

A Thesis Submitted for the Degree of PhD at the University of Warwick

Permanent WRAP URL:

<http://wrap.warwick.ac.uk/134407>

Copyright and reuse:

This thesis is made available online and is protected by original copyright.

Please scroll down to view the document itself.

Please refer to the repository record for this item for information to help you to cite it.

Our policy information is available from the repository home page.

For more information, please contact the WRAP Team at: wrap@warwick.ac.uk

Increasing occupational
participation for people with a
personality disorder and an
offending history:
An intervention development
study

Catriona Connell

Thesis submitted in partial fulfilment of the
requirements for the degree of
Doctor of Philosophy in Health Sciences

University of Warwick, Warwick Medical School

January 2019

TABLE OF CONTENTS

List of tables.....	IX
List of figures.....	XI
Acknowledgements.....	XIII
Abstract	XIV
1 Introduction	1
1.1 Chapter introduction	1
1.2 Target population	2
1.2.1 People with a personality disorder and an offending history.....	2
1.2.2 Impact.....	3
1.3 Occupational participation, health and desistance	5
1.3.1 Participation and health	5
1.3.2 Occupational participation	8
1.3.3 Occupational participation and desistance	12
1.3.4 Occupational participation and risk reduction	14
1.4 Occupational participation in the community: Intervention and effectiveness	17
1.4.1 Criminal justice service interventions.....	18
1.4.2 Interventions in forensic mental health	22
1.5 Policy and practice	23
1.6 Research proposal	26
1.6.1 Rationale.....	26
1.7 Research aim and questions	27
1.8 Conclusion and thesis structure	27
2 Methodology	30
2.1 Introduction	30
2.2 Developing a complex intervention	31
2.3 Patient and public involvement	33
2.4 Philosophical and theoretical foundations of the research	34
2.4.1 Critical realism	35
2.4.2 Model of Human Occupation and critical realism	37
2.5 Methods	38
2.5.1 Work Package 1: Systematic reviews.....	39
2.5.2 Work Package 2: Mixed-methods study	41
2.5.3 Work Package 3: Identifying intervention components	46

2.5.4	Work Package 4: Intervention development.....	48
2.6	Chapter conclusion.....	51
3	<i>Systematic reviews</i>	52
3.1	Introduction.....	52
3.2	Research questions	52
3.3	What is known about the factors that influence occupational participation for PDOs in the community?.....	53
3.3.1	Question and objectives	53
3.3.2	Method	53
3.3.3	Results	57
3.3.4	Synthesis.....	59
3.4	The effectiveness of interventions to improve occupational participation for PDOs in the community.....	61
3.4.1	Question and objectives	61
3.4.2	Method	61
3.4.3	Results	63
3.4.4	Synthesis of results	71
3.5	Discussion	74
3.5.1	Summary.....	74
3.5.2	Heterogeneity in outcome.....	75
3.5.3	Variables/Influencers.....	75
3.5.4	Intervention effectiveness.....	77
3.5.5	Strengths and limitations.....	79
3.6	Conclusions.....	79
3.6.1	Implications for practice	80
3.6.2	Implications for research.....	80
3.7	Chapter conclusion.....	81
4	<i>Identifying what influences occupational participation: Part one - Quantitative</i>	82
4.1	Introduction.....	82
4.2	Research question and objectives	82
4.3	Method.....	83
4.3.1	Participants.....	83
4.3.2	Sampling and recruitment	85
4.3.3	Data collection.....	88
4.3.4	Data analysis.....	91

4.4	Results	96
4.4.1	Participants.....	96
4.4.2	MOHOST items	97
4.4.3	MOHOST sub-scales in comparison to published samples	99
4.4.4	OPHI-II scale items	102
4.4.5	Statistically significant differences within the PDO sample.....	109
4.5	Discussion	111
4.5.1	MOHOST	111
4.5.2	OPHI-II.....	113
4.5.3	Within sample comparisons	115
4.5.4	Strength and limitations	118
4.6	Conclusions	119
4.7	Implications	119
4.7.1	Implications for practice	119
4.7.2	Implications for research.....	120
4.8	Chapter conclusion	120
5	<i>Identifying what influences occupational participation: Part two – Qualitative</i>	121
5.1	Introduction	121
5.2	Research question and objectives	121
5.3	Method	121
5.3.1	Data collection	122
5.3.2	Data analysis	124
5.3.3	Credibility.....	127
5.4	Context description	130
5.4.1	Region	130
5.4.2	Interview setting.....	131
5.4.3	Interviewer	131
5.5	Findings	132
5.5.1	Participants.....	132
5.5.2	Narrative themes	134
5.6	Discussion	169
5.6.1	Literature	170
5.6.2	MOHO sub-systems	173
5.6.3	Occupational adaptation	178
5.6.4	Strengths and limitations.....	180

5.7	Conclusions	180
5.8	Implications	181
5.8.1	Implications for practice	181
5.8.2	Implications for research	182
5.9	Chapter conclusion	182
6	<i>Identifying what influences occupational participation: Part three - Narrative slopes</i>	183
6.1	Introduction	183
6.2	Research question and objectives	183
6.3	Method	183
6.3.1	Data collection	184
6.3.2	Data analysis	187
6.3.3	Credibility	189
6.4	Results	190
6.4.1	Participants	190
6.4.2	Narrative typologies	190
6.5	Discussion	198
6.5.1	Summary	198
6.5.2	Narrative slopes in occupational therapy	199
6.5.3	Narrative research in criminology	202
6.5.4	Interventions	204
6.5.5	Strengths and Limitations	206
6.6	Conclusions	207
6.7	Implications	208
6.7.1	Implications for practice	208
6.7.2	Implications for research	208
6.8	Chapter conclusion	208
7	<i>Identifying what influences occupational participation: Part four – Mixed-methods integration</i>	209
7.1	Introduction	209
7.2	Research question and objectives	209
7.3	Method	210
7.3.1	Data analysis	210
7.3.2	Synthesised member checking	215
7.4	Results	217
7.4.1	Mixed methods integration	217

7.4.2	Synthesised member checking	222
7.5	Discussion	222
7.5.1	Summary.....	222
7.5.2	Compared to systematic review findings	223
7.5.3	Occupational participation for people with a personality disorder diagnosis	224
7.5.4	Compared to assessments from WP2 and the MOHO Sub-Systems 226	
7.5.5	Strengths and limitations.....	231
7.6	Conclusion	231
7.7	Implications	232
7.7.1	Implications for practice	232
7.7.2	Implications for research	232
7.8	Chapter conclusion.....	233
8	<i>Identifying intervention components: a Delphi study</i>	234
8.1	Introduction	234
8.2	Research question and objectives	234
8.3	Method	235
8.3.1	Design	235
8.3.2	Participants.....	235
8.3.3	Sampling and recruitment	237
8.3.4	Data collection and analysis	238
8.4	Results	242
8.4.1	Participants.....	242
8.4.2	Response rate	243
8.4.3	Round one results.....	243
8.4.4	Round two	247
8.4.5	Round three.....	248
8.4.6	Statements not reaching consensus.....	251
8.5	Discussion	252
8.5.1	Summary.....	252
8.5.2	Response rate	252
8.5.3	Compared to other Delphis	253
8.5.4	Mismatch in modifiability and influence	254
8.5.5	Generic and specific content	255
8.5.6	Statements not agreed	257

8.5.7	Strengths and limitations.....	259
8.6	Conclusions.....	260
8.7	Implications.....	261
8.7.1	Implications for practice.....	261
8.7.2	Implications for research.....	261
8.8	Chapter conclusion.....	261
9	<i>Intervention development</i>	262
9.1	Introduction.....	262
9.2	Question and objectives.....	262
9.3	Design.....	263
9.4	Outcomes of objectives.....	264
9.4.1	Specifying intervention components, supporting theory and evidence.....	264
9.4.2	Modelling outcomes.....	270
9.4.3	Relationship between intervention components and theory for the expected effects.....	277
9.4.4	Mediators and moderators.....	281
9.4.5	Evidence for implementation.....	284
9.4.6	Manualisation.....	295
9.4.7	Modelling process.....	296
9.5	Discussion.....	299
9.5.1	Summary.....	299
9.5.2	Specification and relationship between components.....	299
9.5.3	Outcome measures.....	308
9.5.4	Mediators and moderators.....	311
9.5.5	Implementation.....	312
9.5.6	Strengths and limitations.....	313
9.6	Conclusions.....	313
9.7	Implications.....	314
9.7.1	Implications for practice.....	314
9.7.2	Implications for research.....	314
9.8	Chapter conclusion.....	315
10	<i>Discussion and conclusion</i>	316
10.1	Introduction.....	316
10.2	Discussion of main findings.....	318
10.2.1	Gaps in evidence filled by this research.....	318

10.2.2	Additional findings	329
10.3	Strengths and limitations of the thesis	335
10.3.1	Limitations.....	335
10.3.2	Strengths	336
10.4	Implications for future research	337
10.4.1	Feasibility study.....	337
10.4.2	Influencing factors.....	338
10.4.3	Outcome measures	339
10.4.4	Model of Human Occupation	339
10.5	Implications for practice.....	340
10.6	Conclusion	341
11	<i>Abbreviations</i>	342
12	<i>References</i>	343
13	<i>Appendices</i>	372
	Appendix A – Systematic reviews: Data extraction and synthesis	372
	Review one: Data extraction	372
	Review one: Data extraction (continued).....	374
	Review two: Data extraction	377
	Review two: Data extraction (continued).....	382
	Review two: Data synthesis	388
	Appendix B – Process documents from Work Package Two: Ethical approval, sampling framework, interview schedule	390
	Ethical approval	390
	Sampling framework.....	392
	Semi-structured interview guide	396
	Appendix C – Further data from Chapter Four	401
	MOHOST areas of impairment, indicators of low score and comparison to ICD-10 descriptions of dissocial and emotionally unstable personality disorder	401
	OPHI-II areas of impairment, indicators of low score and comparison to ICD- 10 descriptions of dissocial and emotionally unstable personality disorder	405
	Appendix D – Further data from Chapter Five.....	411
	Example thematic map	411
	Appendix E – Further data from Chapter Seven	412
	Pillar Integration Process.....	412
	Example of the matching and checking process.....	419

Factors tabulated against MOHO sub-systems and items in associated assessment tools	423
Appendix F - Member checking documents	431
Simplified visual presentation provided to participants.....	431
Participant feedback form	432
Narrative slope confirmation.....	434
Appendix G – Further data and questionnaires from Chapter Eight.....	435
Ethical approval	435
Delphi questions	436
Final list of statements, agreement level and round consensus achieved ..	450
Statements reaching consensus when analysed by professional background	462
Appendix H – Manualisation and basic logic modelling.....	463
Overview of manual content	463
Basic logic modelling.....	467
Simplified logic model	469
Appendix I - PPIAG meetings summary	470

LIST OF TABLES

Table 1-1 Factors associated with risk of/protection from violent reoffending.....	16
Table 3-1 Search strategy for PsycINFO.....	56
Table 4-1 Inclusion and exclusion criteria	84
Table 4-2 Participant demographics.....	96
Table 4-3 Demographic comparison with published MOHOST sample.....	99
Table 4-4 PDOs mean MOHOST sub-scale scores and confidence intervals compared with published means	101
Table 4-5 PDOs OPHI-II Scale mean scores and confidence intervals compared with published means	109
Table 4-6 Comparison by ethnicity: Statistically significant results.....	110
Table 4-7 Comparison by employment status: Statistically significant results.....	111
Table 5-1 Field note reflection: Effective interviewing.....	123
Table 5-2 Credibility concepts and strategies.....	128
Table 5-3 Individual participant demographics	133
Table 5-4 Summary of demographic data in the whole sample.....	134
Table 5-5 Narrative themes and subthemes	135
Table 5-6 Field note reflection: Lost occupations, forgotten selves.....	148
Table 5-7 Field note reflection: Unexpected narratives and interview work.....	152
Table 5-8 Field note reflection: Changing moods, changing stories.....	156
Table 7-1 Data taken into mixed-methods integration	210
Table 7-2 Factors influencing occupational participation for PDOs in the community	218
Table 7-3 Synthesised member checking agreement levels.....	222
Table 8-1 Inclusion and exclusion criteria	236
Table 8-2 Participant demographics.....	242
Table 8-3 Response rates by round	243
Table 8-4 Factors influencing participation	244
Table 8-5 Modifiability of factors	245
Table 8-6 Factor mean scores and rankings	250
Table 8-7 Statements reaching consensus in each round	251
Table 9-1 Intervention components summary	266
Table 9-2 Markers of success in a normal life	271

Table 9-3 Selected outcome measures	275
Table 9-4 Moderators.....	284
Table 9-5 Papers reporting trials	287
Table 9-6 Considerations and solutions for future intervention research	293

LIST OF FIGURES

Figure 1-1 WHO Model of Health Disability and Functioning.....	6
Figure 1-2 The three levels of doing in occupation	10
Figure 1-3 Model of Human Occupation ²⁶	11
Figure 2-1 Key elements of the intervention development and evaluation process	32
Figure 2-2 Stratified ontology in critical realism.....	36
Figure 3-1 PRISMA diagram for review one.....	57
Figure 3-2 PRISMA diagram for review two	64
Figure 4-1 Sampling and recruitment process.....	87
Figure 4-2 Work Package Two data analysis: Quantitative sub-study highlighted.....	92
Figure 4-3 MOHOST item scores in PDO sample	98
Figure 4-4 Mean MOHOST sub-scales scores in PDO, UKMH and NPCC samples.....	100
Figure 4-5 PDOs mean Occupational Identity Scale item scores	103
Figure 4-6 PDOs mean Occupational Competence Scale item scores.....	104
Figure 4-7 PDOs mean Occupational Settings Scale item scores.....	105
Figure 4-8 PDOs adjusted and unadjusted mean scores on OPHI-II scales compared with published calibration scores.....	108
Figure 5-1 Work Package Two data analysis: Qualitative sub-study highlighted.....	125
Figure 6-1 Process of co-producing narrative slope	186
Figure 6-2 Narrative slope drawn by Mark.....	186
Figure 6-3 Mark’s narrative slope after transfer to template	187
Figure 6-4 Work Package Two data analysis: Narrative slopes highlighted	188
Figure 6-5 Narrative typology: Progressive trajectory.....	191
Figure 6-6 Narrative typology: Consistent instability trajectory	194
Figure 6-7 Narrative typology: Restrained trajectory.....	196
Figure 7-1 Work Package Two analysis process: Integration process highlighted.....	211
Figure 7-2 Visual representation of Pillar Integration Process	213
Figure 9-1 Three levels of doing in occupation.....	273

Figure 9-2 Interrelationship between components.....	278
Figure 9-3 Relationship between components MOHO concepts	280
Figure 9-4 Example of a basic logic model.....	296
Figure 9-5 Logic model for intervention to increase occupational for PDOs in the community	298

ACKNOWLEDGEMENTS

Catriona Connell is funded by a National Institute for Health Research (NIHR) and Health Education England (HEE) Clinical Doctoral Research Fellowship (ICA-CDRF-2015-01-060) for this research project. This thesis presents independent research. The views expressed are those of the author(s) and not necessarily those of the NHS, the NIHR, or the Department of Health and Social Care.

Undertaking this Clinical Doctoral Research Fellowship was a journey shared with many people, from the application and interview process, through engaging with the doctoral research experience alongside my clinical responsibilities, to concluding with the production of this thesis. I would like to thank everyone who played a role along the way and those who continue support my clinical academic career. There are a few parties who I have singled out for particular mention.

My academic supervisors for using their wise words to constrain my stream of consciousness. Thank you Dr Vivek Furtado, Dr Elizabeth McKay and Professor Swaran Singh.

My clinical supervisors for supporting my continued clinical development, and their tactful handling of my many ideas, which enabled me to maintain my perspective of what matters. Thank you Jane Clark, Dr Ashley Fallon, Dr Deborah Alred and Julie Ramsdale-Owen.

My friends and family for forcibly removing me from the country to ensure I achieved some semblance of a work-life balance.

And finally, my thanks to McVities for Hobnobs which made a continuous and vital contribution to my nourishment throughout.

Background

Personality disorder is highly prevalent among people in contact with criminal justice and forensic mental health services. People with an offending history and a personality disorder (personality disordered offenders; PDOs) experience poor health and reoffending outcomes. This impacts the individual concerned, victims of offending, public health and public services. Occupational participation describes undertaking personally meaningful and socially valued activities and roles. It is integral to health and associated with lower risk of reoffending. It is therefore an important outcome for PDOs in the community.

Aim and research questions

This research aimed to address gaps in the literature to inform development of an intervention to increase occupational participation for PDOs in the community. It answered three questions. For this population:

- What factors influence occupational participation?
- What are the required components of an intervention to increase occupational participation, and what should these components include?
- How can a new intervention be implemented in a natural context for a feasibility study and pilot evaluation?

Methods

The research consisted of four work packages informed by Medical Research Council guidelines for developing and evaluating complex interventions. It was underpinned by a critical realist philosophy. Patient and Public Involvement was integrated throughout, along with an established theory of occupational participation and its associated model, the Model of Human Occupation.

Work Package One involved two systematic reviews to establish what is already known about i) the factors that influence occupational participation for PDOs in the community, and ii) the effectiveness of interventions to increase it. The lack of evidence informed the remaining work packages.

Work Package Two used a convergent parallel mixed-methods design to identify factors that influence occupational participation. Quantitative and qualitative data collected from interviews with 18 PDOs were analysed separately in three parallel sub-studies. This was followed by a structured integration process.

Work Package Three utilised a three-round multi-disciplinary Delphi survey to establish consensus on the content of an intervention. In round one, participants rated the importance and modifiability of the factors, and described best practice to modify these. Responses were converted into statements about the potential effectiveness of different aspects of intervention. Participants rated their agreement in rounds two and three. When 75% of participants agreed with a statement, it was used to specify intervention content.

Work Package Four involved specifying the intervention and modelling its outcomes and processes. Established processes to develop a manual, model the intervention, and produce a logic model were applied using the data collected in the previous work packages and additional literature searches.

Results and findings

Twenty-eight factors influence occupational participation for PDOs in the community. Some factors were not described by the Model of Human Occupation. The same factors influenced occupational participation in activities and roles valued by dominant society (prosocial occupations) and those considered deviant, criminal or harmful (antisocial occupations). Elaboration of the Model would increase its explanatory power with this population. The data supported the use of occupational adaptation to inform intervention development.

Delphi participants reached consensus on 121 statements. They rated all 28 factors as above 5/10 for importance, but only eight above 5/10 for modifiability. Consensus was not reached on the integration of digital/internet technology.

An intervention manual and a logic model were produced, both suitable for a feasibility study and pilot evaluation. The modelling process generated further questions and indicated that a process evaluation would be a beneficial addition in future research.

Conclusions

This research established the factors that influence occupational participation for PDOs in the community. It produced consensus on intervention content that is likely to effect change. These results make a unique contribution to knowledge.

A complex intervention was developed to increase occupational participation for PDOs in the community. An intervention manual and logic model of the intervention provide a basis for further intervention development and evaluation. These outputs show the aim of the research was achieved

1 INTRODUCTION

1.1 CHAPTER INTRODUCTION

This research examined how occupational participation can be improved for people with an offending history and a personality disorder in the community. The aim of the research was to inform development of an intervention to increase occupational participation for this population. This aim was informed by users and providers of health and criminal justice services for people with an offending history and a personality disorder, who described occupational participation as a valued outcome of their work together. My own experience working with men with personality disorder who have a serious offending history highlighted that evidence to inform intervention to increase occupational participation in the community would be advantageous to clinical practice.

This chapter introduces the thesis. It begins by defining the population of concern, people with a personality disorder and a history of offending. It presents the potential impact of unmet needs on these individuals and the people and communities around them. Section 1.3 discusses participation in relation to health and critiques the World Health Organization concept of participation. Occupational participation is presented as a more useful construct for this research and is then discussed in relation to offending and desistance (ceasing to offend). Section 1.4 describes current interventions to increase occupational participation in the health and criminal justice system, and discusses the supporting theory and evidence for these. Review of policy and practice guidelines relevant to people with a personality disorder and an offending history highlights the limitations in the evidence for practitioners. Section 1.6 summarises the rationale for conducting research to develop an intervention that improves occupational participation for people with a personality disorder and an offending

history in the community. Section 1.7 sets out the questions addressed in this research. The chapter concludes with an overview of how the remainder of the thesis is presented.

1.2 TARGET POPULATION

The intervention designed in this research is for people with an offending history and a diagnosis, or likely diagnosis, of personality disorder.

Referring to people as *likely* to have a personality disorder is informed by the realities of practice, where most people who would meet diagnostic criteria do not have a formal diagnosis. Likely diagnosis is determined using structured screening processes in routine practice in English probation services.¹ Section 1.5 explains this further.

1.2.1 PEOPLE WITH A PERSONALITY DISORDER AND AN OFFENDING HISTORY

Personality disorder is a term for a series of disorders, characterised by:

“deeply ingrained and enduring behaviour patterns, manifesting as inflexible responses to a broad range of personal and social situations. They represent extreme or significant deviations from the way in which the average individual in a given culture perceives, thinks, feels and, particularly, relates to others. Such behaviour patterns tend to be stable and to encompass multiple domains of behaviour and psychological functioning. They are frequently, but not always, associated with various degrees of subjective distress and problems of social performance”²

Personality disorder is highly prevalent among men and women with an offending history. In the United Kingdom, 64-78% of men and 50% of women in prison would meet diagnostic criteria for at least one personality disorder.³ Data collected from newly sentenced prisoners in 2005-6 identified personality disorder in 62% of men and 57% of women.⁴ In a sample of men in high secure psychiatric facilities, 68% received a definite diagnosis of personality disorder using the International Personality Disorder Examination.^{5, 6} Personality disorder is estimated to affect 48% of men and women under probation supervision.^{7, 8} Of men leaving prison with common mental disorders recruited to a complex intervention study, 85% had a co-morbid personality disorder.⁹ Although prevalence rates vary, studies indicate that there is a large proportion of men and women who are in or will return to the community, who could benefit from an intervention designed specifically to address their needs.

People with a personality disorder (or likely to have one were they diagnosed) *and* an offending history are described in the literature as ‘personality disordered offenders’, abbreviated to PDO. An abbreviation to indicate which population is referred to is necessary for brevity in reporting this research. PDO is adopted for consistency with the literature. It is emphasised here that at all times it refers to *people* with a set of characteristics.

1.2.2 IMPACT

Compared to people with an offending history and no personality disorder, PDOs have worse health, offending and occupational participation outcomes. In a group of newly sentenced prisoners, those with and without antisocial personality disorder (ASPD) were compared. People with ASPD had higher rates of psychotic, mood, anxiety, substance use and somatoform disorders, borderline personality disorder, more frequent and

severe self-harm or suicide attempts, and lower quality of life. People with ASPD were just as likely to have been employed, but were twice as likely to have been fired (OR 2.0 [95% confidence interval 1.2-3.3], $p=0.012$).¹⁰

Whilst this does not show that the differences in health and employment are caused by ASPD, it indicates marked health and employment difficulties among PDOs that have individual and societal costs, and therefore warrant intervention.

In addition to poor health and quality of life, PDOs reoffend at higher rates and are overrepresented among those who commit serious further offences. Meta-analysis showed PDOs were more likely to reoffend in comparison to offenders with other mental disorders or none. On average PDOs were 2.4 times more likely to commit a further violent offence.¹¹ In a study of a UK probation cohort, PDOs were over-represented among those who committed a serious further offence (i.e. violent or sexual offences). However, the sample was too small to determine if this over-representation was statistically significant.¹² These studies do not show that personality disorder causes offending, but indicate that intervention may be warranted to reduce reoffending risk with this population.

Male PDOs report higher levels of impairment in work roles, romantic relationships, friendships and general social contacts when compared to men with an offending history but without personality disorder, and men and women accessing healthcare with borderline or avoidant personality disorder.^{13, 14} Diagnostic criteria for personality disorder include impaired social and occupational functioning. The addition of an offending history appears associated with further impairments in social and occupational functioning. Why this is the case is not clear. It may be that offender populations have more severe personality disorder, a different type of personality disorder, or face additional barriers associated with having an offending history. Nonetheless, as a group PDOs experience more difficulties in occupational participation. This is important for service

providers to consider due to its contribution to health, potential to protect against reoffending and association with desistance (ceasing to offend). The relationship between occupational participation and these outcomes is discussed in the next section.

Failing to address poor occupational participation, health and offending outcomes has a cost to each individual PDO in terms of poor health and quality of life. It also impacts upon potential victims, communities and society as a whole. In 2015/16, the total economic and social cost of crimes against individuals was approximately £50 billion. Violent crimes have the highest cost, due to the higher physical and emotional impact on victims.¹⁵ PDOs are over-represented in these crimes, indicated by the high prevalence of personality disorder in criminal justice and forensic mental health services, and are therefore likely to account for disproportionate cost and impact on others. Intervention to meet the needs of PDOs has potential public health benefits, as higher community crime rates are associated with worse mental health in that community.¹⁶

Poor occupational participation, health and offending outcomes experienced by PDOs suggests there are potential personal limitations and/or environmental barriers to these outcomes that may be modified by intervention. The next section outlines the theory and model applied in this research to identify the influencing factors relevant to an intervention for increasing occupational participation.

1.3 OCCUPATIONAL PARTICIPATION, HEALTH AND DESISTANCE

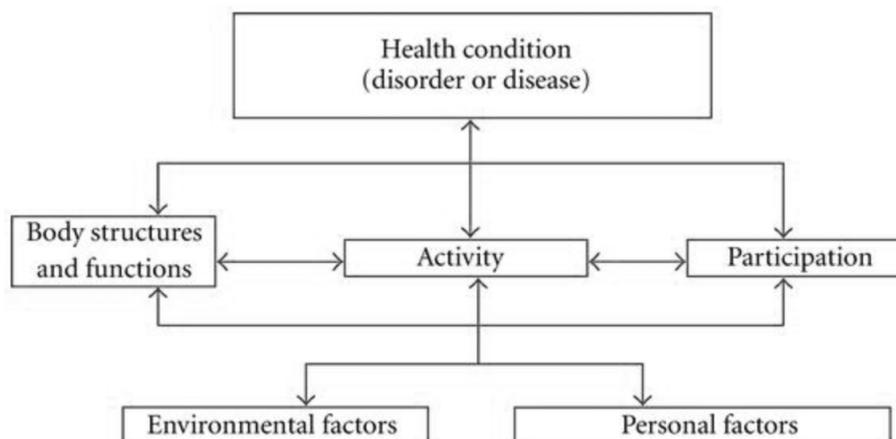
1.3.1 PARTICIPATION AND HEALTH

The World Health Organization's Model of Health, Disability and Functioning (WHO Model for brevity), posits that health results from an

interaction between the structure and functions of the body, capacity to perform activities, and a person's *participation* in activities and roles in a natural setting (see Figure 1-1). This interaction occurs in the context of personal and environmental factors.¹⁷ Participation is defined as "involvement in a life situation" (pg.10) which people can achieve irrespective of disease or disorder.¹⁷ The approach in this research is not to modify a person's personality disorder but to modify their participation.

The International Classification of Functioning (ICF) was developed to describe the components of activities and participation.¹⁸ However, in the ICF activities and participation are not distinguished as separate concepts whilst in the WHO model they have specific definitions. This has resulted in calls for conceptual clarity as to whether this is bipartite or tripartite model. Such clarity would better facilitate the shared use of language and inter-disciplinary communication intended by the development of the ICF.¹⁹ The current ambiguity was problematic for this research.

Figure 1-1 WHO Model of Health Disability and Functioning



A second criticism of the WHO Model and the ICF is their exclusive focus on participation in *prosocial* activities and roles, that is, those activities and roles that are socially valued. It conceptualises these as health-promoting, and any barriers to them as harmful to health. However, some included

activities may actually harm health. Employment is broadly seen as health promoting, however this is not universally the case. For example, shift work and night shift working have been associated with a range of health harms, including increased cardiovascular risk and increased risk of mental disorders.^{20,21} Alternatively, *antisocial* activities and roles that are not recognised in the ICF may confer a health benefit. For example, youth gang activities are broadly conceived as dangerous and harmful to others. However for the individual they may be part of personally meaningful social role, offering a sense of belonging, security from perceived threat, social networks and a source of income.²² The benefits identified from gang-involvement are all considered contributors to health and wellbeing. Nonetheless, gang-involved adolescents are at increased risk of mental and physical health conditions and impaired social functioning in the long term.²³ The relationships between participation and health are more complex than the WHO model suggests.

For this research it was necessary to draw the distinction between *prosocial* and *antisocial* activities and roles. Prosocial activities and roles are those which are both personally meaningful *and* socially valued. Antisocial activities and roles are those that, whilst personally meaningful or functional, are considered socially deviant or criminal. All activities or roles are performed because they have value to the individual person and, as described above, may confer some health and wellbeing benefits. However, where these activities or roles fall outside what is considered socially acceptable, participating in them increases the likelihood of social exclusion and the associated health harms. It is participation in prosocial activities and roles (such as employment, leisure and family roles), that is associated with improved health and criminal justice outcomes. Consequently, this research is focused on increasing participation in prosocial activities and roles.

A final limitation of the WHO model is that it does not describe the mechanisms of interaction between the components or how they may be altered to produce change in participation. Complex interventions are more likely to be effective when they are developed in line with an empirically supported theory of change.^{24, 25} Described below, the Model of Human Occupation²⁶ complements the WHO model with a well-developed theory of *how* participation in activities and roles develops and changes over time.

1.3.2 OCCUPATIONAL PARTICIPATION

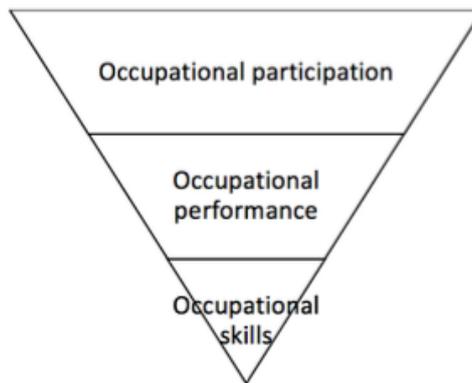
Occupation as understood by occupational therapists refers not only to employment, but to a variety of activities and roles that are required for human health. In the Model of Human Occupation (MOHO), occupation is defined as the “doing of work, play or activities of daily living within a temporal, physical and sociocultural context that characterises much of human life”. (pg.9)²⁷ The Royal College of Occupational Therapists (RCOT) define occupation as “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”.²⁸ The latter definition allows the expanded consideration of occupations that may not neatly fall into one of the three categories of work, leisure or activities of daily living. This is useful when working with populations who may occupy their time, body and mind with activities or roles that are outside social norms or considered antisocial.

Antisocial occupations as a concept and reality are familiar to forensic occupational therapists²⁹ and are increasingly researched from an occupational perspective. For example substance use³⁰ could be categorised as an activity of daily living, to survive and meet basic needs. Graffiti could be considered play.³¹ Neither would ordinarily be acceptable

to society. Outside of forensic practice there are increasing calls to critically reflect on the social and cultural hegemony on what is considered 'meaningful' activity.³² Understanding participation in occupations that are considered socially deviant is essential for forensic practice, where practitioners are required to work with people to reduce participation in these to facilitate successful reintegration into society. However as discussed above, this research focuses on participation in prosocial occupations because it is these which are associated with health and reduced risk of reoffending.

Participation defined by the WHO is argued to be analogous to the construct 'occupational participation' in the occupational therapy models most commonly used internationally.³³ In the Model of Human Occupation (MOHO), occupational participation is described as what humans do, usually in the areas of work, leisure and activities of daily living. It involves consistently performing the activities required to fulfil valued roles in these areas (e.g. worker, footballer, parent).³⁴ Crucially, it is *participating in a role* that indicates someone is 'involved in a life situation'. In MOHO, being able to participate in a role consistent with one's identity is what moves someone from simply performing activities, or possessing the skills to do so, into actually participating in a natural environment. Figure 1.2 visually represents how occupational participation is situated in relation to performing activities (occupational performance) and possessing the skills, competencies and capacities to do so (occupational skills).³⁴

Figure 1-2 The three levels of doing in occupation



The Model of Human Occupation (MOHO)²⁶ was initially developed from open systems theory³⁵⁻³⁷ and has evolved to draw on dynamic systems theory.^{26, 38} MOHO, visually represented in Figure 1-3, conceptualises occupational participation as a complex social phenomenon that results from multiple interacting sub-systems. The personal sub-systems develop and change over time and in response to life events and the environments a person participates in. Similarly, environmental sub-systems change and develop over time and place.

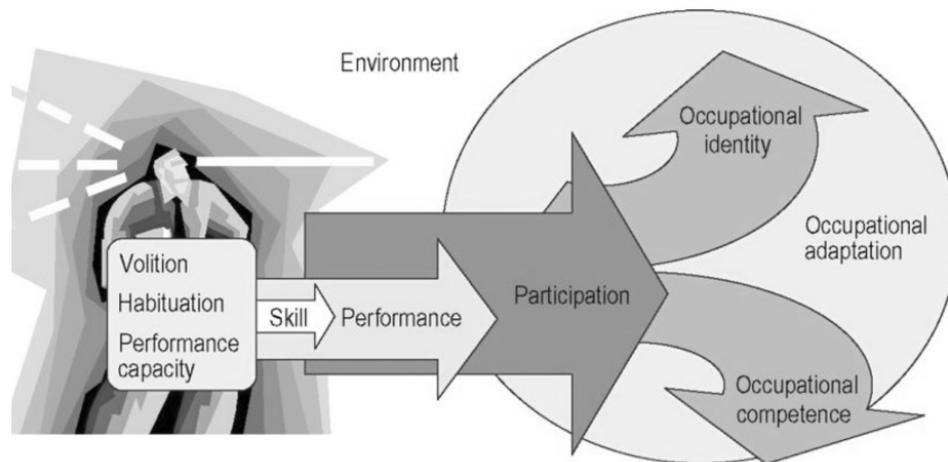
Personal sub-systems include:

- Volition (personal causation, values and interests)
- Habituation (patterns, routines and roles)
- Performance capacity (process, motor, and communication and interaction skills)

Environmental sub-systems include:

- Immediate physical and social environments with barriers/opportunities
- Wider socio-cultural structures which stipulate social norms
- Institutions and organisations with which people interact

Figure 1-3 Model of Human Occupation²⁶



Over time and through occupational participation, a process of occupational adaptation occurs which in turn influences ongoing occupational participation. Together, occupational competence and occupational identity generate occupational adaptation. Occupational identity is a sense of who one is and wishes to become as an 'occupational being', developed from and reflecting life experience. Occupational competence is the ability to sustain a pattern of occupational participation consistent with a one's identity within a particular environment.²⁶ Occupational adaptation is integral to human ability to cope with the demands of a disruption to one or more of the sub-systems and sustain occupational participation.³⁴ This is the theory of change that describes *how* disruption in any of the MOHO sub-systems affects occupational participation.

This research uses the term occupational participation to describe participation in prosocial activities and roles (occupations) unless otherwise stated. This is to make clear the consistency with participation as described by the WHO, but that MOHO provides the supporting model and theory to explain change.

1.3.3 OCCUPATIONAL PARTICIPATION AND DESISTANCE

Desistance is “the long-term abstinence from criminal behaviour among those for whom offending had become a pattern of behaviour” (pg.3).³⁹

Research exploring how desistance is facilitated often describes occupational participation, though it has rarely been focused upon or referred to in such terms. This section outlines and critiques the best known desistance theories, and considers the evidence for the contribution of occupational participation.

Desistance is a distinct phenomenon, not merely the reverse of what caused initial offending or the opposite of reoffending. Theories of desistance may be divided between those that attribute desistance to rational choice and individual self-control,^{40, 41} those articulating a process of redefining the self,^{42, 43} and those arguing for the influence of social structures and opportunity.⁴⁴ Although often described as opposing one another, there is scope to unite these perspectives in a theory of desistance.⁴⁵ All the theories attempt to explain cessation of offending and describe complimentary components of the process in which occupational participation is evident.

Sampson and Laub’s age-graded theory of informal social control takes a life-course perspective and suggests that desistance results from increased social bonds, which are achieved through finding employment or forming a stable relationship in early adulthood.^{44, 46} Further research has identified employment as a ‘turning point’ in criminal careers.⁴⁷ Employment and forming a stable relationship can be conceptualised as occupational participation. However, Sampson and Laub collected data from the markedly different social, cultural and economic environment of 1930-40s America. Employment and marriage are now a less certain prospect and social bonds are more transient.⁴⁸ This does not invalidate the theory, but

highlights some of the modern challenges to achieving occupational participation that could affect desistance.

Paternoster and Bushway have been critical of positioning offenders as passive recipients of social forces, like available employment. They suggest doing so overlooks individual level processes, such as agency and intentions, that influence a person's success in forming and sustaining social bonds.⁴⁹ MOHO supports this, conceptualising occupational participation as resulting from an interaction between the environment *and* individual factors, such as skills or motivation.

