The implementation of a new conceptual framework for occupational engagement in forensic settings: feasibility and application to occupational therapy practice

AUTHORS

Acknowledgements: We would like to thank the occupational therapists from the two secure units for their contributions to this research.

Funding: The project was funded by the University of Cumbria – Research and Scholarship Development Fund

The implementation of a new conceptual framework for occupational engagement in forensic settings: feasibility and application to occupational therapy practice

Abstract

Purpose
Facilitation of genuine occupational engagement rather than a more superficial level of participation that has minimal therapeutic benefit is a challenge within secure mental health settings. The purpose of this study was to develop, pilot and evaluate therapeutic tools based on a framework of occupational engagement.
Design/methodology/approach
The study used action research with occupational therapists from two secure residential units. Focus group discussions gathered participants' views of how the occupational engagement framework could be used to inform a therapeutic tool. Following the development and piloting of the subsequent tools, focus groups were again used to review their usefulness in practice. Discussions were audio recorded and thematically analysed.
Findings
Three tools were designed and piloted. Evaluation revealed a number of benefits and different ways in which the tools could be used in practice.
Research limitations/implications
This research has indicated that the occupational engagement framework has potential for increasing understanding of the relationship between the value and consequences of participating in occupations. The limited timescale of the research restricted the opportunity to fully explore the tools' potential effectiveness as outcome measures.
Practical implications
The clinical tools developed within this research have provided some information to the clinical teams which has contributed to their understanding of how service users experience participating in occupations.
Originality/value
The occupational engagement framework and resulting tools have the potential to enhance understanding of occupational engagement within secure settings.

Keywords: occupational engagement; occupational therapy, secure settings, action research, therapeutic tools

Introduction

Occupational therapists are core members of the multidisciplinary team within forensic mental health services (Holder & Souza, 2016). Their interventions take into account how criminal occupations impact on the lifestyle and wellbeing of their service users (Cronin-Davis *et al.,* 2004) and consequently address the behaviour that gave rise

to the individual's admission (Martin, 2003). Through the provision of personal meaningful activity, occupational therapists have a key role in promoting recovery and reducing the risk of future offending (RCOT, 2017b).

Despite their knowledge and skills, there are a number of challenges for occupational therapists working in forensic settings. As admissions to secure units are often lengthy (Duncan, 2011), it is important that therapeutic programmes evolve to maintain interest and motivation over time (Farnworth *et al.,* 2004). Wellbeing is a subjective positive experience enhanced by participating in occupations which have meaning for a person (RCOT, 2017b). In addition, occupational therapists should ensure that they are able to facilitate *engagement* in purposeful occupation rather than just *participation* in an occupation. It may be difficult to identify when an individual is engaged (and indeed to what degree they are engaged) in an occupation.

Forensic settings have some inherent features that incite individuals to participate in occupations that have little or no therapeutic value for them. Some service users may participate because of the positive consequences of demonstrating 'compliance' with treatment. Being seen to be doing the right thing by those in positions of authority and power was found to influence behaviour during a study carried out by Lin *et al.* (2009). Furthermore, attendance at therapy sessions might simply be prompted by the opportunity to spend some time away from the ward environment. Craik *et al.* (2010) found that some individuals attended therapy sessions merely to relieve boredom, even though they sometimes considered them to be childish or irrelevant. Cronin-Davis *et al.* (2004, p173) discuss how "*occupational enrichment may be difficult to achieve due to patients' often distorted perceptions of meaningful occupations*." Often, preferred occupations are not legal or socially acceptable, resulting in a clear conflict between the needs and desires of the individual and those of the wider society.

This poses a further challenge for occupational therapists as they strive to accomplish a careful balancing act between the needs of society, the responsibility of the service and the preferences of the individual. The role of the occupational therapist to promote 'socially acceptable' forms of occupation to replace previous 'unacceptable' pastimes, could be seen to conflict with the professional tenet that it is the individual who gives meaning to the occupation. In this event, the occupational therapist is at risk of ignoring a person's perceptions of the value of an occupation because society believes it to be distorted.

Measuring Occupational Engagement

A systematic review of outcome measures used in forensic mental health services (Fitzpatrick *et al.,* 2010) found nine measures were being used and these had largely a medical focus. Whilst there are a few tools (e.g. Forensic OCAIRS, Forsyth *et al.*, 2005) which have been adjusted to the unique environmental considerations of the setting, there are no tools available which consider both the value of an occupation and the consequences of participating in it. The development of a clinical tool for occupational engagement will contribute to the evidence base for occupational therapy (RCOT, 2017a).

