
- Explore nature of work  
- Knowledge of patients  
- New admissions and relationships between staff and patients  
- Interpretative phenomenological analysis of interview transcriptions. | Three main themes were identified:  
- Developing relationships with patients (‘Building Bridges’)  
- Seeing the person and managing risk (‘You do forget what they’ve done’)  
- Maintaining boundaries (‘Playing your cards close to your chest’).  
Quantity and quality of time considered important  
Relationship development facilitated by being genuine, caring, and friendly – visible and available; awareness of attachment styles important  
The study highlights the importance of therapeutic relationships in forensic mental health and outlines the perspectives of staff trying to promote these  
While most of the findings are general to wider practice, the importance of the use of meaningful activity and building relationships through ‘doing’ alongside each other is highlighted. | Grade C – Low  
Limitations:  
- Sample size: data not collected until saturation  
- Convenience sample; participants self-selecting  
- Not able to further analyse any sub-group variations. |
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<tbody>
<tr>
<td>Fan (2014)</td>
<td>Descriptive longitudinal study</td>
<td>No intervention</td>
<td>Measures collected:</td>
<td>Occupational profile (MOHOST):</td>
<td>Grade D – Very Low</td>
</tr>
<tr>
<td>[New evidence 2017]</td>
<td>Aim: to contribute to the understanding of forensic patients’ occupational profiles and their occupational participation over time</td>
<td>Retroactive data analysis using clinical information previously collected</td>
<td>• Model of Human Occupation Screening Tool (MOHOST) – six-month periods up to 24 months previous to most recent score</td>
<td>• Patients in low secure units had higher average scores in each subdomain and total MOHOST scores than in medium secure units</td>
<td>Limitations:</td>
</tr>
<tr>
<td></td>
<td>Data analysis of an existing data set derived from clinical records in forensic hospitals</td>
<td>Patients had received occupational therapy.</td>
<td>• Health of the Nation Outcomes Scales (HoNOS) – psychiatric symptoms</td>
<td>• Comparisons statistically significant with exception of motor skills subdomain (p=0.236).</td>
<td>• Convenience sample from six mental health trusts</td>
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<td></td>
<td>Main diagnosis schizophrenia</td>
<td></td>
<td>• Historical, Clinical, Risk Management (HCR-20) – factors for violence.</td>
<td>Occupational participation and risk (MOHOST and HCR-20):</td>
<td>• No data for occupational therapy staff who completed assessments for data collection</td>
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<td></td>
<td>Six trusts: Low secure units n=163</td>
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<td>Analysis included independent t-test and correlation analysis, and regression analysis.</td>
<td>• Occupational participation influenced by five historical risk factors. Patients with relationship instability, employment problems, substance misuse problems, and psychopathy had lower occupational participation in each subdomain and total score</td>
<td>• No data from high secure settings</td>
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<td></td>
<td>Medium secure units n=326</td>
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<td></td>
<td>• Patients with major mental illness had higher occupational participation in each subdomain and total score</td>
<td>• Under-representation of mental health conditions other than schizophrenia</td>
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<td>Mean age: 38.7 years (SD 11.01)</td>
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<td>• All current risk factors highly related to occupational participation</td>
<td>PhD study published by Fan et al (2016).</td>
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<td></td>
<td>Male:female ratio = 453:36</td>
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<td>• All five risk management factors were related to some extent to occupational participation.</td>
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<td>Occupational therapists involved in data collection n=78</td>
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<td>Statistical significance varied across subdomains.</td>
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<td></td>
<td>United Kingdom.</td>
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<td>A few symptomatology factors had moderate corrections with occupational participation: cognitive problems, other mental and behavioural problems and activities of daily living problems</td>
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<td>Regression analysis implied overall participation improved over time.</td>
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<td>Farnworth et al (2004)</td>
<td>Mixed methods design&lt;br&gt;Naturalistic inquiry approach&lt;br&gt;Aim: to describe and understand time use within the context of occupational histories and current environment&lt;br&gt;Quantitative: time use diary&lt;br&gt;Qualitative: interviews (OPHI-II) and field notes&lt;br&gt;Time use and particular occupations of forensic inpatients are discussed in the study&lt;br&gt;Inpatients on two wards (medium and low secure)&lt;br&gt;Eight men, 24–48 years old&lt;br&gt;Seven schizophrenia and one co-morbid poly-substance abuse Australia.</td>
<td>Eight participants completed time diaries for two consecutive days&lt;br&gt;Five interviewed using Occupational Performance History Interview II.</td>
<td>• Time use diary and OPHI-II&lt;br&gt;• Information collected over five-week period&lt;br&gt;• Thematic analysis.</td>
<td>Weekdays:&lt;br&gt;Personal care – 50% of time&lt;br&gt;Recreation and leisure – 40%&lt;br&gt;Weekend:&lt;br&gt;96% of time on personal care, recreation and leisure&lt;br&gt;89% of personal care time was spent sleeping&lt;br&gt;Only 2% of time recorded in recreation and leisure was engagement in sport and outdoor activities&lt;br&gt;Themes included:&lt;br&gt;• ‘Killing time’&lt;br&gt;• Making the most of it&lt;br&gt;• Creating challenges&lt;br&gt;• ‘Doing groups’, and&lt;br&gt;• Barriers to exploiting occupational opportunities.</td>
<td>Grade C – Low&lt;br&gt;Limitations:&lt;br&gt;• It is unclear who conducted the data analysis&lt;br&gt;• Small sample group in one secure facility in Australia.</td>
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<tr>
<td>Fitzgerald (2011)</td>
<td>A pre-test and post-test, between-group comparison design evaluative study</td>
<td>Both groups received treatment as usual (TAU)</td>
<td>Pre- and post-intervention measures for SIP and TAU groups</td>
<td>SIP group scored higher at post-intervention compared with pre-intervention, and TAU group had a lower post-intervention score as compared with their pre-intervention score. Pattern continued for the subscale scores of motivation for occupation, communication and interaction skills and process skills. Pattern of occupation and environment subscale scores improved for both groups but SIP group had larger increase. Overall the SIP group scored significantly better than the TAU group post-intervention (p&gt;0.05 at 0.006). MOHOST subscales indicated differences post-intervention for the SIP group: motivation for occupation; pattern of occupation; motor skills (decrease) and environment. The intervention group demonstrated improved occupational functioning as measured by MOHOST scores.</td>
<td>Grade C – Low Limitations: Small sample, four units at one site, no specific analysis feasible of individual session/group benefits, occupational therapists who completed MOHOST also provided intervention, therefore potential for bias to influence scores.</td>
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Aim: to describe family intervention provided by occupational therapy service to individual in secure environment  
Low secure service  
One man as a participant (age 24 years)  
United Kingdom.                                                                 | Family work.       | Family perspective:  
• Relative Assessment Interview (RAI).  