Other dominant theorists argue that desistance results from a process of adopting a new prosocial identity. Maruna's seminal work describing this process brought the concept of narrative identity from personality psychology into offender rehabilitation.⁴² Maruna identified critical elements supporting identity change, including occupational participation. His data demonstrated that by performing 'generative activities', an individual validates a new valued self and sustains desistance. The generative activities described are prosocial occupations, including: finding gainful employment; giving something back through writing, speaking and mentoring; developing an intimate relationship and forming new social networks. The presence of occupational participation as a mechanism for change reflects ideas presented by Sampson and Laub, that occupational participation acts as a turning point by strengthening social bonds.

Desistance theories were developed mainly with relatively low severity, mainly male offenders. Maruna's analysis has been applied across cultures, genders, and with people with more severe offending histories.⁵⁰⁻⁵²

Suggestions for intervention are emerging and the concept has been incorporated into recent programmes in the UK criminal justice services.^{53,}

⁵⁴ However, there is limited research into if and how high-risk offenders or PDOs desist, or into the relevant contributing factors.

None of the theories elaborate on *how* occupational participation is achieved to facilitate desistance. Do people just one day start employment or build a social network after many years of not doing so? MOHO provides a framework for understanding *how* occupational participation develops and how it can be increased to facilitate desistance. Next, occupational participation is considered for its association with predicting reoffending, further supporting the argument for its importance in intervention.

1.3.4 OCCUPATIONAL PARTICIPATION AND RISK REDUCTION

In research with general offender populations Andrews and Bonta⁵⁵ identified eight factors associated with increased risk of reoffending, which they term 'criminogenic needs.' Five describe unsuccessful occupational participation.

In forensic mental health, empirically derived factors and clinical knowledge have been combined to produce Structured Professional Judgement tools. These tools guide professionals in assessing the presence or absence of factors associated with risk and making a risk prediction. The most widely used is the Historical Clinical and Risk Management-20, currently version 3 (HCR20:v3), which includes 20 factors associated with violent reoffending.⁵⁶ Similar tools exist for other offence types, such as sexual violence⁵⁷ and domestic violence.⁵⁸ Several items are direct or indirect indicators of occupational participation, supporting the assertion that increasing occupational participation may reduce reoffending. The predictive accuracy of the individual factors is yet to be established.

There has been increased attention to identifying factors that predict an avoidance of reoffending, termed protective factors. The mechanism by which these factors are protective (moderating, mediating or having a main

effect) is unclear, but they are not simply the inverse of or the absence of risk factors. One tool for identifying these is the Structured Assessment of Protective Factors (SAPROF),⁵⁹ the items on which point to the importance of occupational participation.

Table 1.1 summarises the factors identified as criminogenic needs,⁵⁵ risk factors for violence (from the HCR-20:V3) and protective factors against violence (from the SAPROF). Areas describing occupational participation are highlighted in bold.

Tools identifying risk and protective factors indicate that occupational participation is associated with reduced offending risk. They do not consider what influences occupational participation itself or provide a guide to intervention content.

The evidence for interventions to increase occupational participation for PDOs in the community are discussed next.

Table 1-1 Factors associated with risk of/protection from violent reoffending

Criminogenic needs	Risk factors for violent reoffending	Protective factors against reoffending
<ul style="list-style-type: none"> • History of antisocial behaviour • Antisocial personality Pattern • Antisocial cognition, including attitudes, values, beliefs, and a personal identity • Antisocial associates and relative isolation from prosocial individuals. • Problematic circumstances of home (family/ marital) • Problematic circumstances at school or work • Few if any positive leisure activities • Substance abuse 	<p><i>Historical items</i></p> <ul style="list-style-type: none"> • Violence • Other antisocial behaviour • Relationships • Employment • Substance use • Major mental disorder • Personality disorder • Traumatic experiences • Violent attitudes • Treatment or supervision response <p><i>Clinical items</i></p> <ul style="list-style-type: none"> • Insight • Violent ideation or intent • Symptoms of major mental disorder • Instability • Treatment or supervision response <p><i>Risk management items</i></p> <ul style="list-style-type: none"> • Professional services and plans • Living situation • Personal support • Treatment or supervision response • Stress or coping 	<p><i>Internal factors</i></p> <ul style="list-style-type: none"> • Intelligence • Secure attachment in childhood • Empathy • Coping • Self-control <p><i>Motivational factors</i></p> <ul style="list-style-type: none"> • Work • Leisure activities • Financial management • Motivation for treatment • Attitudes towards authority • Life goals • Medication <p><i>External factors</i></p> <ul style="list-style-type: none"> • Social network • Intimate relationship • Professional Care • Living circumstances • External control

1.4 OCCUPATIONAL PARTICIPATION IN THE COMMUNITY: INTERVENTION AND EFFECTIVENESS

It is rare for someone to be imprisoned or detained for life. In 2017 there were 63 people with a whole life order in the UK.⁶⁰ Most PDOs will pass through an institution and return to life in the community in a shorter or longer period of time. Some will be spared a custodial sentence or hospitalisation when appropriate treatment or sanctioning can be delivered in the community. Occupational participation in the community (rather than prisons or secure hospitals) is the focus of this research, as this is where practitioners identified the greatest need for evidence-based intervention. Further, it is in the community that there is the greatest challenge to occupational participation, when external controls are lower and the person re-joins the society in which they previously had difficulties.

Despite services for PDOs in the community advocating their focus on not just reoffending but also health, wellbeing and prosocial behaviour,^{61, 62} little is written about how this should be achieved. The low success rate for PDOs (indicated by worse health and quality of life, and higher reoffending rates) is currently poorly explained. It may be related to exclusion from treatment, higher drop-out rates from treatment, interventions that are not designed for PDOs needs or because interventions overlook the potential of occupational participation.^{63, 64}

The importance of occupational participation is argued for by forensic occupational therapists in health and criminal justice services who describe using occupation as a therapeutic medium to facilitate desistance by: supporting development of a prosocial identity and the skills underpinning it; promoting protective factors; and identifying areas of potential risk through assessment in natural settings.^{29, 65} However, interventions based

on these strategies are yet to be developed and tested for effectively modifying community occupational participation.

Interventions conducted in institutions are rarely evaluated for their longitudinal effectiveness on occupational participation when someone returns to the community. Few interventions delivered in the community measure occupational participation as an outcome. Available interventions are discussed below divided between those offered in criminal justice services and health services.

1.4.1 CRIMINAL JUSTICE SERVICE INTERVENTIONS

Reducing reoffending is the primary outcome in criminal justice services. Interventions are focused on achieving this and are evaluated for their impact on reoffending rates. There are examples of interventions that aim to improve occupational participation in the community for people with an offending history, most often employment. There is little research that addresses the needs of PDOs.

Of people with an offending history in the UK referred to employment support agencies, only 16% found and retained a job for six months. This fell to 11% at 12 months.^{66, 67} These figures are likely to include PDOs, but this cannot be confirmed. The results suggest support agencies are not intervening effectively and that specialist intervention is required to ensure employment is not just achieved, but sustained. Prisoners with ASPD had a history of achieving community employment at the same rate as other prisoners but were twice as likely to be fired,¹⁰ indicating that sustained occupational participation is a particular challenge for PDOs.

Employment programmes and studies are often devised and delivered at local level using poor evaluation strategies that limit conclusions about

effectiveness.⁶⁸ A systematic review of employment programmes for people with offending histories reports reoffending rates rather than employment rates, and found the programmes to be of limited benefit in reducing reoffending.⁶⁹ Whilst employment is generally accepted as associated with reduced risk of reoffending, the failure to reduce reoffending by employment focused interventions suggests two conclusions. First, the interventions may be ineffective in supporting people to gain employment. Due to the rapid changes in modern society, interventions may not effectively address the relevant factors to enable someone to access the increasingly digitised and transient nature of employment. There is a risk that approaches developed at a different time, in a different sociocultural context or for a different population, may overlook the barriers to and facilitators of accessing the contemporary UK labour market for people with an offending history. Secondly, the interventions may be ineffective at supporting someone to *sustain* employment. Studies often report only numbers into employment and longitudinal offending outcomes from official data, rather than longitudinal employment outcomes. As sustaining employment is a challenge for all ex-offenders, this may explain why there is no reduction in reoffending despite good initial employment results. Alternatively, employment may not be associated with reduced reoffending in modern society. The type of employment available to people with an offending history may not build social bonds that reinforce a prosocial identity in the same way as at the time of previous studies.⁴⁴

Occupational participation is broader than just employment. It includes involvement in other aspects of daily life, such as independent living, leisure, family roles and community involvement. Reports of interventions that address these aspects of occupational participation or include them as outcomes are lacking.

The main intervention for PDOs specifically comes via the Offender Personality Disorder (OPD) Pathway. The OPD Pathway is centrally concerned with public protection, achieved by improving the psychological health of PDOs and the skills of the criminal justice workforce. The OPD Pathway emphasises a bio-psychosocial approach and an interest in outcomes such as prosocial behaviour and wellbeing.¹ There are several components to the OPD Pathway and longitudinal evaluation is underway.⁷⁰ Preliminary results indicate that occupational participation makes an important contribution,⁷¹ although this is somewhat overlooked.

All residential and treatment services (e.g. prison wings or approved premises) in the OPD Pathway are required to achieve 'Enabling Environment' status.⁷² This involves meeting a range of standards, including providing opportunities for purposeful activity and for taking on roles and responsibilities. This is addressed through 'creative sessions' where people participate in a range of activities. Despite their value,⁷¹ creative sessions and other aspects of occupational participation are given only cursory attention. Their main purpose is suggested to be facilitating someone's engagement in psychological risk reduction interventions. Recently, some of the outcomes and potential mechanisms of change achieved through creative sessions within the OPD Pathway have been suggested based on qualitative work with women in prison. The author identified that the activities may offer opportunities for self-expression, learning and relating to others that could facilitate change.⁷³ There are many areas that require further elucidation, such as: what a practitioner should do to ensure development of the desired skills and facilitate change with different populations and individuals; whether the skills are transferrable to other contexts; how to effectively manage the challenges of facilitating activities with PDOs in criminal justice settings; and whether creative sessions effectively produce a desired change in the short and long term.

From an occupational perspective, creative sessions and other elements of occupational participation in the OPD Pathway utilise activities and roles to enable people to develop the competences to support a new prosocial identity in their community.³⁴ Though creative sessions are framed as facilitating engagement in risk-focused work, these sessions may be important in their own right because they increase occupational participation and thus facilitate desistance.

The whole OPD Pathway is described as the intervention and evaluation was not intended to consider the unique contributions of individual components, such as creative activities. At this stage, there is no evidence the OPD Pathway is effective in reducing reoffending or increasing occupational participation, within institutions or on a person's release. A robust evaluation is required to identify the OPD Pathway's effectiveness, and the unique contributions of the components.

Community OPD Pathway services, termed Intensive Integrated Risk Management Services (IIRMS), are available in some areas of the country. Service formats vary and evaluations have mostly been small or qualitative accounts of staff/user perspectives.⁷⁴⁻⁷⁷ Among a group of people moving between prison and probation, IIRMS reduced most risk indicators. However, there was a strong association with an increase in risk attributed to 'lifestyle and associates'.⁷⁷ Lifestyle and associates could include occupational participation, though it is not clear what the authors refer to. These results initially suggest the intervention may not be targeting lifestyle and associates adequately or may be causing harm. However, people in prison have severe restrictions on lifestyle and association choices, that when released to probation would reduce, irrespective of intervention. This would potentially provide opportunities to make antisocial lifestyle and association choices. The Liverpool IIRMS service 'Resettle', includes supported occupational participation. An unpublished pilot RCT compared PDOs accessing Resettle with PDOs who received

probation as usual.¹³ The research found no effect on reoffending captured in official records, but self-reported reoffending was lower among the intervention group. Measures of social role functioning were taken at baseline in prison, but not repeated at follow up due to an insufficient sample size. Resettle's impact on occupational participation is unknown. Both studies point to the need to fully consider occupational participation outcomes for PDOs in the community when external controls are reduced.

Understanding effective risk reduction is important. However, attention to what prevents or promotes occupational participation among PDOs is also essential, due to its association with health and desistance. The paucity of literature on community criminal justice interventions is a gap in the literature that limits the ability of service providers to deliver evidence-based interventions that are likely to work.

1.4.2 INTERVENTIONS IN FORENSIC MENTAL HEALTH

Forensic mental health services have a dual responsibility to the person and the community. Intervention is therefore both to improve service users' mental health *and* reduce reoffending risk (that exists on account of that mental disorder) on return to the community.⁷⁸ The forensic mental health environment is more responsive to intervention focused on occupational participation for health and wellbeing, and accordingly occupational therapy is a required provision.⁷⁹

Whilst there are practice guidelines for occupational therapists in inpatient forensic mental health settings,⁸⁰ there is no attention to the specific needs of people with personality disorder, no evidence of intervention effectiveness, no systematic attention to community outcomes, and no published accounts of practice in the community setting. Attention to occupational participation is evident in the sparse occupation-focused

literature on inpatient provision for PDOs,^{65, 81} but to date intervention development and evaluation is lacking.

A study has commenced to establish whether a full RCT into the effectiveness of Individual Placement and Support (IPS) is feasible in a community forensic mental health service.⁸² The study sample includes people with personality disorder. IPS is an intervention for increasing employment rates, designed for non-forensic patients with serious mental illness (not personality disorder). The difference in the forensic population and setting may explain some of the implementation barriers identified by the research team. One in particular was difficulties recruiting those with personality disorder,⁸³ indicating there are additional considerations for intervention to increase occupational participation among this group.

There is little literature on effective interventions targeting other aspects of occupational participation in the community for people leaving secure hospitals in the UK, or for PDOs specifically. This research addresses this gap in the literature and in clinical services. In the interim, practitioners must apply existing policy and practice guidelines.

1.5 POLICY AND PRACTICE

The social and economic costs of reoffending among PDOs has driven cross-government investment by the Department of Health and Ministry of Justice in the Offender Personality Disorder (OPD) Pathway.^{1, 84} The OPD Pathway was developed following evaluation of the Dangerous and Severe Personality Disorder Programme (DSPD) which made substantial resources available for the detention and treatment of people considered the highest risk of further offences because of his/her personality disorder.⁸⁵ DSPD was considered insufficiently effective to justify the sizeable investment.^{86, 87}

For some it was considered a failure that does not justify its continuance via the OPD Pathway.⁸⁸ In response to criticisms that DSPD over-concentrated resources in high secure institutions that served few people, the OPD Pathway increases access to intervention by removing the requirement for a diagnosis, and focuses on pathways to lower levels of security and the community.

Individuals of concern to the OPD pathway are those considered “*likely to have a severe personality disorder and who pose a high risk of harm to others, or a high risk of reoffending in a harmful way*” (pg.2).¹ The likelihood of personality disorder is determined by a screening tool, OASys PD,⁸⁹ conducted as part of routine criminal justice service assessments. People screened into the OPD pathway have therefore usually not been formally diagnosed with a personality disorder. This can cause confusion, as the title of the pathway implies a personality disorder diagnosis when this is not the case. It additionally presents complications for precise language in reporting this research. Though recognising the inaccuracy of using the diagnostic term personality disorder for people without a diagnosis, this research uses the term PDO consistent with the approach of the OPD Pathway to reflect the realities of clinical practice rather than a research ideal.

NHS England and the National Offender Management Service (NOMS) published guidance for working with PDOs.⁸⁹ The authors support their recommendations with some suggested reading, but not citations for various statements of fact. Claims are made about effectiveness, for example “using psychological ideas to inform management can be highly effective” (pg.ii) though not what the intended effect is (reduced risk, treatment attendance) or any indicator of how this conclusion was reached. As this guide is for practitioners, academic citations may be unnecessary, and their absence does not necessarily make the claims untrue. Nonetheless, it is a potential overstatement of the facts given the

OPD Pathway evaluation is incomplete. It risks practitioners being overconfident in the effectiveness of their work. However, for practitioners new to this field of work it offers a helpful starting point by introducing attachment theory and the potential impact of trauma, and providing guidance from more experienced practitioners that reflect the realities of practice.

From a healthcare perspective, the National Institute for Health and Care Excellence (NICE) guidelines have been produced for two types of personality disorder which are common in people on probation. NICE guidelines for antisocial personality disorder advise a full assessment including the need for 'occupational rehabilitation or development'.⁹⁰ The meaning of this is unclear, but is taken to refer to employment needs rather than occupational participation as understood in this research. There are no further recommendations of what an assessment or any intervention should consist of in this area. The guidelines advise that when someone has a personality disorder linked to a high risk of serious offending, a cognitive behavioural approach of extended duration and intensity should be supplemented by follow up and booster sessions, additional staff support and supervision. However, the focus is on reducing risk rather than treating personality disorder or improving health. Guidelines for people with Borderline Personality Disorder advise assessment and identification of occupational *and* wider participation needs.⁹¹ However, there are no specific recommendations for intervention in this area, or recommendations for working with people with an offending history.

The lack of practice guidance for effective intervention to increase occupational participation among people with personality disorder, and PDOs specifically, requires attention. Currently practitioners working with PDOs cannot be confident that their interventions are likely to be effective in achieving the desired change.

1.6 RESEARCH PROPOSAL

1.6.1 RATIONALE

Occupational participation is an important outcome for PDOs because it is integral to health and associated with reduced risk of reoffending and desistance. Review of the literature reveals a number of gaps in the evidence that must be addressed if occupational participation outcomes are to be improved.

Firstly, the lack of focus on occupational participation means it is potentially overlooked altogether in practice. PDOs face barriers to occupational participation that are not fully understood. As a result, services may not be identifying and adequately targeting these barriers in intervention. This reduces the likelihood that interventions will effectively increase occupational participation.

Secondly, interventions to improve occupational participation among PDOs in the community are minimally reported and not clearly described. Where intervention is delivered, it cannot be informed by evidence of what is likely to work, may lack a theoretical basis for how or why it might work, and at worst may cause harm. Interventions need to be developed and tested to enable practitioners to intervene in a way that is likely to be effective.

Finally, the lack of well-defined interventions to increase occupational participation precludes research to establish effectiveness, further perpetuating difficulties in providing evidence-based intervention to meet the needs of PDOs.

1.7 RESEARCH AIM AND QUESTIONS

This research had two aims to address gaps in the literature. Firstly, to produce a clearly defined, evidence-based and theoretically supported intervention to increase occupational participation in the community for PDOs. Secondly, to determine how this intervention could be delivered in a natural context for the purposes of future research.

To achieve these aims, the following questions were answered:

- What factors influence occupational participation for PDOs in the community?
- What are the required components of an intervention to increase occupational participation for PDOs in the community, and what should these components include?
- How can a new intervention to increase occupational participation for PDOs in the community be implemented in a natural context for a feasibility study and pilot evaluation?

1.8 CONCLUSION AND THESIS STRUCTURE

This chapter highlighted gaps in evidence, policy and practice pertaining to interventions to increase occupational participation for PDOs in the community. These gaps directly informed the rationale for conducting an intervention development study and the research questions answered in this thesis.

Chapter Two presents the research methodology. It describes the philosophical and theoretical foundations of the research, and how these

were applied in four work packages to answer the research questions. Together the four work packages form an intervention development study consistent with Medical Research Council guidelines for developing and evaluating complex interventions.²⁵

Each work package is presented separately in Chapters Three to Nine. More detailed methods are provided, followed by the results and findings, discussion and conclusions, and implications for practice and research.

Chapter Three reports Work Package One, which involved two systematic reviews that answered the following questions:

- i) What is known about the factors that influence occupational participation for PDOs in the community, and what are the theories and mechanisms for their effects?
- ii) How effective are interventions to increase occupational participation for PDOs in the community, and what is the theory and mechanisms by which they are proposed to work?

Chapters Four to Seven report the results of Work Package Two which responded directly to systematic review findings that there is insufficient evidence for the factors that influence occupational participation for PDOs in the community. Work Package Two was a mixed-methods study. It applied a convergent parallel mixed-methods design⁹² involving four sub-studies using the same sample of PDOs. The first sub-study analysed standardised assessment scores of factors influencing occupational participation (Chapter Four). The second analysed narrative and semi-structured interviews (Chapter Five). The third analysed co-produced narrative slopes (Chapter Six). The fourth sub-study integrated the results of the preceding sub-studies using a structured mixed-methods process to produce a list of factors that influence occupational participation for PDOs

in the community. The results were validated by 50% of the participants (Chapter Seven).

Chapter Eight reports Work Package Three, which responded directly to the results of the second systematic review. This review revealed that there is insufficient evidence for effective interventions to increase occupational participation for PDOs in the community, and that existing interventions are poorly described and lack hypotheses for how they may work. A Delphi survey identified the required components of an intervention and what these should include to increase occupational participation for PDOs in the community.

Chapter Nine reports Work Package Four which involved synthesising all the findings in the preceding work packages to model the intervention. The synthesis was used to produce a manual describing the intervention and a logic model for how the intervention may be delivered in a natural context. Both are designed to inform a future feasibility study and pilot evaluation.

Finally, Chapter Ten concludes the thesis with a discussion of the main results and findings as they relate to the original aim and questions. Additional findings are also discussed. Chapter Ten then summarises the strengths and limitations of the research overall. It concludes by clarifying the unique contribution to knowledge made by this research and the implications for future research and practice.

A list of abbreviations is presented at the end of the thesis, followed by the references and appendices.

2 METHODOLOGY

2.1 INTRODUCTION

This research developed an intervention to increase occupational participation for people with an offending history and likely diagnosis of personality disorder (PDOs) in the community. This chapter details the methodological, philosophical and theoretical foundations of the research, and how they were applied to answer the research questions.

The chapter begins by outlining the decision to characterise the intervention developed as complex and thus apply the Medical Research Council (MRC) guidelines for developing and evaluating complex interventions.²⁵ It then discusses how and why Patient and Public Involvement (PPI) was designed into the research. The research followed a critical realist philosophy which underpins the application of mixed-methods. Consistent with critical realism and the MRC guidelines, the research systematically integrated the best available theory of occupational participation, the Model of Human Occupation (MOHO). MOHO is described in Chapter One and is briefly reviewed here to demonstrate its consistency with critical realism.

The research was separated into four work packages. Section 2.5 presents each work package with the question it addressed, the rationale for selecting specific methods, the relationship of the methods to the underpinning theoretical and philosophical assumptions, PPI and the outputs to date.

2.2 DEVELOPING A COMPLEX INTERVENTION

Complex interventions are those consisting of several interacting components, which is common in health and other public service interventions. A complex intervention is effective when its components are delivered together.^{25, 93} In addition to multiple interacting components, other indicators of a complex intervention are:

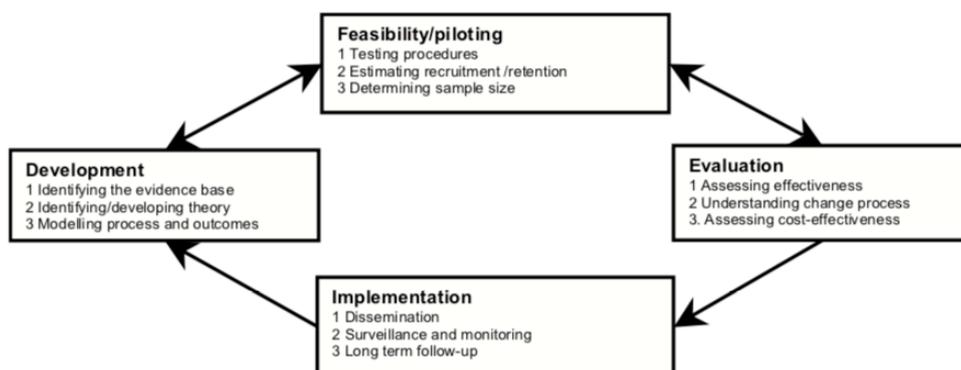
- More than one target for change
- Several complex behaviours required by those delivering or receiving the intervention
- Several groups or organisational levels targeted by the intervention
- Several outcomes of different variability
- A degree of flexibility or tailoring of the intervention
- Effectiveness is influenced by the site and process of implementation^{25, 93}

Intervention to improve occupational participation was considered likely to be complex, as there are multiple factors that influence occupational participation operating at individual, environmental and societal levels. Consequently, there is more than one potential target for change. Practitioners will be required to use complex interpersonal and technical competence to deliver an intervention with a population whose motivation to seek and complete intervention can be poor.^{63, 64, 94, 95} Recipients must also be able to demonstrate new and complex skills to engage in the intervention and underpin change in occupational participation. The intervention was considered likely to involve training and engaging both practitioners delivering the intervention and the wider team to ensure it is supported and delivered as intended. When occupational participation is operationalised, it includes sub-components that can be considered as outcomes or indicators of change. Their relevance will vary depending on the intervention recipient. Occupational participation is a personal

outcome and thus the intervention will require tailoring to individual characteristics, circumstances, preferences and abilities. PDOs access services from health, criminal justice, social work and third sector services, indicating intervention may require tailoring according to intervention context. The process and success of implementing the intervention is likely to vary by site. Additionally, any change in occupational participation involves the person’s engagement with immediate social groups and wider society, which may also moderate or mediate intervention effects. In all respects an intervention to increase occupational participation for PDOs in the community meets the criteria for a complex intervention.

Developing and evaluating a complex intervention is a non-linear process of development, feasibility and piloting, evaluation, and implementation. See Figure 2-1. The lack of evidence and multiple levels of complexity, described above, informed the focus of this research on the intervention development phase.

Figure 2-1 Key elements of the intervention development and evaluation process



Consistent with MRC Guidelines, the research involved systematically integrating the best available theory and Patient and Public Involvement, identifying gaps in the current evidence, conducting primary research to inform the intervention, and modelling the process and outcomes of delivering the intervention. This ensured clarity in the intended outcomes,

that the mechanisms of change had a coherent theoretical basis and that consideration was given to practice realities.

2.3 PATIENT AND PUBLIC INVOLVEMENT

Patient and Public involvement (PPI) refers to patients and the public fully collaborating as partners in research, rather than research being done to or about them.⁹⁶ There is emerging evidence that PPI leads to better quality research and research that produces outcomes relevant to the target population.^{97, 98} This was particularly important for this research, because people with traits associated with a dissocial personality disorder are less likely to view an intervention as necessary.^{94, 95} To maximise the likelihood of PDOs engaging with and sustaining commitment to the intervention developed, PPI provided valuable insights into whether the intervention would be perceived as relevant, could be feasibly delivered and would be acceptable to all stakeholders.

One means of PPI is to form a project advisory group.⁹⁶ A PPI Advisory Group (PPIAG) was established. It met four times throughout the research and had email discussions between meetings. Appendix I includes a brief summary of the meetings' minutes. The PPIAG had the following remit:

- Ensure that the intervention is likely to be acceptable to PDOs
- Ensure that the intervention can be feasibly delivered in practice
- Appraise the research methods to ensure they would effectively and safely recruit and retain the target samples
- Review outputs for face validity
- Communicate about the research in their respective settings
- Build collaborations within research and practice across the country

People were invited to the PPIAG if identified within or recommended by my professional networks, or if they made contact via the project website (<https://poppedproject.weebly.com>). It was intended for the intervention to be deliverable by any practitioner in the range of services that PDOs access (health, criminal justice, social work, third sector). Although INVOLVE suggest that those with a professional role are not members of the public,⁹⁶ practitioners from a range of settings were invited due to their ability to input on feasibility and acceptability in varied contexts. The PPIAG therefore included individuals with a diagnosis of personality disorder, practitioners working with PDOs in health or probation settings, educators, academics, members of the public and a magistrate. Barriers to payment precluded the involvement of people with lived experience of the criminal justice system invited via the probation service. Her Majesty's Prison and Probation Service (formerly National Offender Management Service) advised local contacts that this was not permitted. I compensated for this by visiting services for PDOs to engage directly with them.

Considering acceptability, feasibility and implementation throughout intervention development was essential, as was the systematic integration of a theory to explain *how* the intervention may work, and that the theory was consistent with the philosophical assumptions of the research.

2.4 PHILOSOPHICAL AND THEORETICAL FOUNDATIONS OF THE RESEARCH

Systematically integrating theory improves the likelihood of designing an effective complex intervention compared to purely empirical or pragmatic approaches.^{24, 25} This research adopts a critical realist philosophy and applies the Model of Human Occupation (MOHO).²⁶ This section outlines the rationale for these choices and the compatibility of the two.

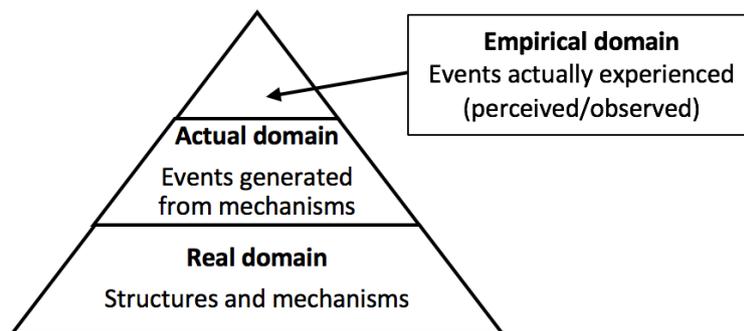
2.4.1 CRITICAL REALISM

Critical realism is a philosophical system distinct from positivist or constructivist philosophies. Critical realism assumes that there is an external reality which we all share. However, this reality is not entirely within human awareness and our interpretation of it is subject to our implicit or explicit theoretical models of the world.⁹⁹ Critical realism is argued to be useful to health researchers studying complex social phenomena because it provides a cohesive framework that considers personal and environmental factors, and individual interactions with them. Yet it does not deny the existence of a reality that health professionals are working within and to change.^{100, 101} In this research the phenomenon under consideration is occupational participation. Understanding occupational participation as a real phenomenon, permits the study of the influencing factors as real factors or constructs that can be modified to produce change. However, it does not overlook the fact that the understanding of this reality will be shaped by the interpretations of the participants and myself in view of our implicit and explicit theories about the world and about occupational participation.

In critical realism, reality is considered to consist of three domains (see Figure 2-2). The *real* domain is independent reality, which is opaque and contains the structures and mechanisms that influence events. These events occur in the *actual* domain, regardless of whether or not humans experience them. Finally there is the *empirical* domain which contains that which we see and experience.¹⁰² This research draws data from the empirical domain. This is the participant's interpretations of occupational participation and how to modify it. It is assumed that the data is reflective of each participant's reality, but that there are aspects of reality that are outside their awareness in the real and actual domain. Considering reality outside a person's awareness is relevant to this research which seeks to identify and modify the factors that influence occupational participation,

many of which may be unknown to the participants. These factors were examined using abductive reasoning, defined as ‘inference to the best explanation’ (described below), by applying MOHO to theorise the structures and mechanisms that were unseen in producing participants’ occupational participation.

Figure 2-2 Stratified ontology in critical realism



Because critical realism integrates ontological realism (assumes there is an external reality) and epistemological constructivism (that this reality is only understood through human interpretation informed by implicit theories) the method that is most appropriate to answering a specific question can be qualitative, quantitative or a mixture of the two without sacrificing philosophical coherence. Several authors applying mixed-methods instead adopt a philosophy of pragmatism, an almost ‘anti-philosophy’ position.^{103, 104} This involves ignoring competing philosophical understandings and focusing on the method that will best answer a specific research question. However, ignoring philosophical differences risks incoherence in the arguments based on the research findings.¹⁰⁰ Critical realism offers a sound philosophical basis for selecting the most appropriate method for answering a particular question.

This research applies different methods across four work packages to best answer the question posed in each. ‘Critical methodological pluralism’ supports research using multiple approaches and methods to study the

same phenomenon. This plurality is argued to produce a closer approximation of reality.⁹⁹ Critical methodological pluralism was adopted in Work Package Two, which used different data collection and analysis methods to answer the same question, and then integrated the findings and results to more closely approximate the factors that influence occupational participation for PDOs in the community. Therefore, practitioners can have more confidence in these results than if a single quantitative or qualitative approach was used.

Critical realism recognises that human (and research) interpretations are always shaped by implicit and explicit theories of a phenomenon. Explicit use of a theoretical framework supports the additional abductive and retroductive reasoning strategies described in critical realism. Abductive reasoning, or ‘inference to the best explanation’, involves generating or applying a theory to explain a series of results.¹⁰⁵ Retroductive reasoning involves identifying the fundamental factors that make a phenomenon possible.⁹⁹ Abductive and retroductive reasoning are strategies for finding the prerequisites, or basic conditions, that operate in the real domain and explain the existence of a phenomenon.⁹⁹ Work Package Two used abductive reasoning to infer the best explanation for the structures and mechanisms that support or inhibit the phenomenon of occupational participation. Work Package Four used retroductive reasoning to identify the prerequisites of successful intervention implementation. Using these strategies identified factors outside participants’ awareness. The next section further describes the coherence between MOHO and critical realism.

2.4.2 MODEL OF HUMAN OCCUPATION AND CRITICAL REALISM

The Model of Human Occupation (MOHO) describes occupational participation as sustained involvement in everyday life through

occupations (activities and roles) that are part of one's sociocultural context and are desired or necessary for health and wellbeing.³⁴ Occupational participation is conceptualised in critical realist terms as a complex social phenomenon.

MOHO theorises that occupational participation is influenced by interacting personal and environmental sub-systems that change over time and in interaction with the environment. The MOHO sub-systems are understood in critical realist terms as the structures and mechanisms operating outside individual awareness but that produce events in the actual domain. A person's interpretations of these result from their life history and the implicit and explicit theories they have developed. Together, reality and interpretation of it produce the empirical domain that is accessed in this research and worked with in clinical practice.

MOHO is the model of occupational participation with the most empirical support and is the most commonly applied model in occupational therapy¹⁰⁶ and in forensic occupational therapy.²⁹ Systematically integrating MOHO into this research increases the likelihood the intervention developed will be effective, acceptable and feasible to deliver because of its empirical support and clinical familiarity. The integration of MOHO and critical realism into each work package is outlined next.

2.5 METHODS

This research consisted of four work packages (WPs). Each is taken in turn, stating the question addressed within it and providing an outline of the study design and the rationale for the chosen method. For each, consistency with the MRC Guidelines, MOHO and critical realism is highlighted. PPI and outputs to date (January 2019) are listed, including peer reviewed publications.

2.5.1 WORK PACKAGE 1: SYSTEMATIC REVIEWS

RESEARCH QUESTIONS

Work Package One (WP1) answered the questions:

- What is known about the factors that influence occupational participation for PDOs in the community, including the theory and mechanisms for their effects?
- How effective are interventions to increase occupational participation for PDOs in the community, and what is the theory and mechanisms by which they are proposed to work?

DESIGN/METHOD

Two systematic literature reviews were completed, one answering each question. Both used the Cochrane Collaboration guidelines for conducting systematic reviews¹⁰⁷ with adaptations to include non-randomised designs and qualitative studies. Due to the inclusion of qualitative and quantitative studies, and the predicted low number of results, meta-analysis was replaced by the Cochrane Collaboration four-step method of narrative synthesis of effectiveness studies.¹⁰⁸ The reviews were reported using the PRISMA method.¹⁰⁹ A full account of the methods and results are reported in Chapter Three.

RATIONALE FOR CONDUCTING SYSTEMATIC REVIEWS

Systematic reviews are a crucial component of developing an evidence-based complex intervention.²⁵ Systematic reviews are a more robust and

transparent literature review method than narrative or unstructured reviews. As a highly structured process, systematically reviewing the literature reduced potential bias in the findings. *A priori* publication of detailed protocols^{110, 111} ensured that the method could be scrutinised as a further quality check, and the process replicated.

Work with PDOs is often multi-disciplinary and multi-agency. Potentially relevant research was spread across diverse sources, including medical, psychological, nursing and allied health, social care and criminal justice publications. To ensure that the intervention was informed by the best available evidence and did not duplicate existing effective practice, systematic reviews were the most appropriate method for identifying and synthesising information from the range of sources.

Including qualitative and quantitative studies was consistent with the critical realist position that reality can be more accurately approximated when approached using different methods. Search terms were informed by descriptors of participation from the ICF.¹¹² By identifying and synthesising the highest quality evidence, gaps were identified which were addressed in Work Packages Two to Four.

INVOLVEMENT

Search terms were reviewed at a meeting of the Offender Personality Disorder Occupational Therapy Network attended by a commissioner and national lead for the Offender Personality Disorder Pathway. Results were reviewed by the Patient and Public Involvement Advisory Group (PPIAG).

OUTPUTS

WP1 had the following outputs:

- Both reviews are published in peer reviewed journals.^{113, 114} The papers are inserted at the back of the thesis, separate from the appendices
- Results were presented as a poster at two national conferences^{115, 116}

2.5.2 WORK PACKAGE 2: MIXED-METHODS STUDY

RESEARCH QUESTION

Work Package Two (WP2) answered the question:

- What influences occupational participation for PDOs in the community?