Development of a conceptual framework for occupational engagement in forensic settings

A conceptual framework for occupational engagement in forensic settings emerged as a product of a PhD research thesis by Morris (2012). This research used case studies to explore occupational engagement of five men living in a regional secure unit in England. It is based upon the notion that every occupation holds a level of personal value and perceived consequences in terms of feedback from physical, social and cultural

environments. The development of the conceptual framework is reported elsewhere (Morris & Cox, 2017).

The framework is presented in two parts. Part one is illustrated in Figure 1. Levels of 'value' are represented as a continuum with *Participation* as the anchor and entry point. *Interest*, *Engagement* and *Absorption* represent graded levels of positive value. To explain further, *engaging* occupations require more carry more value than those that *interest*, but not as much as those that *absorb* the individual. At the other end of the continuum, *Indifference*, *Disengagement* and *Repulsion* represent graded levels of negative value.

INSERT FIGURE 1 HERE

It should be noted here that *Non Participation* is not considered to be part of the continuum as the definition of 'occupation' is active. However, it is important and must be remembered as it serves a purpose. For example, it may be the only way that individuals have of controlling their environment.

As well as value, the person will perceive positive or negative consequences to participation which may change over time in response to feedback from their environment. An occupation with positive value for the individual can have negative consequences and vice versa.

To give an example, illicit substance use might stimulate occupational *interest* or *engagement* (therefore positive value) but can result in deteriorating mental health and legal action (which therefore carries negative social and personal consequences). On the other hand, attending a drug awareness course might be accompanied by occupational *indifference* (classed as negative value) but can result in overcoming problems with substance misuse (and therefore hold positive consequence for the individual and society).

It is accepted that it is not possible for all occupations to have positive value and consequences. It is therefore important to acknowledge the negative value of some required occupations. For example, cleaning up may be *disengaging* but the consequence is positive in that it is more comfortable to live in a clean environment. However, people who lack a sense of wellbeing tend to have more occupations with negative value and consequences. The aim of successful rehabilitation therefore is to achieve wellbeing through minimising the number of such occupations and developing occupations with positive value and positive consequences. The intended result is that the individual engages in occupations that are personally fulfilling and acceptable to the community in which they live.

The second part of the framework is illustrated in Figure 2. The two ends of the scales represent perceived consequences, with *Positive* consequences represented by the left side and *Negative* consequences represented by the right side of the scales. Each sphere on the scales represents an occupation. Blue spheres represent those with positive value and green represent those with negative value. Additionally, white spheres represent occupations of neutral value.

INSERT FIGURE 2 HERE

The first set of scales on Figure 2 illustrates that the individual positively values more occupations that have negative consequences whilst more of the occupations with positive consequences are valued negatively. The scales are therefore weighted more towards occupations that have negative consequences. In the third set of scales the balance has been tipped as there are now more positively valued occupations with positive consequences. Additionally, more of the occupations with negative consequences are now valued negatively. A greater sense of wellbeing is now achieved. This explanation of the framework formed the basis of the training session described below.

Aim

The aim of this research was to develop, pilot and evaluate a therapeutic tool based on the Occupational Engagement Framework (Morris, 2012).

Objectives

- To explore occupational therapists' current understanding of occupational engagement and methods of evaluating this
- To design a therapeutic tool for occupational engagement for use in forensic mental health settings
- To pilot the therapeutic tool in forensic mental health settings for six months
- To evaluate the usefulness of the tool for clinical practice
- To review both the conceptual framework and therapeutic tool

Study Design

Method

The research was carried out in three stages:

- *Stage 1*: Introduction to and training on the conceptual framework of occupational engagement followed by an exploration of its potential use in a practice setting
- *Stage 2*: Development and piloting of the new tool for six months
- *Stage 3*: Review of the framework and therapeutic tool

The research used action research to begin to explore the potential of the occupational engagement framework for occupational therapists working in a forensic mental health setting. Action research is a collaborative and cyclical process which

involves a cooperative and reflective partnership between the researcher and participants with the aim of designing, implementing and evaluating a change in practice (Reason & Bradbury, 2008). Action research was chosen to ensure that the clinical tool takes into account the requirements of the occupational therapists from the earliest possible stage and to add value to their practice with their patients. The clinical OTs were involved throughout the whole process in developing, testing out and evaluating the tools. Ongoing evaluation through regular meetings between the university researchers and the clinical OT teams generated information which prompted change and development of the tools.

Ethics

NHS ethical approval for this research project was granted (reference number 12/WA/0315). In addition to NHS ethical approval, NHS Trust research governance approval, service manager approvals and University ethical approval were granted before commencing the project. Two Research and Scholarship Development Fund grants from the University of Cumbria were awarded to facilitate visits to the units and some research assistant support for the early stages of data collection.