Patient:  
• Model of Human Occupation Screening Tool (MOHOST)  
• Assessment of Communication and Interaction Skills (ACIS)  
• Social skills plan  
• Occupational Circumstances Assessment Interview and Rating Scale (OCAIRS). |
|                        |                                                                                                                                                                                                                       |                    | • Central to the role of the occupational therapist in this area of practice are interventions to modify service user's social and physical environment  
• Focus on goal-orientated activity, roles, self-esteem, adaptive habits  
• Use of MOHOST to demonstrate improved occupational performance  
• Importance of consistency of approach, need for multidisciplinary team involvement; sessions consider needs of both family and service user.  
Graded community exposure valuable  
• Suggestion that family work is a complement to occupational therapy skills, facilitated activity outside of the ward and ongoing recovery.  
Occupational therapists can play a key role in family work and ‘interventions can enhance occupational engagement, assessment and function’.  | Grade D – Very Low  
Limitations:  
• Single case study  
• No rationale for selection of participant.                                                                 |                     |
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<tr>
<td>Fitzgerald et al (2011)</td>
<td>Qualitative study Description of an occupational therapy-led initiative to use the ‘serious game format’ to engage low secure unit patients in the design, layout and refurbishment of the unit Self-selecting 25 out of 30 participated United Kingdom.</td>
<td>‘Serious game approach’ is a game that has a useful outcome or models real life situations Familiarity of format, non-threatening facilitation of communication, and used creatively to address a serious issue Monopoly format Promoted through posters and community meetings Five players per game played on four occasions over four months. Prize at end of game.</td>
<td>Engagement of patients.</td>
<td>Based on case study Management wanted to change medication procedure, but via the game patients were able to raise objections, therefore plan did not go ahead Positive feedback from patients on the game Some generalisations but overall appropriate Recommendation to use format to engage patients in service development.</td>
<td>Grade D – Very Low Limitations: • Transferability and ability to replicate.</td>
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<td>Garner (1995)</td>
<td>Descriptive account of a prevocational training course for mentally disordered offenders on return to the community Medium secure unit in West Midlands Referrals via clinical team n=20 patients Age range 20–51 years Male:female ratio = 16:4 United Kingdom.</td>
<td>Prevocational training course:  - Five individuals per course, modular design with length of time varying (due to funding) from 10 to 20 weeks  - Course managed by multidisciplinary group including an occupational therapist, social worker, nursing officer and educationalist  - Core skills taught: literacy, numeracy, problem solving, interaction skills, social skills, and work tasters.</td>
<td>Measures include:  - Completion of course (voluntary)  - Production of Personal Development Programme (PDP)  - Attendance rates.</td>
<td>• 20 patients had joined the programme, 2 did not complete  • 18 completed a PDP  • 6 registered for in-house City and Guilds programme  • 8 planned to move on to part-time training or education  • Almost 100% attendance  • 12/20 progressed to other forms of vocational training or education  - Programme helped with confidence and patients’ ability to compete in mainstream provision (this was not measured). Programme membership assisted towards discharge.</td>
<td>Grade D – Very Low Limitations:  - Unclear about relationship of author and participants  - Small-scale, clinical intervention described  - No reasons given why two individuals did not complete the programme.</td>
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<td>Green et al (2011)</td>
<td>Mixed methodology study Aim: to develop a brief and simple questionnaire, the Recovery Journey Questionnaire (RJQ), to measure patients' experience of recovery over their inpatient journey; the questionnaire must be reliable and feasible for use in forensic mental health services Medium secure unit Two focus groups n=12 Mean age 35 years All men In-depth interviews n=4 Mean age 39 years All men Questionnaire n=69 Mean age 38 years Male:female ratio = 57:12 United Kingdom.</td>
<td>Three-stage process to develop questionnaire – focus groups, in-depth interviews, and then administration of questionnaire.</td>
<td>Questionnaire asks individuals to indicate (0–100%) extent to which they feel recovery principles were being met Respondents were also asked to rate the questionnaire on a 5-point scale (very useful to not very useful).</td>
<td>Focus group themes for things important to recovery: • Working together • Support and preparation • Empowering service users • Providing good role models • Things to do. From questionnaire, 78% of participants (n=54) reported that the tool/assessment was very useful Authors conclude that this would be a useful tool to administer at regular intervals, e.g. before Care Programme Approach meetings. It assesses patients' subjective experiences of recovery in a forensic setting, but requires further study.</td>
<td>Grade C – Low Limitations: • Self-report questionnaire may bias the responses more favourably • Sampling bias and limited involvement of patients who were women • Small sample group from one catchment area • Did not test for quality of life and other clinically relevant factors.</td>
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<td>Jacques et al (2010)</td>
<td>Audit/evaluation Aim: to review the needs of the men in the medium secure service who had been inpatients for more than five years Patient information from one service Demographic details were collated and then patients’ nurses were interviewed to collect data using the CANFOR-S Questionnaire completion by responsible clinician on patients: n=21 Mean age 41.5 years All men United Kingdom.</td>
<td>Occupational therapy.</td>
<td>Questionnaire covering: • Demographics • Diagnoses • Camberwell Assessment of Need: Forensic version (CANFOR); assesses needs in 25 domains, covering health, social, clinical and functional domains.</td>
<td>95% of patients had occupational therapy as part of their overall programme. Only 19% attended their entire programme. 81% of the group being rated as requiring support to structure day/occupy their time The study concludes a significant population of men in this particular medium secure service had been inpatients for more than five years (21% had been longer than three-year intended stay) This group has different needs from those who progress at a faster rate through medium security, and it is suggested that services should be tailored to meet these needs Additionally, audit suggests that patients are difficult to engage in the therapeutic activities on offer, and the need to consider flexible and alternative activities for this cohort must be emphasised.</td>
<td>Grade D – Very Low Limitations: • Small sample from one trust • CANFOR-S – individual usually rates themselves separately from their carer, in this study only the carer (primary nurse or care co-ordinator) rating was obtained • No patient rating of CANFOR-S.</td>
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<tr>
<td>Kottorp et al (2013)</td>
<td>Exploratory study</td>
<td>Administration of AMPS and A³ following manualised procedures</td>
<td>Assessment of Motor and Process Skills (AMPS):</td>
<td>ADL motor ability mean = 1.68 logit (SD 0.61)</td>
<td>Grade C – Low</td>
</tr>
<tr>
<td></td>
<td>Aim to investigate:</td>
<td>AMPS ADL tasks performed by participant, following which an A³ interview was initiated</td>
<td>ADL process ability mean = 0.83 logit (SD 0.43)</td>
<td>ADL process ability mean = 0.83 logit (SD 0.43)</td>