DESIGN/METHOD

The design was a convergent parallel mixed-method design.⁹² Three sub-studies were conducted in parallel using different data collection and analyses methods with a single sample of PDOs. Convergence occurred in a fourth sub-study which integrated the results and findings to answer the research question.

Each sub-study was informed by narrative research principles and worked with narratives as the data.¹¹⁷ A narrative is a series of signs that are linked

together to convey meaning, which could be written or verbal accounts, items created, or a life enacted.¹¹⁷ The verbal narratives collected from the PDOs were considered to be their understanding of the reality of their occupational participation over time and their lives enacted. The research designs are summarised below and reported fully with their respective results and findings in Chapters Four to Seven.

Sub-Study One, reported in Chapter Four, analysed scores from interviewer-rated standardised assessments of aspects of occupational participation. Scores were compared with published data for other populations. Using Mann Whitney U-tests, within sample comparisons established differences in occupational participation. The narrative perspective was reflected in the quantitative measures, which used narrative principles in collecting data to score them and included past experiences among the scored items.¹¹⁸

Sub-Study Two, reported in Chapter Five, analysed qualitative data collected at interview with PDOs using open and a semi-structured narrative interviewing.¹¹⁸ Analysis used a grounded theory informed approach to identify themes across participant narratives that described factors influencing occupational participation. This included concurrent data collection and analysis, producing codes that were developed into themes, and focusing themes on occupational participation.¹¹⁹⁻¹²¹

Sub-Study Three, reported in Chapter Six, analysed participants' narrative slopes. A narrative slope is a visual representation of a person's perception of the trajectory of their life. These were drawn collaboratively at interview. Narrative thematic analysis¹²² involved analysing the participants' narratives in their entirety. Predominant themes and ideas, and similarities and differences between the participants' narratives¹²² were reflected in three narrative typologies.

Sub-Study Four integrated the data in a structured process to produce a list of factors that influence occupational participation. Half the original participants confirmed the findings reflected their experiences during member checking.¹²³

Ethical approval was obtained from the Biomedical Science Research Ethics Committee, University of Warwick. Additional approvals were obtained from Birmingham and Solihull Mental Health NHS Foundation Trust as the researcher's employer, and the National Offender Management Service (NOMS) for recruiting people identified through the National Probation Service.

RATIONALE FOR MIXED-METHODS RESEARCH

The systematic review of what is known about the factors that influence occupational participation for PDOs in the community identified a gap in the literature. Before quantitative methods based on an existing model of occupational participation (MOHO) could be applied with confidence, a qualitative exploratory approach was required to ascertain its explanatory power with PDOs. However, a purely qualitative approach would limit the generalisability to the wider PDO population. For these reasons, WP2 used mixed-methods.

Mixed-methods involves combining qualitative and quantitative methods to a research problem and is advocated in complex intervention research.⁹³ The strengths of each approach compensates for the limitations of the others and allows a closer approximation of the phenomenon under study to be attained.^{92, 99}

A narrative research approach was selected due to its suitability for studying occupational participation in disadvantaged and socially excluded populations, and for studying identity change and adaptation over time, which influence occupational participation.^{30, 124-130} Analysis of offenders' narratives identified identity transformation as a key factor influencing adaptation to a prosocial lifestyle.^{42, 50} However difficulty maintaining a stable identity and adapting to change are diagnostic criteria for personality disorder,² indicating narrative research had potential to identify influencing factors particularly relevant to PDOs.

Consistent with the view of narrative as constituting experience,¹³¹ an occupational narrative is described as a person's occupational participation over the life course. A person's occupational narrative influences occupational participation in the present, how they attribute meaning to occupations and how they anticipate their future.¹³² Occupations come to hold their meaning when they are situated within the context of someone's occupational narrative, as part of an overall plot.¹³³⁻¹³⁵ Occupational narrative provides a vehicle to identify the factors influencing occupational participation at a point in time, but also the distal factors that act as mechanisms to influence occupational participation and result in it having a particular meaning. Considering factors, mechanisms and processes and how they had been shaped over time facilitated a more comprehensive understanding of the influences of occupational participation for PDOs in the community.

Narrative research was also relevant to intervention development. When an intervention is understood as an event in an unfolding occupational narrative, practitioners can hypothesise how that intervention will be received. Intervention should be tailored to maximise the likelihood that it is received positively, by ensuring it is meaningful within the context of an

individual's occupational narrative.¹³⁶ Each person's occupational narrative is unique, but identifying commonalities across participants informed intervention development.

In this research narratives are understood from a critical realist perspective. A participant's narrative encapsulates their life experience, and is the lens through which they make meaning of their occupational participation. Participants were not required to name or know what influenced their occupational participation. Critical realist analysis techniques of abduction and retroduction⁹⁹ applied to analysing their narratives identified structures and mechanisms outside their awareness.

INVOLVEMENT

The PPIAG were involved in designing participant facing documents. They advised on ethical issues, and ensured interview content was likely to gather useful data and was unlikely to cause harm. Group members appraised the face validity of the initial results and findings drawing from their experiences.

OUTPUTS

This WP had the following outputs:

- List of factors that influence occupational participation for PDOs in the community
- Methods and preliminary results presented at national conferences¹³⁷⁻¹³⁹
- Keynote presentation at a national conference¹⁴⁰

- Presentation of initial findings to the National Probation Service Offender Personality Disorder Team in the West Midlands
- Results submitted to a peer reviewed journal

2.5.3 WORK PACKAGE 3: IDENTIFYING INTERVENTION COMPONENTS

RESEARCH QUESTION

Work Package Three (WP3) answered the question:

- What are the required components of an intervention to increase occupational participation for PDOs in the community, and what should these components include?

DESIGN/METHOD

A multi-round Delphi survey^{141, 142} was conducted with a multidisciplinary panel of experts. Chapter Eight reports full details of the method and results.

As a separate study from that conducted in WP2, ethical approval was obtained from the Biomedical Science Research Ethics Committee, University of Warwick. Additional approvals were obtained from Her Majesty's Prison and Probation Service (HMPPS), formerly National Offender Management Service (NOMS), for recruiting people identified through the National Probation Service (NPS).

The systematic review confirmed a lack of evidence for interventions that aim to increase occupational participation for PDOs in the community. The few interventions were not well described and there was poor articulation of how interventions may facilitate change.¹¹³ The lack of discussion in the literature indicated a consensus seeking method was appropriate.

Delphi surveys have been effectively used to develop consensus in health intervention research, including studies relating to offenders with personality disorder¹⁴³ and identifying targets for and means of occupational therapy intervention.¹⁴⁴⁻¹⁴⁶ An online survey was most pragmatic due to the geographical spread of experts working and researching with PDOs. This additionally avoided the potential limitations of meeting in physical groups, such as one well-known expert or dominant personality reducing the confidence of others to disagree. The survey gathered opinions about what best practice should be, converted these to statements and ascertained agreement with the statements across the panel.

WP3 was underpinned by the critical realist perspective that each person brings an interpretation of reality framed by their knowledge, theories and experience. Interpretation of reality is likely to vary between professional groups and individuals within them. By accessing the perspectives of multiple participants with different professional backgrounds a more nuanced appreciation of what may work was elicited. Producing consensus based on multiple expert opinions supported the development of an intervention that is more likely to be effective than if it was developed based on the opinion of a single person or profession.

To be adopted in practice, a new intervention must be perceived as useful, acceptable and feasible to those asked to deliver it.⁹³ Including service

providers in intervention development enhanced its relevance to practice, maximised interest in future intervention research, and will ultimately support its implementation.

INVOLVEMENT

The PPIAG were involved in identifying expert panel members, piloting the questionnaires and appraising the results in relation to their experience.

OUTPUTS

This work package had the following outputs:

- List of statements grouped into preliminary intervention components
- Results presented at national and international conferences with results from WP4^{147, 148}
- Presented to the Offender Personality Disorder Occupational Therapists Network in December 2018

2.5.4 WORK PACKAGE 4: INTERVENTION DEVELOPMENT

RESEARCH QUESTION

Work Package Four (WP4) answered the question:

- How can a new intervention to increase occupational participation for PDOs in the community be implemented in a natural context for a feasibility study and pilot evaluation?

DESIGN/METHOD

WP4 synthesised the results and findings from the preceding WPs to model the intervention, its processes and its outcomes. WP4 was informed by published objectives for modelling complex interventions.¹⁴⁹ A manual suitable for feasibility studies and pilot evaluations was produced using a framework for manualising complex psychosocial interventions.¹⁵⁰ This was enhanced by using guidelines for intervention reporting in research^{151, 152} to ensure the intervention was adequately described to permit replication in clinical and research settings. A logic model was developed using an established guide¹⁵³ to indicate how the intervention could be implemented in a natural context for the purposes of a feasibility study and pilot evaluation. Chapter Nine presents full details of the methods.

RATIONALE

Results from the preceding WPs confirmed the requirement to apply complex intervention development principles. The MRC guidelines stress the importance of giving adequate attention to *developing* complex interventions to prevent future problems in implementation and evaluation.²⁵ In developing complex interventions, the final phase involves modelling the intervention, its outcomes and the process of implementation.²⁵ This is crucial for specifying what the intervention consists of, why and how it works, and what the expected outcomes are.¹⁴⁹ Doing so ensures the intervention can be replicated accurately and evaluated.⁹³ Modelling the intervention will support future feasibility study and pilot evaluation.

A feasibility study can either test the feasibility of delivering the intervention or the feasibility of conducting an evaluation of it. A pilot

evaluation involves running a small-scale version of the full evaluation to test the design before upscaling.¹⁵⁴ Research naivety in forensic mental health and probation services indicate all these should be addressed in future research of the complex intervention developed.

Consistent with MRC guidelines for systematic application of theory, MOHO was applied to articulate the theoretical mechanisms of change and in modelling the expected intervention outcomes. The PPIAG critiqued and modified the models produced. This was consistent with the critical realist position that different perspectives of the same phenomenon, in this case how the intervention may work in practice, would more closely reflect reality than one person's perspective.

INVOLVEMENT

The PPIAG reviewed the intervention models and identified additional moderators and mediators of intervention delivery in practice. Those working with PDOs appraised the feasibility, acceptability and tailoring requirements for their respective practice settings. Appendix I summarises the PPIAG meetings minutes.

OUTPUTS

This WP had the following outputs:

- Model of the intervention and outcomes
- Preliminary logic model of the intervention in a natural context
- Stage one intervention manual for feasibility study and pilot evaluation

- Results presented at a national and international conferences with results from WP4^{147, 148}
- Presented to the Offender Personality Disorder Occupational Therapists Network in December 2018 with results from WP3

These outputs demonstrate that the aim of this research, to develop a complex intervention to increase occupational participation for PDOs in the community, was achieved. The outputs will inform a feasibility study and pilot evaluation of the intervention to determine its effectiveness. This will have clinical applications in services for PDOs in the community, where practitioners currently lack evidence for effective interventions to increase occupational participation.

2.6 CHAPTER CONCLUSION

This chapter described how critical realism, the Model of Human Occupation and the Medical Research Council guidelines for developing and evaluating complex interventions provided a coherent philosophical, theoretical and methodological basis for this research. Systematic application of these frameworks across four work packages indicates that readers can be confident in the conclusions drawn from the results. The next chapter reports the methods and results of Work Package One.

3 SYSTEMATIC REVIEWS

3.1 INTRODUCTION

Work Package One (WP1) consisted of two systematic literature reviews. Each review was published in a peer reviewed journal.^{113, 114} In these papers the term 'social outcomes' is used for its familiarity to a multidisciplinary audience. However, the papers make clear this term is used to describe participation as defined by the World Health Organization.^{17, 112}

In this chapter, the method and results of each review are reported separately in the same format as the publications. The results from both reviews are then discussed together followed by the implications for practice and research.

3.2 RESEARCH QUESTIONS

By systematically reviewing the literature, WP1 answered the questions:

- i) What is known about the factors that influence occupational participation for PDOs in the community, including the theory and mechanisms for their effects?
- ii) How effective are interventions to increase occupational participation for PDOs in the community, and what is the theory and mechanisms by which they are proposed to work?

3.3 WHAT IS KNOWN ABOUT THE FACTORS THAT INFLUENCE OCCUPATIONAL PARTICIPATION FOR PDOS IN THE COMMUNITY?

3.3.1 QUESTION AND OBJECTIVES

The first review answered the question:

For adult offenders with personality disorder, what influences occupational participation (including participation in employment, prosocial leisure, and independent living) in the wider (non-institutional) community?

The objectives were to:

- Identify the variables/influencers that moderate or mediate occupational participation
- Identify the theories and mechanisms by which the variables/influencers influence occupational participation

3.3.2 METHOD

The review followed the Cochrane Collaboration stages for systematic reviews.¹⁰⁷ Search strategies typically address the population of interest, interventions, comparators and outcomes. For the purpose of the review question, intervention was omitted to allow a more exploratory approach to identifying variables and influencers. Methods and inclusion criteria were prespecified in a protocol and registered on PROSPERO (ID = CRD42016042303).¹¹⁰

INCLUSION CRITERIA

TYPES OF STUDIES

The review included English language reports of research using any study design, with no limitations on date or quality. It excluded opinion pieces, commentaries or service descriptions, editorials and publications addressing laws, policies, and/or media reports.

POPULATION

The population of interest was people with a diagnosis of personality disorder or psychopathy, who had committed a criminal offence and who lived in the community (i.e. non-institutional) setting. Offender status was defined as having a conviction of at least one criminal offence (determined from official source or self-report). Personality disorder was considered present where participants had been diagnosed according to a specified method, and psychopathy where individuals had scored above an accepted threshold on a recognised psychopathy scale. In a clarification to the published protocol,¹¹⁰ studies reporting a mixed sample (e.g. including offenders with other diagnoses or none) were included where at least 60% of the sample had a personality disorder/psychopathy and 60% had an offending history.

PHENOMENA OF INTEREST

Studies were included where variables or other influencers of occupational participation were described, measured, or inferred. The review identified variables/influencers that moderated or mediated the relationship between the variables/influencers and occupational participation.

OUTCOME

The outcome of interest was occupational participation, i.e. participation in personally meaningful and socially valued activities and roles in a community (non-institutional) setting. This is described by the World

Health Organization (WHO) as “involvement in a life situation.”¹⁷ Terms for describing occupational participation were taken from the chapters on activities and participation in the WHO International Classification of Functioning, Disability and Health.¹¹²

SEARCH STRATEGY

The search strategy was tailored to the database requirements of 11 multidisciplinary research databases (Web of Science, SCOPUS, PubMed, EMBASE, AMED, CINAHL, ASSIA, PsycINFO, National Criminal Justice Reference Service Abstracts Database, Cochrane collaboration, Campbell collaboration) and grey literature. Searches were completed in July 2016 and updated until September 2017. It included review of the reference lists of included studies and key papers.

Table 3-1 shows how the search strategy was applied to PsycINFO.

STUDY SELECTION

Duplicates were removed and all titles and abstracts were screened against inclusion criteria by CC. A second reviewer (VF) screened 430 randomly selected citations (23%). Reviewers reached 97% agreement with divergence resolved by the third reviewer (EAM).

QUALITY APPRAISAL

All studies were low quality, based on appraisal using an appropriate tool for study type.^{155, 156}

Table 3-1 Search strategy for PsycINFO

Search strategy PsycINFO
<p>(SU.EXACT("Mentally Ill Offenders") OR (SU.EXACT("Male Criminals") OR SU.EXACT("Perpetrators") OR SU.EXACT("Female Criminals") OR SU.EXACT("Criminals"))) OR (ti(offen* OR crim* OR delinq* OR felon* OR gang* OR perpetrat* OR justice*) OR ab(offen* OR crim* OR delinq* OR felon* OR gang* OR perpetrat* OR justice*)))</p> <p>AND</p> <p>(SU.EXACT.EXPLODE("Personality Disorders") OR (ti(personality disorder* OR psychopath*) OR ab(personality disorder* OR psychopath*)))</p> <p>AND</p> <p>((SU.EXACT("Supported Employment") OR SU.EXACT("Employment Status")) OR SU.EXACT("Leisure Time") OR (SU.EXACT("Hobbies") OR SU.EXACT("Recreation") OR SU.EXACT("Active Living") OR SU.EXACT("Self-Care Skills") OR SU.EXACT("Activities of Daily Living") OR SU.EXACT("Lifestyle") OR SU.EXACT("Interests") OR SU.EXACT("Activity Level"))) OR (ti(("social participation" OR "activity participation" OR "time use" OR activit* OR occupation* OR self-care OR function* OR work* OR employ* OR volunteer* OR vocation* OR education* OR role OR leisure OR recreat* OR sport* OR hobb* OR faith OR religio* OR spiritual* OR participat*))) OR (ab(("social participation" OR "activity participation" OR "time use" OR activit* OR occupation* OR self-care OR function* OR work* OR employ* OR volunteer* OR role OR education* OR leisure OR recreat* OR sport* OR hobb* OR faith OR religio* OR spiritual* OR participat*))))</p> <p>AND</p> <p>(SU.EXACT("Reintegration") OR SU.EXACT("Protective Factors") OR (ti(probation OR release* OR discharge* OR integrati* OR reintegrat* OR rehabilitat* OR desist* OR reent* OR re-ent* OR re-settl* OR resettle* OR protective OR positive) OR ab(probation OR release* OR discharge* OR integrati* OR reintegrat* OR rehabilitat* OR desist* OR reent* OR re-ent* OR re-settl* OR resettle* OR protective OR positive)))</p>

DATA EXTRACTION

After piloting, a structured tool was used to extract data relevant to the review. Appendix A presents the full data extraction.

DATA SYNTHESIS

The Cochrane collaboration four-step method of narrative synthesis¹⁰⁸ was adapted to meet review aims. Steps involved:

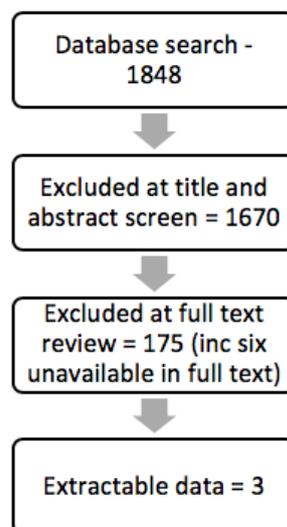
- (1) Identifying variables/influencers of occupational participation and theorising mechanisms of action
- (2) Preliminary synthesis of findings
- (3) Exploring relationships in the data within and between studies
- (4) Assessing the robustness of the synthesis

3.3.3 RESULTS

INCLUDED STUDIES

Figure 3-1 summarises the study selection. Three studies reported occupational participation outcomes for 67 men.

Figure 3-1 PRISMA diagram for review one



DEFINING PARTICIPATION

A records-based study reports community outcomes for 54 men treated in a UK high security hospital.¹⁵⁷ 60–61% of the original sample (not all were discharged to the community) had personality disorder according to DSM-III-R.¹⁵⁸ ‘Good social outcome’ required a ‘good’ score in each of four categories: social interaction, employment, accommodation, and (absence of) substance misuse. Scoring was on a purpose-designed tool involving rating against prespecified but arbitrary criteria set by the authors. Occupational participation includes social activities, employment, and independent living skills. Therefore the “good social outcome” construct was relevant.

A qualitative exploration of the experiences of PDOs accessing a community forensic psychology service identified occupational participation outcomes in a theme about “return to work and independence”. This theme included references to employment, education, and “full independence”.⁷⁶

A single case study, to evaluate the applicability of the Good Lives Model to treatment of high-risk offenders with high psychopathy checklist scores, describes attending college and learning to drive, developing prosocial relationships with peers, and forming an intimate relationship.¹⁵⁹ These are indicators of occupational participation. Success was reported in achievement or not of these outcomes.

VARIABLES TESTED FOR THEIR POTENTIAL EFFECT ON PARTICIPATION

Reiss, Grubin and Meux¹⁵⁷ tested “all recorded background and treatment factors”, although limited information is given about what was tested and

the scoring procedure. They report significant results from their univariate analysis. Variables indicative of a future good social outcome were higher IQ (good outcome mean=107.6, poor outcome mean=98.5, mean difference 9.0, $t=2.3$, $p<0.03$) and adequate or better assertiveness in the first 18 months of admission, as rated by staff (OR 6.0, 95% CI [1.3, 28.2]). Though reporting the rate of good outcomes on the separate components for a subsample of younger men ($n=28$, mean age 19.2 years at admission), the variables were not tested for their influence on the separate components.

The case study and qualitative study were exploratory.^{76, 159} Potential influencers from the perspective of participants and study authors were extracted from the supporting material. Return to work and independence was a theme identified by Jacobs et al.⁷⁶ who attribute success in this area to “increased social confidence”, mediated by supported participation in vocational activity. In quotations supporting this assertion, a participant describes “growing and maturing” and having “more hope” since being in the service. The influencers of occupational participation identified in the single case study by Whitehead, Ward and Collie¹⁵⁹ were sustaining motivation, developing and validating a prosocial identity, social and practical skill development, avoiding previous problematic activities and routines, and practical assistance and information given by staff.

3.3.4 SYNTHESIS

INFLUENCING VARIABLES

Cross-study synthesis was restricted by the low number and quality of studies. Reiss, Grubin and Meux¹⁵⁷ identified assertiveness at admission and IQ to be indicative of future occupational participation. As historical

factors, these may be considered potential moderators between institutional treatment and occupational participation. Neither assertiveness nor IQ featured in the qualitative or case study.

There were commonalities between the qualitative and case study in reporting prosocial identity and self-efficacy as facilitative of occupational participation, achieved by supported participation in different activities and social roles. Supported participation may mediate the relationship between self-efficacy and/or identity, and occupational participation. Whitehead, Ward and Collie¹⁵⁹ also allude to habitual destructive activity patterns as a potential mediator of the relationship.

THEORY AND MECHANISMS OF HOW VARIABLES INFLUENCE PARTICIPATION

Whitehead, Ward and Collie¹⁵⁹ offered a theoretical basis to describe the mechanisms by which influencers may impact upon occupational participation. They applied the Good Lives Model,¹⁶⁰ which posits that being unable to achieve normal 'human goods' in prosocial ways results in increased risk of offending. These 'goods' can be explicitly or implicitly linked to occupational participation, for example, 'excellence in work'. How the person achieved occupational participation was identified from the supporting information. This included: enhanced motivation for participation in prosocial activity through setting goals and evoking cognitive dissonance with current activities; identity transformation through envisaging and enacting a prosocial role; and personalised practical support from staff to facilitate this, including providing knowledge and opportunities, culturally relevant mentoring, and practical assistance.

3.4 THE EFFECTIVENESS OF INTERVENTIONS TO IMPROVE OCCUPATIONAL PARTICIPATION FOR PDOS IN THE COMMUNITY

3.4.1 QUESTION AND OBJECTIVES

This review answered the question:

How effective are interventions to increase occupational participation for PDOs in the community, and what is the theory and mechanisms by which they are proposed to work?

The objectives were to:

- Identify interventions and determine their effectiveness in increasing occupational participation for PDOs in the community
- Describe the interventions and the theories and mechanisms by which they are proposed to influence occupational participation

3.4.2 METHOD

The same methods were applied as in review one (PRISMA method and Cochrane Collaboration guidelines). As an intervention effectiveness review, no amendments were required. Review methods and inclusion criteria were pre-specified in a protocol and registered on PROSPERO (PROSPERO 2016:CRD42016042304).¹¹¹

INCLUSION CRITERIA

The same inclusion criteria as review one were applied to study types and population. Rather than describing participation as the phenomena of

interest, studies were instead included where an intervention was reported and occupational participation was one of the outcomes.

SEARCH STRATEGY AND STUDY SELECTION

Results from the search conducted in review one were screened with the additional criterion that the paper reported an intervention. Searches were completed in July 2016 and updated until September 2017.

DATA EXTRACTION

The data extraction tool from review one was modified for the purpose of review two. It included: year of data collection, country of origin, aim/hypothesis of the study, study design, inclusion criteria, participant demographics, personality disorder diagnosis method and prevalence within sample, offender status, occupational participation outcome of interest, description of intervention, analysis method, and results. Due to the small number of studies, CC extracted the data which was checked by the second and third reviewers (VF, EAM). See Appendix A.

RISK OF BIAS ASSESSMENT

Validated structured tools appropriate to study type were used to assess study quality.^{155, 156, 161} Studies were not excluded on this basis.

SUMMARY MEASURES

No outcome measures were prespecified. As occupational participation is rarely discussed in the literature, to identify relevant outcomes a range of terms were derived from the WHO International Classification of Functioning, Disability and Health chapters on activity and participation.¹¹²

DATA SYNTHESIS

The Cochrane Collaboration four-step method of narrative synthesis of effectiveness studies¹⁰⁸ was applied with consideration to the inclusion of non-RCT designs. It was anticipated that the number and quality of studies would be insufficient to conduct meta-analysis. The steps were:

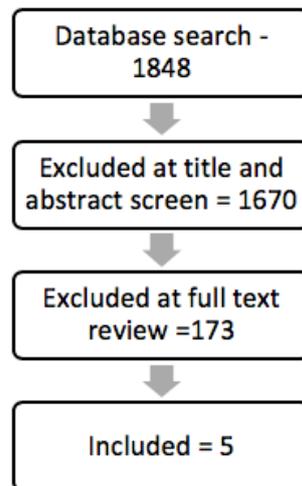
- 1) Develop a theory of how interventions operate
- 2) Preliminary synthesis of findings
- 3) Explore relationships in the data within and between studies
- 4) Assess the robustness of the synthesis

3.4.3 RESULTS

INCLUDED STUDIES

Study selection is summarised in Figure 3.2.

Figure 3-2 PRISMA diagram for review two



Of 1848 citations, 178 were reviewed at full text. Of these, 173 were excluded because they did not meet inclusion criteria and six because full-text could not be obtained. Five studies met inclusion criteria.

Four studies involving 94 participants reported occupational participation in the community for PDOs following an intervention. One study¹⁶² did not specify the number of the 148 participants in their study who were PDOs.

STUDY CHARACTERISTICS

Studies are presented in order of robustness of study design. The three cohort studies are presented in order of quality from high to low. The data extracted are summarised here. Appendix A presents the full data extracted.

Davidson et al.¹⁶³ report a feasibility randomised controlled trial (RCT) to test the effectiveness of cognitive behavioural therapy (CBT) for reducing violence and aggression among 52 men with antisocial personality disorder (ASPD) in the community. Social functioning was included as an outcome

measure, measured using the Social Functioning Questionnaire (SFQ).¹⁶⁴ The SFQ involves a person self-rating their participation in activities and social roles, so was considered a relevant occupational participation outcome.

Öhlin, Fridell and Nyhlen¹⁶² report a prospective observational study involving 7-year follow up of 148 heroin dependent patients who received a voluntary multi-modal treatment including mandated employment. Outcomes included rates of employment and subsidised education among those retained in treatment compared to those who dropped out. This is the only study to include women.

Fortune et al.¹⁶⁵ conducted a two-year prospective cohort study of 54 men from three forensic personality disorder services, 24 of whom were stated to be in the community. They collected baseline data in 2005-06 and followed up in 2007-08. These services were delivered by teams spanning medium secure units and the community, one of which aimed to assist patients to find occupational participation opportunities in the local community. Similar to the other UK study,¹⁶³ social functioning is taken as an outcome, though in this study it is measured using the Work and Social Adjustment Scale (WSAS).¹⁶⁶

Krampen¹⁶⁷ conducted an observational cohort study to identify the five-year outcomes of long-term integrative psychotherapy for men referred for 'acting out' and 'violence against intimates'. A sub-group of their sample had ASPD, for whom results are separately reported. Psychotherapy was provided for an average 1 year (7-19 months) and included a range of clearly described techniques. Outcomes included change in employment rates, with employment defined as being "on the job" (inferred to mean stable employment) for two years, and social adjustment although this is not defined or compared with a baseline score.

Finally, Whitehead, Ward and Collie¹⁵⁹ present a case study, purposefully selected to illustrate the application of the Good Lives Model¹⁶⁸ in treatment for high risk offenders. Indicators of success in both reducing risk and increasing occupational participation were described in a qualitative format as attending university, forming an intimate relationship and redefining social networks. The case study is a 28 year old Maori man (indigenous New Zealander) whose scores on the psychopathy checklist screening version Hart et al.¹⁶⁹ were reported to be indicative of high levels of psychopathy, and who had an extensive and serious offending history.

INTERVENTION DESCRIPTIONS

COGNITIVE BEHAVIOURAL THERAPY

Davidson et al¹⁶³ tested CBT developed for personality disorder¹⁷⁰ delivered in either 15 sessions over 6 months or 30 sessions over 12 months, each session lasting up to 1 hour. The authors outline that firstly, CBT encourages participants to engage in treatment through a cognitive formulation of their problems. Secondly, CBT focuses on beliefs about self and others, and behaviours that impair social and adaptive functioning.

An element of CBT was included in two of the observational cohort studies.^{162, 167} However, as part of a wider intervention the specific effect of CBT cannot be determined.

NON-SPECIFIED MULTI-MODAL TREATMENT

Öhlin, Fridell and Nyhlen¹⁶² present a multi-modal intervention for heroin users. The treatment programme appeared to run indefinitely as all those not still within the programme at the seven year follow up point were reported as 'non-completers.' The treatment programme included five

components: (1) pharmacological treatment with buprenorphine to manage opioid addiction; (2) prohibition of misuse of drugs; (3) access to drug-free accommodation, although no further detail is given; (4) achieving structured employment (work or studies) although this component is not clearly described (the paper refers to working with a local employment agency, and that an existing 'employment contract' was required for inclusion in the programme); and (5) psychosocial treatment sessions to modify drug use and 'prevent passivity' which included manual-based cognitive-behavioural therapy, psychodynamic therapy or family-oriented counselling.

MULTI-DISCIPLINARY FORENSIC PSYCHIATRIC SERVICES

Fortune et al.¹⁶⁵ evaluated outcomes for patients treated in three medium secure units and associated community services. The authors state the services aimed to provide treatments to reduce the risk of re-offending, address mental health needs and improve social functioning. One community service was a residential local housing organisation service that provided social care for eight residents. This included assistance exploring local opportunities for education, employment and other activities. What was done on an inpatient basis in preparation or by the other community teams to target social functioning is unclear.

INTEGRATIVE PSYCHOTHERAPY

Krampen¹⁶⁷ describes integrative psychotherapy as including cognitive-behavioural, relaxation and psychodynamic methods. Treatment principles, the four therapeutic aims and the techniques of the psychotherapy delivered are described in depth. Therapeutic aims were: (1) enhanced social-emotional skills, empathy and morality; (2) reduced psychophysiological arousal in favour of impulse control and mastery; (3) developing adaptive self-statements; and (4) reconstructing attachment abilities, trust and social relationships.

Whitehead, Ward and Collie¹⁵⁹ describe treatment informed by the Good Lives Model which aims to provide the internal and external conditions that make successfully achieving a good life possible. Five phases of treatment are described with reference to case material as follows: (1) identifying life goals and the motivation for pursuing them; (2) defining desired identity and determining the barriers/opportunities to achieving this; (3) producing a good lives informed formulation; (4) developing a plan to equip the offender with values, attitudes, skills and resources to achieve their goals in a prosocial way; and (5) enacting the plan, including undertaking any interventions to address criminogenic barriers such as substance use or attitudes towards violence. Which components were relevant to achieving occupational participation is not made explicit. There were elements of practical assistance, counselling and guidance in addition to what was covered in the therapy sessions.

RESULTS OF INDIVIDUAL STUDIES

Davidson et al.¹⁶³ use intention to treat principles in their analysis. SFQ scores were taken at baseline and the participants last attended session. Mean difference in SFQ scores was calculated, adjusted for baseline levels. There was no significant difference in social functioning between the combined CBT groups (those who received either 6 or 12 months) and treatment as usual (TAU) group. Mean difference was -0.7 (95% CI =-3.3 to 1.8), $p=0.54$. The authors report a trend toward significance for those who received 6 months of CBT to have improved social functioning compared to TAU ($p=0.08$, data not shown). However, they also acknowledge that the study is underpowered to reliably detect change.

Öhlin, Fridell and Nyhlen¹⁶² report frequency counts and percentages of those in employment at the start and end of the 7-year period, and compare results for those retained in treatment compared to those who dropped out. They offer no statistical analysis on this outcome. Reasons for drop-out are not given. They report that 69% of patients were employed in a regular job at 7 years compared to 22% at baseline and 29% earned their living by a subsidised wage compensation compared to 9.5% at baseline. 2% conducted academic studies. Proportionally more women than men were in work or education (70% vs 60%) but there was a 30% improvement for both in movement from precarious work to employment in the regular labour market. Subsidised wage compensation increased by 19% during the first two years of follow-up. The authors report that all participants who dropped out lost employment soon after and did not resume, compared to those who sustained their engagement with treatment and retained employment. Whilst showing positive trends, as work was a mandated component of the intervention it is not possible to ascertain if change would be sustained on completion. As there was no control group change cannot be attributed to the intervention.

In assessing social functioning, Fortune et al.¹⁶⁵ used a paired t-test to detect statistically significant change on WSAS scores at baseline, six and 24 months. For the group reported to be in the community, initially 24 men, there was no significant difference in social functioning at 6 or 24 months. Mean WSAS at baseline = 20.42 (SD 12.12). Mean at 6 months = 19.53 (SD 10.97), $T=0.81$, $p=0.43$. Mean at 24 months = 14.5(8.3), $T=1.04$, $p=0.33$.

Like Öhlin, Fridell and Nyhlen,¹⁶² Krampen¹⁶⁷ reports pre-and post-employment rates in frequency counts but no further statistical analysis. For the ASPD sub-group, those in stable employment for two years increased from 41% (n=7) to 71% (n=12). At follow-up, 76% (n=13) had what the author terms social adjustment, although there is no pre-

intervention rate or explanation of what this is based upon. There was no control group, so change is not attributable to the intervention.

Whitehead, Ward and Collie¹⁵⁹ use no formal analysis procedures, reporting a case study and formulation to make inferences about treatment effectiveness and the potentially active mechanisms. The authors frame intervention as a success, particularly in comparing violent reoffending with that occurring during the participant's last parole. The participant commenced university and a diving qualification but did not complete either. He had started learning to drive but completion was not reported. The participant was also reported to be in an intimate relationship and to have had success in establishing a new prosocial peer group. As single case study, it is not possible to ascribe change to the intervention.

RISK OF BIAS / QUALITY APPRAISAL OF INDIVIDUAL STUDIES

Studies were appraised using the Downs and Black tool¹⁵⁶ with the exception of Davidson et al.¹⁶³ which was the only RCT, and was thus also assessed for bias using the Cochrane tool.¹⁶¹

Davidson et al.¹⁶³ was a feasibility study in which only the data collectors were blind to the intervention groups. The inability to conceal psychotherapy interventions from participants and practitioners is well documented. The small sample size (total n=52) mean there was insufficient power in statistical analysis. Overall risk of bias was rated as medium.

Öhlin, Fridell and Nyhlen¹⁶² provide the most comprehensive report of the observational cohort studies. However, details of the intervention itself are limited. There was no control group, it is unclear how long treatment

lasted and there was no reported adjustment for length of follow up. Risk of bias was rated high.

Fortune et al.¹⁶⁵ was the only cohort study to use statistical tests to determine the significance of any change in the outcome of interest (social functioning). However, the description of the intervention is lacking. It was delivered by three different real-world teams and thus potentially varied considerably. Refusal to participate was high (39%) limiting confidence in the representativeness of the sample. There was no control group. Risk of bias was rated high.

Krampen¹⁶⁷ was judged to be very high risk of bias because of the limited reporting of key criteria to judge the study. For example, confounding factors, description of when measures were taken and by whom, and whether those lost to follow up had different characteristics. There is no control group.

Whitehead, Ward and Collie¹⁵⁹ report a purposively selected case, deliberately chosen to illustrate the that intervention informed by the Good Lives Model can be effective with challenging PDOs. High risk of bias is evident in the stated aim of the authors to make this point.

3.4.4 SYNTHESIS OF RESULTS

Meta-analysis was not possible due to limitations in the designs of the studies and high heterogeneity. Results were analysed using narrative synthesis with two components: synthesis of the occupational participation outcomes measured and effectiveness of interventions in modifying these; and synthesis of the mechanisms by which the interventions were hypothesised to improve occupational participation. Appendix A details the summarising of the data for synthesis.

INTERVENTION OUTCOME AND EFFECTIVENESS

SOCIAL FUNCTIONING

Three studies attended to social functioning. Davidson et al.¹⁶³ measured changes on the Social Functioning Questionnaire¹⁶⁴ following CBT. No significant difference was found after CBT although the study was underpowered. Fortune et al.¹⁶⁵ similarly found no significant change in scores on the Work and Social Adjustment Scale¹⁶⁶ during two years of multidisciplinary forensic mental health intervention. No power calculation is reported. Whitehead, Ward and Collie¹⁵⁹ demonstrated the results of intervention informed by GLM in a single case. The participant developed prosocial networks, leisure pursuits and an intimate relationship. As a single case, change cannot be attribute to GLM informed treatment.