Participation in the research was voluntary. Participant information sheets were provided and written consent was obtained. Participants were able to withdraw from the project at any time and without any negative consequences. The university based researchers did not have any direct contact with patients at any stage of the research. No identifying patient information was gathered or shared. The clinical occupational therapists used their professional judgment about how they used the tool and this information was included within the evaluation of the effectiveness of the tool. All research data were stored securely on password protected computers belonging to the

University of Cumbria. Only the named researchers had access to these files. Any paper information was stored in a locked filing cabinet.

Participants

Following a seminar about the occupational engagement framework at a national occupational therapy conference, two units expressed interest in the subsequent research to explore the framework's utility. All qualified occupational therapists from two secure mental health units were invited to participate in the research.

Data collection and analysis

Focus group discussions were used at stages 1 and 3 of the research. First, at stage 1, to gather participants' views of the framework and identify how it could be used to inform a therapeutic tool. Then, following the development and piloting of a therapeutic tool, to review its usefulness in practice. Interviews were audio recorded. Field notes of the researchers' reflections on the focus group discussions were also taken.

All occupational therapists at the two units were invited to attend a training session about the occupational engagement framework, immediately prior to stage 1 of the research. The training consisted of an exploration of the conceptual framework as described within this article, followed by a consideration of how this concept could be applied to their own practice. Following the training session, the occupational therapists were then invited to participate in the first focus group discussion. The focus groups lasted approximately one hour and explored two issues; how the teams thought the framework could contribute to their services and the features of a useful clinical tool based on the framework. This information was analysed and used to design new clinical tools. At site A, this process was led by the university team in consultation with the occupational therapists. At site B, the process was led by the clinical team with input from the

university. Each site designed a different clinical tool to meet the needs of their own service. When the tools were agreed by both the clinical and academic teams, they were piloted within the services for six months. University team members were available for support during the piloting period (stage 2).

The third and final stage of the research consisted of a second focus group discussion at each site. As with the first ones, these lasted approximately one hour and explored two issues; how the teams thought the tool had contributed to their services and their views of the occupational engagement framework in practice. There was also some reflection about the experience of participating in an action research project.

Data from the first focus group interviews were thematically coded by the university team (DePoy & Gitlin, 2015; Silverman, 2013). These themes informed the development of the new clinical tools. Data from the second focus group interviews, completed after the trial period were also thematically analysed. At both these stages, two researchers reviewed the audio recordings and discussed identified themes. The researchers identified themes separately and then came together to discuss, refine and agree the themes. At the end of the research, the findings from all the audio recordings were reviewed again. Themes considering the clinical tool, the occupational engagement framework and the action research process were identified and discussed.

Findings

The findings are presented in two parts. A summary of each stages 1 and 3 of the research is presented.

Stage 1: Tool design

At both units all of the staff members who were in work on the specific day chose to participate in the first focus group discussions. Staff discussed the potential uses and disadvantages of the framework within their respective settings and proposed ideas regarding how they would like a tool to look. Following the discussions, staff at both units chose to focus on designing a tool aimed at a specific part of their service. The staff involved in these teams continued to participate in the research. This comprised four participants at site A and seven participants at site B.

Due to service users' dislike of paper based assessments, the participants working at Site A chose to design a very practical tool to be used in conjunction with service users. This comprised using a recording form along with an actual set of scales and mosaic tiles. Each tile represented a specific activity and the colour chosen represented the value of the activity. Service users were asked to choose a tile for each activity, to symbolise its perceived value and then to put it in one side of the scales (the sides of the scales represented positive and negative consequences of participation). In addition to notes recording the discussion, photographs of the completed scales exercise were taken (see Figure 3). The participants agreed that they would each pilot the tool using two service users and that they would carry this out on at least a monthly basis.

INSERT FIGURE 3 HERE

The participants working at Site B chose not to use actual scales with service users. They designed a three phase process based on the occupational engagement framework:

- Phase 1 – Ask the service user to look at a diagram which explains and gives examples of positive and negative consequences of participation in an activity and different levels of participation.
- Phase 2 – Ask the service user to list their daily activities.
- Phase 3 – Ask the service user to plot out where they feel their activities should be positioned on the occupational engagement summary sheet and record a summary of the discussion (see Figure 4).

INSERT FIGURE 4 HERE

The occupational therapy teams at both units were enthusiastic about being involved in the project to evaluate the framework's application to practice settings. The lack of consensus about how a tool could be used in practice may be attributed to differing perceptions regarding the theory and purpose of a tool. However, it is in keeping with the collaborative nature of the project to support each team in developing a tool to suit the particular needs and demands of their own service.

Stage 3: Tool evaluation

The second focus group discussions were held approximately twelve months after the first focus groups and aimed to review the tool which had been designed by each unit. Both focus groups were analysed together and themes identified. Three main themes emerged: Process issues; Tool functions and Utility of the tool. These are summarised in Table 1.

INSERT TABLE 1 HERE

Process issues

Participants discussed their experiences of using the tools from the perspectives of their service users and themselves.