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<td></td>
<td>• Activities of daily living (ADL) functioning for clients in a forensic psychiatry evaluation unit</td>
<td>Two AMPS observations and two A³ interviews completed (time taken 45–60 minutes).</td>
<td>Awareness A³ mean value = 0.60 logit (SD 0.69)</td>
<td>Awareness A³ mean value = 0.60 logit (SD 0.69)</td>
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<tr>
<td>[New evidence 2017]</td>
<td>The relationship between ADL functioning and awareness of their ability to perform ADL.</td>
<td></td>
<td>Rasch analysis:</td>
<td>Rasch analysis:</td>
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<td></td>
<td>Participants identified from data records from the Assessment of Awareness of Ability international database</td>
<td></td>
<td>• Awareness of ability and motor ability showed moderate and significant relationship (rho = 0.49, p&lt;0.01)</td>
<td>• Awareness of ability and motor ability showed moderate and significant relationship (rho = 0.49, p&lt;0.01)</td>
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<td></td>
<td>Mental health diagnosis criteria:</td>
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<td></td>
<td>• Not totally restricted to ward environment/clinic to perform ADL tasks</td>
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<tr>
<td></td>
<td>• Motivated to carry out ADL tasks under observation</td>
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<td></td>
<td>• Willing to be interviewed regarding performance.</td>
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<td></td>
<td>35 participants</td>
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<td></td>
<td>Mean age: 34.5 years (SD 12)</td>
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<td></td>
<td>Male:female ratio = 27:8</td>
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<td></td>
<td>Sweden.</td>
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<tr>
<td>Lin et al (2009)</td>
<td>Qualitative study – using phenomenology</td>
<td>Interview using interview guide, audio-taped and transcribed verbatim (45–60 minutes)</td>
<td>No specific measures used – interviews.</td>
<td>Occupation provided consistency and coherence to time. Many sought and engaged in positive and meaningful occupation</td>
<td>Grade C – Low</td>
</tr>
<tr>
<td></td>
<td>Aim: to explore the nature and meaning of occupational engagement with forensic patients living in the community</td>
<td>Data analysis using occupational lens process.</td>
<td></td>
<td>Overall structure and meaning of occupation in the community consists of four main essences:</td>
<td>Limitations:</td>
</tr>
<tr>
<td></td>
<td>Potential sample of 150 mentally disordered offenders</td>
<td></td>
<td></td>
<td>• Doing the right thing</td>
<td>• Lack of detail about research procedure</td>
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<td></td>
<td>n=10</td>
<td></td>
<td></td>
<td>• Connecting with others</td>
<td>• Multiple interviews preferable</td>
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<tr>
<td></td>
<td>Age 27–54 years</td>
<td></td>
<td></td>
<td>• Challenges to occupational engagement</td>
<td>• Participants were encouraged to participate by key workers</td>
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<td></td>
<td>Male:female ratio = 5:5</td>
<td></td>
<td></td>
<td>• Importance of freedom and responsibility.</td>
<td>• Not all participants chose to comment on findings via member check session</td>
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<td></td>
<td>All had some support while living in the community and had been there 3–80 months</td>
<td></td>
<td></td>
<td>Participants engaged in occupations which they chose and enjoyed – felt need to demonstrate to authorities they were doing well in their occupations</td>
<td>• Individuals were living in the community and no longer restricted.</td>
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<td></td>
<td>Canada.</td>
<td></td>
<td></td>
<td>Engagement assisted with creating structure, a source of competency, self-worth, socialisation and a source of identity. Abundant free time was considered a barrier to occupational engagement.</td>
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<tr>
<td>Lindstedt et al (2011)</td>
<td>Participatory action research. One-year follow-up design</td>
<td>Patients all visited on site.</td>
<td>Measurements at Time 1 (T1) on admission and Time 2 (T2) – one year later</td>
<td>74 in original group and 36 at second time measurement</td>
<td>Grade C – Low</td>
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<tr>
<td></td>
<td>Examined patient’s life conditions and daily occupations one year after standard forensic psychiatric care</td>
<td></td>
<td>Occupational Performance (OP):</td>
<td>One year after admission 61% of original sample still hospitalised, 18% were cared for on conditional release, 5% were discharged from care and 16% relocated</td>
<td>Limitations: • Only two assessments undertaken – issue with the short time interval for effective clinical change</td>
</tr>
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<td></td>
<td>Focus on change in occupational performance and social performance and differences between still hospitalised and community living patients</td>
<td></td>
<td>• Capability to Perform Daily Occupations (CPDO)</td>
<td>Occupational performance and social performance satisfaction improved between T1 and T2</td>
<td>• High attrition rate (51%) between two data collection points but analysis suggests no systematic bias but may be increased risk of T2 errors</td>
</tr>
<tr>
<td></td>
<td>Sample of 180 identified from Central Archive at Swedish National Board of Forensic Medicine</td>
<td></td>
<td>• Self-efficacy Scale</td>
<td>Frequency of occupational performance deteriorated over one year. Questions how patients are prepared for community life. Need early, goal-directed interventions in occupational performance and social performance for alterations in daily occupations</td>
<td></td>
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<td></td>
<td>Four high secure and seven medium secure units, six general psychiatry hospitals</td>
<td></td>
<td>Social Performance (SP):</td>
<td>Target group needs more jointly planned daily occupations and interventions to support housing in the community.</td>
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<td></td>
<td>n=74 (36 at follow-up)</td>
<td></td>
<td>• Manchester Short Assessment of Quality of Life (MANSA)</td>
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<td></td>
<td>Mean age of follow-up group 33 years</td>
<td></td>
<td>• Interview Schedule for Social Interaction.</td>
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<td></td>
<td>All men</td>
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<td></td>
<td>Sweden</td>
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</table>
| Lindstedt et al (2005) | Cohort study | Interviews, self-report, demographic data and assessment tools. KSP left for completion. | Assessment:  
- Karolinska Scales of Personality (KSP)  
- Capability to Perform Daily Occupations (CPDO)  
- Allen Cognitive Level Screen (ACLS)  
- Manchester Short Assessment of Quality of Life (MANSA). | Life history is an important factor which influences occupational performance and life satisfaction  
KSP scores indicated:  
- High levels of proneness for anxiety (restless, worry, lack of self-confidence, muscle tension and fatigue)  
- Low socialisation scores (lack of positive interpersonal family experiences, empathy and satisfaction).  
Patients appeared to see themselves as performing occupations without burden, whereas ACLS scores indicated low abilities in occupational performance  
The authors suggest that certain personality traits are important in relation to occupational performance and life satisfaction (socialisation, anxiety proneness and assessed psychopathy). | Grade B – Moderate  
Upgrade from Grade C  
rationale:  
- Several methods for data collection  
- Cohort size represented 8.7% of total estimated population of 850 mentally disordered offenders at the time in Sweden.  