There is no evidence that the reported interventions increase social functioning.

EMPLOYMENT AND EDUCATION

Three studies report on employment and education. Krampen¹⁶⁷ identified presence or absence of a 2-year period of job stability. Öhlin, Fridell and Nyhlen¹⁶² referred to employment as including competitive work and receiving subsidised wage compensation, without specifying length of employment. They also report those who went on to education. Both studies showed an increase in employment rates. However as observational studies, it is not possible to attribute change to the interventions. Whitehead, Ward and Collie¹⁵⁹ reported participation in education as an outcome. Successfully commencing university is cited as a success though limitations of the case study design are acknowledged.

There is evidence that employment can be achieved by PDOs over time. However, the study designs prevent attribution of change to the interventions.

INTERVENTION MECHANISMS

Three potential mechanisms that supported occupational participation for PDOs in the community were identified; skill development, defining a prosocial goal and identity, and real-world experiences achieved through practical assistance.

Two interventions mention developing skills relevant to occupational participation. The integrative psychotherapy intervention described by Krampen¹⁶⁷ included social and emotional skills training, and anger and self-control training. Whitehead, Ward and Collie¹⁵⁹ refer to equipping their participant with values, attitudes, skills and resources that supported him to achieve his goals through prosocial means. Based on the assumption that skill deficits are a barrier to success, skill development may give PDOs the ability to overcome barriers to accessing prosocial activities; better cope with challenges that disrupt occupational participation; or develop new strengths that support sustained occupational participation.

Two studies described prosocial goals and identity. Krampen¹⁶⁷ refers to developing 'life projects' in interventions that are 'consciousness creating.' Whitehead, Ward and Collie¹⁵⁹ describe how they drew out prosocial goals and orientated treatment around achieving these. Enabling a PDO to identify with prosocial roles and working towards achieving these may operate to achieve change by enhancing motivation and engagement for change, and by identifying and addressing relevant barriers and opportunities for occupational participation.

Three studies referred to using real-world participation achieved through practical assistance. Öhlin, Fridell and Nyhlen¹⁶² explicitly included employment in their intervention, although how this was delivered and whether this was integral to treatment outcome is not well described. In

Fortune et al.,¹⁶⁵ one of the three community services provided practical assistance to access local opportunities for occupational participation, though outcomes for this group cannot be distinguished from the whole sample. Whitehead, Ward and Collie¹⁵⁹ provided practical assistance for their participant to attain experiences in university. Through supported occupational participation, service users may have learned skills, begun to view themselves differently and experienced enhanced motivation to pursue their prosocial goals through mastery experiences. However, practical assistance may not equip the PDO to continue occupational participation independently, given the unemployment rates among the dropouts in the study by Öhlin, Fridell and Nyhlen,¹⁶² and the lack of statistically significant change in social functioning in other studies.^{163, 165} There may be a need for PDOs to learn to generate their own occupational participation if it is to be sustained.

3.5 DISCUSSION

3.5.1 SUMMARY

Two systematic reviews identified that little is known about the factors that influence occupational participation for PDOs in the community, or the effectiveness of interventions that aim to increase occupational participation for PDOs in the community. Neither review found sufficient evidence to answer the question posed. Outcomes, outcome measures and interventions were heterogenous, preventing comparisons. There was limited attention to theories of occupational participation to justify a focus on particular variables/influencers or explain why interventions may work. Only one study included women.

3.5.2 HETEROGENEITY IN OUTCOME

Results reveal limited attention to occupational participation and social outcomes for PDOs. This is reflected in the wider literature, and consequently studies use heterogeneous concepts, for example, social functioning,^{163, 165} quality of life/wellbeing¹⁷¹ and prosocial behaviour.¹ Studies need to be comparable and consensus is required on the outcomes of interest and their measurement.

Occupational participation is analogous to the WHO concept of participation.³³ Researchers in physical health and paediatrics describe it in detail using the International Classification of Functioning, Disability and Health (ICF).¹¹² However, using WHO participation as an outcome, particularly in mental health and offender populations, is complicated by its focus on socially acceptable activities and roles and debate about its operationalisation. As a result, several measures have been developed. The majority are for physical health conditions and many conflate the ICF concepts of activities and participation causing measurement inaccuracies.¹⁷² Until consensus is achieved on the outcome of interest and its measurement, there is a risk of continued heterogeneity that prevents research synthesis.

3.5.3 VARIABLES/INFLUENCERS

There is insufficient evidence to determine the factors that influence occupational participation. Reiss, Grubin and Meux¹⁵⁷ identified moderators of occupational participation as IQ and staff-rated assertiveness on admission to a high-secure hospital. Although historical, service providers may consider whether additional support is required for those with lower assertiveness or IQ.

Participants' experiences of occupational participation in education, employment and prosocial leisure suggests this contributed to increased self-belief and new identity formation, which in turn facilitated occupational participation.^{76, 159} These findings are consistent with desistance and recovery literature that both describe identity transformation and experiences of occupational participation, particularly those involving a social contribution, as central components.^{42, 173, 174} However, it remains unclear what influences occupational participation itself, whether occupational participation precedes identity change or vice versa, or whether these are parallel processes. More research is required to disentangle this relationship.

Transforming patterns of activity is not straight-forward, as habitual patterns of antisocial participation were found to be difficult to immediately overturn.¹⁵⁹ This may be a factor in the lack of evidence for effectiveness in the studies that used supported occupational participation. Some individuals may be unable to sustain activities and roles over time without assistance, thereby returning to previous patterns of occupational participation once assistance is withdrawn. The issue of sustaining change is highlighted among ex-offenders, as despite structured support to access occupational participation in the form of employment, only 11% sustain this at 12 months.⁶⁷ Where support is given to increase occupational participation, attention must be paid to ensuring the individual has the skills, motivation and a conducive environment to continue independently.

Researchers could identify the features of a personality disorder diagnosis that influence occupational participation, such as traits or severity, and thus target treatment at the traits or symptoms. This would be based on the assumption that it is personality pathology that causes impairments in occupational participation. An alternative approach is to identify the factors influencing occupational participation itself using an empirically and theoretically supported model that recognises interaction with the

environment. Intervention would then be focused on modifying relevant components of occupational participation, rather than attempting to ameliorate signs and symptoms of disorder/s. This approach is more familiar to rehabilitation professionals, who advocate the WHO position that health and functioning are achievable irrespective of disability, disorder or disease.¹⁷

3.5.4 INTERVENTION EFFECTIVENESS

There is insufficient evidence for effective interventions to increase occupational participation for PDOs in the community, although there was evidence that employment rates can increase over time. All but one paper lacked theoretical explanations of how the intervention may work to improve occupational participation. To maximise effectiveness, interventions should be developed based on evidence of what the relevant influencing factors are, and a theory of the mechanisms by which they operate to bring about a desired outcome.²⁵

Three potential mechanisms of change were identified from synthesis of the intervention descriptions. The first was skill development, which follows the hypothesis that a lack of social, emotional or practical skills impede occupational participation. Skills training is well established in criminal justice programming, including specific programmes for PDOs.^{e.g.175} However, interventions are institution based and research is required to determine if any skills learned are transferred and applied to occupational participation in the community on release from prison or discharge from hospital.

The second mechanism was facilitated change in values and identity, achieved through supported prosocial goal attainment and validation of efforts. This approach is increasingly adopted in forensic practice to

address motivation for and engagement in risk-focused intervention, by framing offending as a barrier to achieving prosocial goals.¹⁷⁶ Those practicing from an occupational perspective argue that 'volitional realignment' (a change of motivation toward prosocial goals) and identity transformation occur through mastery of new prosocial activities.²⁹ However, interventions using this approach are yet to be tested for effectiveness.

The final mechanism was practical assistance given to compensate for participants' difficulties, for example taking someone to a leisure centre. Whilst this has an immediate effect, it does not impart a change in the individual him or herself, and thus may not support continued occupational participation on a long-term basis. This approach is consistent with the Individual Placement and Support model, which has been shown to be effective in supporting individuals with serious mental illness into employment.¹⁷⁷ However, whether employment is then sustained is less clear from the literature. For offenders supported into employment, nine out of ten fail to sustain employment for 12 months.⁶⁷ This is an important consideration in providing interventions of long-term effectiveness and when working with individuals with personality disorder, whose difficulties may fluctuate over time.

To design an intervention that is effective at producing lasting change in occupational participation, intervention developers should consider applying established theories. These reviews used the World Health Organization (WHO) definition of participation and the categories detailed in the associated classification system. However, the WHO model does not provide a theory of how different factors interact to produce participation, and as discussed, the operationalisation of participation remains contested. As outlined in the introduction to this thesis, this problem is overcome by applying the Model of Human Occupation (MOHO).²⁶ Within MOHO, the definition of occupational participation is analogous to

participation as defined by the WHO. MOHO presents a coherent theory of how occupational participation is achieved, experienced, maintained and changed. It has valid and reliable measures for the influencing factors. Although MOHO has not been tested specifically with PDOs, it is based on universal principles. Its utility is evident in its use in international forensic research and practice.^{29, 178, 179} Applying MOHO to guide this research presented a starting point for identifying factors that influence occupational participation for PDOs and the mechanisms of change that can be exploited in intervention.

3.5.5 STRENGTHS AND LIMITATIONS

Including papers where at least 60% of the sample had personality disorder/ psychopathy and at least 60% had committed an offence permitted the inclusion of Reiss, Grubin and Meux¹⁵⁷ and Öhlin, Fridell and Nyhlen¹⁶². The findings from these studies may be influenced by the inclusion of people without a personality disorder.

Due to the inclusion of low-quality studies, conclusions drawn must be interpreted cautiously.

3.6 CONCLUSIONS

Factors influencing occupational participation and the mechanisms by which they operate cannot be determined from the current evidence. No interventions were specifically designed to improve occupational participation in the community for PDOs. There is some evidence that employment rates can improve over time, but changes cannot be attributed to interventions. Consequently, service providers are unable to

apply evidence-based interventions that are likely to increase occupational participation for PDOs in the community.

3.6.1 IMPLICATIONS FOR PRACTICE

Services providers working with PDOs in the community:

- Lack evidence to inform interventions to increase occupational participation
- May consider adaptations for people low in assertiveness or with lower IQ
- May consider intervention that supports a person to achieve a prosocial identity; targets skill deficits that impact on successfully maintaining occupational participation; or provides practical assistance to access occupational participation *and* equips the person to continue independently

3.6.2 IMPLICATIONS FOR RESEARCH

Research with PDOs in the community is required to:

- Establish consensus on the outcomes of interest, how they are operationalised, and which valid and reliable measures are used
- Establish the variables/influencers of occupational participation
- Develop an intervention that targets these factors

3.7 CHAPTER CONCLUSION

This chapter presented the results of two systematic reviews which highlight gaps in the literature pertaining to the factors that influence occupational participation for PDOs in the community and effective interventions to improve it. The lack of attention to occupational participation in the literature, despite its importance for health and desistance, highlights the contribution of this research. The following chapters report the results of research which addressed these identified gaps.

4 IDENTIFYING WHAT INFLUENCES OCCUPATIONAL PARTICIPATION: PART ONE - QUANTITATIVE

4.1 INTRODUCTION

Systematic review of the literature indicated that currently very little is known about what influences occupational participation for people with an offending history and a personality disorder (PDOs) in the community.¹¹⁴ The relevant influencing factors must be identified if an intervention is to be developed to modify these and thus increase occupational participation.

Work Package Two (WP2) used a convergent parallel mixed-methods design⁹² to identify these influencing factors. Four sub-studies used different data collection and analysis methods to answer the question: what influences occupational participation for PDOs in the community? The rationale for adopting mixed-methods is detailed in Chapter Two. Each sub-study is presented in a separate chapter which reports specific methods, and results and findings. This allows each sub-study to be fully considered in relation to the wider literature.

This chapter reports the quantitative methods and the results from the first sub-study. It includes the sampling and recruitment process relevant to all the sub-studies, as the same participants provided data for each. The results are discussed followed by implications for practice and research.

4.2 RESEARCH QUESTION AND OBJECTIVES

WP2 answered the question: what influences occupational participation for PDOs in the community?

This sub-study had the following objectives:

- Conduct semi-structured and narrative interviews with PDOs in the community
- Score interviewer-rated standardised assessments of factors that influence occupational participation

4.3 METHOD

4.3.1 PARTICIPANTS

Participants were PDOs living in the community. They were sampled and recruited via the National Probation Service (NPS) in the West Midlands, from records of approximately 4000 people who met criteria for the Offender Personality Disorder Pathway. Chapter One discussed how these men and women may not have a formal diagnosis of personality disorder, but are categorised as PDOs on the basis of routine screening using the OASys PD Screen.⁸⁹ The study sample thus reflected the realities of practice rather than a research ideal.

INCLUSION CRITERIA

Table 4-1 shows the inclusion and exclusion criteria. Consideration was given to practical and ethical issues. The latter involved ensuring that participation in the research would not risk or cause harm to the individual, other people, their relationship with the NPS, or myself as the researcher.

An ethical challenge faced was that not all PDOs were aware that they had been identified as such when this study commenced. I was ethically required to make explicit what the study was about and why participants were invited. Should the research be the first time they were made aware

of being screened as a PDO, the individual may feel deceived, betrayed or that others were making unfair judgements on their character. It would be unlikely to facilitate recruitment and could have implications for the individual, their risk level, and their relationships with their Offender Manager, the NPS and society in general. Therefore, PDOs were only included if they were aware that their case had been identified for Offender Personality Disorder (OPD) Pathway.

Table 4-1 Inclusion and exclusion criteria

Inclusion criteria	Exclusion criteria
<ul style="list-style-type: none"> • Screened into OPD Pathway. Men: i) Assessed as presenting a high likelihood of violent or sexual offence repetition and high or very high risk of serious harm to others; ii) Likely to have a severe personality disorder; iii) A clinically justifiable link between the personality disorder and the risk. Women: i) Current offence of violence against the person, criminal damage, sexual assault including against children; ii) Assessed as presenting a high risk of committing an offence from the above categories; iii) Likely to have a severe form of personality disorder; iv) Clinically justifiable link between the above. • Aware of screening into the OPD Pathway • Capacity to give informed consent • Gives written informed consent • English speaking • 18+ years old 	<ul style="list-style-type: none"> • Not screened into the OPD Pathway • Currently in prison/secure hospital • Unaware of screening into OPD Pathway • Does not have capacity to consent • Does not give consent • Does not speak English • Under 18 years old • Presents a risk to researcher – determined by probation staff risk classification for ‘risk to staff’. Those rated in the top category were reviewed with the respective offender manager, and were excluded if it is considered the risk cannot be safely managed

WP2 contained a large qualitative sub-study (reported in Chapter Five). In qualitative work, rather than having a predefined target recruitment number, sampling ceases when no new findings emerge from data analysis (referred to as data saturation). However, there was a time limitation on how long sampling could continue. The target was 20 participants based on projections of two interviews completed per month for ten months.

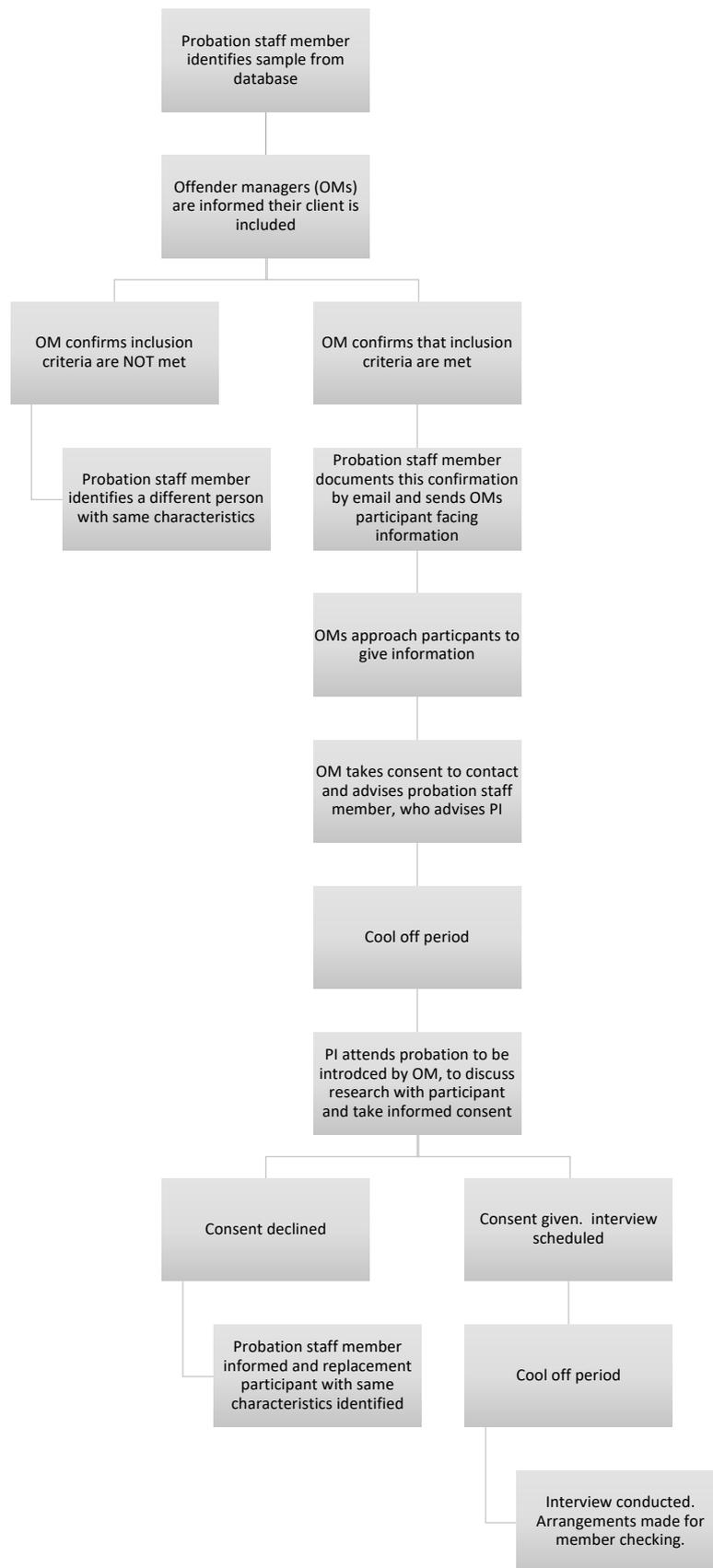
This study applied stratified purposive sampling,¹⁸⁰ a non-probability sampling procedure in which participants were selected for their particular characteristics, based on the fit with the aim of the study and the inclusion criteria. A sampling framework minimised coverage bias, which occurs when there is over-coverage of people with certain characteristics in the target population, and under-coverage of others.¹⁸¹ This was the case for women who make up only 5% of the West Midlands NPS caseload. Stratified purposive sampling allowed factors common across individuals to be identified, so that an intervention could be designed for use with PDOs with different characteristics.

Potential participants of different ages, sex, ethnicity, offence type and employment status (a proxy for successful occupational participation) were identified. These variables were relevant to offending, personality disorder and occupational participation. Women were oversampled to ensure representation and in response to their absence in the literature.^{113, 114} Appendix B details the sampling framework and the rationale for selecting different characteristics.

The approach to participants and taking consent was detailed and cautious to protect all parties. A NPS administrator, KW, identified potential participants from the NPS database. KW approached respective Offender Managers to confirm the potential participant was aware they were

screened into the OPD Pathway. Offender Managers took consent from the potential participant for me to contact them. I obtained informed consent at the potential participant's next routine probation contact. A cooling off period was given before continuing with the interview another day or later the same day. Where a potential participant refused, KW identified an alternative potential participant with similar characteristics. Figure 4-1 illustrates this process.

Figure 4-1 Sampling and recruitment process



4.3.3 DATA COLLECTION

Interviews were conducted at the NPS premises where the participant attended routine appointments. Interviews consisted of two parts:

- Narrative interview using broad open questions, e.g. “what is day-to-day life like for you?” which allowed participants to share what was most relevant to them without predetermined topics.
- Semi-structured interview utilising Occupational Performance History Interview – Version Two (OPHI-II).¹¹⁸ The OPHI-II covers five themes (daily routine, roles, activity choices, the environment and turning points) in relation to the past, present and future. The semi-structured nature of the OPHI-II provided more guidance to participants but continued to use questions designed to elicit narrative responses. The order of themes was amended from the manual with advice from the Patient and Public Involvement Advisory Group (PPIAG) to maximise the likelihood of developing a good enough relationship with the participant to discuss more sensitive topics later in the interview. Appendix B includes the semi-structured interview guide.

Four interviewer-rated assessments scales were completed based on the interviews. These are described below.

MODEL OF HUMAN OCCUPATION SCREENING TOOL (MOHOST)

The Model of Human Occupation Screening Tool (MOHOST)¹⁸² measures components of occupational participation using a four-point ordinal rating scale on twenty-four items across six sub-scales. The sub-scales have four items each and represent motivation for occupation, pattern of

occupation, communication and interaction skills, process (cognitive) skills, motor skills, and the environment. Each point on the scale is assigned a letter. F indicates the item facilitates participation, A indicates that it allows participation, I that it inhibits participation and R that it restricts participation. Scores are determined using criteria in the manual.

Research into the psychometric properties of MOHOST with a sample of people with mental health conditions demonstrated construct, convergent and discriminant validity, and person separation reliability.¹⁸³ MOHOST is sensitive to individual level change over time in patients in low and medium security forensic mental health settings.¹⁸⁴ Although the forensic mental health sample consisted predominantly of people with schizophrenia,¹⁸⁴ forensic mental health populations include a large number of people with problematic personality traits if not diagnoses.⁵ Therefore, MOHOST was suitable for measuring components of occupational participation in this research.

OCCUPATIONAL PERFORMANCE HISTORY INTERVIEW – VERSION TWO SCALES

The OPHI-II has three associated scales measuring occupational identity, occupational competence and occupational settings (environment). These are referred to together as the OPHI-II scales.¹¹⁸ Occupational identity, occupational competence and occupational settings underpin the occupational adaptation process and therefore influence occupational participation.

- The Occupational Identity Scale consists of eleven items that measure “the degree to which a person has internalised a positive occupational identity (e.g. having values, interests and confidence,

seeing oneself in various occupational roles, and having an image of the kind of life one wants)” (pg.5)

- The Occupational Competence Scale consists of nine items that measure the “degree to which one is able to sustain a pattern of occupational participation that reflects one’s occupational identity” (pg.5)
- The Occupational Settings (Environment) Scale consists of nine items that measure the challenge of tasks, the level of social support and the availability of space and resources in the environments where someone participates in home, leisure and productive occupations (pg.5)¹¹⁸

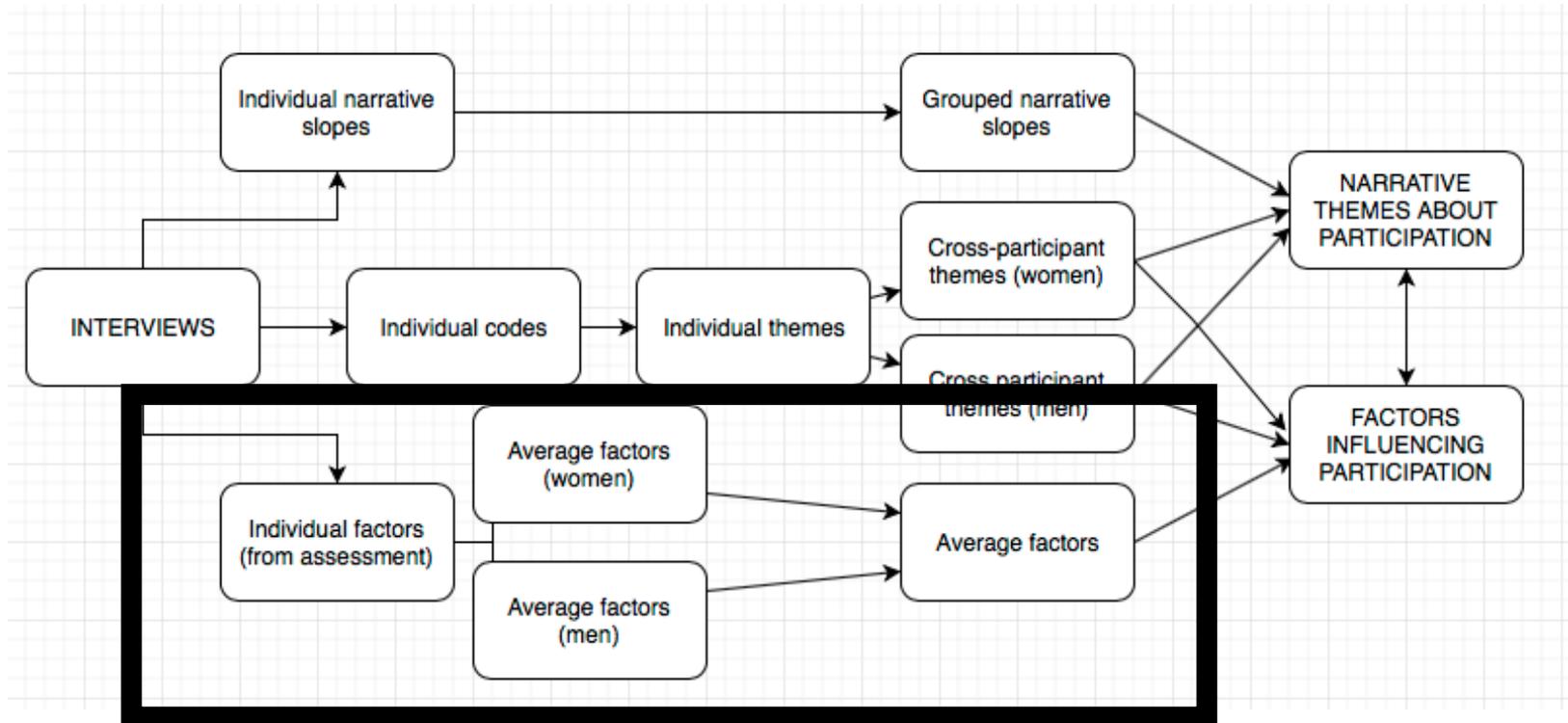
On the OPHI-II scales, the interviewer scores items on a four-point ordinal scale using criteria in the manual. People score 4 when exceptionally competent, 3 for good/appropriate/satisfactory, 2 where there are some problems and 1 where there are extreme problems. The ordinal data of the item scores is converted to interval data to produce an overall score for each scale. Where item scores do not fit an expected pattern, the manual advises one of two actions. Either to conclude the measure is not working as intended and omit the scoring system, or to exclude scores that deviate from expectations to produce an adjusted score.¹¹⁸

In a study of the psychometric properties of the OPHI-II scales, including people with mental health diagnoses, all three scales demonstrated person and item separation reliability, and construct and discriminant validity. Only the data for the sample with physical or no diagnoses are presented in the paper. Raters were all self-trained with the manual, reflecting the realities of practice.¹⁸⁵ The inclusion of people with mental disorders and its strong theoretical basis indicate the OPHI-II scales were suitable for this sub-study.

4.3.4 DATA ANALYSIS

Figure 4-2 shows the overall analysis in Work Package Two with the process in this sub-study highlighted. The term 'factors' refers to the items on the MOHOST and OPHI-II scales as factors influencing occupational participation. Terminology relating the other sub-studies is described in Chapters Five and Six.

Figure 4-2 Work Package Two data analysis: Quantitative sub-study highlighted



MOHOST ITEM SCORES IN THE PDO SAMPLE

MOHOST item scores for each participant were converted to numerical scores where 1 represented ‘restricts participation’ and 4 represented ‘facilitates participation’. Mean scores on MOHOST items were used to identify trends within the PDO sample in areas of strength (above 3.5 when rounded to the nearest 0.5) and impairment (below 2.5 when rounded to the nearest 0.5).

Items of impairment were compared to features of dissocial personality disorder and emotionally unstable personality disorder from the ICD-10 to establish if and how these measures capture the factors influencing “social and occupational dysfunction”, which is included in making a diagnosis of personality disorder.²

MOHOST SCORES IN COMPARISON TO OTHER SAMPLES

There is no normative data for MOHOST items or sub-scales. However, mean sub-scale scores have been published for a sample of United Kingdom mental health (UKMH) service users.¹⁸⁶ Mean sub-scale scores were produced for the PDO sample to allow comparison using the same method. Whilst taking a mean from ordinal data is inexact, this approach was the only available comparison method.

Lee et al.¹⁸⁶ present data by ‘care cluster’. Care clusters are a way of categorising mental health service users in the UK according to level and type of needs.¹⁸⁷ Guidance suggests that those with severe or problematic personality disorder should be allocated to cluster eight, ‘non-psychotic chaotic and challenging disorders’ (NPCC). Mean sub-scale scores from the PDO sample were compared with those for the published NPCC sample.

Lee et al.¹⁸⁶ only present MOHOST sub-scale scores (not item level data) and insufficient data to compare the differences with PDOs statistically. Due to this limitation, a meaningful difference was defined as where the published means for the MOHOST sub-scales in the UKMH and NPCC samples fell outside the 95% confidence interval from the mean MOHOST sub-scale scores in the PDO sample. This was informed by a logical assumption that the two distributions were meaningfully different if the published mean fell outside the 95% confidence interval for the mean scores in the PDO sample.

An alternative to testing statistical significance is to determine if there is a minimal clinically important difference (MCID). MCID is the smallest change in score that can be recognised by the patient (or clinician) in the concept being measured.¹⁸⁸ As MCIDs have not been established for MOHOST items, a pragmatic approach was taken. MCID was determined as a difference in score of 0.5, as this difference would permit someone to move between levels on the ordinal scale on an individual basis (e.g. from an item inhibiting occupational participation to allowing occupational participation). Due to the pragmatic assumptions, for a result to be considered a MCID there had to also be a meaningful difference in the distributions.

OPHI-II SCALES ITEM SCORES IN PDO SAMPLE

Mean scores on the items in each of the three OPHI-II scales were calculated and used to identify trends within the PDO sample in areas of strength (above 3.5 when rounded to the nearest 0.5) and impairment (below 2.5 when rounded to the nearest 0.5).

As with MOHOST items, items of impairment were compared to features of dissocial personality disorder and emotionally unstable personality disorder from the ICD-10.²

OPHI-II SCALE SCORES IN COMPARISON TO OTHER SAMPLES

OPHI-II scale scores were compared to published calibration scores for people with physical disability and no diagnosis.¹⁸⁵ Statistical analysis was not possible as spread around these calibrations were not reported. No MCIDs have been established on OPHI-II items or scales for different diagnoses, or at group or individual levels. The Rasch analysis method of weighting items differently in conversion to interval data prevented pragmatic assumptions about MCID. Therefore, a meaningful difference in mean scores was noted where the published calibration scores fell outside the 95% confidence interval for the mean scores in the PDO sample.

WITHIN GROUP COMPARISONS

Between group analysis was conducted to identify statistically significant differences and MCIDs between groups by sex, age, ethnicity, offence type and employment status. MOHOST sub-scales and the OPHI-II scale scores were assumed to be representative of interval data or converted to interval data respectively. Initial analysis indicated the distributions were not normal across items or scales on either measure. This prevented use of a parametric test with good efficiency and ability to account for sample size, such as the t-test. The non-parametric alternative, Mann Whitney-U tests, were the most appropriate statistical test to compare item scores between groups.¹⁸⁹

For individual items and sub-scales from the MOHOST and the OPHI-II items, any statistically significant differences between means were also judged for MCID using the same criterion as above (a mean difference of greater than 0.5). The OPHI-II full scales of occupational identity, competence and settings were compared statistically. It was not possible to assume about the MCID on this tool.

Quantitative data analysis was supported by SPSS.¹⁹⁰

4.4 RESULTS

4.4.1 PARTICIPANTS

Data saturation was achieved after 16 interviews. Two outstanding appointments for interview were honoured and recruitment ceased at 18 participants. Demographic characteristics are summarised in Table 4-2.

Table 4-2 Participant demographics

	Number (%)
Sex	
Male	13 (72)
Female	5 (28)
Age	
Under 35	11 (61)
35+	7 (39)
Ethnicity	
Caucasian	13 (72)
BAME*	5 (28)
Offence type	
Violent	13 (72)
Sexual	5 (28)
Employment status	
Employed	5 (28)
Unemployed	13 (72)

*Black, Asian or Minority Ethnic

4.4.2 MOHOST ITEMS

Figure 4-3 shows the mean MOHOST item scores among the PDO sample.

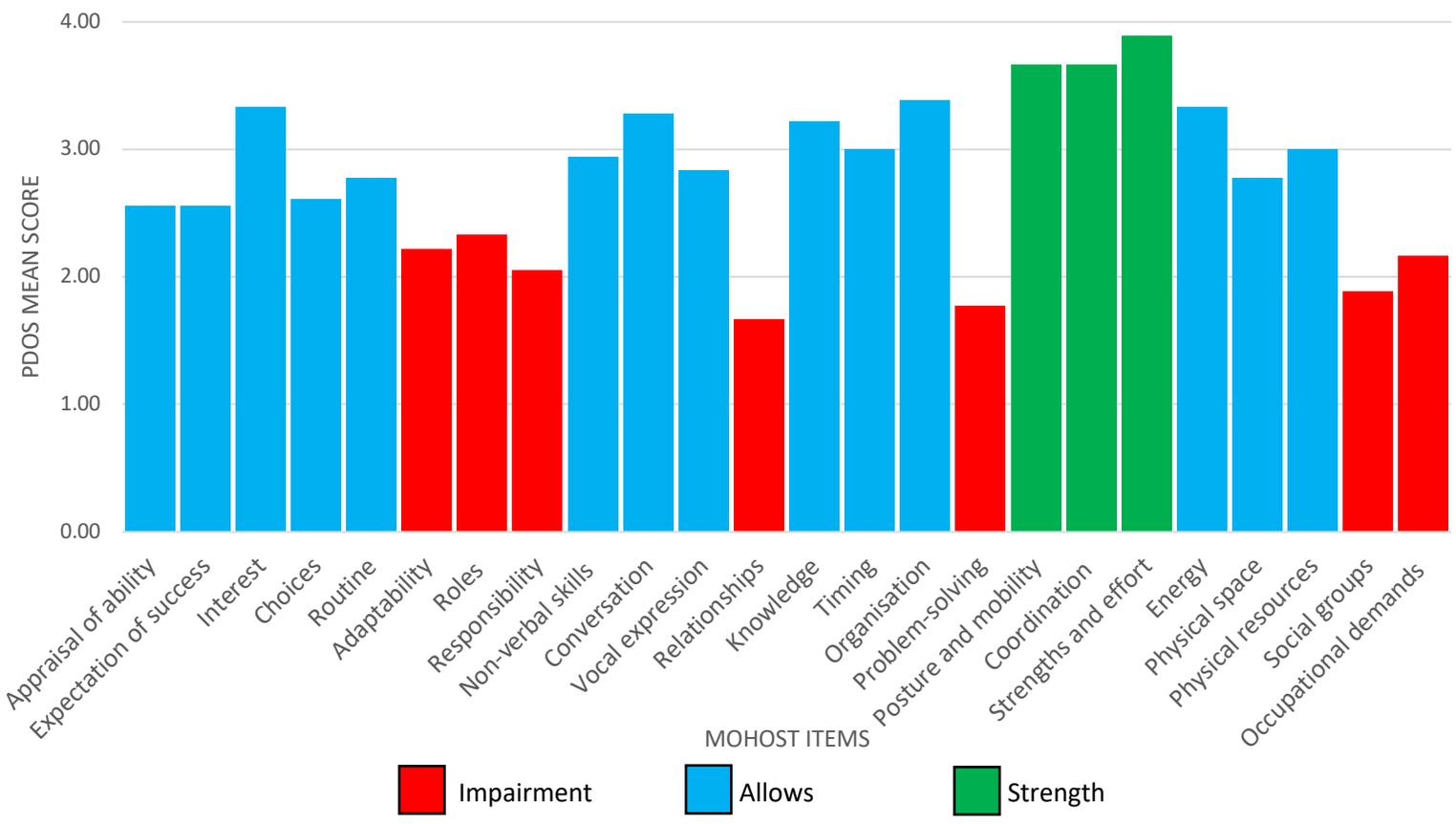
Items which scored below 2.5 on average, indicating an impairment, were 'adaptability', 'roles', 'responsibility', 'problem solving', 'social groups' and 'occupational demands'. These are highlighted in red.

Items scoring above 3.5 on average, indicating a strength were 'posture and mobility', 'co-ordination' and 'strength and effort'. These are highlighted in green.