There was general consensus amongst participants at both units that the tools were easy and understandable to use. It was acknowledged that some people did struggle with the language used to describe the differential levels of engagement and therefore the use of colours and numerical rating scales were used instead. Some participants expressed that they found the tool difficult to explain to service users, though acknowledged that this could have been simply because it was new to them.

An interesting point was a concern from one participant that the tool had somehow lost the original theory. When further questioned about why he felt this he replied that it was because it was "*simple*" and "*useable*". This was qualified by another participant who laughed when commenting that many people think that "*it should be hard to be useful*". They commented on how locum occupational therapists were able to understand how to use it immediately without any need for "*a big manual or a day long training course*".

Participants appreciated the visual aspect of the tools over a more traditional written assessment. Viewing occupations in the scales or on a grid enabled service users to reflect on how they felt about what they were doing and encouraged deeper thinking about the value of occupations. It was suggested that the "*less formal*" nature of the tool meant that it did not feel like an assessment and consequently was better received by service users who are too often "*assessed to death*".

It was acknowledged by both units that there was a tendency for participants to carefully select which service users the tools were used with. Neither unit used it with those considered to be in the "acute"/ "stabilisation" phase. One unit acknowledged in

hindsight that they eliminated those who would express negative views. Consequently, there was a leaning towards more balanced or positive views towards occupations.

A similar issue was the tendency for service users to select occupations that they valued and ignore ones that they did not. Encouraging them to consider all occupations undertaken within a specific timeframe, for example over a single day, addressed this.

Tool functions

There was considerable discussion at both units regarding how the tool fitted into the occupational therapy process.

Participants at Site A considered that their tool would be most useful as part of the initial assessment in identifying what service users enjoy and therefore helping the occupational therapists to get to know them. They felt that it would be less useful at a later stage.

The timescale of the research meant that the participants had not had the opportunity to really use the tools as an outcome measure. However, it was felt that they would enable the gathering of information to review changes over time and would be useful to implement before a case review. One participant stated that it had already enabled them to identify issues that they wouldn't otherwise have picked up on. There was a sense at Site B that the tool could help to capture feelings towards future activities and would therefore be of value in planning the transition to the community upon discharge.

Participants at Site B also felt that the tool could have value as a supervision aid in assisting occupational therapists to consider the assumptions that they bring to their practice.

Utility of the tools

The participants at both units were generally positive about the contribution of the tool to their work.

Participants at both units expressed how the tools prompted discussion about how service users were actually feeling, at a deeper level than they were accustomed to. The tools enabled the occupational therapists to understand what really motivates service users and capture changes in the reason for engagement. For example, a service user who previously engaged in an activity as a means of avoidance but now engages in the same activity as it provides a sense of productivity and meaning.

The collaborative aspect of the tool was emphasised by all participants. One stated "*it was interesting to see what their [service users] real thoughts were about activities that we referred them to*" –perhaps suggesting that the tool prompted more honesty than other tools. There was a strong sense that it encouraged services users to take on increased responsibility.

There are examples of instances where the tool uncovered essential information that otherwise would have led to clinical teams "*going completely down the wrong lines and adopting the wrong treatment strategy*". Consequently, the tool can promote accuracy in intervention planning. One example was a service user who was reluctant to shower. It was being assumed that this was due to his mental health and lack of motivation to attend to self-care. On completing the tool, it emerged that the reason he did not shower was simply because the water kept going cold.

Furthermore, participants felt that service users had been enabled to learn something from using the tools. For some it prompted conversations about real life and the idea that "*we all have to do some things that we don't enjoy*" because of the consequences. Some more specific examples were identified:

- A service user who did not enjoy or value psychology sessions but was able to identify the positive consequences of the sessions.
- Similarly, a service user who did not value the weekly multi-disciplinary review meeting agreed to attend after being able to identify the positive consequences of doing so.
- Conversely, a service user who highly valued playing computer games was able to identify the negative consequences in terms of anger and frustration.

One participant stated that the tool "*acknowledges the complexity of activity*" adding that "*it was quite respectful and helped with the therapeutic relationship*".

Encompassing a multidisciplinary perspective, it was felt that the tool provides a more holistic view of how service users spend their time and is not solely about occupational therapy sessions. It helped to broaden ideas of what is meant by occupation.

Discussion

The clinical tools developed within this research have provided some information to the clinical teams which has contributed to their understanding of how service users experience participating in occupations. This is in line with the recommendations that occupational therapists should recognise the specific intrinsic value of occupation and facilitate meaningful occupational choices (RCOT, 2017a). An increased awareness of the consequences of occupational choices is anticipated to help service users to maintain and continue in their recovery journey and reduce reoffending (Morris, 2012). With further development and evaluation, the tools should contribute to the evidence of the value placed on occupations and how this changes over time within a secure environment.