Limitations recognised:  
- Administration of KSP by post  
- High attrition rate and sample selection  
- Low numbers = low power for statistical analysis; however, three dependent variables means that the results can be viewed as ‘trustworthy’. |
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<tr>
<td>Lindstedt et al (2004)</td>
<td>Descriptive cross-sectional comparative multi-method</td>
<td>Self-report, observation of occupational performance</td>
<td>Occupational performance (OP):</td>
<td>The mentally disordered offenders reported some disability in performing occupations and participating in community life. However, they were satisfied with their performance and participation, implying limited awareness of their disabilities</td>
<td>Grade B – Moderate</td>
</tr>
<tr>
<td></td>
<td>Aim: to describe occupational performance and social participation of mentally disordered offenders and compare professionals and mentally disordered offenders’ appraisals of these abilities</td>
<td>Demographic and register data from the Swedish National Board of Forensic Medicine were utilised</td>
<td>• Capability to Perform Daily Occupations (CPDO)</td>
<td>Upgrade from Grade C rationale:</td>
<td></td>
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<tr>
<td></td>
<td>Sample of 161 identified from Central Archive at Swedish National Board of Forensic Medicine</td>
<td>Interview and one-year follow-up interview – conducted by one author at the hospital site.</td>
<td>• Self-Efficacy Scale (SES).</td>
<td>• Several methods for data collection</td>
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<td></td>
<td>Participants n=74</td>
<td>Professionals used:</td>
<td>Professionals used:</td>
<td>• Cohort size represented 8.7% of total estimated population of 850 mentally disordered offenders at the time in Sweden.</td>
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<td></td>
<td>Mean age 34.2 years</td>
<td>• Allen Cognitive Level Screen (ACLS).</td>
<td>Social participation (SP):</td>
<td>Limitations recognised:</td>
<td></td>
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<tr>
<td></td>
<td>All men</td>
<td>• Interview Schedule for Social Interaction.</td>
<td>• Interview Schedule for Social Interaction.</td>
<td>• No reasons for dropout of six participants</td>
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<td></td>
<td>Sweden.</td>
<td>Professionals used:</td>
<td>Professionals used:</td>
<td>• Limitations of self-reports</td>
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<tr>
<td></td>
<td></td>
<td>• Forensic psychiatric investigation (FPI)</td>
<td>• The Global Assessment Functioning Scale.</td>
<td>• Attrition rate was 54% of the eligible subjects</td>
<td></td>
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<td></td>
<td></td>
<td>• Psychosocial and environmental problems</td>
<td></td>
<td>• MDO and professionals used different instruments to rate OP and SP.</td>
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<tr>
<td></td>
<td></td>
<td>• The Global Assessment Functioning Scale.</td>
<td></td>
<td>Assessments not all relevant to mental health, e.g. CPDO and the SES.</td>
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<tr>
<td>Long et al (2011)</td>
<td>Evaluative study</td>
<td>Pre- and post-move to a purpose-built unit</td>
<td>Clusters, physical features of environment:</td>
<td>Staff judged the new unit to have more homely features than the old unit; patients were satisfied with the new unit generally, but significantly in terms of physical environment</td>
<td>Grade C – Low</td>
</tr>
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<td></td>
<td>Factors influencing design of a purpose-built medium secure facility for women and effects of moving from an adapted ‘Victorian’ medium secure ward to a purpose-built facility, where design influenced by patients</td>
<td>Focus on space and treatment programme requirements, functional needs and relationships, environment and security, accommodating the daily schedules and staff requirements</td>
<td>• Architectural checklist.</td>
<td>Symptomatology reduced significantly (BPRS) following the move (p&lt;0.05)</td>
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<td>Consider domestic ambiance, patient satisfaction and symptomatology</td>
<td>Social climate:</td>
<td>No significant differences in the levels of aggression when comparing wards</td>
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<td></td>
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<td>Included separate rooms for occupational therapy, educational and recreational pursuits.</td>
<td>• Ward Atmosphere Scale (WAS).</td>
<td>The reduction in overall symptomatology, anxiety and guilt (BPRS) may reflect the effect of a more satisfactory ‘homely’ physical environment or time in treatment</td>
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<td>Satisfaction with environment: • Inpatient satisfaction questionnaire.</td>
<td>The physical environment of psychiatric facilities is an important determinant of behaviour and WAS.</td>
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<td>Symptomatology: • Brief Psychiatric Rating Scale (BPRS).</td>
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<td>Risk: • Overt aggression scale.</td>
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Limitations:
- Patients may have felt coerced into participating due to the power imbalances in secure units
- Small sample size of staff and patients
- Use of the WAS which has been criticised regarding its statistical properties and its failure to address perceived safety.
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<tr>
<td>Long et al (2008)</td>
<td>Cohort study&lt;br&gt;Aim: to assess quality of life in a cohort of detained mental health inpatients and identify the characteristics of satisfied and less satisfied patients to assist with service improvement&lt;br&gt;75% of patient samples participated&lt;br&gt;n=90&lt;br&gt;Mean age 41.4 years&lt;br&gt;Male:female ratio = 63:27&lt;br&gt;The majority of patients (85%) were on medium and low secure locked wards, the remainder on open rehabilitation wards&lt;br&gt;United Kingdom.</td>
<td>There was no intervention, administration of the assessment tools listed in the outcomes.</td>
<td>Social, leisure, work and personal:&lt;br&gt;• Lehman Quality of Life Interview (QOLI) – Brief Version.&lt;br&gt;Depression/anxiety:&lt;br&gt;• Hospital Anxiety and Depression Scale.&lt;br&gt;Psycho-social, energy, motivation:&lt;br&gt;• Schizophrenia Quality of Life Scale&lt;br&gt;• Brief Psychiatric Rating Scale – Expanded Version.</td>
<td>60% of participants were mostly satisfied with life in general&lt;br&gt;There was an association between high quality of life and lower levels of anxiety, depression, hostility symptoms and side effects&lt;br&gt;The univariate analyses indicated that patients in low secure wards reported a significantly higher level of satisfaction with their living situation (QOLI) and with their personal safety (QOLI)&lt;br&gt;The authors conclude that interventions that enhance patients' perceptions of control and mastery are critical. In addition, attitudes, as well as the working practices of staff, are likely to be an important determinant of quality of life.</td>
<td>Grade C – Low&lt;br&gt;Limitations:&lt;br&gt;• Only those patients capable of understanding the purposes and procedures of the study took part; the authors suggested that there are problems inherent in measuring quality of life for those with mental health needs&lt;br&gt;• Lack of sensitivity of QOLI – suggested to use alongside others and utilise Camberwell Assessment of Need: Forensic version (CANFOR).</td>
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<tr>
<td>McQueen (2011)</td>
<td>Mixed methodology study Report to Scottish Government Aim: to review current provision of vocational rehabilitation by Allied Health Professionals (AHPs) in Scotland and produce national guidance Questions focus on evidence for vocational rehabilitation in forensic mental health - Evidence review - Patients' views (n=10) Focus groups and interviews - AHP contribution (n=42) Online survey. Scotland.</td>
<td>Vocational rehabilitation – work preparation, voluntary and paid work.</td>
<td>Patients: qualitative comments from interviews and focus groups AHP survey: - Areas of work and profession - Models used to guide vocational rehabilitation - Partnership working - Barriers and challenges. Model of Human Occupation used most frequently Others used Canadian Model of Occupational Performance and Individual Placement and Support (IPS).</td>
<td>Evidence: limited relating to vocational rehabilitation and forensic mental health. Supported employment more likely to result in competitive employment compared to prevocational training Patient themes: - Normalising my life: the positive impact of work - Gradual steps: facing barriers - Practical help and encouragement: feeling supported. AHPs: challenges include lack of services, restrictions of security setting, attitudes, concerns re disclosure relating to mental health and criminal convictions - Need to promote benefit of physical wellbeing - Need for core outcome measures. Overall conclusion that all forensic mental health patients should be asked about their aspirations towards paid employment early in their rehabilitation.</td>
<td>Grade C – Low Limitations: - Little detail on the methodologies used for each approach – difficult to assess rigour - Limited information about service user participants - Not all references forensic related - Scotland based – not all policies may be applicable UK wide.</td>
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| Morris (2012) | Qualitative study Aim: to investigate what value patients in a regional secure unit place on occupation and how that changes over one year Regional secure unit Criteria: men, post-court, expected to stay in the unit for at least 18 months Volunteers Participants n=5 All men Four men aged 26–64 years. Fifth man younger United Kingdom. | Interviews, occupational questionnaire and participant occupation.            | Four data collection tools:  
  - Interviews (initial interview and then three subsequent interviews at approximately three-month periods)  
  - Occupational questionnaires (initial and discussed again at interview)  
  - Participant observation  
  - Review of clinical notes.  