Items with a mean score of three (when rounded to the nearest 0.5) on an individual basis, would indicate the item 'allows' occupational participation. These are represented in blue.

Appendix C shows the key concepts of each item scored below 2.5 on average, the indicators for giving a low score, and compares the items to descriptors of dissocial and emotionally unstable personality disorder. With the exception of occupational demands, the items which on average were scored as indicating impairment are reflected in descriptors of dissocial and emotionally unstable personality disorder. Occupational demands is reflected in the general descriptor of personality disorder, whereby behaviours are categorised as outside cultural norms.

Figure 4-3 MOHOST item scores in PDO sample



4.4.3 MOHOST SUB-SCALES IN COMPARISON TO PUBLISHED SAMPLES

PDOs mean scores for the six MOHOST sub-scales were compared to mean scores in the UK mental health sample (UKMH) and the non-psychotic chaotic and challenging (NPCC) sample.¹⁸⁶ Demographic comparison between the three samples is summarised in Table 4-3. Figure 4-4 shows a graph comparing the mean scores. Mean score comparisons and confidence intervals are reported in Table 4-4.

Table 4-3 Demographic comparison with published MOHOST sample

	PDO sample	UKMH sample	NPCC sample
Men % (n)	72.2 (13)	43.7 (273)	43.5 (7)
Women % (n)	27.8 (5)	56.3 (352)	56.3 (9)
Mean age in years (sd)	36.2 (10.6)	58.8 (22.1)	46 (not reported)
Employed % (n)	27.8 (5)	7.9 (29)	Not reported

Figure 4-4 Mean MOHOST sub-scales scores in PDO, UKMH and NPCC samples

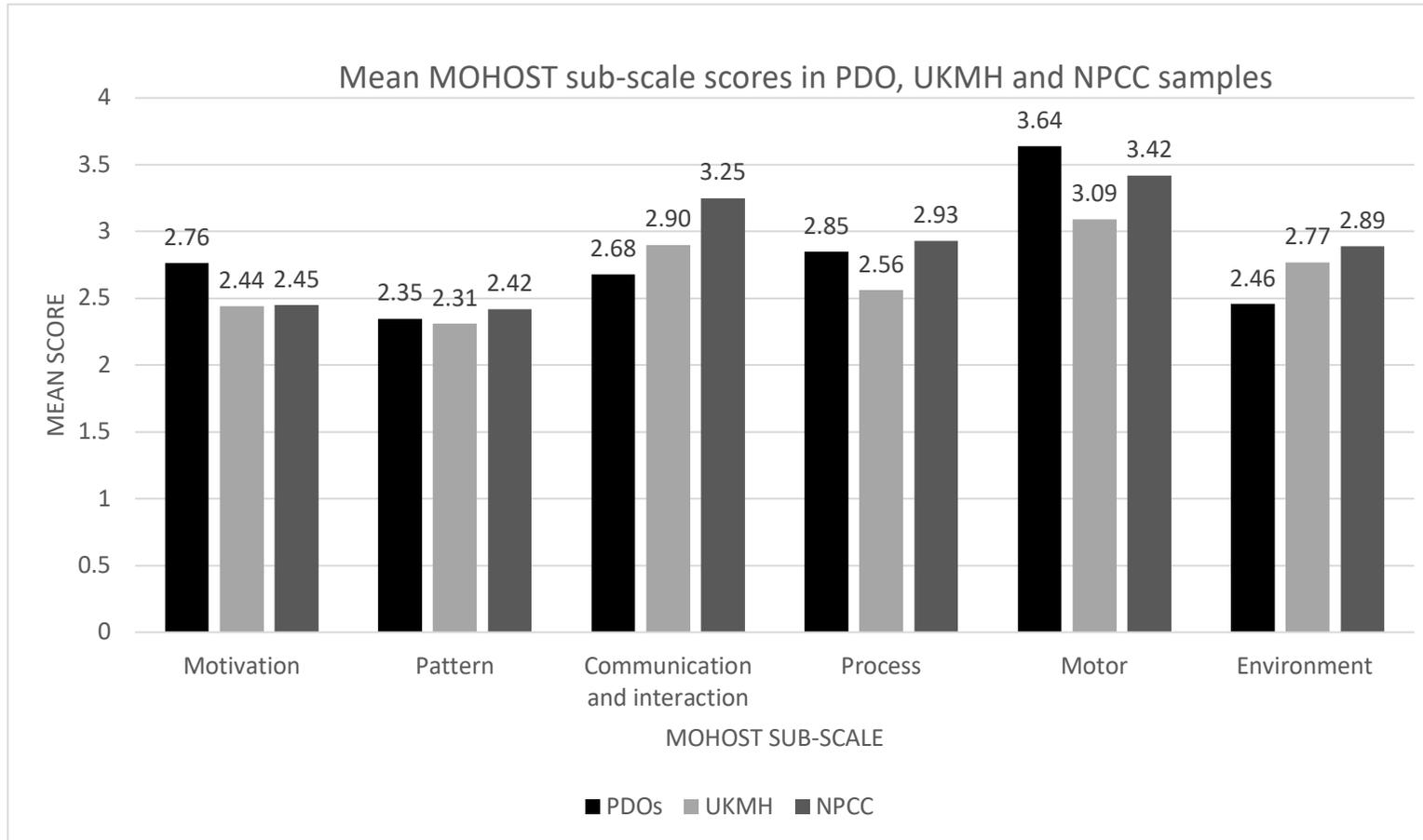


Table 4-4 PDOs mean MOHOST sub-scale scores and confidence intervals compared with published means

MOHOST Subscale	Mean PDO	Standard Error	Lower bound	Upper bound	Mean UKMH	Mean NPCC
Motivation	2.76	0.87	2.58	2.95	2.44	2.45
Habituation	2.35	0.13	2.07	2.63	2.31	2.42
Communication and interaction	2.68	0.16	2.35	3.01	2.90	3.25
Process	2.85	0.12	2.59	3.10	2.56	2.93
Motor	3.64	0.12	3.38	3.90	3.09	3.42
Environment	2.46	0.11	2.22	2.69	2.77	2.89

Compared to the UKMH sample, the PDO sample was on average younger (mean 36.2 years, s.d. 10.6 vs mean 58.8 years, s.d. 22.1), contained a higher proportion of men (72.2% vs 43.7%) and was more likely to be employed (27.8% vs 7.9%). The mean motor skills sub-scale score was the only comparison that reached the pre-defined MCID. The PDO sample scored higher on average (PDOs 3.64, CI 3.38-3.90, UKMH 3.09). This difference was not sustained for the NPCC sample.

Compared to the NPCC sample, the PDO sample was on average younger (36.2 years, s.d. 10.6 vs 46.0 years, s.d. not reported) and contained a higher proportion of men (72.2% vs 43.5%). Employment rates could not be compared. The mean communication and interaction skills sub-scale score was the only comparison to reach the pre-defined MCID (PDOs 2.68, CI 2.35-3.01, NPCC 3.25) with the PDO sample scoring lower on average.

Several published mean sub-scale scores fell outside the 95% confidence interval for the PDO sample, but did not differ by 0.5 or more to reach a MCID (Table 4-4). On average the PDOs appeared to have higher motivation and process skills but a less supportive environment than the UKMH sample. On average PDOs were more motivated and had less supportive environments than the NPCC sample.

4.4.4 OPHI-II SCALE ITEMS

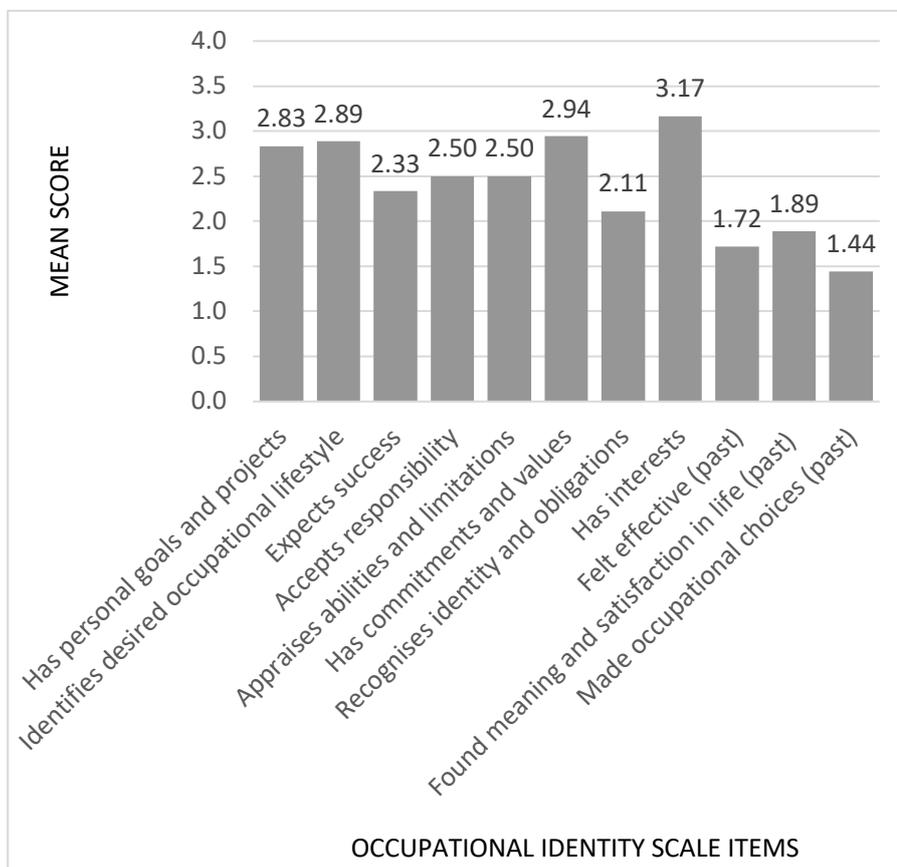
Appendix C shows the key concepts of each item scored below 2.5 on average, indicators for giving a low score, and any relationship to descriptors of personality disorder in the ICD-10.² The relationship was less clear between OPHI-II items and ICD-10 descriptors of dissocial and emotionally unstable personality disorder. OPHI-II goes into depth on internal experience and relating this to occupational participation, whereas

ICD-10 descriptors focus more on observable behaviours that are not explicitly linked to participation in roles or activities.

OCCUPATIONAL IDENTITY SCALE

Figure 4-5 shows that on the Occupational Identity Scale items, five of the eleven items were identified as areas of impairment (scored below 2.5 on average): ‘expects success’, ‘recognises identity and obligations’, ‘felt effective in the past’, ‘found meaning and satisfaction in lifestyle in the past’, and ‘made choices in the past’. The only item to reach an average score of three (on an individual basis this would indicate good/appropriate/satisfactory occupational functioning) was ‘has interests’. No items scored above 3.5 on average to indicate strengths in occupational identity.

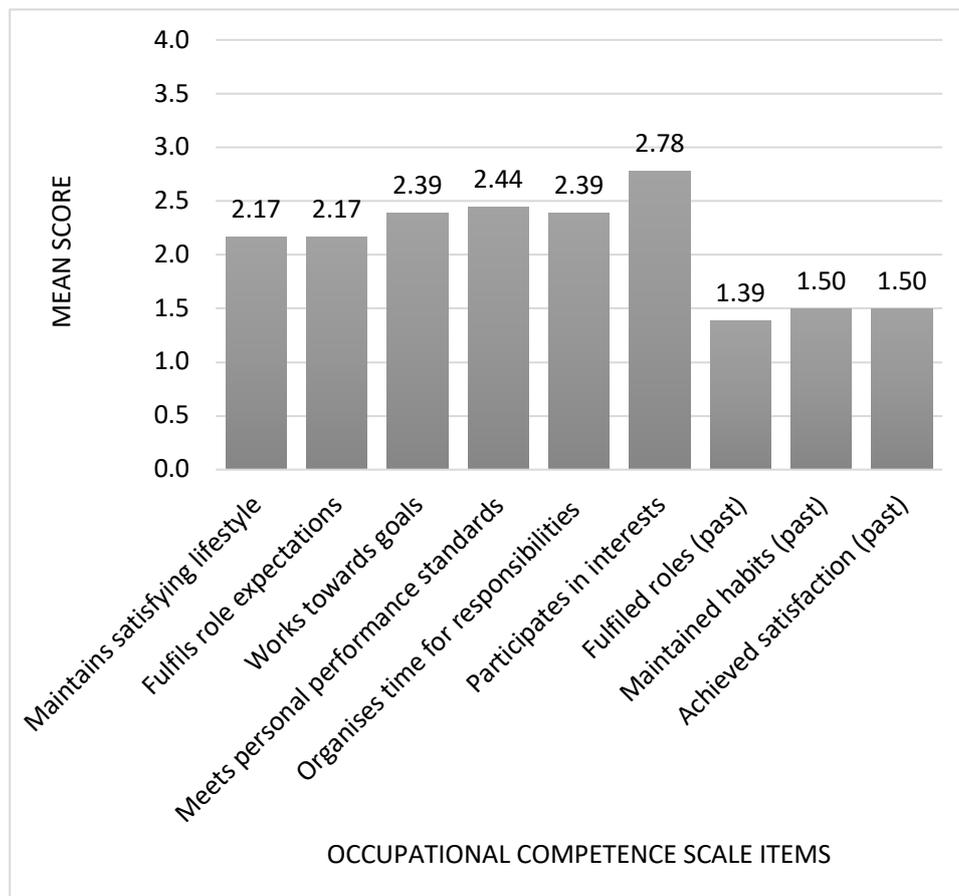
Figure 4-5 PDOs mean Occupational Identity Scale item scores



OCCUPATIONAL COMPETENCE SCALE

Figure 4-6 shows that on the Occupational Competence Scale items, eight of the nine items were identified as areas of impairment (scored below 2.5 on average): 'maintains a satisfying lifestyle', 'fulfils role expectations', 'works towards goals', 'meets personal performance standards', 'organises time for responsibilities', 'fulfilled roles in the past', 'maintained habits in the past', and 'achieved satisfaction in the past'. The only item approaching an average score of three (on an individual basis this would indicate good/appropriate/satisfactory occupational functioning) was 'participates in interests'. No items scored above 3.5 on average to indicate strengths in occupational competence.

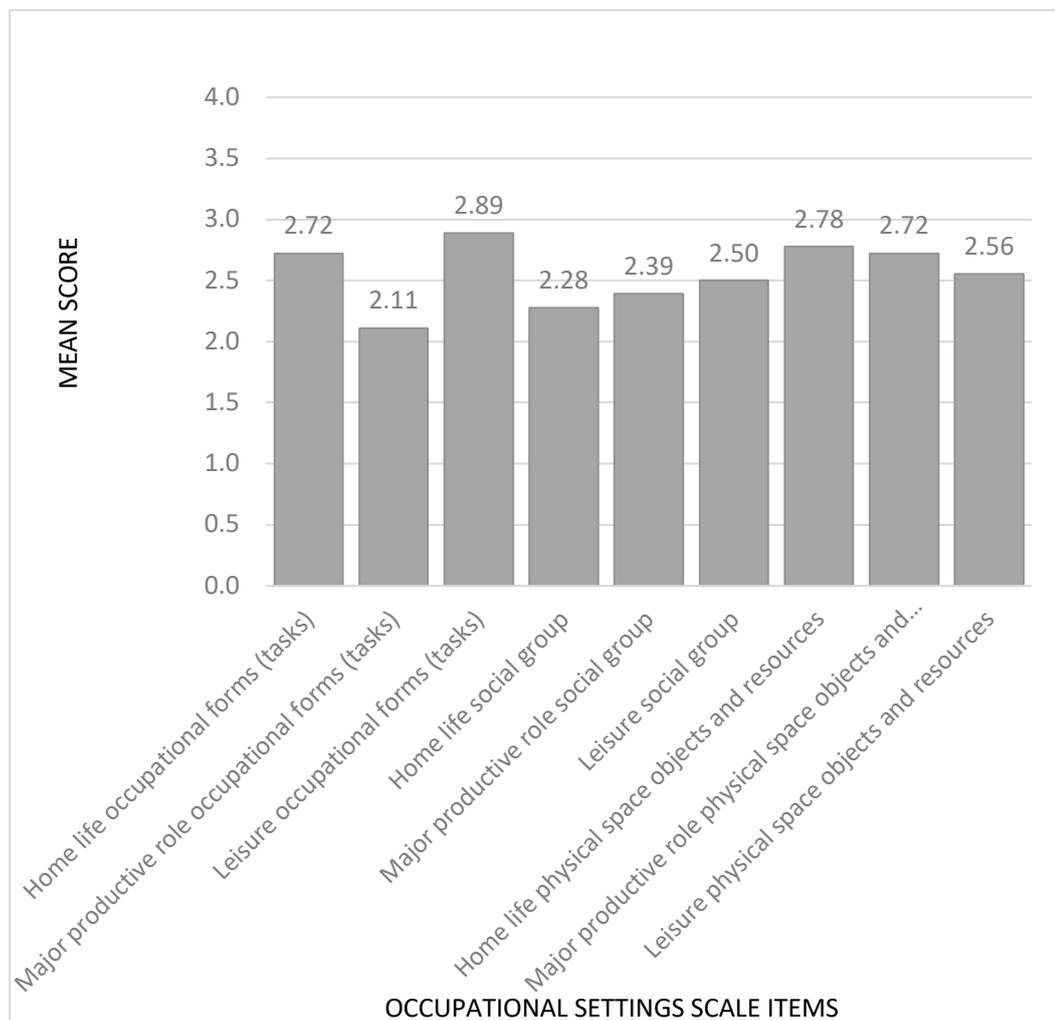
Figure 4-6 PDOs mean Occupational Competence Scale item scores



OCCUPATIONAL SETTINGS SCALE

Figure 4-7 shows that on the Occupational Settings Scale items, three of the nine items were identified as areas of impairment (scored below 2.5 on average): 'major productive role occupational forms (tasks)', 'home life social group', and 'major productive role social group'. Two items were approaching an average score of three (on an individual basis this would indicate good/appropriate/satisfactory occupational functioning): 'leisure occupational forms' and 'home life physical space, objects and resources'. No items scored above 3.5 on average to indicate strengths in occupational settings.

Figure 4-7 PDOs mean Occupational Settings Scale item scores



Most participants scored in a way that deviated from the expectations set out in the manual, i.e. scoring lower on items considered easier than those considered more challenging. The manual advises that either the measure is assumed not to be working as intended, or that these unexpected scores are excluded during conversion to interval data to produce an adjusted score. The areas where the PDOs scores deviated most markedly were on ratings of past occupational identity and occupational competence. Because the influence of the past was confirmed to be an important influencing factor in the other sub-studies (reported in Chapters Five and six), the adjustment was made to explore how much this may influence scores on existing psychometric measures.

Figure 4-8 shows the mean adjusted and unadjusted scores alongside the calibration scores reported for people with physical health conditions and no diagnoses.¹⁸⁵ Table 4-5 shows the mean adjusted and unadjusted OPHI-II scale scores and 95% confidence intervals beside published calibration scores.

Before adjustments, PDOs scored noticeably lower than people with physical disability or no diagnosis on the Occupational Identity Scale and Occupational Competence Scale. The calibration scores in both comparison samples fell *outside* the 95% confidence interval in the PDO sample, indicating a meaningful difference. The Occupational Settings Scale scores did not require adjustment. PDOs had a lower mean score. Only the calibration score for the no diagnoses sample fell outside the 95% confidence interval in the PDO sample, indicating a meaningful difference.

Following adjustments, the calibration scores on Occupational Competence Scale in both comparison samples fell *within* the 95% confidence interval in the PDO sample, suggesting no meaningful difference. The calibration

score on the Occupational Identity Scale in both comparison samples *remained outside* the 95% confidence interval in the PDO sample, sustaining the meaningful difference indicated before adjustment.

Figure 4-8 PDOs adjusted and unadjusted mean scores on OPHI-II scales compared with published calibration scores

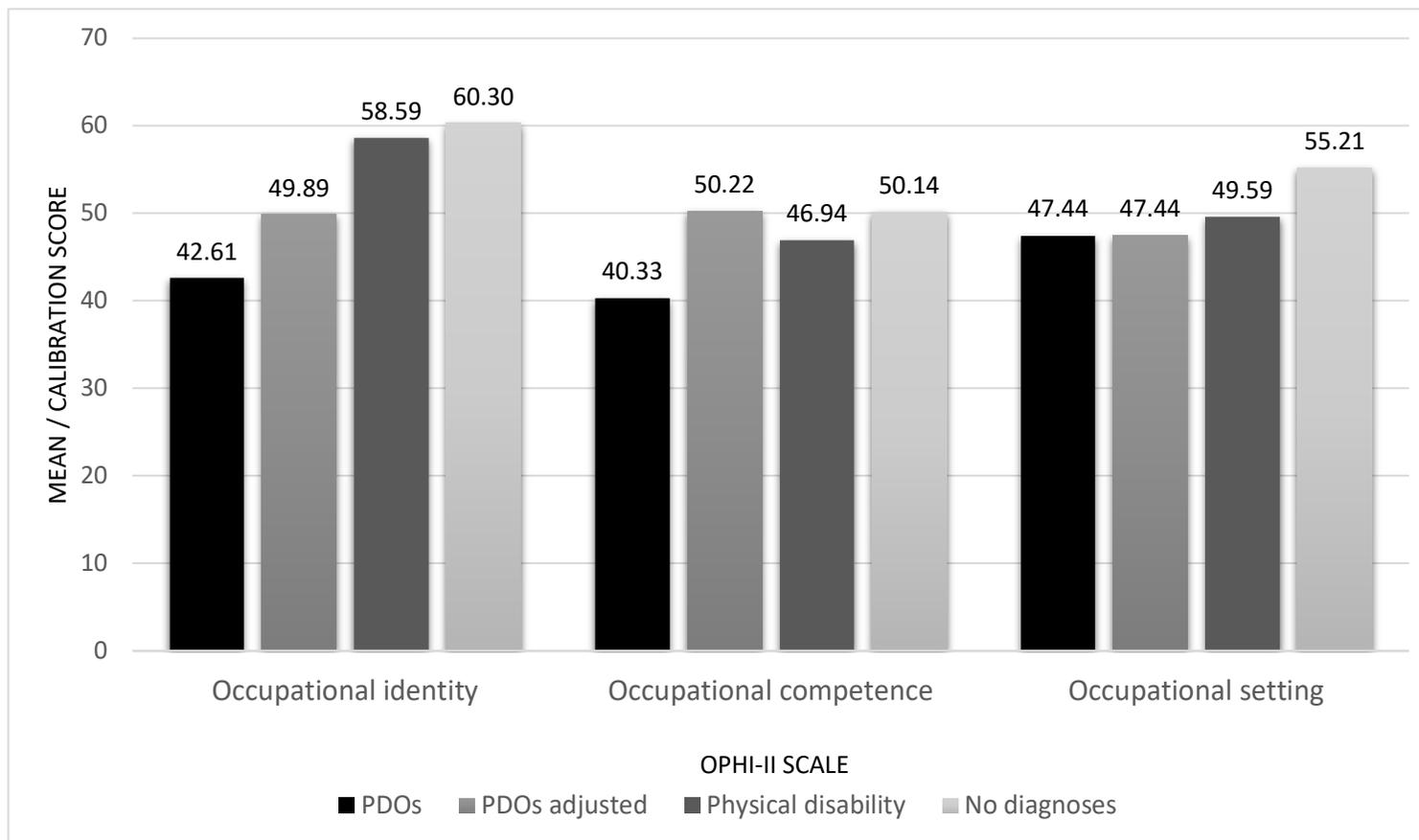


Table 4-5 PDOs OPHI-II Scale mean scores and confidence intervals compared with published means

OPHI-II Scale	PDO mean	Standard error	Lower bound	Upper bound	Physical disability mean	No diagnoses mean
Identity	42.61	2.17	38.03	47.19	58.59	60.3
Competence	40.33	2.77	34.47	46.19	46.94	50.14
Settings	47.44	2.68	41.79	53.09	49.59	55.21
Identity (adjusted)	49.89	2.79	44.01	55.77	58.59	60.3
Competence (adjusted)	50.22	2.7	44.53	55.92	46.94	50.14

4.4.5 STATISTICALLY SIGNIFICANT DIFFERENCES WITHIN THE PDO SAMPLE

COMPARISON BETWEEN MEN AND WOMEN

Statistically significant differences were identified in MOHOST item scores for ‘non-verbal skills’ ($p=0.041$) and ‘timing’ ($p=0.046$), with women on average scoring higher than men.

On the OPHI-II items, the only statistically significant difference was on the score for ‘have felt effective in the past’, where women scored lower than men on average ($p=0.046$).

There were no differences on the MOHOST sub-scales or OPHI-II scales.

COMPARISON BY AGE

No statistically significant differences were found between those aged 35 and under, or over 35.

COMPARISON BY ETHNICITY

Participants from a Black Asian or Minority Ethnicity (BAME) background scored higher on average than Caucasian participants on all areas where statistically significant differences were identified. Table 4-6 lists these.

Table 4-6 Comparison by ethnicity: Statistically significant results

	P value
MOHOST items	
Routine	0.046
Adaptability	0.026
MOHOST subscales	
Communication and interaction	0.046
OPHI-II items	
Has personal goals and projects	0.019
Major productive role occupational forms	0.035
Major productive role social groups	0.026
Leisure physical space, objects and resources	0.026
OPHI-II scales	
Occupational settings	0.026

COMPARISON BY OFFENCE TYPE

No statistically significant differences were found between participants on the basis of the offence for which they were on probation, being either violent or sexual.

COMPARISON BY EMPLOYMENT STATUS

In all areas where statistically significant differences were identified, participants in employment scored higher on average than unemployed participants. These are listed in Table 4-7.

Table 4-7 Comparison by employment status: Statistically significant results

	P value
MOHOST items	
Responsibilities	0.046
Problem solving	0.046
MOHOST subscales	
Habituation	0.046
OPHI-II items	
Has personal goals and projects	0.019
Made occupational choices in the past	0.019
Maintains a satisfying lifestyle	0.014
Fulfils role expectations	0.026
Works towards goals	0.026
Organises time for responsibilities	0.003
Participates in interests	0.035
Fulfilled roles in the past	0.026
OPHI-II scales	
Unadjusted occupational identity	0.003
Unadjusted occupational competence	0.001
Adjusted occupational identity	0.007
Adjusted occupational competence	0.002

4.5 DISCUSSION

Four interviewer-rated assessments of factors that influence occupational participation were completed for 18 participants. Scores were examined for trends in the PDO sample and compared with published data from other samples to ascertain if there was a minimal clinically important difference between means. Statistically significant differences were identified within the PDO sample using Mann-Whitney U Tests to compare results by sex, age, ethnicity, offence type and employment status.

4.5.1 MOHOST

PDOs presented with a pattern of scores on the MOHOST that indicated most impairment in the areas of adaptability, roles, responsibility,

relationships, problem solving, social groups and occupational demands. This is unsurprising given the recognition of these concepts within diagnostic criteria for personality disorder.² For example, a low score for adaptability would be awarded where a person 'desires immediate satisfaction, lacks patience despite all attempts to support change... is volatile, explosive, aggressive, physically violent or verbally abusive in relationship to change'. This is reflected in criteria for dissocial personality disorder when a person exhibits 'very low tolerance to frustration and a low threshold for discharge of aggression, including violence'. It is also reflected in criteria for emotional unstable personality disorder where a person whose 'outbursts of intense anger may often lead to violence or "behavioural explosions"; these are easily precipitated when impulsive acts are criticised or thwarted by others'. Appendix C shows how all areas of impairment on MOHOST items relate to criteria for personality disorder.

When the PDOs mean scores on the six MOHOST sub-scales were compared to a UKMH sample, the only area of difference was 'motor skills.' This likely reflects the younger age of the PDOs and the inclusion of people with dementia in the UKMH sample.

Compared to the NPCC sample, mean score was lower among PDOs on the MOHOST sub-scale 'communication and interaction' which includes the item 'relationships', on which PDOs had marked impairment. A lower score on the communication and interaction subscale suggests the addition of an offending history to the experience of personality disorder causes further difficulties interacting with others. Former forensic mental health inpatients with psychotic disorders were fearful of stigma and experienced rejection even within the mental health community due to their offending histories. This led to hesitance about participating in social relationships.¹⁹¹ In a study of released prisoners, in the USA, anticipated stigma was predictive of lower community participation. Though this was not a sample of PDOs, it is likely that some of the participants would have met diagnostic

criteria for personality disorder given its high prevalence in the adult prison population.¹⁹² Additional stigma due to an offending history may contribute to the lower 'communication and interaction' sub-scale score among PDOs by reducing confidence to engage in social relationships.

4.5.2 OPHI-II

Item scores on the OPHI-II scales showed impairment on many of the items. Impairments were most severe on the items related to past occupational identity and past occupational competence. This is likely because all participants described past adversity, abuse, failure in normal developmental roles and participation in 'deviant lifestyles'. This continued to impact markedly on their occupational participation and is discussed more fully with the qualitative findings in Chapters Five and Six.

According to the Rasch analysis process, items rating the past should be easiest to score highly on. The lowest scores being on these items among the PDOs meant the OPHI-II scores did not fit the expected pattern.¹⁸⁵ One option advised in the manual is to exclude these unexpected scores. This produced higher scores on the Occupational Identity Scale and Occupational Competence Scale. However, the adjustment is problematic for two reasons. Firstly, adjusting the scores potentially resulted in an inflated representation of PDOs true occupational competence and occupational identity. This would suggest to an assessor that a person has fewer difficulties in occupational participation than are actually experienced. Using the unadjusted scores may give a more accurate representation of the degree of impairment. Secondly, the adjusted scores did not reflect the influence of the past on current occupational participation. One of the core assumptions of the OPHI-II scales is that occupational identity and occupational competence are shaped over time

by occupational participation. Excluding items that detail the past undermines the construct validity of the OPHI-II scales.

The alternative option suggested by the manual is conclude that the OPHI-II may not be working as intended for this population. However, this may be a premature conclusion. The reason the unexpected pattern occurred is because, as stated in the manual, the OPHI-II scales are based on the assumption that people would present to a service following a deterioration in occupational participation on account of illness or injury. As will be seen more clearly in Chapter Six, the PDOs did not self-present for assistance and their current occupational participation was, at worst, a continuation of the low levels it had always been at. Past or current participation in 'antisocial' occupations are scored low on the scales but these 'deviant' developmental trajectories need to be considered for their impact on someone's occupational participation in the present. Occupational participation among PDOs cannot be fully explained if the impact of participation in antisocial activities and roles are ignored, as occurred when removing scores in the adjustment process. Therefore, it does appear that the tool was working as intended, by demonstrating the marked impact of past occupational participation on the present. It is the expected pattern that requires alteration, as it is based on an assumption that doesn't apply to PDOs.

Lower scores on the three OPHI-II scales compared to people with no diagnosis is unsurprising. UK government surveys consistently demonstrate that people with a disability are significantly less likely to participate in activities and roles (e.g. employment, volunteering, cultural activities, leisure, sport) than people without a disability.¹⁹³ Compared to people with physical disability, PDOs had lower unadjusted occupational competence and unadjusted occupational identity. The impact on occupational participation of having committed an offence and having a personality disorder may be greater than the impact of physical disability.

4.5.3 WITHIN SAMPLE COMPARISONS

Most statistically significant differences were found when comparing participants who were employed with those who were unemployed. This comparison was also the only one to identify statistically significant differences in occupational identity and occupational competence. Employment status was taken as a proxy for successful occupational participation, so higher scores would be expected. This suggests the OPHI-II scales may be sensitive enough to identify different levels of occupational participation in a PDO sample.

The second largest number of statistically significant differences were found when comparing participants from different ethnic backgrounds. Participants who were from a BAME background scored higher on average than Caucasian participants on these items. This was the only comparison to identify difference on the Occupational Settings Scale, which captures physical and social environmental influences on occupational participation. Differences suggest PDOs from BAME backgrounds may be more likely to have access to physical and social environments that facilitate occupational participation. Supportive environments would include those where stigma was not experienced or expected. Moore, Stuewig and Tagney¹⁹² found that despite equal levels of anticipated stigma between Caucasian and African American people released from prison, stigma only predicted impaired community participation in Caucasian participants. The authors hypothesised that the African American participants had experienced stigma and discrimination on the grounds of race and were thus better psychologically prepared and protected against it, which enabled them to more successfully participate in the community environment. However, the transferability of the results to the UK context is limited by the differences in criminal justice policy, and historical and cultural influences on perceptions of ethnic/racial difference. Additionally, the division between

Black and Caucasian overlooks differences between people from other ethnic backgrounds.

In the UK, national survey data indicates a mixed picture when comparing the degree to which people of different ethnic backgrounds feel a sense of belonging to and integration into their community environment. People from an Asian (64%) or mixed ethnicity (65%) background are more likely than white (61%) or black (60%) respondents to feel that they belong in their neighbourhood. Asian respondents experienced a higher sense of community integration (85%) compared to black (77%) or white (81%) respondents.¹⁹⁴ Given the small sample size in this research, exploration in a larger sample is needed to determine the nature and degree of any environmental differences experienced by people from different ethnic backgrounds, if and how this relates to occupational participation, and whether a supportive environment mediates the relationship between anticipated stigma and occupational participation among PDOs. Nonetheless, intervention development and delivery should consider potential differences in the experience of occupational participation for people from different ethnic backgrounds to maximise its cultural sensitivity.

Few statistically significant differences were identified between men and women, and these were only at item level. The different experiences of men and women are argued to warrant gender-specific interventions for PDOs.⁸⁹ Further evidence for the differences between men and women in the factors influencing occupational participation would need to be confirmed in a larger sample to justify developing different interventions at this stage, though gendered experiences of occupational participation should be considered within any intervention.

There was no difference in occupational participation between older and younger participants. Criminologists have argued for a maturational effect

that results in less crime as people age,^{195, 196} and there is evidence for a symptomatic recovery from personality disorder over time.^{197, 198} However, despite symptomatic remission for 78% of people with borderline personality disorder after eight years, only 40% achieve good social and vocational functioning.¹⁹⁸ The lack of difference in occupational participation between older and younger PDOs indicates that even if people desist and experience a resolution of their more problematic personality traits, impairments in occupational participation may remain.

It is often argued that people with a sexual offending history are a stigmatised group, even within groups of offenders,¹⁹⁹ a stigma which is associated with avoidance of community participation.²⁰⁰ No statistically significant differences in scores were identified in the PDO sample between those with a sexual or violent index offence. Difficulties in occupational participation associated with having committed a serious violent offence may be equally as problematic as those resulting from a history of sexual offending. Alternatively, the severity of personality difficulties may overshadow difficulties in occupational participation associated with having committed either type of offence.

These results should be considered preliminary on account of the small sample sizes involved. Nonetheless, differences were identified using conservative comparisons which warrant further examination in a larger sample. This would clarify whether there are robust statistically significant and clinically important differences in the factors influencing occupational participation for PDOs compared to other populations, and between sub-groups of PDOs with different demographic characteristics. This knowledge would enable tailoring of intervention development and delivery to demographic characteristics at group or individual level.

4.5.4 STRENGTH AND LIMITATIONS

Although using a small and non-random sample, this is the first research to use assessment of occupational participation with PDOs in the community. Mann-Whitney U-tests were used for within sample comparisons, which is appropriate for non-normal distributions but less sensitive than their alternative parametric statistical tests. Nonetheless, statistically significant differences were identified.

There are no population norms for MOHOST scores to which the PDO sample could be compared. Comparing PDO scores with the UKMH and NPCC sample, both groups with high levels of impairment, may suggest the levels of difficulty experienced by PDOs are less concerning than if they were contrasted with scores among people with no diagnosis. Differences were still identified despite the highly impaired comparison group, although the parameters for MCID were arbitrarily set in a pragmatic approach. The PDO and NPCC samples were small, and it was not possible to ascertain if differences were statistically significant. Several of the published means fell outside the 95% confidence interval for the PDO sample but did not reach a difference of at least 0.5. Conducting this analysis with larger samples, including people with no diagnoses or offending history, would be beneficial for identifying the degree of impairment experienced by PDOs and to ensure interventions are designed to target the relevant factors.

Having a single rater of the assessments ensured consistency but does not guarantee an absence of error bias. However, the assessments have been demonstrated to be reliable and valid through self-training with the manuals and I have several years of experience using both tools in clinical settings with PDOs.

4.6 CONCLUSIONS

Factors influencing occupational participation for PDOs in the community can be identified using existing interviewer-rated standardised assessments. Areas of impairment were consistent with descriptors of personality disorders common among people on probation, and consistent with the impact of having a history of difficulty in occupational participation.

The OPHI-II scales often did not produce an expected pattern of scores for occupational identity and occupational competence. These results highlight problems with the assumptions of the OPHI-II, namely that people have achieved a socially valued occupational identity and occupational competence to support it in the past. The unadjusted OPHI-II scale scores, that include past impairments, may more accurately represent PDOs levels of occupational participation than excluding 'unexpected' scoring. It would also maintain the OPHI-II scales construct validity.