Forensic mental health, and therefore occupational therapy within these settings, is attempting to serve the needs of both the service user and society. These two 'masters'

are at times in conflict. The two overarching aims of treatment are the recovery from illness and maintenance of good mental health and the instilling of an on-going desire to participate and engage in in socially acceptable behaviours. Working within the forensic services requires acknowledgement of the negative consequences of some required occupations. Occupational therapists work with people to understand and minimise these and to work with people to develop occupations with positive value and positive consequences (occupational engagement). The concept of recovery has become embedded within forensic services through 'My Shared Pathway' (NHS Networks, 2012; Drennan & Alred, 2013). While the term recovery is becoming better understood, individual components are less well understood. This research has increased understanding of the concept of "occupational engagement" and, through the development of the clinical tools, has begun to contribute to the emerging understanding of the negative side of occupation (Aldrich & White, 2012; Twinley & Addidle, 2012; Twinley, 2012, Twinley & Morris, 2014).

Evaluation of the action research process

The experience of participating in this piece of action research has been a valuable experience for both the clinical and university based teams. It has enabled participants to reflect on the occupational nature of their work and explicitly discuss the relationship between theory and practice.

The participants from one of the units were much more involved in the process of developing the tool that they used. From the findings it appeared that this led to a greater sense of ownership and therefore much more of a positive impact on perceived confidence to use the tool. It appeared that this sense of ownership seemed to lead to a greater commitment to engage in the research process. The team admitted that if they had merely been *given* a tool to pilot that they probably would not have been motivated to do so.

It became apparent during the focus group interview with this team that part of the reason for them being more involved was because the service manager who was taking a lead in driving the project forward had been late for one of the initial meetings. Consequently, it had been necessary for the team to take greater responsibility in the process. The manager and the team all felt that this accidental incident had actually had a very positive impact on the whole process and throws up an important issue relating to the balance of support versus autonomy in the action research process. The team also acknowledged that the process had not been easy and that "*ownership*" requires a certain level of discomfort.

A key issue was the admission of participants from both units that they had been selective about which service users they had used the tool with and therefore the leaning towards more positively valued occupations. This potentially limited the scope for a more comprehensive evaluation. Furthermore, the limited timescale of the research restricted the opportunity to fully explore the tools' potential effectiveness as outcome measures.

Conclusion

This research has indicated that the occupational engagement framework has potential for increasing understanding of the relationship between the value and consequences of participating in occupations. Evaluation of the tools developed over a more extended period of time will provide information regarding therapeutic impact of the tools which the current study was unable to determine. It is of course also essential that the tools are evaluated from the perspectives of the service users. This would also enable the gathering of data to inform the development of written guidance regarding how to use the tools in practice and how to formulate and document information gathered from the tools.

References

Aldrich, R. and White, N. (2012), "Reconsidering violence: a response to Twinley and Addidle (2012) and Morris (2012)", *British Journal of Occupational Therapy*, *75*(11), 527-529.

Craik, C. Bryant, W, Ryan, A. Barclay, S. Brooke, N. Mason, A. and Russell, P. (2010), "A qualitative study of service user experiences of occupation in forensic mental health", *Australian Occupational Therapy Journal*, 57(5), 339-344.

Cronin-Davis, J. Lang, A. Molineux, M. (2004), "Occupational science: The forensic challenge", in: Molineux, M. ed. *Occupation for occupational therapists*, Blackwell, Oxford, pp. 169–179.

DePoy, E. and Gitlin, L. (2015), *Introduction to research methods: Understanding and applying multiple strategies.* 5th ed. Elsevier Mosby, St Louis.

Drennan, G. and Alred, D. (Eds.) (2013), *Secure recovery: Approaches to recovery in forensic mental health settings*. Routledge, London.

Duncan, G. (2011) *Pathways to unlocking secure mental health care*. Centre for Mental Health, London.

Farnworth, L. Nikitin, L. and 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.

Fitzpatrick, R. Chambers, J. Burns, T. Doll, H. Fazel, S. Jenkinson, C. Kaur, A. Knapp, M. Sutton, L. and Yiend, J. (2010), "A systematic review of outcome measures used in forensic mental health research with consensus panel opinion", *Health Technology Assessment*, 14(18), 1-94.

Holder, S. and Souza, R. (eds) (2016), *Standards for forensic mental health services: Low and medium secure care*. Royal College of Psychiatrists, London.

Lin, N. Kirsh, B. Polatajko, H. and Seto, M. (2009), "The nature and meaning of occupational engagement for forensic clients living in the community", *Journal of Occupational Science*, 16(2), 110-119.

Martin, M. (2003), "The foundation of good practice", in Couldrick, L. and Alred, D. eds. *Forensic occupational therapy*, Whurr Publishers, London, pp. 22–29.