Content and thematic analysis. | Case story approach  
Super theme of ‘balancing the needs and consequences of security and treatment/therapy’  
Themes overlapped and co-dependent relationship  
Sub-themes:  
Power: feeling disempowered; irritated by rules; compliance; taking control; staff communication; escorts  
Therapy or punishment: punishment; therapy; settled; can’t wait to get out; impact of tiredness; impact of health  
Opportunities within restrictions: opportunities; restriction; freedom; waiting; boredom  
From the stories, a conceptual framework for occupational engagement was developed. | Grade C – Low  
Limitations:  
- Case stories could not be expanded with personal details due to need to ensure confidentiality  
- Response of participants to researcher as member of staff – an ‘insider’ or ‘outsider’. |
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<td>O'Connell et al (2010)</td>
<td>Naturalistic inquiry Aim: presentation of time use for two patients across two different environments and the role activity/passive activity plays Explore how prisoners with mental illness and forensic patients use their time and what factors influence occupational engagement in both the prison setting and the secure mental health unit Purposive sampling Two patients (men, one in 30s and one in 50s in terms of age) participated who met criteria. Both were moved from prison to secure mental health unit Staff focus group – members of multidisciplinary team, including a senior occupational therapist Australia.</td>
<td>Analysis of time use.</td>
<td>• 24-hour time diaries • Semi-structured interview • Occupational Performance History Interview II (OPHI-II) • Observation of the environment • Policy review • Staff focus group.</td>
<td>Time use dominated by sleeping and passive leisure at both sites Acknowledges changes due to the different environments – one case of increased sleep and the other increase in reality-based occupations Data indicates that the secure mental health unit offered the potential for more optimum level of occupational engagement than prisons OPHI-II effective tool and study validates its use Acknowledges the role of delusional-driven activity Suggests that occupational choices influenced by past occupational roles. Current illness symptomatology also has impact.</td>
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Grade D – Very Low Limitation: • Sample size – case study • Not representative.
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| Prebble et al (2011)   | Descriptive case study  
Aim: to investigate how health professionals and patients initiate and maintain a healthy living programme in a locked forensic unit  
Programme A:  
Medium secure unit, unit-wide programme  
Mean age 47 years  
Male:female ratio = 5:2  
Programme B:  
Voluntary programme in pre-discharge minimum secure unit  
Mean age 36.5 years  
Male:female ratio = 8:1  
Staff n=17  
New Zealand. | Two healthy living programmes  
Programme A: compulsory unit-wide treatment  
Programme B: health promotion approach, support choice of health behaviours. | Participants  
(patients and staff) interviewed, minutes of meetings analysed and patient notes accessed  
Health status measures:  
• Body mass index  
• Glucose tolerance tests  
• Blood pressure  
• Medication use. | Success requires flexible multidisciplinary approach, open/closed groups, large/small groups, and motivation of staff  
Job satisfaction and commitment important  
Understanding the effects of the physical and psychological contexts in which healthy living programmes are established, and the way challenges and benefits are affected by context, has practical significance for development of healthy living programmes in forensic units. | Grade D – Very Low  
Limitations:  
• Information that staff were spurred on by recent death of an inpatient who was an obese woman. |
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<tr>
<th>Source</th>
<th>Design and participants</th>
<th>Intervention</th>
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<tr>
<td>Schindler</td>
<td>Pre-test/post-test design Aim: examine whether adults diagnosed with schizophrenia demonstrated improved task, interpersonal skills and social roles when involved in an individualised intervention based on the Role Development Programme (RDP), compared to intervention based on a multi-department activity programme Maximum secure facility 42 in both treatment and control groups All men, 18–55 years United States of America.</td>
<td>Intervention: Role Development Programme Control: Multi-department activity programme routine provision.</td>
<td>On admission, 4, 8 and 12 weeks • Interpersonal skills • Task behaviour • Staff and patient perspectives. Quantitative measures: • Role Functioning Scale • Task Skills Scale • Interpersonal Skills Scale. Qualitative measures: • Staff focus groups • Patient interviews.</td>
<td>Significant differences in interpersonal skills and task skills between the groups (p=0.000) Qualitative: Programme positive aspect of hospitalisation Comparison group ‘use of time’, with experiment group citing specific skills and roles learnt RDP group demonstrated greater improvements in social roles than control at 4, 8 and 12 weeks Quantitative and qualitative measures support the use of the RDP Individuals with schizophrenia: willing and able to develop roles and underlying skills Staff willing to provide a theoretical intervention.</td>
<td>Grade C – Low Limitations: • Not described in a means that would allow replication. Only staff training really described. 18 staff trained and manual used • None withdrew; however, only assessed for length of time in hospital therefore subject numbers declined by week 12.</td>
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| Smith et al (2010)          | Reflective and descriptive account of work-based learning programme designed for forensic learning disability patient group  
Learning disability services – 31 medium, 31 low and 16 rehabilitation beds  
Involved three partners: the hospital, a workplace in the community and a local further education institution  
Four participants’ views sought via interviews  
United Kingdom.                                                                 | Programme aims:  
• Offer graded progression to working in community  
• Offer accredited course (work-related skills, literacy and numeracy)  
• Develop appropriate social interaction  
• Increase self-esteem and confidence by promoting personal responsibility  
• Increase awareness of health and safety.  