Statistically significant differences in scores were identified when sub-groups were compared on the basis of sex, ethnicity, and employment status, but not age or offence type. However, the small sample size indicates these are tentative and should be further investigated in a larger sample.

4.7 IMPLICATIONS

4.7.1 IMPLICATIONS FOR PRACTICE

- MOHOST and the OPHI-II scales can be used to identify factors that influence occupational participation for PDOs in the community

- OPHI-II scales should only be used as indicative until psychometric testing confirms the validity in populations whose past occupational participation has markedly deviated from social norms
- Scores on MOHOST and OPHI-II scales need to be contextualised within a person's experience of life with particular demographic characteristics

4.7.2 IMPLICATIONS FOR RESEARCH

- The Model of Human Occupation and associated psychometric measures warrant further examination with populations whose past occupational participation deviates from socially valued and expected norms
- Minimal clinically important differences should be developed for MOHOST and the OPHI-II scales to allow between sample and population comparisons

4.8 CHAPTER CONCLUSION

This chapter presented the results from the quantitative sub-study in Work Package Two (WP2). These results are integrated with the findings from two further sub-studies in Chapter Seven to produce conclusions about what influences occupational participation for PDOs in the community. The next chapter continues to report WP2, with the findings from the large qualitative sub-study.

5 IDENTIFYING WHAT INFLUENCES OCCUPATIONAL PARTICIPATION: PART TWO – QUALITATIVE

5.1 INTRODUCTION

This chapter reports the method and findings from the second sub-study in Work Package Two (WP2). Sub-Study Two was a qualitative study analysing participants' narratives collected at interview to identify influencers of occupational participation in the community. Findings are discussed followed by implications for practice and research.

5.2 RESEARCH QUESTION AND OBJECTIVES

WP2 answered the question: what influences occupational participation for PDOs in the community?

Objectives of this qualitative sub-study were:

- Conduct narrative and semi-structured interviews with participants
- Use a grounded theory informed approach to analyse participants' interview transcripts and identify commonalities in historical, current and potential future influences on occupational participation

5.3 METHOD

This section details the data collection and analysis methods of Sub-Study Two in WP2. Chapter Four describes how men and women with a history of

offending and a likely diagnosis of personality disorder (PDOs) were sampled and recruited from the National Probation Service (NPS). Throughout WP2 I maintained field notes containing factual accounts of the interviews, reflections and preliminary interpretations. These were not integrated into the analysis but were used to prompt reflexivity. Ideas developed from field notes are presented throughout this chapter in tables. These demonstrate the reciprocal influences between the data collection and analysis process, and myself as a researcher from a clinical background. The reflexive process highlighted considerations relevant to practice with PDOs.

5.3.1 DATA COLLECTION

Participants' narratives about occupational participation were collected at interviews. Interviews took place at the NPS office where the participant attended routine supervision with their Offender Manager. This section describes the process of data collection, with more detail on the context provided in Section 5.4.

Interviews had two parts. First, participants were asked a broad open-ended question, "what is day-to-day life like for you?" This was to elicit narrative accounts of experiences that were important to the person or that they considered most relevant. Part two followed a semi-structured format from the Occupational Performance History Interview – Version Two (OPHI-II) which is included in Appendix B. The OPHI-II guides discussion of five themes that discuss past, present and future to inform construction of an occupational narrative. The interview themes were ordered to put the anticipated challenging questions (about 'critical life events') last. Daily routine was covered first as this was anticipated to be less intrusive and allow development of rapport and trust. Themes were:

- Daily routine
- Roles
- Environment
- Activity/occupational choices
- Critical life events (turning points)

Using both an unstructured and semi-structured approach ensured that the narratives of participants were not curtailed by interviewer questioning. Table 5-1 presents a reflection on this choice and the outcome, developed from field notes.

Table 5-1 Field note reflection: Effective interviewing

Field note reflection: Effective interviewing
<p><i>To avoid leading participants, the open-question was used first. Most participants struggled to provide a narrative with the broad open question, often answering with one or two words, for example “crap” or “it’s alright.” This may have been due to the participant often having experiences of questioning where someone (a representative of the state) was looking for a specific piece of information that they may or may not want to give, for fear it was used against them in some way. Alternatively, this population may not have been used to talking about their lives and lacked the range of language to describe their experiences. They may have been unsure of whether they could give a ‘true’ account to me without a negative judgement. This was unsurprising, based on my experiences in clinical practice with ‘new’ patients, the literature,²⁰¹ and input from the Patient and Public Involvement Advisory Group (PPIAG).</i></p> <p><i>When cuing with the semi-structured interview began this problem was largely overcome, indeed the opposite often occurred. This may be due to participants being more relaxed as they learned the kind of information I was interested in. As rapport with me built it possibly reduced anxiety about saying the wrong thing, and a trust developed that I could tolerate the accounts they would</i></p>

share.

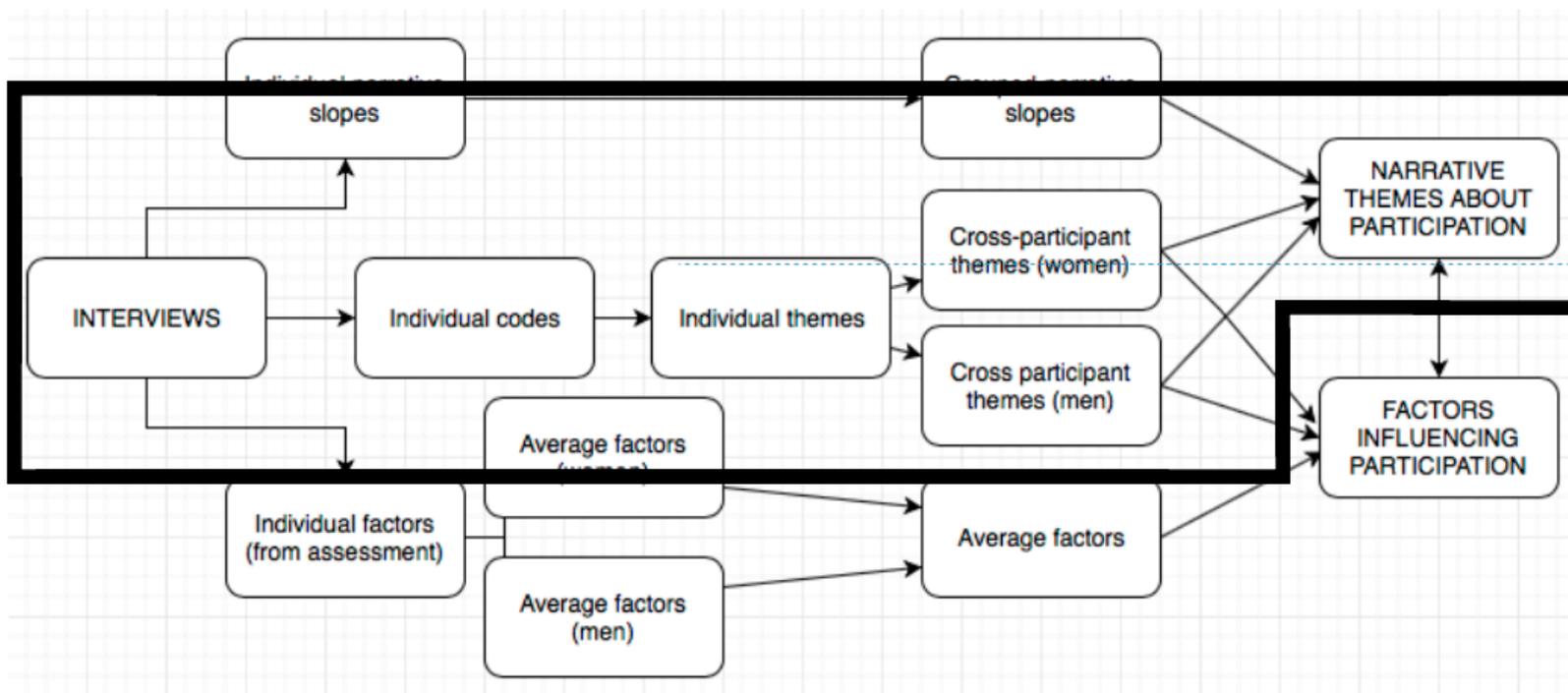
For some early participants I allowed the interview to go on too long. For example, in one interview, the participant frequently went off topic talking about his offence, the injustice and becoming emotionally aroused. Dealing with this in clinical practice is easier where you have the established relationship to challenge or contain someone through re-focusing on the aim of a session, and can go back if a session needs to be ended. Through supervision in my clinical role, I reflected that my prioritisation of narrative interviewing (e.g. minimal interruptions) was preventing me from accessing relevant information. This freed me to be more assertive bringing people back to topic as I would in the clinical setting. It required a compromise between collecting narratives uninterrupted, however it was important for collecting data relevant to occupational participation. I return to differences between clinical and research contexts and the tension between a desire to be therapeutic and curtailment by role, context and reality in later reflections.

There is potential for a participant to become preoccupied when talking or thinking about something that elicits an emotional response. Practitioners will need to be prepared, either through training or clinical experience, to assertively manage this in the context of an intervention to ensure that the intervention is not diverted from its aims (consciously or not), both parties are kept safe within it (not triggering unhelpful patterns of perceived rejection/disrespect that are linked to risk behaviours), and the person's engagement is maintained (does not irreparably damage trust that the intervention is of value).

5.3.2 DATA ANALYSIS

Figure 5-1 shows the process of data analysis for WP2 with analysis conducted in this sub-study highlighted.

Figure 5-1 Work Package Two data analysis: Qualitative sub-study highlighted



Analysis involved the following steps:

1. Interviews. Familiarisation with the data by conducting and transcribing interviews. Participants were given a pseudonym to protect their anonymity and during transcription identifying details were removed.
2. Individual codes. Transcripts were analysed using open coding to generate initial codes, remaining open to any potential themes and ideas.
3. Individual themes. Axial coding involved linking codes by comparing and contrasting within each participant interview to identify individual narrative themes. Initial connections were made with theoretical possibilities in field notes, which were revisited as the number of interviews increased.
4. Cross-participant themes. Thematic maps were separately developed for men and women. Appendix D shows an example of a thematic map. Themes were related to occupational participation and compared and contrasted across transcripts from participants of the same sex. Sixteen themes were identified for women and 19 for men. This deepened understanding of occupational participation by identifying commonalities and differences.
5. Narrative themes about participation. Themes from the men and women were compared and contrasted to produce 21 sub-themes. These were further compared and contrasted, maintaining occupational participation as the central focus, to develop the final four themes.

MAXQDA,²⁰² a mixed-methods data analysis programme, supported analysis. It includes features such as colour coding, memos, lexical searches and visualisations.

5.3.3 CREDIBILITY

Qualitative research cannot demonstrate reliability or validity in the same way as quantitative studies. Instead, it is evaluated for its credibility, which incorporates trustworthiness, transferability, dependability and confirmability.²⁰³ Table 5-2 describes these, and the strategies in this research that demonstrate credibility.

Table 5-2 Credibility concepts and strategies

Credibility concept	Strategies
<p>Trustworthiness Reader can be confident in the findings as they are supported by good quality data</p>	<ul style="list-style-type: none"> • Constant comparative methods: Concurrent data collection and analysis allowed ideas and potential themes to be clarified in subsequent interview. • Member checking: Participants confirmed whether the 21 sub-themes reflected their experiences (see Chapter Seven). • Triangulation: Findings were integrated with those from other sub-studies using the Pillar Integration Process²⁰⁴ (see Chapter Seven). • Direct quotation: Quotations presented to indicate that findings are rooted in the data • Regular supervision: Monthly research supervision was held throughout the WP to challenge thinking, decisions, conduct, analysis and write-up.
<p>Transferability Details enable reader to make comparisons and apply findings to other contexts</p>	<ul style="list-style-type: none"> • Context description: Descriptions of the regional demographics, recruitment sites, and researcher's background are presented in the next section. Wider context is included in the thesis introduction. • The PPIAG confirmed initial findings related to their experiences.
<p>Dependability Findings are repeatable as process and methods are clear</p>	<ul style="list-style-type: none"> • Methodological description: Reporting in this chapter. • Regular supervision (as above).

Continued overleaf

<p>Confirmability</p> <p>Findings are supported by the data collected, as the researcher neutrality and attempts to mitigate bias are clear</p>	<ul style="list-style-type: none"> • Reflexive statement: Prior to the sub-study, a reflexive position statement summarised pre-existing thoughts, ideas and beliefs about the study, population and potential findings. This was referred to throughout to challenge interpretations and analysis, mitigating for confirmation bias. It informed the reflective excerpts that illustrate how clinical and academic perspectives were active throughout. • Field notes: Account of the interview process, thoughts and personal reactions were maintained throughout WP2. These were scrutinised for any impact on decisions, conduct, analysis. • Independent secondary analysis: A proportion of interviews were coded by a senior researcher (EAM) experienced in narrative methods. Codes were consistent. • Direct quotation: (as above).
---	--

5.4 CONTEXT DESCRIPTION

A description of the research context enables findings to be appraised by the reader for their transferability to other settings. Further, context is an important consideration in intervention development (and evaluation), as there may be context-specific mechanisms that influence a phenomenon, or that moderate or mediate the phenomenon's existence and the effects of any intervention on it. By detailing the context in which an intervention is developed, findings can be used to understand why a future intervention works, does not work or works differently from how it was anticipated to in different contexts.

5.4.1 REGION

This study was conducted in the West Midlands in the United Kingdom. Participants were sampled from National Probation Service (NPS) within the West Midlands Combined Authority (WMCA) area. The WMCA covers a region with a population of 2,834,000. It includes the large city of Birmingham, smaller cities Wolverhampton and Coventry, and five other large urban towns.

There is regional variation, with some areas of relative wealth and low diversity.²⁰⁵ However, compared to other city regions, the WMCA area has the highest unemployment rate (7.5% vs 4.7-5.1%), lowest employment rate, highest rate of Job Seekers Allowance claimants, highest number of people without qualifications and over double the national average level of ethnic diversity (29% vs 14%).²⁰⁵⁻²⁰⁷

5.4.2 INTERVIEW SETTING

Interviews were held at the NPS office where the participant attended routine appointments with their Offender Manager (this term incorporates probation officers at different levels of training and experience).

Participants were familiar with the layout of the buildings and the necessity to allow the researcher to sit closest to the door and/or adjacent to the call button. All interview rooms were fitted with CCTV and a telephone. They were bare, containing only a desk and a limited number of chairs, sometimes with posters advertising schemes and services available through the NPS. For initial meetings to gain informed consent, I either waited in an interview room and was joined there by the participant and their Offender Manager, or the participant and Offender Manager would meet first, and the participant would wait in the interview room while I was collected and then introduced. Offender managers then left for the consent taking process. For interviews, I usually collected the participant from the waiting area and showed them to the exit independently without the Offender Manager being present.

5.4.3 INTERVIEWER

I was transparent about my clinical background and ongoing employment in the National Health Service (NHS) as an occupational therapist in forensic services. Prior to commencing this research, I had worked in different mental health in-patient services across Birmingham. For three years I was the occupational therapist for a medium secure service for men with a diagnosis of personality disorder.

5.5 FINDINGS

5.5.1 PARTICIPANTS

Table 5-3 shows each participant's demographic data. Data is grouped to prevent participant identification. Categorisation by ethnicity and sex were made by NPS staff. Table 5-4 summarises the demographic characteristics of the whole sample.

Table 5-3 Individual participant demographics

Name	Employment	Age	Ethnicity*	Offence type	Gender/Sex
Jackie	Unemployed	35 or under	Caucasian	Violent	Female/ Woman
Ali	Employed	35 or under	BAME	Violent	Male/Man
Mark	Unemployed	35 or under	Caucasian	Sexual	Male/Man
Shelley	Unemployed	Over 35	Caucasian	Violent	Female/ Woman
David	Employed	35 or under	Caucasian	Violent	Male/Man
Angela	Employed	Over 35	Caucasian	Sexual	Female/ Woman
Jamie	Unemployed	Over 35	Caucasian	Violent	Male/Man
Faisal	Employed	35 or under	BAME	Violent	Male/Man
Loelle	Unemployed	35 or under	BAME	Violent	Female/ Woman
Marcia	Unemployed	35 or under	BAME	Violent	Female/ Woman
Paul	Employed	Over 35	Caucasian	Violent	Male/Man
Danny	Unemployed	Over 35	BAME	Violent	Male/Man
Steve	Unemployed	35 or under	Caucasian	Sexual	Male/Man
Aaron	Unemployed	35 or under	Caucasian	Violent	Male/Man
Richard	Unemployed	35 or under	Caucasian	Sexual	Male/Man
Michael	Unemployed	Over 35	Caucasian	Sexual	Male/Man
Brendan	Unemployed	35 or under	Caucasian	Violent	Male/Man
Gary	Unemployed	Over 35	Caucasian	Violent	Male/Man

*Grouped into 'Caucasian' and 'Black Asian or Minority Ethnic: BAME'

Table 5-4 Summary of demographic data in the whole sample

	Number (%)
Sex	
Men	13 (72)
Women	5 (28)
Age	
Under 35	11 (61)
35+	7 (39)
Ethnicity	
Caucasian	13 (72)
BAME	5 (28)
Offence type	
Violent	13 (72)
Sexual	5 (28)
Employment status	
Employed	5 (28)
Unemployed	13 (72)

5.5.2 NARRATIVE THEMES

Twenty-one sub-themes were identified by comparing and contrasting individual level themes between men and women, and then in the whole sample. These were further compared and contrasted to produce four overarching themes describing influencers of occupational participation. This section presents the sub-themes within each overarching theme and illustrates these with verbatim quotations to demonstrate a basis in the data. Table 5-5 shows each overarching theme and the sub-themes it represents.

Table 5-5 Narrative themes and subthemes

Function of occupation	
Responding to/ escaping unpleasant feelings <i>"I feel like crap... I just drink"</i>	Enacting identity <i>"The chance to be what they are"</i>
Avoiding an unpleasant feeling <i>"Avoid detection"</i>	Experience mastery <i>"I'm amazing myself I can do these things"</i>
Seeking a pleasant feeling <i>"Buzz"</i>	Status/significance (men only) <i>"In this world you either need the money or power"</i>
Creating stability/sense of security <i>"Prison set me that routine"</i>	
Influence of the past	
I've matured <i>"I'm all grown up now, you get me?"</i>	Turning points <i>"Put a fire in me"</i>
I've missed out <i>"I've missed out on quite a lot"</i>	Intruding past <i>"It's affected me like, severely"</i>
Consistent/lost occupations <i>"I used to enjoy it man"</i>	
External forces	
Mood and mental disorder <i>"Like a yo-yo"</i>	Interfering authorities <i>"We're not allowed so. Just a case of having to jump through hoops"</i>
External circumstances <i>"Everyday life, it happens, and there's nothing I can do about it"</i>	Helpful rescuers <i>"It's what I needed"</i>
	Faith and purpose <i>"God guides me"</i>
Learning and adaptation	
Learning adult norms <i>"What I'm doing now is what most people do when they're a teenager"</i>	Exploring <i>"Get around and travel a bit"</i>
Shaping a new identity <i>"You're the geezer who used to come in my shop"</i>	Discovering new reasons to participate <i>"We just do normal things, like what we shoulda done in the first place"</i>

FUNCTION OF OCCUPATION

This theme reflects how occupational participation performed certain functions for the participants. The *form* of the occupation (e.g. fishing, cooking, 'drifting', using substances) was often irrelevant compared to the need it met for the individual.

Seven sub-themes describe commonly identified functions: responding to/escaping unpleasant feelings when they are experienced; avoiding experiencing an unpleasant feeling at all; seeking a pleasant feeling; creating stability/a sense of security; enacting identity; and experiencing mastery. A final sub-theme was found only in the men's narratives: experiencing status/significance.

ESCAPING UNPLEASANT FEELINGS

When experiencing troublesome thoughts, feelings or emotions many participants described a need to 'escape' from them through occupational participation, which could lead to conflicted motivation. For example, Loelle described how she tried to manage strong feelings and unpleasant thoughts by going to the gym. However, her past occupations (alcohol/substance use) that had effectively performed this function continued to hold a strong attraction for her.

Cos if I get really irritable, I, I have to, go to the gym for like five hours... Cos I need to get all my energy out. Or. If I haven't got no energy I, try and get energy... Or if I'm feeling like shit. S'cuse my language. Erm. I just drink, all day. Drink, drink, drink, drink. Like I used to take drugs but I don't anymore. Erm... But if I drink, then it's not good, cos I'm. I end up doing something stupid. So I try not to do that. So now it's just the gym

Loelle

Richard also talked about escaping sadness through substance misuse in the past. He identified how he now used technology to perform the same function.

Think that's a bit of a, a distraction though I think sometimes. Erm. Phone can be a bit of a erm, a way to escape.

Richard

Mark described how his past strategies for escaping difficult experiences continued to shape his occupational participation in higher education.

I think it [school] was a form of escapism for me when I was younger. And then obviously it's just developed from, that into what I believe now, because school was an escape for me.

Mark

Danny and Faisal also talked about escaping from unhappiness associated with their home lives, but instead through occupational participation in a gang. Both men continued to view their gang activity as the best time in their lives, illustrating the ongoing effect of having found an effective strategy to reduce unpleasant emotion.

The best time of life was when I was on the streets doing what I was doing with my friends and that. You know what I mean. That was the best time... You know what I mean. Staying out too late, an. An it be like. To me it was like. It was like, freedom [emphasised] you get me because like. I don't know man. We got, we did things that no one else was doing and that like.

Danny

AVOIDING UNPLEASANT EXPERIENCES

Many participants sought to avoid unpleasant experiences all together. It was common for participants to explain that they kept themselves to themselves, resisted setting goals, and avoided occupational participation that would bring them into contact with others. This was usually a deliberate strategy to avoid situations where they anticipated a risk of failure, experiencing shame or exposure.

Michael talked about how he avoided being exposed as an 'offender' and judged as inferior to his peers by avoiding social activities, but this left him unfulfilled.

I think then the best way to deal with that is just to not see them type of people... But, regarding people in my own private life, if I haven't seen them for years, I'm not gonna go, "oh by the way I've been in prison two and a half years and I'm on licence." I, I wouldn't do that. But that's not, that's not being normal. That, that, that's like having to think about how you can, avoid, er, detection I suppose for want of a better word. Erm. So yeah. It's kind of like er. I wouldn't say I'm living a lie, but. I'm certainly not living the life that, that I crave.

Michael

Some participants feared that they may encounter a situation in which they could not control their response, and may result in them behaving in a way that caused further conflict with people and the authorities. Here Steve talks about curtailing his occupational participation because he was fearful of 'flaring up.' This was a strong and recurring theme in his narrative that influenced his decisions not to participate in what he wanted to.

I don't go out at nights. I don't party or, interact with friends much. Just in case, these situations occur. Everyday life. It occurs and

there's nothing I can do about it. So. The only thing I can do about it is keep myself to myself. Saves me getting into trouble, saves me flaring up... Say, say if. It's a lovely day now, It's a lovely day. An I like, I could just. I'd love to go on my bike and have a ride round but I can't. Cos I know. I dunno. If I bump into someone. Or if someone bumps into me, I'm gonna flare up.

Steve

SEEKING A PLEASANT EXPERIENCE

Just as participants sought to avoid discomfort, they also sought positive experiences and feelings such as excitement, belonging or being cared for through occupational participation. Faisal talks about undertaking dangerous activities and made the connection that these activities give him a 'buzz' and come from past experiences of occupational participation.

I don't break (exhales like laugh/scorn) speed limits or nothing like that but, I I-, I like drifting innit like I done, I used to drift all the time, back in the days... I don't do it for no- any reason, it's just to, just to get a buzz out of it man. Just to feel like, "oh yeah, back to how." But I'm not innit, but in my head, it's like, I'm thinking I'm doing something innit (laughs) but I'm not.

Faisal

Here Jamie describes how despite fishing seeming boring he continued throughout his life because of the adrenaline rush when catching a fish.

But then, when you get the big one. And you feel that hit. And its, and your hand is bringing in and the fish is massive, and you're doing everything to catch it, release the tension. It's amazing, it's an amazing feeling do you know what I mean? [doing actions of fishing and using the reel, leaning back with the strain]

Jamie

The participants mostly described a history of instability in their lives, of frequent moves, relationship breakdowns and never being in a position to sustain occupational participation. As a result, many sought occupational participation that brought them a sense of personal safety and stability. Lack of experience of this, and the tendency to respond to environmental demands, continued to cause difficulties in sustaining occupational participation.

Jackie described the best times of her life as when an external actor imposed 'structure', a recurring theme in her narrative that she felt contributed to her previous repeat reoffending. She both sought the structure of prison and lacked the ability and opportunity to structure her life outside in the past. Having had a shift in values, Jackie was now attempting to replicate the same routine in the community.

That's probably why I kept going back. Because when I'm not there I haven't got that structure, but when I'm there, there's everything that's in place... It's just, li- basic what I've learnt from being, (pause) in prison.

Jackie

Richard spoke about the desire for structure since his recent release, and how he slept to manage the experience of being unable to participate in valued occupation due to his curfews.

I have to try and discipline myself when it comes to, my free time. Well at the moment, I've had more free time. Not being able to go and do anything. Where I find myself, s- sitting there thinking what am I gonna do? And then all of sudden I feel tired and I think, "you know what, I'm gonna go, shut my eyes for a few minutes." And

then, two hours of the day is just wasted. An that. That can be a bit depressing as well.

Richard

ENACTING AN IDENTITY

Occupational participation allowed the enactment of an identity, like Faisal's example above of driving to access the memory of how he used to feel as a young gang member. All participants performed different roles that gave them an identity. This could be a positive and empowering experience. For example, Marcia talked about how her occupational participation as a mother included activities such as preparing the children's favourite food to take to contact visits and saving up for technology that they would use together. She strongly characterised her identity as a 'fighter' who was showing the world she had changed.

me can't let nothing at all take me off a the, off of the track I'm in really. Like me just keep in fighting. Look after kids, and myself, and me just want to show other mothers, have for sure like, family member, certain people in a better position, you know. Especially like some government people, more of a show them, you know what? People can change.

Marcia

Similarly, Danny talked about how important it was to him to act as a role model to other young men involved in gang activity and drug use. But what was most important to him was his voluntary work, which he said 'kept him sane' and offered him a new identity in which he was valued for his expertise.

And they're there offering the chance to be what they are as well.

Danny

However, there were examples where occupational participation contributed to a socially undesirable identity, that had been internalised and brought confusion, distress and social disapproval. Ali talked about how he was a sinner because of his participation in activities that are forbidden in his religion. His narrative expresses the constant conflict of his position of seeing himself as failing and sinning, unable to move to an accepted identity.

If I was abiding by my laws and my religion, I swear I wouldn't have none of these problems.... I'm basically, I'm constantly sinning basically... I know wrong and right, do you get what I'm saying. But I told ya, I'm stuck in limbo, not limbo, I'm stuck in the middle. I'm basically stuck in the middle thinking with a question mark beside my head. And I've been doing that for the past three, four years, while suffering

Ali

EXPERIENCING MASTERY

A few participants talked about occupational participation that brought them a sense of pride and achievement. Angela, who had moved to a new area away from her family for the first time, took great pleasure in activities that strengthened her new sense of identity.

I was never a very handy sort of person, as I say, I've never done gardening before, I've never really done much DIY before. But I'm living in a town where I don't know anyone so you know I, sort of got, wiki how [instructions website] open on the screen telling me how to do it and I'll er, you know a tool in the other hand and I'll go and do a bit and (laughs) go back and find out the next step, so I'm amazing myself that I can do these things. Erm. Which is positive really.

Angela

Paul also talked with pride about mastering social skills and learning his trade. He was enthusiastic about demonstrating his new abilities at work and the esteem in which he was held by colleagues trusting him to do a job well.

*Every now and then. They'll say er, "right you, you do this address."
(pause) You know. I, I knock on the door, (bright tone of voice)
"good morning, erm. [charity name], we've got your delivery."
(smiles)... But you've gotta know what you're talking about.*

Paul

EXPERIENCING STATUS/SIGNIFICANCE

The final function of occupation that was identified across participant narratives was only found in the men's narratives. Some of the men described seeking occupational participation that contributed to a sense of status or significance in the world.

Mark was motivated to pursue occupational participation in higher education, despite twice being unable to complete university previously. He was seeking a position of influence and significance.

I guess it's the power. Erm. And being able to change things around the world because, er that's one thing that I've always wanted to do change the world for the better. Erm. And unfortunately, in this world you either need the money or power and that comes with the job title.

Mark

David was similarly concerned with having a status. He had struggled to bring this about in relationships and as a father, and as a result he valued his employment very highly. Although he suggested it would be easy to find another job, it was clear this would be a blow to him and the image he

wanted to portray of himself. His employment enabled him to purchase status items like a new car and property, but also was critical for his sense of importance.

I don't know if I can say, my sons, the most important because I never see em. Erm. I'd say at the moment, sounds selfish, but the most important thing at the moment. My job. (pause). Without my job, I'd have nothing.

David

The function of occupations played a large role in motivating occupational participation. The participants learned the effectiveness of particular occupations for performing the function they desired, and repeated them, indicating the important influence of past occupational participation on current occupational participation. The next theme expands on the influence of the past.

INFLUENCE OF THE PAST

Some participants were able to trace their current patterns of occupational participation, beliefs about themselves and the world, and their expectations for the future to their past life experiences. Others were not able to make these connections but gave insights through their narratives. Five sub-themes were identified here: I've matured; I've missed out; consistent/lost occupations; turning points; and intruding past.

I'VE MATURED

Several participants looked upon their past behaviour unfavourably, citing foolishness, thoughtlessness, ignorance, arrogance, weakness or vulnerability. Recognising their past occupational participation as

'different' allowed them to position themselves in the present time as more mature, wiser and seeing things clearly. Some could integrate their past experiences into a narrative in which they had changed direction, and were using recollection of these experiences to further their occupational participation. This was particularly evident in the participants who wanted to become support workers.

Danny frequently reflected how he used to behave and compared it with himself now, emphasising that he values things differently.

It's just a build up. Er. I'm all grown up now, you get me. If I'm sitting in a class nowadays. I'm thirty-six years an sitting in a class. I actually took time out of my busy day, or my day, to go and sit in that class. So I'm there for a reason and just. Learning you get me. So, that's the way I look at it, innit. I'm there for a reason which is to learn, which is what I should've been saying to myself when I was kid.

Danny

Not everyone was able to reach this new position. Here Steve talks about ambivalence about becoming a peer worker, recognising his difficulties empathising.

When someone's telling me about their problems, even though I'm trying to be a support worker. I need to learn to, take that on board. Cos sometimes I think, "God. I don't really care. Shut up."

Steve

Whereas Shelley described how she did not feel mature and able to cope because she was only now starting to encounter 'adult' things like paying bills.

I don't feel like I've grown up in the head. You know I still feel like this little child, like, you know. And it was only a week ago I hit the bottle, erm... Because I was unhappy.

Shelley

I'VE MISSED OUT

Some of the participants attributed their difficulty to having 'missed out' on what they assumed to be normal formative occupational participation. This led to, as identified in the learning and adaptation theme below, a need to learn the norms of adult occupational participation. Participants also made a significant attribution to having missed out on love and belonging.

Here Mark talks about childhood adversity limiting his ability to relate to his peers in the present.

Like a lot of people have memories of, like, going like, going out playing with friends or just going round the end of the street to someone's or erm, having friends round, the house but I haven't had any of that so I feel like I've missed out quite a lot.

Mark

Like Mark, and many other participants, Richard identified missing out on having parents to help him feel secure in the world. He considered this influential in his seeking of a sense of acceptance through religious occupational participation over his lifetime.

I just sort of shut into my own world and. Erm. No matter how much services may try and no matter how much a foster carer may try. No matter how much er. Carers in the home may try. They will never be able to really, er, er, erm (pause) be a parent. To a, to a kid... I was

believing and having faith in something. And I was believing that I was, a part of something you know, bigger than myself, I was accepted.

Richard

CONSISTENT/LOST OCCUPATIONS

Most participants had one or more occupations that they had consistently participated in over time. These could be both socially valued or disapproved of, with many participants having both.

Jamie talked about fishing and engaging with wildlife as occupations he had participated in since childhood, and which still formed an important part of his routine. He described the way he sustained this valued occupational participation even whilst in prison. In this excerpt he explains how he went 'fishing for ducks' when he couldn't go fishing.

I have stopped on the odd occasion. Obviously when I was in prison for four years. Couldn't go fishing there. Fishing for ducks... The ducks were in the prison full of them. With babies.... I used to find their eggs and all.

Jamie

Some participants had not managed to sustain valued occupational participation. During the course of the interview, participants recalled past occupations that they had abandoned or lost during the tumult of their lives. For Aaron, this happened a few times and was very exciting and motivating to him. In the interview, he made commitments to restart his occupational participation.

I just forgot all the ingredients what to buy you see. When I was, when I was with her I knew what ingredients to buy and cook it meself. But obviously I want to get back to the stage where I was

buying ingredients and just erm, cooking it meself. Because I enjoyed cooking as well. I used to enjoy it man. To be fair. She used to say to me, "you enjoying that int ya, cos you can, oh yeah I can tell." Yeah. An then. When I used to like cook and it used to come out the em, oven I think, "yeah, I've done that." Yeah and that, that would give me a buzz as well like.

Aaron

The motivation and commitment to change expressed within the interview highlighted the potential power of effective interviewing as an intervention to increase occupational participation. Table 5-6 contains reflections developed from field notes made after Aaron's interview.

Table 5-6 Field note reflection: Lost occupations, forgotten selves

Field note reflection: Lost occupations, forgotten selves
<p><i>The excitement Aaron felt when identifying past occupational participation that had contributed to a sense of pride and mastery was palpable. His eyes sparkled and he grinned talking about cooking meals for his partner, but he had 'obviously' just forgotten how to do it. He reminded me of an excitable young boy who thrived on giving and being valued, not a high-risk personality disordered offender who posed a threat to society. Of course, the challenge of working in this field is to remember that people can be both, and not to forget that people are more than a 'risk.'</i></p>
<p><i>The fact that Aaron had forgotten this aspect of himself was sad, but also highlighted that men and women on probation do not routinely get asked about their occupational participation over time. Transforming Rehabilitation has resulted in the NPS carrying a higher than expected caseload of only high-risk men and women. Their capacity to attend to elements of rehabilitation other than risk management is reduced. The apparent simplicity of the every day, which could have a huge impact on identity and act as a significant protective factor, may be overlooked.</i></p>

In clinical practice, using the OPHI-II as an assessment establishes the basis of ongoing therapeutic work. In the research setting there was no follow up. Despite his enthusiasm, Aaron's account of his living environment and other areas of impairment in his occupational competences indicated that realising a return to preparing homemade meals would be difficult. Thinking that he would leave and likely return to struggling to live in a way that brought him fulfilment, saddened me. Similarities in Aaron's narrative to someone I know personally, who I am equally unable to assist, may have contributed to my compassionate feelings. In the research setting, it was easier to prevent any impact of emotional responses, whereas clinically there is potential for strong empathy to change practice or reduce attention to risk. Seeing aspects of the 'high risk offender' that are unseen in the media and public narratives is what enables people to work in this setting. The constant tensions for rehabilitation focused forensic clinicians will have to be considered in the intervention developed in this research.

The thrill Aaron experienced remembering past success in occupational participation, and contrasting it with what he did and how he felt about himself now, highlighted the power of a well-conducted interview as an intervention. For some men and women, simply identifying a difference may be enough to elicit motivation for change that they can act on independently. Identifying when this is the case will assist in identifying when and for whom further intervention is required.

TURNING POINTS

This sub-theme describes how a past event or interaction with a person could, for better or worse, impact on the trajectory of someone's occupational participation. Most participants talked about how a person or service let them down in some way in their youth. For many, committing the offence for which they were currently under probation supervision served as a bittersweet turning point in their life. It resulted in their involvement with the criminal justice system, but also in getting the help

they realised (in hindsight) they had needed. Richard, who had a high level of psychological input compared to other participants, evident in his language, articulated his turning point.

It's. Sad, that it had to come, to me going to prison, to kind of see things differently... It's kind of made me realise that, "hang on a minute, I am not the person I thought I was." The worthless person I thought I was. And that was just. You know, that low self-esteem and that, erm. Feelings of inadequacy and that, that was. The. Something that was entrenched in me from, from a child.

Richard

Jackie too talked positively about the impact of her most recent prison experience, where she had experienced supportive and caring officers.

They were unlike any other prison that you go to, and they're really supportive. They're not shouty or anything, and they kind of let you get on with what you've gotta get on with. Even though the structure's there. But they're just there to reinforce it. And that's it. But you can have a laugh, you can have a joke with them.

