Quick Reference Guide

The Quick Reference Guide provides a summary of the recommendations in the Royal College of Occupational Therapists practice guideline *Occupational therapists’ use of occupation-focused practice in secure hospitals*. It 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 full practice guideline together with implementation resources can be found on the Royal College of Occupational Therapists website: https://www.rcot.co.uk/practice-resources/rcot-practice-guidelines/secure-hospitals


1. Introduction

The aim of this practice guideline is to provide specific evidence-based recommendations to support the use of occupation-focused occupational therapy for adults (18 years and above) in secure hospitals. The guideline aims to support the occupational therapist's decision-making and clinical reasoning but, being based on evidence, cannot cover all aspects of occupational therapy practice within the secure setting. The recommendations are intended to be used alongside the therapist's clinical expertise in their assessment of need and implementation of interventions. The practitioner is, therefore, ultimately responsible for the interpretation of this evidence-based guideline in the context of their specific circumstances, environment and patients' needs.

This resource provides a quick reference to the guideline recommendations, together with tables outlining the nature of the strength and quality grading categories of the recommendations. Extracts from the full guideline document and an overview of the occupational therapy role are also provided. Evidence-based recommendations are, however, not intended to be taken in isolation and must be considered in conjunction with the contextual information, and full guideline development methodology, described in the practice guideline document, together with current versions of professional practice documents, of which knowledge and adherence is assumed (RCOT 2017, p17).

The evidence from 41 studies used to develop the recommendations is summarised in the guideline document (Section 5), and in evidence tables (Appendix 6). A total of 4.9% of the evidence from which the recommendations were developed was assessed as being moderate (Grade B) quality studies. 63.4% of the evidence was graded as low (C) and 31.7% as very low (D) quality. The overall grade of a recommendation is depicted in the guideline with a numerical, then alphabetical grade to reflect the strength of the recommendation and quality of the evidence (e.g. 1A – strong recommendation, high quality). Seventeen of the 20 recommendations are graded as strong.
2. Policy and service delivery context

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 2013). 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.

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 the guideline.

3. The occupational therapy role

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 2006, p20).

*Occupational therapy enables people to achieve health, wellbeing and life satisfaction through participation in occupation* (WFOT 2013, p48). ‘Occupation’ as a term refers to practical 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 (RCOT 2017).

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).

The ultimate aim of occupational therapy is to enable patients to experience occupational enrichment and thus achieve optimal occupational functioning. Occupational enrichment in forensic settings can be considered as both the goal and process of occupational therapy interventions.

4. Guideline recommendations

The guideline recommendations are presented under categories that reflect the Model of Human Occupation (MOHO). 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:** the process by which occupation is organised into patterns or routines.

**Performance capacity:** refers to the physical and mental components, and the subjective experience, that assists the ability to do things.

**Environmental considerations:** 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 2017).
4.1 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.

<table>
<thead>
<tr>
<th>Volition</th>
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| 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])* |
| 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])* |
| 3. **It is recommended** 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.  
  *(Lindstedt et al 2004 [B])* |
| 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]* |
| 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])* |
| 7. **It is recommended** that occupational therapists ascertain patients’ aspirations towards paid employment at the earliest opportunity, and during rehabilitation.  
  *(McQueen 2011 [C])* |

4.2 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.
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])*

4.3 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 pre-vocational 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 were the subject of a number of studies, with encouraging evidence also noted for a social inclusion programme.

Performance capacity

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

   *(Clark 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]; Teychenenne 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])*
4.4 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 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.

Environmental considerations

<p>| | |</p>
<table>
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<tr>
<td><strong>Environmental considerations</strong></td>
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<tr>
<td>14.  <strong>It is recommended</strong> that occupational therapy staff fully value the therapeutic use of self as being integral to the positive engagement of patients in occupations.</td>
<td>1C</td>
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<tr>
<td>(Evans et al 2012 [C]; Mason and Adler 2012 [C]; Tettie et al 2009 [C])</td>
<td></td>
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<tr>
<td>[Statement amended, new evidence 2017]</td>
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<tr>
<td>15.  <strong>It is recommended</strong> 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.</td>
<td>1C</td>
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<tr>
<td>(Cordingley and Ryan 2009 [C])</td>
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<td>16.  <strong>It is suggested</strong> that occupational therapists recognise the role and contribution of families and friends in the recovery of patients.</td>
<td>2C</td>
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<tr>
<td>(Absalom et al 2010 [C]; Fitzgerald et al 2012 [D])</td>
<td></td>
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<tr>
<td>[Statement amended 2017]</td>
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<tr>
<td>17.  <strong>It is recommended</strong> that occupational therapists consider the impact of the environment on quality of life and occupational engagement.</td>
<td>1C</td>
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<tr>
<td>(Craik et al 2010 [C]; Fitzgerald et al 2011 [D]; Long et al 2008 [C]; Long et al 2011 [C]; Morris 2012 [C])</td>
<td></td>
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<tr>
<td>18.  <strong>It is suggested</strong> that occupational therapists liaise with a range of community services to facilitate replication of patients’ pro-social behaviours developed during an inpatient stay.</td>
<td>2C</td>
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<tr>
<td>(Elbogen et al 2011 [D]; Lin et al 2009 [C]; Lindstedt et al 2011 [C])</td>
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<tr>
<td>19.  <strong>It is recommended</strong> that occupational therapists demonstrate their competencies (skills and training) to facilitate identified therapeutic groups, enhancing the confidence and participation of patients.</td>
<td>1C</td>
</tr>
<tr>
<td>(Mason and Adler 2012 [C])</td>
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<tr>
<td>20.  <strong>It is recommended</strong> that occupational therapists articulate, to patients and the multidisciplinary team, their role and the contribution of occupational therapy to the overall treatment programme.</td>
<td>1C</td>
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<tr>
<td>(Cronin-Davis 2010 [C])</td>
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It is additionally recommended that occupational therapists use the audit tool that is available to support this guideline to undertake audit against the above recommendations.
5. Recommendation Grade Guide

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</td>
<td>1</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>Conditional</td>
<td>2</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>
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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>
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<tbody>
<tr>
<td>High</td>
<td>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 very unlikely to change confidence in the estimate of the effect.</td>
</tr>
<tr>
<td>Moderate</td>
<td>B</td>
<td>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.</td>
<td>True effect likely to be close to the estimate of the effect but 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.</td>
</tr>
<tr>
<td>Low</td>
<td>C</td>
<td>Based on observational evidence, or from controlled trials with several very serious limitations.</td>
<td>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.</td>
</tr>
<tr>
<td>Very low</td>
<td>D</td>
<td>Based on case studies or expert opinion.</td>
<td>Any estimate of effect is very uncertain and may be far from the true effect.</td>
</tr>
</tbody>
</table>
Evidence References


Farnworth L, Nikitin L, Fossey E (2004) Being in a secure forensic psychiatric unit: every day is the same, killing time or making the most of it. British Journal of Occupational Therapy, 67(10), 430–438.


Supporting information references


Model of Human Occupation Clearinghouse (2017) Introduction to MOHO. Chicago, IL: University of Illinois at Chicago. Available at: http://www.cade.uic.edu/moho/resources/about.aspx


Royal College of Occupational Therapists (2017) What is occupational therapy? London: RCOT. Available at: https://www.rcot.co.uk/about-occupational-therapy/what-is-occupational-therapy


All websites in these references were accessed on 17.05.17.