Worked one day a week 09.30 – 15.30 hours, expanding to two days a week. | Interviews sought views from patient group about involvement in the programme  
Occupational Therapy Task Observation Scale (OTTOS) suggested for future development/research as an outcome measure. | Increase in social skills, work skills, literacy and numeric skills  
Increased self-esteem – transferable  
Concluded that work environment provided context for patients to demonstrate increased self-confidence, self-esteem, motivation and sense of achievement  
Better hospital team collaborative working as a result. | Grade D – Very Low  
Limitations:  
• Decision trail not defined  
• Very small sample as main limitation, but highlighted further research areas  
• Lack of clear outcome measures. |
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</table>
| Stewart and Craik (2007) | Quantitative and qualitative mixed methodology study  
Aim: impact of detention on performing occupations. Explore how people with schizophrenia experience occupational engagement in forensic mental health secure units  
Multi-site – two regional secure units  
Site 1: 65-bedded medium and low secure units  
Site 2: 265-bedded medium and low secure and specialist unit  
Convenience sampling used. Semi-structured interviews  
Sample: three men, two women  
Age range 20–49 years  
United Kingdom. | Interviews to determine the participants’ understanding of the personal and environmental influences on time use  
Occupational questionnaire involved participants recording time use over previous 24 hours, ½ hourly intervals, categorising occupations as work, daily living tasks, recreation and rest  
Also judged perceived competence, enjoyment and value. | Nature and perceived time use via:  
• Occupational Questionnaire – quantitative data  
• Semi-structured interviews (transcribed verbatim and content analysis). | Majority of waking hours resting and engaging in recreation  
Significant correlations (p<0.01 level) between competence and enjoyment (t=0.493) and value and enjoyment (t=0.527)  
Self-chosen activities were more likely to be enjoyed (p<0.05)  
73% of time spent in self-initiated occupations  
Daily living tasks 15%, work 8%, recreation 23%, rest 15% and sleep 39%. Time use characterised mainly by engagement in passive leisure and rest occupations  
Occupations chosen based on expectations – enjoyment, success, association with independence and normality  
Themes from interviews were motivation for occupation, the value of occupations, choice and autonomy and pattern of occupation. Demonstrates time use in secure units and the bias towards passive engagement, use of occupation as a means of ‘escape’. | Grade C – Low  
Limitations:  
• Recruitment difficulty and small sample, patients wanted to be paid  
• May be bias as less motivated patients were not involved  
• Single interview only  
• Results not transferable. |
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</table>
| Tetlie et al (2009) | Qualitative phenomenological study  
Aim: to explore in what ways nursing staff use exercise as part of treatment for patients with severe mental illness  
Regional secure unit – purposeful sampling  
Patients interviewed n=15  
Mean age 33.4 years  
Male:female ratio = 12:3  
Focus groups and individual semi-structured interviews with nursing staff n=5  
Male:female ratio = 2:1  
Norway. | Secure setting where existing structured approach to exercise as intervention  
Compulsory  
Exercise programme occurs three times a week, for three hours in the morning as part of a scheduled treatment plan.  
Group based  
Mix of hikes, skiing, gym, swimming, games and play to include aspects of social interaction  
Member of staff assigned to each patient. | Semi-structured interviews  
Focus group. | Four themes emerged:  
• Therapeutic relationships (likeness and shared experiences)  
• Mandatory treatment (provides challenges)  
• Positive reinforcement (a key ingredient to successful outcomes)  
• Instructors.  
Therapeutic relationships are integral to any intervention – therapeutic relationship, rather than the approach, creates favourable treatment outcomes. This relationship is considered the most effective ingredient of all therapeutic practices  
In addition the authors believe emphasis on physical health promotion may lead to increased participation in rehabilitation activities. | Grade C – Low  
Limitations:  
• Little detail regarding demographics, etc.  
• Missing information about relationship of the researcher to participants, data collection and form of the thematic analysis  
• Small sample and difficulty therefore to generalise  
• Data collection not the same for staff and patients. |
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</table>
| Tetlie et al (2008) | Before and after study | 8–12-week group-based exercise programme | Before and after exercise intervention  
• Body mass index  
• Triglyceride levels  
• Glucose levels  
• Cholesterol levels  
• Fitness level via treadmill monitoring  
• Seven symptoms of psychological wellbeing rated by individual after exercise using visual analogue scales. | 13/15 completed programme  
Statistically significant improvement in resting heart rate and systolic blood pressure post-treadmill test (p<0.05)  
No statistically significant changes in body mass index  
Participants report statistically significant changes in feelings of wellbeing and safety  
Exercise has positive impact on physical health. Self-reported improvement on psychological outcomes but further research needed. | Grade C – Low  
Limitations:  
• Two participants dropped out due to hospital transfer  
• Difficult to generalise  
• Small study and no control group  
• High compliance – staff know patients and programme had structure and supervision  
• Analogue scale used for measuring psychological symptoms. |
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<tr>
<td>Teychenne et al (2010)</td>
<td>Literature review</td>
<td>Aim: to investigate the effect of sedentary behaviour and physical activity on the risk of depression in adults.</td>
<td>Seven observational and four intervention studies included in the review.</td>
<td>Positive associations were found between sedentary behaviour and risk of depression. Results contradicted by the intervention studies.</td>
<td>Grade C – Low Limitations: • Number of studies had methodological weakness. • Mainly self-report measures so unable to determine causality and direction of relationship.</td>
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<td>Völlm et al (2014)</td>
<td>Service evaluation survey</td>
<td>Thrapies and Education Department (TED) mixture of therapeutic interventions including education programmes, workshops, sports, leisure activities</td>
<td>Self-report questionnaires developed with closed and open questions</td>
<td>Patient responses = 150 (54.3%)</td>
<td>Grade D – Very Low</td>
</tr>
<tr>
<td></td>
<td>Aims:</td>
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<td>Staff responses = 65 (58%)</td>
<td>Limitations:</td>
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<tr>
<td></td>
<td>• Identify levels of education and previous work experience</td>
<td></td>
<td></td>
<td>42 were occupational therapists and technical instructors</td>
<td>• Large proportion of patients did not participate</td>
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<td></td>
<td>• Describe current engagement in occupational therapy and vocational skills sessions</td>
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<td>• Educational levels of those patients surveyed fell short of general population</td>
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<td></td>
<td>• Explore views of patients and staff on services in relation to future employment, and on the importance of work for mental health and in prevention of reoffending.</td>
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<td>• 63.3% of patients surveyed had some job or employment prior to admission</td>
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<td></td>
<td>• IT, English, maths, marketing and arts most commonly identified by patients and staff to be most beneficial educational courses for future employment</td>
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<tr>
<td>Patients – 276 eligible</td>
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<td>• Patients and staff most commonly identified cooking as most relevant vocational qualification for future employment</td>
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<td></td>
<td>Exclusion: dangerous and severe personality disorder service</td>
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<td>• Most staff and patients agreed the need for more ‘real work’ in vocational services</td>
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<td>Mean age 38 years (20–74 range)</td>
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<td>• Staff felt more strongly than patients that work-related skills lost during admission</td>
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<td>Male:female ratio = 127:23</td>
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<td>• Patients and staff recognised the importance of work for mental health and prevention of reoffending.</td>
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<tr>
<td>Staff – 106 approached (all those directly involved in delivery of work-related activities or who had overall responsibility for patient care)</td>
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<td>Provides evidence for meaningful work opportunities for forensic patients.</td>
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<td>United Kingdom.</td>
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Grade D – Very Low

Limitations:
• Large proportion of patients did not participate
• Patients likely to be over-represented by those who were more confident, able to engage and already accessing interventions, less acutely unwell
• Levels of achievement may be overestimated
• Questionnaires limited qualitative response
• Differences between patient groups may not be identified due to small number of participants
• No ethical approval (not required from trust R & D board as service evaluation).