Jackie

Even where the intervention was perceived as negative, there was potential for this to trigger a drive to change occupational participation, instead motivated by the desire to prove others wrong. Marcia talked about how the hurtful comment of a single social worker triggered her 'fighting' spirit.

She said something to me one day which really just like, she just, put fire inside me stomach. She says to me (pause), "me would never change". Yeah. She said some more horrible things. I will never forget she I will never forget her, never. Ever... It gave me fight

inside my stomach honestly. An I look upon her and I says to her, “you know what (pause), you’ll never get rid of me.” She said, “beg your pardon?” I said, “you heard me”. Yeah. And from that day.

Marcia

INTRUDING PAST

The final sub-theme relating to the influence of the past was where participants could not keep the past in the past. It intruded into their day-to-day life uncontrollably and disrupted their attempts at occupational participation, or elicited occupational participation which functioned to manage distressing feelings associated with the intrusions. One participant was aware that he had a diagnosis of Post-Traumatic Stress Disorder, but others described behaving in ways suggestive of ongoing impact from past distressing situations.

Here Mark talks about always needing a room from where he can see his doorway and the impact on his confidence to go out in public.

So I can just see who’s at the door and whatever and, like even like, with like. If I hear anything, in the corridors, something like, erm, people speaking really loud. That’s a trigger, for me. Erm. Even shouting my name out really loud, that’s a trigger like it’s....And then I just freeze and it’s. Erm. So it’s, like, affected me quite deeply and because of like the after effects of it as well

Mark

The disruptive power of these intrusions was particularly evident in Shelley’s narrative. The past impacted on her occupational participation, but also on her ability to stay in one time period during the interview. This was a trait shared with other participants, some going deeper into distressing experiences like Shelley, and others quickly moving to talk

about something else. The below extract followed me asking Shelley about her new hobby.

No, no I've never gardened before. No. So. My life was just about sitting there drinking and smoking drugs, which I've done for the past 20 years. I was in er, a relationship and he was schizophrenia. And it was really difficult and he was into drugs and that. And I ended up going onto drugs, and I think that's where it all escalated from. From drugs and drink, abusive relationships erm, me be in a, with my dad, he sexually assaulted me from a young age, from the age of eight up until I was eighteen. And er. Yeah. I think my life was just traumatic and in the end that, that's wor I done [index offence], because I felt like I wasn't getting any help or anything.

Shelley

When there were marked temporal disruptions in participants' narratives, it was more challenging as an interviewer to establish the order of events, or which were current or past descriptions of occupational participation. Table 5-7 expands on the reflections from field notes written following Shelley's interview about the unexpected parts of participants' narratives and the work of the interview.

Table 5-7 Field note reflection: Unexpected narratives and interview work

Field note reflection: Unexpected narratives and interview work
<i>Some participants experienced difficulty in holding a temporal position, like in Shelley's example above. It was challenging for me to understand what happened when, as her story jumped between fragments of time, traumatic experiences and confusion. It highlighted that not everyone lives or tells their story in the way that is 'expected,' that narratives may include very difficult things to hear, and that the life experience of the person and the interviewer may be significantly different. I return to the idea of unexpected narratives in the discussion in the next chapter, where the participants' narratives in their entirety are compared to</i>

those in the literature.

The regular 'intrusions' of traumatic experiences in talking about what appeared to be unrelated topics left me tired after some interviews. This may have been from the high cognitive and emotional load held by me in:

- i) concentrating hard to understand the narrative*
- ii) maintaining a constant awareness of the persons emotional state in case of a need to interrupt to keep the interview from causing further distress*
- iii) not allowing diversions to continue too long and being sensitive in any interruptions*
- iv) managing my response to what was described by another person as a 'trauma firing range'*

In the car on the way back to the office after one of these, I would feel the strong emotional response that I didn't register consciously in the interview. It was usually anger. Part of the anger belonged to the person and their fury that no one had protected them, and part was my own, directed both towards the people who had caused such damage and towards myself for being unable to do anything so many years after the fact and in my single contact with the person.

Practitioners working with PDOs outwith the context of an established relationship, or who do not plan to provide further support and intervention, like I did in these interviews, should be mindful that there is a high probability that the person has experienced trauma, abuse, adversity and/or hardship in the past. Revisiting this may be emotionally distressing during and after the interview for both parties.

I was aware of this from my clinical experience, the literature and the advice of the PPIAG so I was prepared and able to manage this within the session. I additionally planned with each person how to deal with any distress arising later. Though participants often minimised the need for support, all took details of crisis numbers and one commented on how thoughtful this was. Giving a crisis number felt small after the candid accounts people had shared, and the attempt of the participant to validate my efforts further humbled me. The discomfort may have been due to the difference in my role, where I had to entrust to unknown

others the safety of that person after I left.

I did not make preparations for my own reaction to the participants emotional narratives. In my prior clinical role, I never reflected on how hard the work was, likely because I was well supported by routine clinical supervision and the camaraderie of working within a team. The unexpectedness of not knowing people's histories first was an additional challenge in the research context. As I have predominantly worked with men, the higher personal relatability of the women's experiences presented a further complexity. The challenge of working effectively with people who have experienced and disclose past or current abuse is nothing compared to being the person themselves. However, the impact on the practitioner, or researcher, should not be underestimated in an intervention.

I was conscious of a need to minimise how my own emotions influenced how I analysed the narratives. It sometimes impacted on my motivation to re-immense myself in the analysis itself. The challenges of engaging in the analysis for me may be similar to how people feel when affected by the emotional load of delivering clinical services for PDOs. It therefore could have been alleviated by using clinical supervision, enabling me to work more efficiently. Clinical supervision, or supervision that considers the emotional impact of working with people whose lives have included traumatic experiences, may be beneficial to other researchers, and probation service staff who work closely with high risk PDOs over prolonged periods.

The 'influence of the past' theme indicates that past experiences of occupational participation have a marked impact on what participants did and did not do, if and how participants understood their current occupational participation, and on motivation for future occupational participation. Within their narratives, some participants were able to identify how their participation had changed over time, which was often influenced by an event or experience that acted as a catalyst for change. Many continued to view change as something under the control or external forces, as described in the next theme.

EXTERNAL FORCES

Participants described how things out with their control influenced their occupational participation. Sub-themes describe the main 'forces' as: mood and mental disorder; uncontrollable circumstances; interfering authorities; helpful rescuers; and faith and purpose.

MOOD AND MENTAL DISORDER

Participants often explained that they were restricted because of daily fluctuations in how they felt, which could very rapidly change in response to 'minor' events. Marcia described her life as 'like a yo-yo,' referring to changing moods. Brendan illustrated how his changing feelings influenced his occupational participation.

If I feel good I clean straight away. If I feel bad. I have a drink and that first and. Jump back in bed and just, slouch around and take, take my tablets straight away like... Like every day I still feel like, "oh I want to go and see them, I wanna chill, cos I feel good there.

Brendan

However, the rapidly changing nature of his feelings and thus how he was able to describe his life changed during the interview. He started by telling me of the improvements in his life since he stopped drinking and using drugs, and how good he felt about establishing himself in his new flat.

Lot of things that are, you know. But erm. Mm. Like. getting there, it's getting there. I'm positive anyway about it. I'm positive about it.

Yet later in the interview he described life as 'shit.'

Life's shit. To be honest. Just put on brave face. I just put on a face for everyone. To be honest... It's cold, eerie. Crackheads trying to sell

their Nans and ladyboys trying to look like your girlfriend. They're fucking, the worlds a horrible place man. I (exhales), don't like it. I just don't like it. I just put on a face, cos it's just shit, to be honest.

Brendan

Danny described how his mood influenced his choices. And he recognised that although he was able to continue to participate in his valued activities, this took some effort and he felt he was seen differently by others.

Nothing much happens you know. It's just that like, my moods low and that. Like. Like, I'm not a happy chappy and that, you know what I mean. Or. Not as bubbly as I used to.

Danny

Changes in mood and perception had a strong influence on occupational participation, and in interview conduct, which I reflect on in Table 5-8. Feelings were not something that the participants recognised as within their power to change, largely viewing themselves as buffeted through a day by their mood.

So. Sometimes I wake up in a good mood, you know?

Jamie

Table 5-8 Field note reflection: Changing moods, changing stories

Field note reflection – Changing moods, changing stories
<p><i>The way Brendan's story changed within a 90-minute interview was not uncommon. Several other participants contradicted themselves when describing what they did and how they perceived occupational participation. This is similar to working in clinical practice with PDOs, and I reflected about what could have been occurring.</i></p> <ul style="list-style-type: none">• <i>Participant's may have wanted to portray themselves in a particular way</i>

so as to elicit a particular response from me, or to control the way they were perceived. However, maintaining a façade could be difficult over a prolonged interaction, leading to a shift to a more accurate account later in the interview.

- Where participants started off with a particular ‘script’ or story, this may have been because they had assumed what I wanted to hear, developed from their interactions with other professionals. As the interviews progressed and they began to learn what I was interested in, rather than what they typically told probation, the stories shifted.*
- It could be attributed to the participant developing trust in me as the interview progressed and rapport developed, to feel able to reveal less ‘comfortable’ aspects of their story. This was evident in actions as well. For example, one participant kept a heavy winter coat on despite the interview room being very hot and invitation to make herself comfortable. After I had listened to her account of serious adversity and traumatic experiences, she eventually removed this jacket. This exposed her severe scarring. There is potential that participant wanted to check whether I was going to exhibit judgemental or negative evaluations of her experiences before she ‘revealed’ aspects of herself that were hidden. Some may argue this was a provocation in an attempt to shock and unsettle me, however waiting until later in the interview suggests the former was more likely.*
- The participant’s actual perception, rather than their story, changed within the interview in response to feelings elicited by the interaction. It is possible that Brendan held both positions, that everything is coming together and is great, but that the world is “shit”, which were expressed when his mood was higher or lower respectively.*

Given the multitude of potential explanations for changing stories, it is important that a practitioner does not always accept the first account given as the ‘truth’. Not in the sense that the participant is being deliberately dishonest (although some may be), but that the story told may be only partial, subject to change or dependent on the practitioner’s reaction. Similar to considering the function of an occupation, participants have reasons for telling a story in a particular way, potentially to protect themselves from rejecting responses or

resulting from the mood they are in at the time. That an entire outlook on life may change in response to mood is consistent with the 'emotional instability' characteristic of personality disorder.

UNCONTROLLABLE CIRCUMSTANCES

Similar to being buffeted by their moods, many participants saw their occupational participation as dependent on uncontrollable events unfolding around them. They lived in a cycle of responding to constant change rather than being and feeling in control of life.

Steve had a view of the world as completely unpredictable and threatening. He viewed other people as likely to behave in a way he felt was unacceptable and lacked a sense that he could manage his response to others and the world. He tended to avoid situations that may expose him to unpredictable situations, including driving or riding his bike. Here he talks about why he avoids going out in public using the example of the supermarket, and his difficulties coping.

Someone in a supermarket, the trollies. They leave their trolley over there and they walk up to the other aisle. That irritates me. A couple of times I've rammed their trolley out the way. Just. Bashed it cos, it's just, frustrating for me. But I'm trying, I'm trying my hardest to keep a lid on it... Whatever's happened's annoyed me. I'm taking it out on the world cos I think the worlds coming to get me. I know it's not right but that's the way I think. And when I think about, I can't help. I can't, switch off. If you know what I mean. It's more. It's more, yeah. I can't switch it off. I know it's happening. Cos that little bit in, that rational sides that still there. But. I can't do nothing about it. It's horrible. I just can't do nothing about it.

Steve

Steve's animated account of being unable to control anything, contrasted to his and other participants' accounts of home-based activities. Cleaning and maintaining order were reported to be very important by many participants. The function of cleaning varied and would need to be analysed on an individual basis, but it often appeared to provide a sense of control, security or stability in the tumult of community life and shared housing. Some participants sustained participation in cleaning and their role as 'home-maintainer' due to past experiences of pride, satisfaction and control when they successfully met the responsibilities for upkeep of their personal space (often for the first time in their lives experiencing this in prison). Loelle describes the importance of cleanliness and control for her:

I don't like living in a pigsty. [In prison] no one could come in if I told them that. You know. They can't come in. In there [shared housing in community] it's like. "Aww". I get goosebumps, do you know what I mean, (shows goosebumps on arm) even talking about it.

Loelle

Caution must be exercised in assuming that cleaning is always positive. A few participants suggested they were 'over the top' or 'OCD', and others commented that they could not bear to feel 'dirty'. Conversely, Brendan described being unable to wash when particularly low in mood, because he felt 'exposed'. This highlights the importance of individual analyses of occupational participation.

It's everyday tasks like... There's times where my, my paranoia, my depression, my paranoia, everything, anxiety gets that bad, I don't wash. I don't get. I've got water, I've got thingy. I just don't wanna do it. I don't wanna. I don't wanna have that feeling of feeling clean because then I feel exposed... I dunno if it's animal instinct. Parts of my brain seem to, do you know what I mean. Like. I dunno. Try to survive.

Brendan

INTERFERING AUTHORITIES

The relationships participants had with various service providers or criminal justice agencies were complicated. For some, the available support was highly valued and considered necessary. For others, the 'authorities' were a consistent thorn in their side, hampering their progress towards what, to them, had been unproblematic in the first place. Some participants held both views.

Michael talked about the restrictions on returning to his family, and how he has withdrawn from involvement with the authorities as far as possible to avoid acting on his frustrations.

I want to be able to decorate the house and do it up and sell it. (pause) But at the moment. You know. We're, we're not allowed so. Just a case of having to jump through hoops, for them.... Strangers are dictating to us. It's just. It does me head in, having to do all this conforming and. You know like. People that don't even know you telling you what to do. It just drives me potty.

Michael

An additional external constraint related to authorities was societal or organisational responses to a participant's criminal record. Whilst this was understandable to the participants, it caused frustration and restricted occupational participation.

Shelley talks about feelings of exclusion and isolation.

I'm bored. And. With my offence, it's difficult... So I find that every day like, you know, it, that hangs over me. And I can't do anything so I get frustrated, you know. And sometimes it still feels like I'm in prison.

Shelley

Social attitudes also indirectly effected occupational participation as many participants decided not to follow plans, goals and opportunities for valued occupational participation, to protect themselves against rejection and disappointment.

Here Michael talks about the barriers related to having committed a sexual offence.

I could be walking through a town, and, they could pick my face up and go "oh well, he's a known offender. Oh it's, ten- send a car down, see what he's up to." And. I don't wanna live like that.

Michael

Whereas Aaron was fearful of public failure.

Cos if you don't do it, that's gonna make you look stupid then.

Aaron

However, a few of the men had found strategies to avoid this, 'blagging' their way into employment without disclosing, or selecting employment where a disclosure is not likely to be requested.

You know what I'm not gonna lie to you. There's a little way, I use it as a trick. Because basically, it sounds like a cheat, but you know, it worked. It's not a cheat, you know... I said "I've done a bit of that work."

Ali

HELPFUL RESCUERS

Several participants reported the need for services or friends to assist them, by solving difficulties for them, teaching them new skills, accompanying them, or making opportunities available. This sub-theme

was more apparent in the women's narratives but was also found in the men's narratives.

Participants reported that they needed others to recognise their need for support and to 'keep on top of things'. Here Jackie talks about her offender manager's persistence in making contact when Jackie had a 'blip with alcohol' and was trying to ignore the offender manager.

And I call [offender manager] the, the 'persistent little [indicates swearing but doesn't] before, yeah. Cos she just doesn't give up (smiling)... At the time, it was just like, "just leave me alone." But looking back on it, you know maybe I needed it. So. Cos if I wasn't in then she would've recalled me, so. And that's not something I wanted.

Jackie

Some participants talked about how important it was to them to have their offender manager and other people recognise the changes they had made and trust them, which sustained them in efforts to participate in occupations.

[Probation services] let me leave the country and go back to a different country and stuff. They don't usually do that you know. Erm. The. Sometimes I think like, er, I'm not sure if they believe in me. You know what I mean. [offender manager] says he does, but I, I'm not a hundred percent sure, you know.

Jamie

Richard explains about the fear of recall for doing something wrong, which was evident in many of the narratives, but that this not happening strengthened his belief that his offender manager was genuinely supportive.

The worst-case scenario that I think isn't always gonna be what, is gonna happen. I, I thought I'm gonna get recalled here. Erm. And that hasn't happened, erm. Because obviously [offender manager] knows what I've been through. Erm. How far I've come. How good I've done.

Richard

FAITH AND PURPOSE

The final sub-theme relating to external forces, was the idea of faith or a belief in something bigger than oneself. This enabled participants to consider their life purposeful and continue to progress in a prosocial direction. Mark describes this.

I'm here for a reason. Erm. It's linked to my beliefs. But, it's a bit more, because I feel that, I have, a purpose. Not that I'm hundred percent sure what it is yet... Yeah it's just that hope that, my. (pause) I get to that place, in the end and then, I can, look back at my history. And look, be like, that's like, that's [emphasised] what I've come from and look at what I've achieved

Mark

Many participants reported a religious affiliation, which often came with challenges. For example, feeling they did not measure up to the expectations of the faith, or being unable to fully participate in the activities it demanded because of travel or disclosure requirements. This could contribute to feeling ashamed, judged and rejected and was a complex negotiation of values, belonging and practicality. Angela's experience of trying to re-engage with the church whilst being aware of the church's safeguarding obligations illustrates this.

I can't complain about all the restrictions. And I can't, you know, be upset that the church for example wants me to sign a contract,

because, you know, I think that's what they should be doing and I think it's good that there is all this safeguarding, so. Erm. Although it's frustrating.

Angela

Within this theme there were variations in the way participants viewed the external forces acting on their lives, in the degree they felt they could control them or their response to them, and whether they were a help or a hindrance. The more participants felt a sense of personal control the more they recognised that they had the potential to learn new strategies and adapt to the changes in their lives. This process of learning and adaptation is discussed in the next theme.

LEARNING AND ADAPTATION

The final overarching theme from the narratives was about the need to learn and adapt to new ways of occupational participation, and using activities and roles to facilitate this adaptation process. The inter-relationship between occupational participation as means of change and the outcome of change is captured in four sub-themes: learning adult norms; shaping a new adult identity; exploring; and discovering new reasons to participate.

LEARNING ADULT NORMS

Many participants talked about how they were learning how to participate in activities and roles for the first time. This was often attributed to having limited applicable knowledge learned from prosocial childhood role models. Here Paul talks about how he is only now learning social skills, by watching other men around him. He attributes his lack of skill to his childhood experience of his father.

How they. Resolve conflicts without using violence. An I, I try to pick up on that. (long pause). Yeah cos er. Wh- wh- when I was a kid er, I was never hugged or anything like that so. Yeah. It, because. Er. The dad was an asshole. I. Stayed in my room most of the time. (pause)... Yeah. I, I'm, I'm not a people skills person. That's, that's why when I'm, listening to the er, guys at work. How, how they deal with the customers on the door. (pause).

Paul

Angela talked explicitly about having to learn how to participate as an adult after living in the shadows of her parents and mental disorders her entire life.

And I feel like, this is, maybe what I'm doing now is what most people do when they're a teenager. You know when they're sort of, finding themselves and growing, and I just missed out on that stage, so. Erm. In a sense, although I'm in my fifties I feel like I'm just learning now. Who I am and what I want. And. I'm happy to, you know, keep, maturing, keep growing (laugh) and see where it goes.

Angela

SHAPING A NEW IDENTITY

Linked to the theme on occupation performing the function of allowing participants to enact their identity, here the participants were trying to build a new identity for themselves. Participants had different levels of success.

Some participants were able to integrate their past, such as Danny in his pursuit of a support worker role or Marcia in her fight for survival against the odds. Ali talks about the change to being an adult responsible for his own property and learning the responsibilities of this new adult identity.

Got a washing machine there. Put- wash that up, wash my own dishes now. Usually before it was like I owned nothing. Now I'm washing my own dishes. It's crazy. You know what I'm saying?

Ali

Shaping a new identity was fraught with challenge and conflict. Several participants talked about how their past identity could be a hindrance to their self-belief or result in rejection of their attempts to change. Danny talked about his fears that people would remember who he used to be, instead of seeing the man he is now.

Coming out an changing my life but like, remembering that, I could walk into a shop and the shopkeeper might remember me and say that like, "oh, like, you're the geezer that used to come in my shop and take this and take that."

Danny

Equally, Faisal found that the identity of 'criminal' caused tensions even within his immediate family as he tried to demonstrate change.

I can tell my brother-in-law doesn't like me... his philosophy is, every person in, a criminal person, has chosen that life... you know what, he's, he's got some brains and maybe, all criminal people are not that bad.

Faisal

Like Faisal, Loelle was acutely aware of the multi-level stigma towards her that placed external constraints on developing the new identity she wanted.

It's like, day to day life, being (through laugh) a young black woman, having three children that don't live with ya. It's kind of a

statistic innit. Growing up in care, been to prison, lived in [known area for poverty, gangs]. It's like, "aw shit". I need to take that statistic and move that aside. And just be, (banging on table to emphasise) a young woman, who has a job (short laugh – hmh) and like. Going up in the world. That's what I wanna be.

Loelle

For many, shaping a new identity involved starting from scratch, a process of finding out how they like to participate in daily life, through trying new activities and roles. This is expanded in the exploring sub-theme.

EXPLORING

A lot of the participants talked about how they were experiencing a completely new situation and being given opportunities to participate in new ways. Some found this exciting, such as Danny and his support work and Angela and her DIY. Faisal talks about the excitement he experiences when exploring after growing up in the inner city, but also illustrates how seeking immediate stimulation could be preventing him from making decisions for the future.

I'm not weird, it's like, I just like to, venture out innit. And then. For every weekend my sister's "save up," I go "I'm not saving" cos I go, I go to Wales, round the countryside, and I go for mad walks... Since I been in jail you, you think about, f- freedom more innit.

Faisal

Brendan and others were frightened to explore preferring to stay in their homes.

sometimes it's really bad that I get scared. Like I've felt good all day but I'm still scared to go out... For three years I've been alone, really,

*at home. These these good days that I have. Erm. There not very, er.
Regular occurrence.*

Brendan

Jackie was also, satisfied with her structured and safe routine that involved going out as little as possible and blocking out a lot of new experiences.

*But if I've got my music on, which is all the time when I'm out, then I
um, an I can't hear what's going on around me, then I'm alright.
Just do what I gotta do, if I've got shopping, my music's still on, I
know what I gotta get, I've kind of pre-planned it in my head. Race
round the shop, get what I've gotta get, and pay and then leave.*

Jackie

DISCOVERING NEW REASONS TO PARTICIPATE

Some of the participants described how, for the first time ever, or in a long time they were participating in activities or roles out of choice rather than in reaction to a need. This was less common, but it was significant for those who described it.

Here Marcia is talking about previously having participated in employment because it performed a survival function. Whereas now she wants to be a support worker out of choice and because it functions to reinforce her new identity as survivor.

*Me have to. Huh. Survive. So have to work. Always. (pause) not job
that me really want, but. You know cleaning jobs a lot. Gosh. Yeah
lot's of cleaning jobs yeah. That was hard.*

Marcia

Loelle is talking here about being able to value participation in simple things now that she is no longer seeking occupations that performed an escape function.

Picks me up. We go out to eat. Or sometimes we stay in and I cook. An we go shopping. Like. We just do normal things. Like, what we shoulda been doing in the first place. Do you know what I mean and it's just like. I'm just happy. That we've got back to that normal place.

Loelle

The participants were all attempting to adapt to a life in the community where their identity had changed, and were learning new ways to participate in occupations that supported this change. It was a challenge for many of the participants, who had a long history of difficulties. They approached occupational participation differently, with different levels of social support and with different levels of success.

5.6 DISCUSSION

Analysis of 18 people's narrative interviews produced four overarching themes describing influences on occupational participation: function of occupations; influence of the past; external forces; and learning and adaptation.

This section first discusses the findings in relation to the literature, focusing on other narrative studies of the experiences of people with a personality disorder and people with an offending history. The findings are then discussed in relation to the Model of Human Occupation (MOHO),

specifically considering whether the data confirms the theorised interacting sub-systems and the occupational adaptation process.

5.6.1 LITERATURE

PDOs often participated in occupations (activities or roles) because of the function of the occupation, with functions most often identified as related to emotion. The choice of occupation and the function(s) it performed were individualised and strongly influenced by past experiences of occupational participation. This finding is supported by findings from a narrative study involving people referred to personality disorder services.²⁰⁸ This study focused on narratives about self-cutting, which is an occupation, albeit one that is often considered dysfunctional or maladaptive. The past effectiveness of self-cutting in reducing unpleasant emotions resulted in it becoming an established pattern of occupational participation. The participants in Morris et al.²⁰⁸ were seven women and one man. This research, which includes a larger sample and larger proportion of men, extends the findings of Morris et al.²⁰⁸ by demonstrating that many occupations (those valued by society as well as those considered deviant or harmful) are undertaken by PDOs because they perform a function, and that both the occupation and its function varies between people.

In the men's narratives, occupations performed an additional function that was not identified for women, meeting the need for status and significance. In transformation narratives (narratives about a change for the better) Herrschaft et al.⁵¹ investigated status related statements in the narratives of eight men and 23 women with stigmatised identities, including some with offending histories. All the men identified status factors in their narrative of change (100%, n=8), but only 43.5% (n=10) of women. The sample in Herrschaft et al.⁵¹ included seven women with

offending histories compared to five in this research. This suggests that had more women sampled in this research, status and significance may have been identified as influencing occupational participation for some women.

The influence of past occupational participation was a considerable factor influencing occupational participation in the present, and anticipation of the future. In addition to occupational participation that functioned to meet particular needs becoming habituated, whether they remained helpful or not in the changing environment, the participants also described high level of past and current adversity. This was reflected in the quantitative data which showed that marked impairment in historical occupational participation had an impact on occupational identity and occupational competence in the present (see Chapter Four). Adverse childhood experiences are common among people in contact with criminal justice services. Childhood adversity is known to effect health outcomes and increase the likelihood of violence or self-directed harm.²⁰⁹ These findings suggest that childhood adversity also has a lasting impact on occupational participation. There is limited literature that considers how childhood adversity may continue to influence occupational participation as an adult. In the introduction to this thesis, I argue that occupational participation is integral to health and associated with better criminal justice outcomes. It may be that the relationships between childhood adversity and health and/or violence are moderated by occupational participation as a child.

Some participants described experiences consistent with post-traumatic stress and/or their narratives were disrupted by recollections of accumulated traumatic experiences. The very high rates of co-morbid post-traumatic stress among people with emotionally unstable personality disorder (EUPD) has led to questions about whether EUPD is a distinct form of complex post-traumatic stress disorder.²¹⁰ Among offenders, there are also high rates of past adverse experiences.³ Literature that considers how

past (and ongoing) traumatic experiences may influence current occupational participation is limited. These findings suggest that the ongoing, and at times unexpected, distress may influence occupational participation by repeatedly disrupting activity performance preventing habituation, or causing previous patterns of occupational participation to re-emerge due to their established effectiveness for managing emotion. Whilst the past is not modifiable in an intervention, the ongoing influence of traumatic experiences and childhood adversity on occupational participation may be modifiable. It must be better understood across populations and warrants further research attention.

Considering the past did not exclusively focus on adversity. Periods of success were actively enquired about. Discussing past occupational participation where a participant experienced mastery and other positive outcomes could be a powerful means of generating internal motivation. Facilitating someone to become aware of what is important to them and the fact they may not be doing it is a key principle of motivational interviewing, an approach with broad application in behavioural change interventions that is particularly useful where there may be resistance and with offenders.^{211, 212}

Participants did not always view themselves as able to make the changes they aspired to, attributing power to external forces. This finding is supported by a narrative study of people with and without Borderline Personality Disorder (BPD), where a lack of agency differentiated the narratives of participants with BPD from those without BPD.²¹³ In the quantitative sub-study of WP2, on average participants did not score poorly on 'appraisal of ability' or 'expectation of success' on the Model of Human Occupation Screening Tool (MOHOST) which appears to indicate agency. However, they were markedly impaired on the Occupational Identity Scale which includes similar items. The latter uses a narrative approach and includes past experiences in devising a score, suggesting that

MOHOST, which takes a snapshot of activity performance may overlook areas of severe difficulty experienced by PDOs that can only be seen when sustained occupational participation is assessed.

Occupational participation was found to be the outcome of a change process, but also a contributing factor to the change process. This was also noted in systematic reviews (see Chapter 3). It was through occupational participation that PDOs shaped a new identity, learned and consolidated skills and achieved social validation for their efforts from the environment. This resulted in continued occupational participation. Within MOHO, this process is referred to as occupational adaptation. Although not explicitly cited, occupational adaptation is recognisable within studies of recovery among users of general or forensic mental health services^{191, 214-216} and desistance from offending.^{42, 168} This study provides detail of how what is variously termed ‘meaningful activity’, ‘generative activity’, ‘excellence in work’ etc... operates to facilitate a change process whereby the person redefines themselves as a person in society distinct from an illness, disorder or offence.

5.6.2 MOHO SUB-SYSTEMS

The Model of Human Occupation (MOHO) sub-systems (volition, habituation, performance capacity, environment) are conceptualised from a critical realist perspective as mechanisms influencing a phenomenon, namely occupational participation. This section discusses how the findings from this sub-study support the existing MOHO conceptualisations of the sub-systems. It is argued that modifications are required based on these findings.

Occupational participation describes participation in socially valued (prosocial) activities and roles. This section discusses the potential for the

MOHO sub-systems to explain 'antisocial' occupational participation. For clarity, the term 'prosocial occupational participation' is used to refer to the MOHO conceptualisation. 'Antisocial occupational participation' is used to describe participation in activities and roles considered deviant by society.

MOHO SUB-SYSTEM: VOLITION

MOHO describes volition as motivating prosocial occupational participation through an interaction between personal causation, values and interests.²¹⁷ Developing a sense of oneself as capable of causing an effect is the preliminary step in developing a sense of personal causation, integral to human volition.²¹⁷ However as evident in the 'external forces' theme and discussed above, many PDOs lack a sense of personal effectiveness and agency. This may be considered an under-developed volitional sub-system among PDOs. If practitioners wish the person to increase prosocial occupational participation, they may first need to address personal causation and self-efficacy, as the person may be unable to relate to the idea that they could initiate a change in the desired direction.

The constant process by which volition develops and influences choices has been described using narrative of individuals with psychiatric disorders²¹⁸ but not personality disorders. Among PDOs volition appears to differ. Whilst MOHO volitional factors are present, the findings suggest that these are secondary to the 'function' of an occupation. Most commonly, functions were to fulfil unmet needs. Need fulfilment is not explicitly considered in MOHO. The findings in this research suggests that a modification to the volitional sub-system is indicated to ensure that it captures this functional aspect of motivation. Applying critical realist strategies of reasoning has identified a mechanism influencing

occupational participation that has not previously been identified and considered fully within MOHO.

These differences in the volitional sub-system have implications for practitioners working with PDOs. Recognising that all occupation is functional and reinforced over time highlights the importance of examining the function of any occupation that the person or service wants to change or eliminate. If it is meeting a need, removal may have unintended consequences, such as seeking need fulfilment in 'antisocial' or harmful ways. Applying principles from behavioural psychology and functional analysis provides a framework for assessing functional motivation that has been demonstrated to be consistent with occupational adaptation and applicable to assessment and informing intervention with PDOs.²¹⁹

It is clear that volition, often when it was functional, also motivated antisocial occupational participation. For example, substance misuse, self-injury and 'drifting'. The same was identified in a narrative study of self-cutting, which found this was motivated by the need to manage strong emotion.²⁰⁸ The key MOHO text only makes brief mentions of antisocial occupational participation, describing this as being indicative of a "failure" of interests (pg.50).²¹⁷ This research indicates that the PDOs were not always interested in the occupations they selected, but were still motivated by the functional component of the volitional sub-system and thus the volitional sub-system can be used to explain antisocial occupational participation.

MOHO SUB-SYSTEM: HABITUATION

Modifying the volitional sub-system will impact the remaining sub-systems. Habituation incorporates habits and internalised roles. When prosocial or

antisocial occupational participation effectively performed a specific function for the individual, it was reinforced and repeated when that particular function was required, forming patterns over time. There is brief mention in MOHO texts about how habits can become 'dysfunctional' when a person or their environment changes and habits no longer lead to prosocial occupational participation.²²⁰ Irrespective of the habits and consistent behaviour not always being 'prosocial' or health promoting, habit formation is consistent with the conceptualisation in MOHO.

The internalised roles sub-component involves taking on an identity, and the perspective and actions consistent with it. Roles are developed in the social world beginning in childhood.²²¹ The PDOs recognised that they had missed out on 'normal' childhood roles and were often learning for the first time the roles available to them other than 'offender' or 'sinner'. Internalised roles includes the requirement for these to be valued and recognised in the social environment, which PDOs were only beginning to experience.

Working with the habituation sub-system, intervention may involve establishing the habits that contributed to difficulties and reconstituting these into a pattern supportive of prosocial occupational participation. Practitioners should recognise that due to their often adverse and atypical developmental trajectories, PDOs may have established habits and internalised roles that are inconsistent with prosocial occupational participation. Intervention may focus on providing opportunities to internalise a new occupational identity.

Some of the habits and internalised roles held by the PDOs were incompatible with the MOHO conceptualisation of (prosocial) occupational participation. Nonetheless, they developed as a result of the same processes of the habituation sub-system indicating its utility in explaining antisocial occupational participation.

MOHO identifies that performance capacity can be objective and subjective. In measurement, three types of skills are considered: motor, process (cognitive), and communication and interaction. The PDOs described examples of performance capacities that enabled them to cook, shop or do DIY. However, situations that involved a social element and/or role participation, which is what moves someone's activity from performance to participation, were areas of difficulty. For example, David's difficulty being a father.

This is consistent with the WP2 quantitative results that indicated high levels of motor, process and communication and interaction skills at a moment in time, but impairments in occupational identity and occupational competence, which measure factors that support sustained participation in a role. Participating in a role requires social and emotional skills, suggesting a mechanism within the performance capacity sub-system that is only active in contexts that demand those skills.

Practitioners must consider the impact of context on the operation of the performance capacity sub-system. This suggests avenues for intervention in supporting the PDO to make choices about the social environments they enter, interventions acting directly on the social and relational environment, or interventions acting on the development of social and relational skills.

MOHO considers the performance capacity sub-system as influencing prosocial occupational participation. However, PDOs also applied their skills in activities and roles that were incompatible with dominant societal views. Antisocial occupational participation equally requires the performance capacity sub-system.

MOHO SUB-SYSTEM: ENVIRONMENT

Each of the above sub-systems acts in relation to the wider social, physical, economic, political, and cultural environments. Here we see how the world in which PDOs live markedly impacts on prosocial occupational participation over time. For example: in the need to disclose a criminal record; the shame and stigma felt at being a 'sinner' when living in a religious family; the experience of being from a minority ethnic background; or the requirement to respond to events that evoke strong emotional responses.

Intervention should consider the opportunities and constraints of the immediate, local, and national context in which prosocial occupational participation occurs. This follows from the MOHO understanding that (dis)ability is not located within the person, but in a person's relationship with their environment. It also reflects the need to recognise that some mechanisms acting to influence prosocial occupational participation are only triggered in certain contexts.

The environment provides opportunities for prosocial occupational participation, but as the PDOs illustrated in their narratives, it could also facilitate antisocial occupational participation. Many of the PDOs recognised the people around them or the location of their homes as facilitators of the latter.

5.6.3 OCCUPATIONAL ADAPTATION

Occupational adaptation is the mechanism that enables sustained occupational participation in a changing environment.³⁴ It was evident in the 'learning and adapting' theme. PDOs described how they had to learn the occupational competencies to perform their new identities and sustain

occupational participation. However, the PDOs' narratives indicated that the occupational adaptation process also acted to facilitate sustained antisocial occupational participation. For example, Faisal and Danny described how participating in gang activities as youths gave them the knowledge, skills and sense of identity to adapt to living in the city in difficult family situations.

The majority of studies into occupational adaptation describe a process in response to acquired disability, disease or physical illness.²²² Among people with mental health conditions, occupational identity has been studied in adolescents with Attention-Deficit-Hyperactivity-Disorder,²²³ and occupational competence among people accessing a supported employment intervention.²²⁴ There is limited research into occupational adaptation in populations who have deviated as far from normal developmental trajectories as the PDOs in this study, with the exception of a case study illustrating its applicability in a medium secure service for PDOs.⁶⁵ This study demonstrates that occupational adaptation was the same for PDOs despite the additional mechanisms identified within the sub-systems, and was the same whether describing change in prosocial or antisocial occupational participation.

This research did not seek to identify processes indicated in antisocial occupational participation. Nonetheless, this was a clear finding. MOHO is often used in forensic mental health settings to explain antisocial occupational participation and to inform intervention to reduce it.²⁹ The findings from this study suggest that it is defensible to use MOHO in this way. However, this is not currently supported by published MOHO theory which only explains prosocial occupational participation. Further empirical and theoretical research is required with large and diverse samples to determine if the mechanisms described within MOHO are relevant to a broader scope of occupational participation, including those activities and roles considered antisocial, and if the modifications suggested within the

volitional and performance capacity sub-systems enhance the explanatory power of MOHO.