Morris, K. (2012), *Occupational engagement in a regional secure unit.* PhD. Lancaster University, Lancaster.

Morris, K. and Cox, D. (2017), "Developing a descriptive framework for "Occupational Engagement"", *Journal of Occupational Science*, 24(2), 152-164.

NHS Networks (2012), *My shared pathway*. Available at: *http://www.networks.nhs.uk/nhs-networks/my-shared-pathway* (accessed 04 January 2017).

Reason, P. and Bradbury, H. (2008), *Handbook of action research: participative inquiry and practice*. 2nd edn. Sage, London.

Royal College of Occupational Therapists (2017a), *Occupational Therapy: Improving lives, saving money.* Royal College of Occupational Therapists, London.

Royal College of Occupational Therapists (2017b), *Occupational therapists' use of occupation-focused practice in secure hospitals Practice guideline.* Second Edition. Royal College of Occupational Therapists, London.

Silverman, D. (2013), *Doing qualitative research.* 4th ed. London: Sage.

Twinley, R. (2012), "The dark side of occupation: A concept for consideration", *Australian Occupational Therapy Journal*, 60(4), 301-303.

Twinley, R. and Addidle, G. (2012), "Considering violence: the dark side of occupation", *British Journal of Occupational Therapy*, 75(4), 202-204.

Twinley, R. and Morris, K. (2014), "Editorial: Are we achieving occupation-focused practice?", *British Journal of Occupational Therapy*, 77(6), 275.

Figure 1: Part 1 of the conceptual framework for occupational engagement (Morris, 2012)

The lines between the occupation and consequences are dotted to represent their interrelationship. The negative and positive occupations are represented by different colours; these colours are also used in part 2.