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<tr>
<td>Walker et al (2013) [New evidence 2017]</td>
<td>Qualitative ethnographic approach&lt;br&gt;Aim to investigate:&lt;br&gt;• Staff and patients' understanding of community day leaves&lt;br&gt;• Ways that escorting staff members facilitate rehabilitation aims and foster recovery.&lt;br&gt;Secure mental health facility, recruitment via patient community ward meeting&lt;br&gt;Predominant diagnosis schizophrenia&lt;br&gt;Paired patient and staff member escorting&lt;br&gt;Observations: nine patients (all male)&lt;br&gt;Interviews following the observed leaves:&lt;br&gt;• Ten staff&lt;br&gt;• Nine patients. Australia.</td>
<td>Observation of ten escorted community day leaves (CDLs) over three-month period&lt;br&gt;Escorted day leaves progress generally from basic community skills to linking with agencies and services in the community&lt;br&gt;21 semi-structured interviews with staff and patients.</td>
<td>Observed CDLs:&lt;br&gt;• Field notes taken to supplement the observations&lt;br&gt;• Reflective journal&lt;br&gt;• Interviews.&lt;br&gt;Staff:&lt;br&gt;• Understanding of function of CDLs&lt;br&gt;• Role of CDLs&lt;br&gt;• Why particular decisions made during the observed leave.&lt;br&gt;Patients:&lt;br&gt;• Understanding of function of their CDL&lt;br&gt;• Experience of this and other CDLs.&lt;br&gt;Thematic analysis.</td>
<td>Staff and patients had a similar overall understanding of the function of CDLs:&lt;br&gt;• To successfully reintegrate into the community&lt;br&gt;• To develop and practise daily living skills&lt;br&gt;• Diversional therapy/ease boredom&lt;br&gt;• Increase awareness of public/learn to be around people&lt;br&gt;• Avoid institutionalisation/challenge self&lt;br&gt;• Assessment in the community/demonstrate ability to cope in the community.&lt;br&gt;Three narratives were used to illustrate rehabilitation and fostering of recovery from staff&lt;br&gt;Style of interaction and decisions/actions of staff providing the escort significantly impacted on the potential benefits of CDL&lt;br&gt;CDLs require:&lt;br&gt;• Guidelines on facilitation from a recovery perspective&lt;br&gt;• Planning and preparation regarding purpose&lt;br&gt;• Evaluation and feedback to patient.&lt;br&gt;CDLs need to be shaped by recovery principles.</td>
<td>Grade D – Very Low&lt;br&gt;Downgraded from C due to:&lt;br&gt;• No information about triangulation of findings or member checking&lt;br&gt;• No discussion about limitations / potential for bias.&lt;br&gt;Limitations:&lt;br&gt;• Selective sampling from intensive rehabilitation unit who already have on average 10 hours of community day leave per week&lt;br&gt;• One facility only&lt;br&gt;• Male patients only, predominantly schizophrenia diagnosis&lt;br&gt;• Limited number of leaves in the data collection period&lt;br&gt;• Not specific to occupational therapy&lt;br&gt;• Limited observation of different disciplines/styles (seven psychiatric nurses, one agency psychiatric nurse, one occupational therapist, one psychiatric support officer).</td>
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<td>Source</td>
<td>Design and participants</td>
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<td>Williams and Chard (2016)</td>
<td>Practice analysis and critical reflection</td>
<td>Participant met with occupational therapist: discussed past and current interests, occupational and social deficits, strengths, limitations and future intentions</td>
<td>Evaluation of Social Interaction at baseline and follow-up scores – post-intervention (reported in logits) Seven skill domains: • Initiating/terminating social interaction • Producing social interaction • Physically supporting social interaction • Shaping content of social interaction • Maintaining flow of social interaction • Verbally supporting social interaction • Adapting social interaction. Rating of quality of 27 social interaction skills within the domains on a four-point scale: competent, questionable, ineffective, severely limited.</td>
<td>ESI baseline scores: all had scores below competence cut-off and below well age-matched sample ESI follow-up scores post-interventions (five participants): • Clinically significant improvement in quality of social interaction score n=3 (≥0.4 logits) • Clinically observable change n=1 (0.3 logits) • No observable improvement n=1. ESI assisted in identification of specific social interaction skills that either supported or limited competent quality of social interaction Patients gained a better understanding of why they had social interaction difficulties when setting own goals based on ESI results – increased insight Informal feedback: • Positive reinforcement provides improved motivation in engagement in treatment planning • Positive change in team working; staff expressed greater understanding of challenges in activities and social skills for patients.</td>
<td>Grade D – Very Low Comments: • Results reported by clinical significance, not statistical significance. Limitations: • Evaluation not research • Very small sample; six of 12 patients consented to participate • Follow-up scores for five patients (one discharged) • Difficult to control confounding variables due to pervasive nature of social skills.</td>
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<tr>
<td>[New evidence 2017]</td>
<td>Low secure forensic inpatient unit (12 bedded, male) Diagnoses varied, all identified as having poor social skills Six participants who had been in unit between three months and three years (average two years) Age range 24–56 years All male participants United Kingdom.</td>
<td>Baseline observation by occupational therapist during two social exchanges: occurred in typical settings (in or outside of unit) with usual social partners, e.g. social conversing during break, giving or receiving feedback, group discussion Discussion post-baseline assessment with participant to inform intervention plan with focus on social interaction skills that were limiting engagement in social occupations Activities chosen by the patients based on what was meaningful to them and to meet occupational goals Group and individual interventions including a ten-week social skills group and opportunities to practise skills within real settings.</td>
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### Appendix 7: Glossary and abbreviations

| AMPS | **Assessment of Motor and Process Skills**  
An observational assessment used to measure the quality of a person's activities of daily living (ADL) by rating the effort, efficiency, safety, and independence of 16 ADL motor and 20 ADL process skill items, while the person is doing chosen, familiar, and life-relevant ADL tasks.  