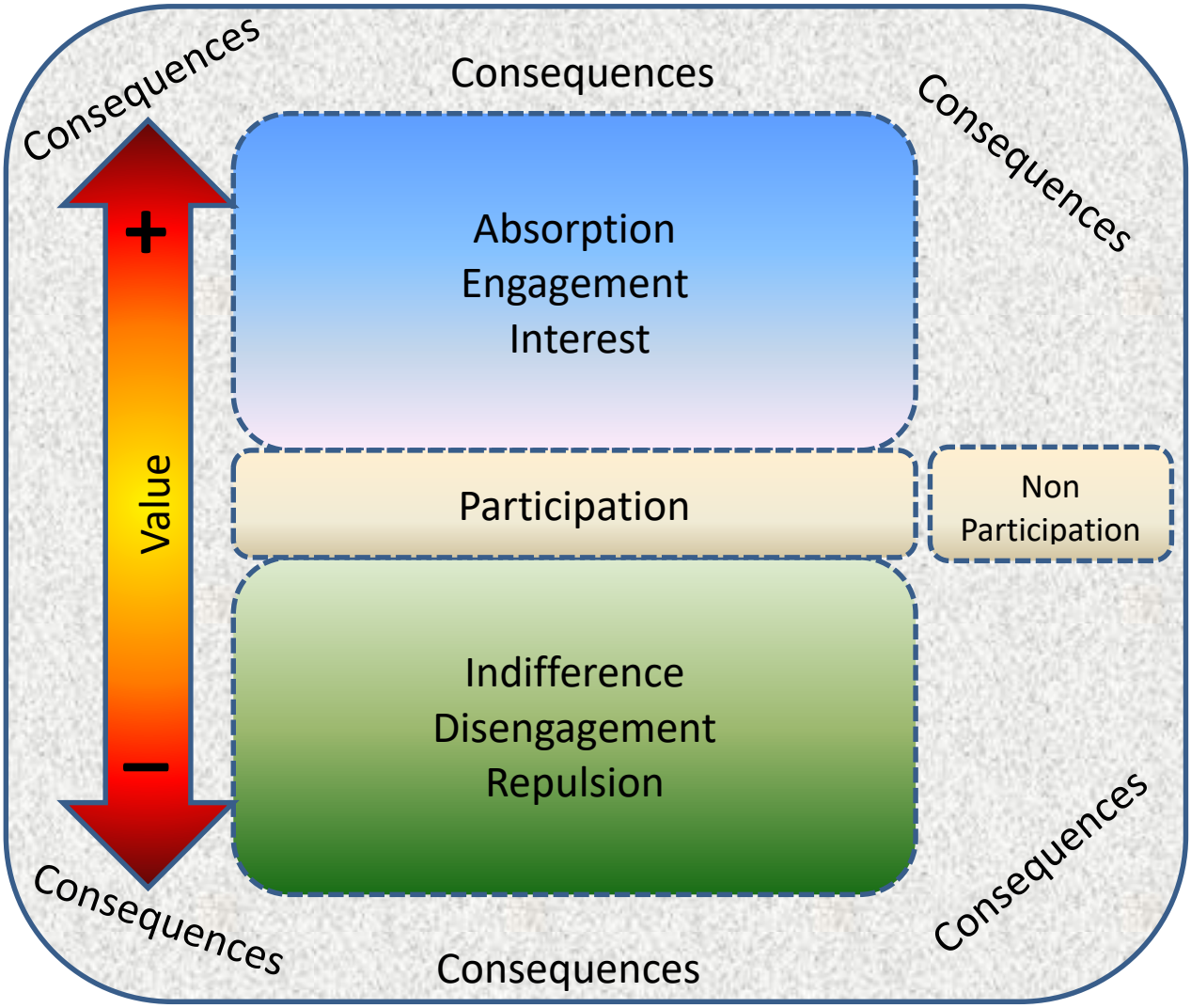
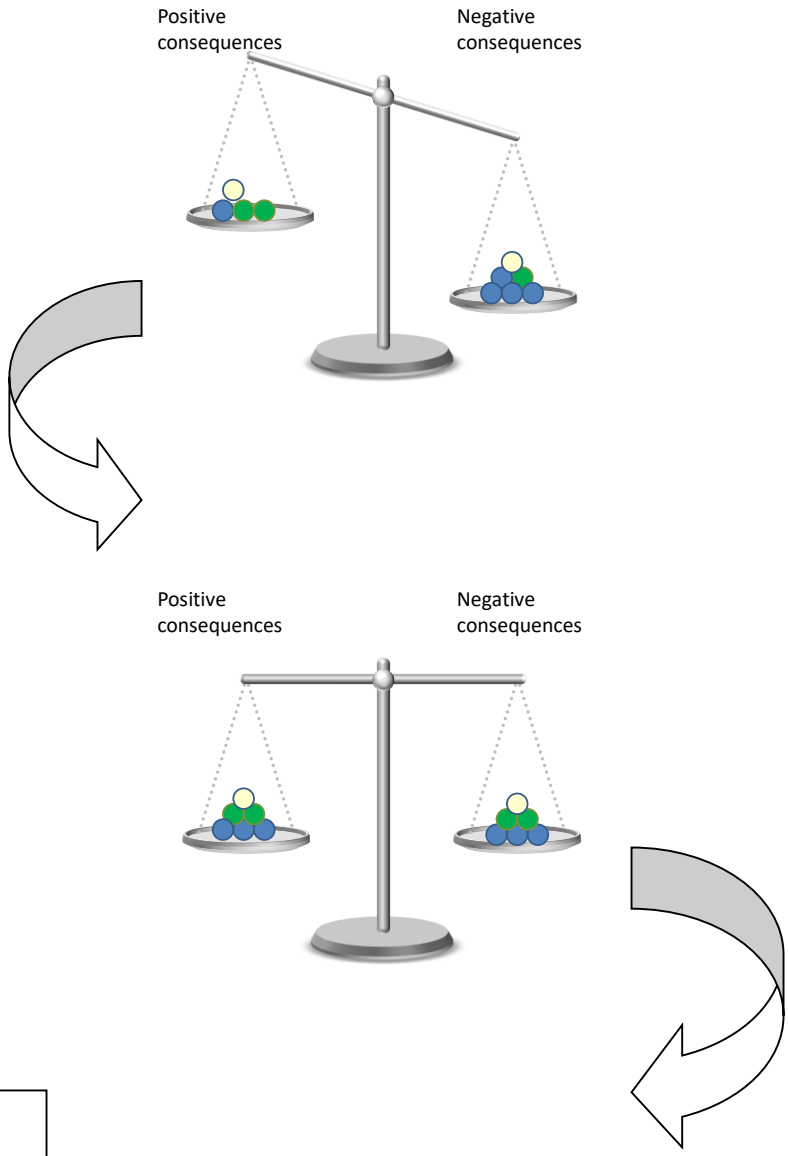


Figure 2: Part 2 of the conceptual framework for occupational engagement (Morris 2012)



Key:

Blue sphere = positive value

Green sphere = negative value

White sphere = neutral value – participation or non-participation

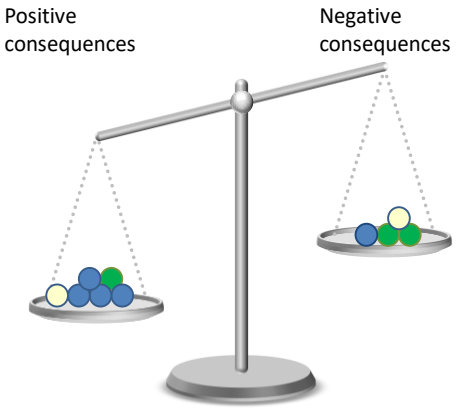


Figure 3: Photograph depicting the completed scales exercise (Site A)