(AMPS UK and Ireland at: [http://www.ampsukandireland.com](http://www.ampsukandireland.com)) |
| A³ | **Assessment of Awareness of Ability**  
The A³ explores the discrepancy between observed strengths and limitations in the performance of activities of daily living (ADL) and limitations described by the patient.  
| Behavioural dysregulation | Characterised by difficulty inhibiting harmful behaviour (e.g. substance abuse, aggression, binge eating), which can lead to marked impairments in social, physical and occupational functioning (Wupperman et al 2012). |
| CMOP | **Canadian Model of Occupational Performance**  
Focuses on the dynamic relationship between a person, their occupations and their environment. Spirituality is at the core of the model (Canadian Association of Occupational Therapy at: [http://www.caot.ca](http://www.caot.ca)). |
| COT | **College of Occupational Therapists**  
A wholly-owned subsidiary of the British Association of Occupational Therapists operating as a registered charity. The College sets the professional and educational standards for the occupational therapy profession and represents the profession at the national and international levels. (As of April 2017 the College of Occupational Therapists became the Royal College of Occupational Therapists (RCOT)). |
| COTSS-MH Forensic Forum | **College of Occupational Therapists’ Specialist Section – Mental Health, Forensic Forum**  
A branch of the College in which members support each other’s professional development and work co-operatively to shape and influence mental health and wellbeing national policy. The Forensic Forum enables occupational therapists working in the same speciality to network, provide learning opportunities and support each other. |
| CPA | **Care Programme Approach**  
A form of care management in which person-centred assessments and care plans are co-ordinated by a named individual. |
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<th>Abbreviation</th>
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<tr>
<td><strong>ESI</strong></td>
<td><strong>Evaluation of Social Interaction</strong>&lt;br&gt;A dynamic observational instrument used to evaluate a person’s quality of social interaction during natural social exchanges with typical social partners.&lt;br&gt;(AMPS UK and Ireland at: <a href="http://www.ampsukandireland.com">http://www.ampsukandireland.com</a>)</td>
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<td><strong>HCR-20</strong></td>
<td><strong>Historical, Clinical, Risk Management-20</strong>&lt;br&gt;The HCR-20 is an assessment which looks at risk factors related to violence: historical (past), clinical (current), and risk management situational factors (future).&lt;br&gt;(HCR-20 information at: <a href="http://hcr-20.com">http://hcr-20.com</a>)</td>
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<td><strong>High secure</strong></td>
<td><strong>High secure hospitals/units</strong>&lt;br&gt;Provide facilities for patients who are detained and considered to be an immediate grave and serious danger to the public and who require a significant period of treatment (DH 2012b).</td>
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<tr>
<td><strong>IPA</strong></td>
<td><strong>Interpretative phenomenological analysis</strong>&lt;br&gt;Aims to explore the insider’s views and perceptions of the participant’s world, and concurrently integrates the researcher’s interpretation of that world (Cronin-Davis et al 2009).</td>
</tr>
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<td><strong>Low secure</strong></td>
<td><strong>Low secure hospitals/units</strong>&lt;br&gt;Provide facilities for patients who are detained because of the level of risk or challenge they present, and cannot be treated in an open mental health unit (DH 2012b).</td>
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<td><strong>MDO</strong></td>
<td><strong>Mentally disordered offender</strong>&lt;br&gt;A person who has a ‘disability or disorder of the mind’ and has committed or is suspected of committing a criminal offence.</td>
</tr>
<tr>
<td><strong>Medium secure</strong></td>
<td><strong>Medium secure hospitals/units</strong>&lt;br&gt;Provide facilities for patients who are detained and who represent a significant danger to the public (DH 2012b).</td>
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<tr>
<td><strong>MOHO</strong></td>
<td><strong>Model of Human Occupation</strong>&lt;br&gt;A model of occupational therapy practice in which humans are conceptualised as three interrelated components: volition, habituation and performance (Kielhofner 2008).</td>
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<td><strong>MOHOST</strong></td>
<td><strong>Model of Human Occupation Screening Tool</strong>&lt;br&gt;MOHOST is an assessment that addresses the majority of MOHO concepts (volition, habituation, skills, and environment), allowing the therapist to gain an overview of the client’s occupational functioning.&lt;br&gt;(MOHO Clearinghouse at: <a href="http://www.cade.uic.edu/moho">http://www.cade.uic.edu/moho</a>)</td>
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<td><strong>Occupational deprivation</strong></td>
<td>A state of preclusion from engagement in occupations of necessity and/or meaning due to factors that stand outside the immediate control of the individual (Whiteford 2000).</td>
</tr>
<tr>
<td><strong>Occupational enrichment</strong></td>
<td>The deliberate manipulation of environments to facilitate and support engagement in a range of occupations congruent with those that the individual might normally perform (Molineux and Whiteford 1999).</td>
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<tr>
<td><strong>Physical security</strong></td>
<td>‘The fences, locks, personal alarms and so on that keep people safe’ (Royal College of Psychiatrists, Quality Network for Forensic Mental Health Services 2015, p4).</td>
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<tr>
<td><strong>Procedural security</strong></td>
<td>‘The policies and procedures in place to maintain safety and security’ (Royal College of Psychiatrists, Quality Network for Forensic Mental Health Services 2015, p4).</td>
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<tr>
<td><strong>Pro-social</strong></td>
<td>Pro-social activity is voluntary and intended to help or benefit others. It is the antithesis of anti-social behaviour.</td>
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<tr>
<td><strong>Recidivism</strong></td>
<td>A habitual or repeated relapse into crime.</td>
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<tr>
<td><strong>Recovery college</strong></td>
<td>A recovery college delivers peer-led education and training programmes within mental health services. Two of the defining features of a recovery college are the ‘co-production between people with personal and professional experience of mental health problems’, and the ‘reflection of recovery principles in all aspects of culture and operation’ (Perkins et al 2012, pp 3–5).</td>
</tr>
<tr>
<td><strong>Relational security</strong></td>
<td>‘The knowledge and understanding staff have of a patient and of the environment, and the translation of that information into appropriate responses and care’ (Royal College of Psychiatrists, Quality Network for Forensic Mental Health Services 2015, p5).</td>
</tr>
<tr>
<td><strong>VR</strong></td>
<td><strong>Vocational rehabilitation</strong>&lt;br&gt;VR is a process to overcome the barriers an individual faces as a result of injury, illness or impairment when accessing, remaining in or returning to purposeful activity, work and employment (COT 2008).</td>
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</tbody>
</table>
References

Evidence references


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Occupational therapists’ use of occupation-focused practice in secure hospitals

Practice guideline
Second Edition

This publication is an evidence-based resource to support occupational therapists working with adults in secure settings. It provides a practice guideline with recommendations for those occupational therapists currently working in this speciality, as well as offering a useful reference document for students. It can also be used to inform patients and carers, together with other health professionals, managers and commissioners working in forensic mental health services, about the roles and responsibilities of the occupational therapist in this clinical area.