Figure 4: Interview summary sheet (Site B)

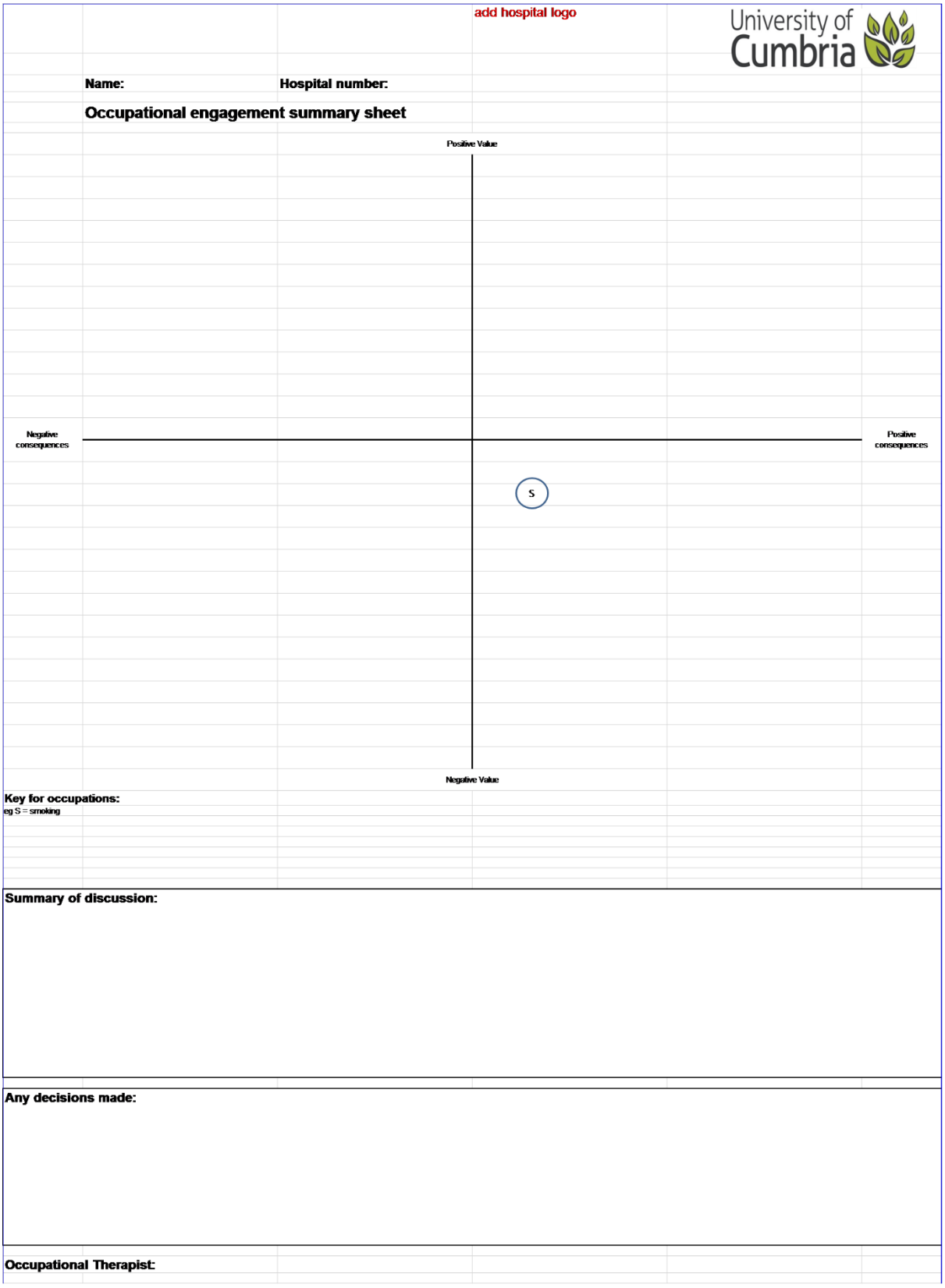


Table 1: Identified themes

THEME 1: PROCESS ISSUES

Patients

- Easy and understandable to use
- Language
- Visual aspect/pictorial learning
- "doing" aspect
- Choice of occupations for discussion

Occupational therapists

- Labour intensive/difficult to explain
- Use of practical examples to explain concepts
- Selection of patients

THEME 2: TOOL FUNCTIONS

OT process

- Part of initial assessment
- Intervention planning
- Evaluation – programme review/case review
- Transition/discharge planning

Professional development

- Supervision tool

THEME 3: UTILITY OF THE TOOL

- Depth of information
- Collaborative/inclusive
- Promotes accuracy of intervention
- Develops patient's understanding of occupation
- Enhancement of therapeutic relationships
- Multidisciplinary perspective