5.6.4 STRENGTHS AND LIMITATIONS

The critical realist approach to analysis identified factors that influence occupational participation that are common between the PDOs and supported by theory. This strengthens the inferences that can be made to other PDOs and other populations.

Bringing a theory to analysis may risk biasing the findings. However, findings did not fully support the pre-determined theory, indicating the strategies to strengthen credibility were successful.

Whilst efforts were taken to purposively select PDOs with a diverse range of experiences, there is always an element of selection bias in research. Those unwilling to participate may have been people with the most difficulties or who had very different experiences. However, the narrative approach allowed participants to discuss historical experiences where their engagement with probation and society would have precluded participation in this research, indicating that these experiences may have been captured.

5.7 CONCLUSIONS

Four themes demonstrate that occupational participation was often driven by the function performed by particular occupations. Past experiences of occupational participation could facilitate current occupational participation, but high levels of adversity, traumatic experiences and

'deviant' developmental trajectories caused PDOs difficulties in the present. PDOs often viewed occupational participation as under the control of 'external forces' rather than their own actions. They had to learn, often for the first time, and adapt to occupational participation as an adult.

The MOHO sub-systems were supported as mechanisms facilitating occupational participation, but modifications are suggested to fully explain occupational participation for PDOs. The data supports occupational adaptation as the mechanism of change in occupational participation. It is therefore suitable for use in intervention development.

The sub-systems acting as mechanisms to influence occupational participation among PDOs were equally evident in their influence on participation in antisocial activities and roles. By removing the requirement for occupational participation to involve socially acceptable activities and roles, the explanatory power. This conclusion requires further theoretical and empirical testing.

5.8 IMPLICATIONS

5.8.1 IMPLICATIONS FOR PRACTICE

- Narrative assessment can identify factors that influence occupational participation for PDOs
- Practitioners should consider the additional mechanisms within the volitional and performance capacity sub-systems of MOHO in assessment and intervention
- Interventions informed by occupational adaptation are applicable with PDOs
- MOHO can be used to explain participation in antisocial activities and roles

5.8.2 IMPLICATIONS FOR RESEARCH

- Interventions for PDOs in the community that that apply MOHO and occupational adaptation to improve occupational participation should be developed and tested
- Theoretical and empirical research should determine if the additional mechanisms identified in this research are evident in other populations
- Theoretical and empirical research should determine if MOHO can be modified to explain participation in antisocial activities and roles

5.9 CHAPTER CONCLUSION

This chapter presented the findings from the second sub-study in Work Package Two (WP2). The qualitative approach to data collection and analysis identified four themes that describe influencers of occupational participation. The findings reported in this chapter complement the results from the quantitative sub-study reported in Chapter Four and demonstrate the suitability of the Model of Human Occupation to inform intervention development. The next chapter presents a further sub-study from WP2.

6 IDENTIFYING WHAT INFLUENCES OCCUPATIONAL PARTICIPATION: PART THREE - NARRATIVE SLOPES

6.1 INTRODUCTION

This chapter reports the method and findings from the third parallel sub-study in Work Package Two (WP2). This sub-study collected and analysed each participant's narrative slope, which is their perception of the trajectory of their life. The different approach to studying the same phenomenon, factors influencing occupational participation, complemented the quantitative and qualitative sub-studies reported in Chapters Four and Five. Findings are discussed followed by implications for practice and research.

6.2 RESEARCH QUESTION AND OBJECTIVES

WP2 answered the question: what influences occupational participation for PDOs in the community?

Objectives of this sub-study were:

- Co-produce a narrative slope with each participant (see method)
- Group participants' narrative slopes to form narrative typologies and compare if and how differences between them influence occupational participation

6.3 METHOD

Participant sampling and recruitment is described in Chapter Four.

The OPHI-II manual advises that the interviewer draw a narrative slope independently after an interview, and later verify it with the interviewee. The narrative slopes were instead produced with the participant at the end of the interview for two reasons. First, this research intended to ascertain the participant's perspective of events in their life and its direction. Second, although member checks were conducted at a follow up interview to enhance the credibility of the findings, the nature of the population meant that a second appointment was not guaranteed to allow me to present back my interpretation.

The final topic in the semi-structured OPHI-II interview is 'turning points', which asks questions to elicit the participant's narrative about times when things were going well, they felt successful, things were going badly, they felt a failure, and when important events happened in their lives.¹¹⁸ After these questions, I introduced a narrative slope as a way of capturing the participant's account and clarifying my understanding.

Figure 6-1 shows the process of co-producing the narrative slopes, described below.

- Participants were familiarised with the concept of a narrative slope through my illustration of a timeline with an average midpoint on A3 paper. The vertical axis represented satisfaction with occupational participation and the horizontal axis represented the passage of time.
- The good and bad times, successes and failures were revisited in discussion and marked on the timeline by the participant. If they preferred not to do this, I made the markings on their behalf.
- For each event, a mark was made to indicate their level of satisfaction with occupational participation at this time. Other

events on the timeline were used as reference points to determine relative differences. This was prompted by questions such as, “were things better or worse for you at this time compared to ...?”

- Finally, I clarified the trajectory the person perceived their life to be taking (improving, deteriorating or remaining [un]stable) and the person (or I) drew this on the plot. Figure 6-2 shows how Mark drew his narrative slope.
- Following the interview, the participant’s (or my) sketches were transferred onto a template and any clarifying details added to aid recall during analysis. Figure 6-3 shows an example of Mark’s narrative slope following transfer to the template. Some annotation is blocked to maintain anonymity.

The lines between time points are not intended to illustrate an exact rate of change in satisfaction, for example there may be a precipitous drop when an event perceived as negative occurs at a time when things are going well, rather than a gradual deterioration. The lines illustrate a relative difference at time points only. The events are used to facilitate the persons recall of occupational participation and satisfaction with it at those times.

Figure 6-1 Process of co-producing narrative slope

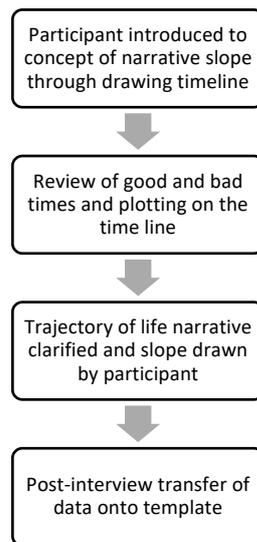


Figure 6-2 Narrative slope drawn by Mark

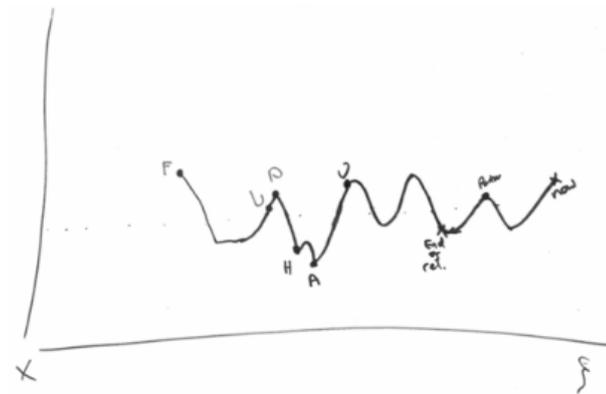
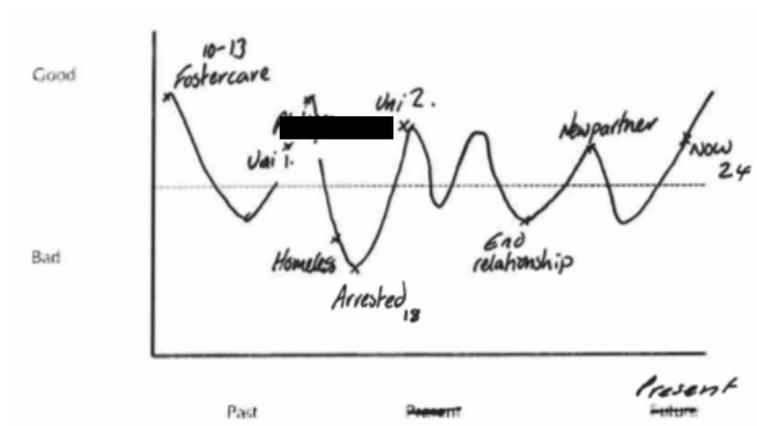


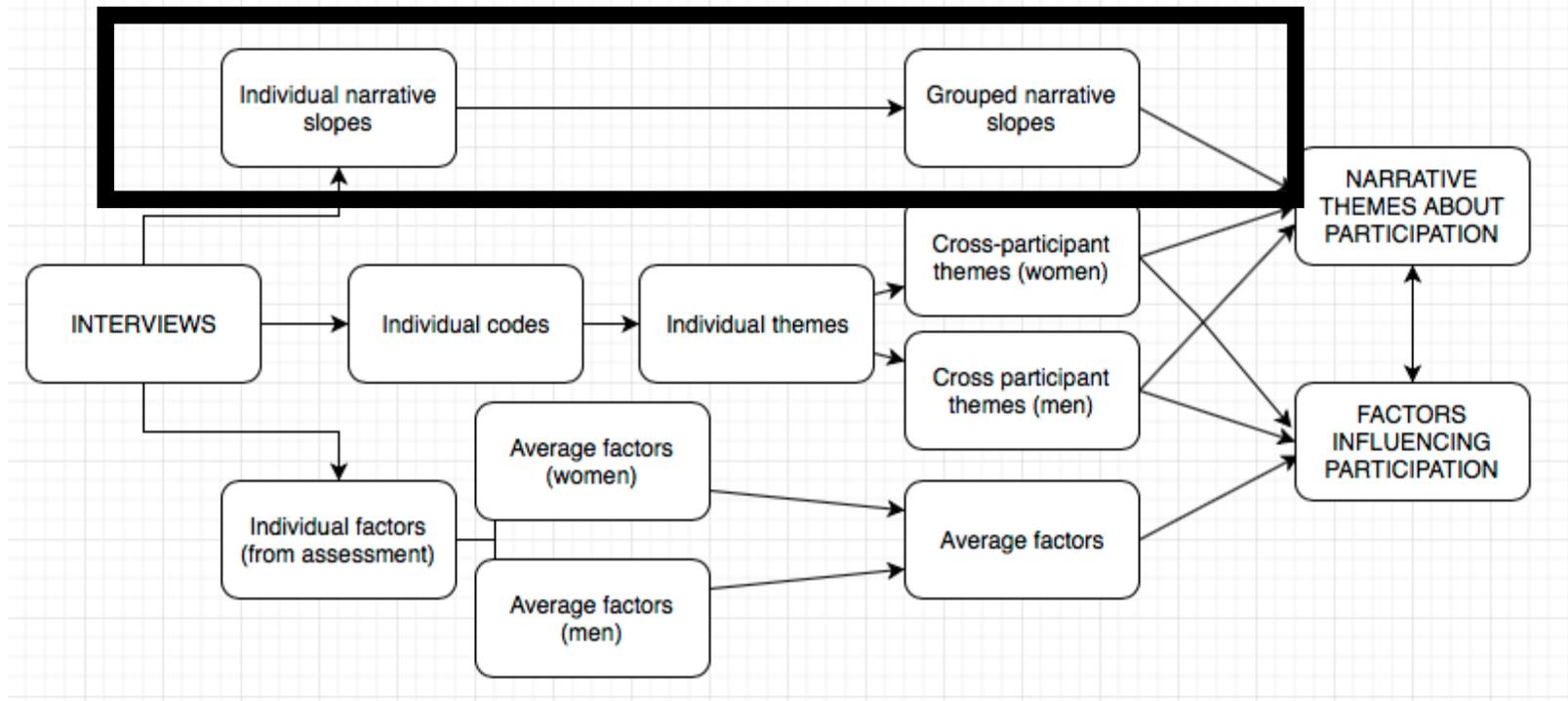
Figure 6-3 Mark's narrative slope after transfer to template



6.3.2 DATA ANALYSIS

Figure 6-4 shows the overall data analysis process of WP2. The process of arriving at the narrative typologies (grouped narrative slopes) is highlighted to demonstrate its position in relation to the data analysis in other sub-studies.

Figure 6-4 Work Package Two data analysis: Narrative slopes highlighted



Narrative thematic analysis¹²² involved analysing narratives as a whole and comparing entire stories. This is in contrast to separating someone's story into codes and themes, as undertaken in Sub-Study Two. The transformed narrative slopes were compared as complete accounts. First, they were compared to one another to identify similarities and grouped into typologies. Secondly, the typologies were reviewed against each participant's interview account to establish if the typologies adequately reflected all participants original narratives.

6.3.3 CREDIBILITY

Additional credibility strategies were added to those used in Sub-Study Two (reported in Chapter Five). Firstly, individual narrative slopes were drawn by or with the participant. This allowed for immediate correction of any misunderstandings, and participants could validate immediately that the narrative slope accurately represented their experience. To mitigate against participants feeling unable to challenge misunderstandings, they were explicitly invited to contradict perceived inaccuracies. Further, each participant's transcript was reviewed to confirm or disconfirm that a narrative typology into which the participant was grouped was consistent with their interview account. Participants who undertook member checking at a follow up interview confirmed which typology they felt represented their experience. This was compared with the typology identified in the analysis.

6.4 RESULTS

6.4.1 PARTICIPANTS

Thirteen men and five women were interviewed. A narrative slope was produced for each. All of the women and eight men collaboratively produced a narrative slope. Of the five remaining men, three interviews had to be concluded due to probation offices closing, and two men wanted to conclude the interview to go to other pre-arranged appointments. In these cases, I produced a narrative slope based on their interview data.

6.4.2 NARRATIVE TYPOLOGIES

Three narrative typologies were identified among the men, and two among the women. These typologies framed the way in which the participants interpreted their current occupational participation, their likely future and also the way they approached the services offered to them.

Each typology is presented below with verbatim quotations to indicate its basis in the qualitative data. These quotations were selected for their representativeness.

“THAT’S WHERE I’VE COME FROM AND LOOK AT WHAT I’VE ACHIEVED”

The first typology of narrative followed a progressive trajectory (Figure 6-5). This was present in three women and four men (n=7, 39%).

Figure 6-5 Narrative typology: Progressive trajectory



These narratives were characterised by a participant's ability to reflect on what had occurred in the past and why, and how it influenced their choices to participate in ways that had caused significant difficulties. The participants viewed themselves as changed, matured and wiser and were using past experiences of occupational participation to propel them towards participation in new activities and roles.

Until I'd thrown away that black and white, spectacles er. I was left with a muddle. When I did it. And now I'm muddling through it (laughs). And that's OK.

Angela

Great wake up call. Look at me now. I'm here today. Doesn't matter. Alright. I'm nearly sixty. It doesn't matter if I was nearly eighty. I can see now. But I can. I can see, to help other people now. Whereas I couldn't before. I was struggling and struggling. A mess. [emphasised] You know...

Gary

The participants described seeking occupational participation that allowed them to enact their changed identity or fulfil ambitions that were derailed

by problems and offending. They reported realistic goals, a sense of agency and accepted that they had to take a step at a time to achieve their ambitions.

By having, goals I guess. Setting personal goals and targets that I'd like to do even though they don't always go, the way that you planned life.

Mark

Very bright. If I continue the way I'm going. I can achieve anything.

Jackie

They described a desire to prove that they could achieve occupational participation despite their past.

And me just want to show other mothers, have for sure like, family member, certain people in a better position, you know. Especially like some government people, more of a show them, "you know what? People can change.

Marcia

That's [emphasised] what I've come from and look at what I've achieved

Mark

The narratives described an apparent appreciation of and confidence in the support offered by external agencies, and a willingness to engage with interventions offered. Participants recognised that their acceptance of support had changed.

When I was down here (points to youth, young adulthood on narrative slope) I had no respect for em. I was fighting em ... Like

with probation, I've grown a lot more respect for them, because. You know [offender manager] I think kind of knew the job she was taking on with me. Erm. But I think in way I've proved them all, wrong that, actually, I've changed...

Jackie

Back in the day yeah, I was a man that. Saw no use in it, coming to probation. Thought it was a way of like, just getting out of court and that... I done a lot of growing up and it's like. It's only like. This [emphasised] time is the first time that I'm like. Opening up [emphasised] to probation. Like. Talking to them, sharing things like. You know what I mean

Danny

The participants whose narrative slope followed a progressive trajectory described a change in the direction of their life from a time where their occupational participation harmed themselves or others, and they were either not offered or they rejected support. They felt they had reached a level of stability and sense of control that gave them hope for a better future, and confidence that they had support from the agencies involved with them. This in turn enabled them to take the risk of participating in new activities and roles, and to benefit from intervention.

“STUCK IN THE MIDDLE THINKING WITH A QUESTION MARK BESIDE MY HEAD”

The second narrative typology described a continual experience of instability (Figure 6-6). This was present in two women and seven men (n=9, 50%).

Figure 6-6 Narrative typology: Consistent instability trajectory



Participants described difficulty taking past experiences into account, a sense of confusion about how to participate in life, a focus on living day to day and an ambivalence about their occupational identity.

I want everything right now, because obviously my life was taken away from me when I was younger. So. Now I. Sometimes I just feel like I deserve it and I just can't get it... I don't think it's fair but then like I said, I don't go into that either, cos then that brings back. Loads of, horrible things. That have just gone on. So. Really I just have to concentrate on, what's going on now [emphasised]

Loelle

I'm basically stuck in the middle thinking with a question mark beside my head. And I've been doing that for the past three/four years, while suffering

Ali

Participants described a limited sense of agency with regard to past and present occupational participation, and an avoidance of goals because of perceived inevitable failure.

Everyday life. It occurs and there's nothing I can do about it.

Steve

I don't like setting goals as I can't keep em you know.

Jamie

Narratives described frequent disruptions through moves, abuse, relationship breakdowns, and early exposure to illegal or harmful ways of coping. These were relayed in fragments, with participants jumping between time periods.

The reason why probably me heads mashed up man. Cos I've never felt set- settled since I left [childhood area].

Aaron

From drugs and drink, abusive relationships erm, me be in a, with my dad, he sexually assaulted me from a young age, from the age of eight up until I was eighteen. and er. Yeah. I think my life was just traumatic and in the end that, that's wor I done, because I felt like I wasn't getting any help or anythink.

Shelley

External agencies, such as probation or mental health services, were viewed as potential rescuers who were expected to take responsibility, yet not fully trusted to do so. This led to fluctuating and partial honesty and engagement.

Because in my mind I was just stupid and "what's the point. It's not gonna come to anything.

Richard

I'm not sure if they believe in me. You know what I mean. [offender manager] says he does, but I, I'm not a hundred percent sure, you know.

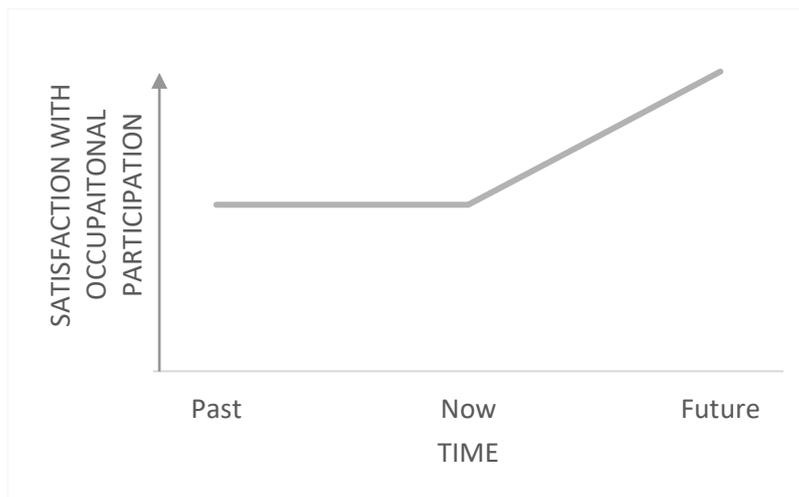
Jamie

Consistent instability was the most common narrative typology. Viewing and experiencing life as unpredictable and uncontrollable appeared to reduce the participants ability to consider themselves agents of change, their ability to see others as supportive, and their confidence that support wouldn't be withdrawn.

“JUMPING THROUGH HOOPS”

The final narrative typology was evident in two men's narratives (11% of sample). The men recounted a sense that other people and the world were unjustifiably restraining them, holding them back from what they could achieve (Figure 6-7).

Figure 6-7 Narrative typology: Restrained trajectory



These men viewed themselves as prevented from occupational participation that was important to them by outside forces, such as other people, women and the authorities.

*I want to be able to decorate the house and do it up and sell it.
(pause) But at the moment. You know. We're, we're not allowed so.*

Just a case of having to jump through hoops, for them... Strangers are dictating to us. It's just. It does me head, having to do all this conforming and. You know like. People that don't even know you telling you what to do. It just drives me potty.

Michael

She's saying that erm I've gotta have people like erm, interfere in my life, and, and erm, they need to know who my new thing of relationship with, they need to inform them that I've had convictions for domestic violence. But I've never been violent, so. I just think it's a load of crap

David

The men often perceived themselves to have achieved a degree of success in work or family life prior to the offence for which they were on probation, successes that they felt had unjustifiably been removed. They therefore did not see the past as something to move away from, or their behaviour as something to change.

I've been on this planet for forty years and there's more to me than, an offence... It doesn't matter how much of a good dad you are, or how much of a good husband, or how thoughtful you are, or loving or caring. That, that, all that, is outweighed by your offence.

Michael

The men thought that this was not the view taken by the probation service, leading them to devalue any assistance or actions they took, and limiting the benefits they gained from any interventions.

I know she'd prefer me to be behind bars... So she can lighten that workload, then she would. So they're all waiting for me to fuck up and do something.

Michael

Come here and they try and tell me like, that I've got all these problems and like, "I shouldn't do this, I shouldn't do that" and try to make you believe what they want you to believe and. I can just lie to em, say "yeah, I'll be like that," just to keep them happy.

David

These men viewed their circumstances as something to endure and to fight to get back their freedom. They didn't share the concerns of the offender managers and were cynical that external agencies were well intentioned. One of these men attended a follow up interview. He confirmed the typology matched his experience.

6.5 DISCUSSION

6.5.1 SUMMARY

Analysis of the 18 participants narrative slopes identified two typologies that were common to both men and women: 'progressive' and 'consistent instability'. Among the men, there was an additional 'restrained' narrative typology. These narrative typologies influenced a person's past and present occupational participation, their perceptions of interventions designed to assist them and their view of the people delivering them. This section discusses these findings in relation to the literature on narrative slopes in occupational therapy, narratives in criminology research, and literature that considers interventions.

The three narrative typologies did not align with those previously identified in occupational therapy research. Theorists and researchers discuss three slopes: progressive, stable and regressive.^{128, 134, 225} The progressive trajectory was consistent. However, the PDO narrative typologies were otherwise different.

The regressive slope is where someone perceives a deterioration in a previously good life and views the future as likely to continue deteriorating. It was not evident in the PDO sample. This may be because the PDOs willing to volunteer, or that offender managers agreed to approach, were in a better position in their life than those who weren't interviewed. Those who weren't interviewed may have had a regressive slope. Alternatively, after a prolonged involvement with the criminal justice system, participants may have learned which narratives are most likely to appease service providers and as thus chosen to portray themselves as reformed and hopeful. However, participants almost all described a past that was troubled, traumatic, unhappy and/or unsafe. Despite being on probation, often with co-morbid mental and physical health conditions, their lives could only be described as improving (progressive), or as a continuation of the same (consistent instability).

The stability slope is difficult to apply, as those narratives that were not progressive, most often followed a trajectory of consistent instability rather than stability. Arguably, this is a stability of sorts, but it was characterised by marked ups and downs. The only example identified in the occupational therapy literature of a possible consistent instability narrative is a single case of a woman who, like many of the participants in this study, was driven by a need to seek refuge from being buffeted by external events.²²⁶ A lack of agency and an unstable sense of self is consistent with the features of emotionally unstable personality disorder,²

which could explain why this typology was the most common. People with a personality disorder are under-represented in occupational therapy research, which may explain why this typology has not previously been described.

In this sample, some men told a narrative of being unfairly restrained by others. This is not reported in the occupational narrative literature. Identifying this typology could be explained by the nature of the population. A view that others are to blame and that one's actions are justifiable are among diagnostic criteria for dissocial personality disorder.² There is minimal occupational therapy research including people with this diagnosis. However, the restrained narrative typology was less common than expected given that antisocial/dissocial personality disorder is the most common personality disorder in probation populations.⁸ Additionally, the screening tool for determining someone's eligibility for the Offender Personality Disorder Pathway, from which the participants were sampled, is best suited for identifying antisocial/dissocial personality disorder.²²⁷ This suggests that either there were fewer people with antisocial personality disorder in the PDO sample than is representative, the sample included people whose traits associated with an emotionally unstable personality disorder diagnosis were more prominent, or that diagnostic criteria may not correlate with narrative experience.

The differences in the typologies identified among PDOs likely reflects the fact that occupational narrative research was developed among populations who had a high level of premorbid functioning before a deterioration associated with their reason for seeking therapy. The current occupational narrative literature does not include people with an offending history, or people who are likely to have personality disorder diagnosis. Most occupational narratives reported to date follow a traditional western discourse of self as agent of change and employment as a marker of success.^{225, 228} This is at odds with the PDOs experiences of limited or

'antisocial' occupational participation throughout their lives, intervention being imposed and where identification with normative trajectories and discourses is limited by their experiences and continued stigma. The literature on occupational narratives has been enhanced by this research highlighting important differences among PDOs and suggesting that further diversifying the samples from which occupational narrative research draws could reveal important results.

The narrative typologies need to be considered in light of a core feature of personality disorder. Reflective function is the ability to understand one's own and others' actions as the result of intentional mental states, and to accurately perceive these mental states.²²⁹ Reflective function can be disrupted by early developmental adversity and has been found to be impaired among people with a personality disorder.²²⁹⁻²³¹ Inability to recognise one's own intentions could partially explain the consistent instability typology, where there was a disjointed description of life and occupational participation that often seemed to the participants to be outside their control. Impaired reflective function may also contribute to unrealistic positivity about the future, or disproportionate attribution of blame to external agencies in the progressive and restrained narratives respectively. There is little research on occupational participation and reflective functioning. One study of people accessing an employment support programme found that personality disorder and reflective function were related to one another and predictive of poor employment outcomes, but also that poor employment outcomes could be attributed to impaired reflective functioning.²³² Appraisal of someone's narrative slope may indicate if and how impaired reflective functioning influences their occupational participation.

Generating narrative typologies among groups is not unique to occupational therapy, with the approach spanning criminology, health, psychology, sociology and other disciplines of research.²³³ In criminological research, Youngs and Canter consider criminal acts to be an enactment of someone's narrative, or an event in an unfolding narrative plot. They argue that when committing a crime, offenders adopt one of four narrative 'roles' (adventure, irony, tragedy and quest). They built typologies by associating each role with cognitive and affective patterns.^{131, 234,235}

Youngs and Canter focus on the story of a crime for the purpose of criminal profiling rather than intervention to increase occupational participation. However this illustrates the wider use of narrative research in criminology. The application of narrative identity theory to criminology by Maruna⁴² has generated a broad literature exploring people's desistance narratives, i.e. narratives about stopping offending. Maruna identified redemption and condemnation typologies in a sample of 55 men and 10 women. People who had committed serious offences, such as the PDOs in this research, were in the minority. The redemption typology was common to those who desisted from crime and corresponds to the progressive typology in this study. From his perspective, Maruna commented that the redemption typology did not always appear to reflect the reality of an individual's life. In contrast, the PDOs were relatively realistic about the need for modest goals and the likelihood of stumbles along the way. Maruna found the condemnation typology was more common in those who reoffended. The condemnation script may be closer to a regressive slope in the occupational therapy literature that was not seen in this sample, although arguably it may incorporate the helpless position reflected by the PDOs in the consistent instability typology. Maruna did not identify a separate restrained typology. This may be due to the focus of his analysis on desistance rather than occupational participation.

Maruna did not find differences between men and women and his findings have been confirmed in women only samples.⁵⁰ In contrast, Herrschaft et al.⁵¹ identified differences in transformation narratives, with men being more likely to cite status factors and women more likely to cite relationship factors as facilitators of success. This research also found differences, only identifying the restrained narrative typology among men. This may be due to the smaller number of women in the sample. The restrained narrative typology represented two men. A larger sample of women may have resulted in its identification. Alternatively, this typology may be uncommon among women.

Narrative research with a sample of released life-sentenced prisoners also identified differences from Maruna's typologies.⁵² Like the PDOs, the released prisoners had all committed serious offences and been incarcerated for long periods. Liem and Richardson⁵² found aspects of the redemption typology in the narratives of both desisters and reoffenders. This offers potential support to the suggestion that people learn the narratives that are desirable to others when they have had prolonged experiences of incarceration. A lack of agency was more common in the group who reoffended. Lack of agency was evident in the consistent instability typology in this research and again indicates that a PDO whose narrative reflects this typology may have a higher risk of reoffending. Differences in the narrative typologies of high-risk offenders and those who have served long prison sentences indicates that Maruna's typologies may not be applicable to all offender populations.

In offender rehabilitation, there are few studies that analyse alternative typologies rather than applying those identified by Maruna, potentially missing important alternative narratives. This study indicates the value of applying other frameworks to categorise typologies and suggests that division into two typologies (redemption and condemnation) may oversimplify the complexity of the contemporary narratives of high-risk PDOs.

Narrative slopes have been associated with outcomes of occupational therapy interventions in observational studies. Patients whose narratives were categorised as progressive were more likely to achieve better outcomes.^{128, 236} However, these studies did not include people who were likely to be PDOs. A small narrative study of participants in an intervention for people with antisocial personality disorder and substance misuse problems supports the suggestion that narrative typologies may be indicative of outcome.²³⁷ In Thylstrup et al.²³⁷ the participant reporting a narrative with progressive features valued, engaged with and took responsibility for the success of the intervention. The progressive narrative was only evident in 39% of the PDO sample and could be less when considering potential selection bias in the sample. This suggests a need to consider how to work effectively with this population to maximise good outcomes.

The case selected to illustrate an unsuccessful intervention by Thylstrup et al.²³⁷ shared the features of ambivalence and lack of agency identified among PDOs with an consistent instability narrative, the most common typology in this sample. These features were similarly evident in the case report of unsuccessful occupational therapy intervention.²²⁶ Identifying, setting, working on and completing goals can be a challenge for those whose narrative reflects the consistent instability typology.²³⁸ This could be explained by having never learned that their actions cause an effect²¹³ and/or having low levels of reflective functioning.²³¹ Both interventions where narratives were analysed as a potentially influencing factor were designed on the basis that the person wanted to make lifestyle changes, and viewed themselves as an agent of change in life moving towards productive contribution to society. Interventions designed in this way may not succeed for PDOs whose narrative reflects the consistent instability typology.

Someone whose narrative reflects the restrained typology may present the most challenges to engaging in an intervention, given the view of these men that what needed to change was other people's unfair restriction of their occupational participation. People with an antisocial personality disorder (ASPD), particularly with comorbid substance misuse disorders, are less likely to receive follow up support and treatment.⁹⁵ Lack of appropriate treatment and practitioners' skills and attitudes are cited as potential reasons by the authors, although they acknowledge that they did not capture if treatment was offered and rejected. Treatment rejecting or drop out, is associated with poor outcomes.²³⁹

A systematic review found non-completion rates for psychosocial therapies at 37% for people with personality disorder. Correlates of non-completion were identified, focusing on factors related to the person or their personality disorder diagnosis.²³⁹ Attributing treatment rejection to someone's personality disorder or person factors alone is problematic. There is an argument that treatment rejection or drop out is not a result of a particular personality disorder, but the result of the available treatment being inconsistent with the person's needs, perception of what is required, and/or ability to sustain engagement. It may be considered appropriate by the practitioner, but if this view is not shared by the person, then genuine treatment engagement will be less likely.

People are more likely to adhere to treatment, and thus it is more likely to be effective, when it is personalised to take account of individual concerns and beliefs about its relevance.^{240, 241} This, along with ethical arguments, drives the person-centred mental health care agenda.²⁴² The impact of tailoring to the individual is also demonstrated in risk reduction interventions, which are incrementally more effective when they address 'responsivity' issues such as learning style.⁵⁵ In a study of people living with HIV/AIDS, Levin et al.¹²⁸ found those with a progressive narrative were

more likely to have a successful treatment outcome and suggest that interventions should be tailored in response to the persons narrative slope rather than traits or symptoms. Other authors have argued that utilising narrative is essential to situate an intervention within the person's world view^{135, 136} and as a method to work-cross-culturally to understand how a person perceives past, present and future.²⁴³ The findings in this research highlight that narrative typologies differ among PDOs compared to other populations. Framing intervention in a way that is consistent with a PDOs world view, perceived needs and treatment goals, may enable practitioners to deliver intervention that is responsive to individual experience and is thus relevant and relatable. This may minimise rejection and maximise successful outcomes.

6.5.5 STRENGTHS AND LIMITATIONS

Individual narrative slopes were not cross-checked against events or changes in occupational participation reported in other sources. However, the focus of this work package was to identify differences in the participants' subjective realities, irrespective of what could be confirmed or disproven by other data.

A regressive narrative typology was not identified, which could be explained by recruitment bias. Although efforts were made to access PDOs who were struggling or engaging poorly in probation, those willing and able to partake in an interview may have been less likely to perceive their life as on a downward trajectory. Nonetheless, the adverse past experiences of PDOs may indicate that their current position was, at worst, a continuation of the same.

Participants may have consciously or unconsciously wished to portray themselves in a way that did not reflect their true perceptions. This may

have been heightened by conducting interviews on probation premises, leading the person to question the researcher's independence.

Disentangling what is a 'true' portrayal is a challenge in all therapeutic work. The results should be considered with the recognition that they were produced with people who have had experiences that may make honest disclosure unfamiliar or undesirable. However, the participants narrative slopes were supported by the accounts given at 45-120 minute interviews.

A further complication was the potential for the person's perception to change. However, eight of nine participants confirmed the typology allocated was still accurate during member checks, giving confidence in the stability of the typologies.

6.6 CONCLUSIONS

Three narrative typologies were identified among PDOs that differ from those reported in the literature to date. These narratives typologies influence occupational participation and may influence the person's participation in any intervention offered to improve it. Applying narrative approaches in practice must be critically considered if working with diverse populations who may not share the same narratives as intervention providers or narratives reflected in dominant social discourse. Ensuring an intervention is relevant and relatable to the person concerned may be facilitated by ascertaining their narrative slope and making appropriate adaptations to engage with the person in an intervention.

6.7 IMPLICATIONS

6.7.1 IMPLICATIONS FOR PRACTICE

- Practitioners should recognise that PDOs often do not share the narratives of dominant social discourse that practitioners may implicitly adopt
- A narrative slope may be used to inform an intervention, to maximise its relevance and respond to a person's experience and skills. This may increase the likelihood of successful intervention outcomes.

6.7.2 IMPLICATIONS FOR RESEARCH

- Occupational narratives need to be gathered from more diverse populations to ascertain how occupational participation is influenced among people whose life history significantly deviates from cultural norms
- Intervention research may consider comparing outcomes between participants whose narratives fall into different narrative typologies

6.8 CHAPTER CONCLUSION

This chapter presented the findings from Sub-Study Three in Work Package Two (WP2). The narrative approach to data collection and analysis identified three narrative typologies that influence of occupational participation. The next chapter reports the mixed-methods convergence, which involved integrating the results of this sub-study with the results and findings from Sub-Studies One and Two to identify the factors that influence occupational participation for PDOs in the community.

7 IDENTIFYING WHAT INFLUENCES OCCUPATIONAL PARTICIPATION: PART FOUR – MIXED-METHODS INTEGRATION

7.1 INTRODUCTION

This chapter reports the method and results from the final sub-study in Work Package Two (WP2). This sub-study represents the convergence process in the convergent parallel mixed-methods design. The quantitative results, qualitative findings, and the narrative typologies reported in the preceding three chapters were integrated to identify what influences occupational participation for people with a personality disorder and an offending history (PDOs) in the community. Results are discussed followed by research and practice implications.

7.2 RESEARCH QUESTION AND OBJECTIVES

WP2 answered the question: what influences occupational participation for PDOs in the community?

Objectives of this sub-study were:

- Integrate the findings and results from three sub-studies to produce a list of factors that influence occupational participation for PDOs in the community
- Determine if results resonate with the research participants

7.3 METHOD

The fourth sub-study involved no new data collection. Data from the previous sub-studies were analysed using a structured mixed-methods integration process. Table 7-1 highlights the data from each sub-study that were used in the analysis.

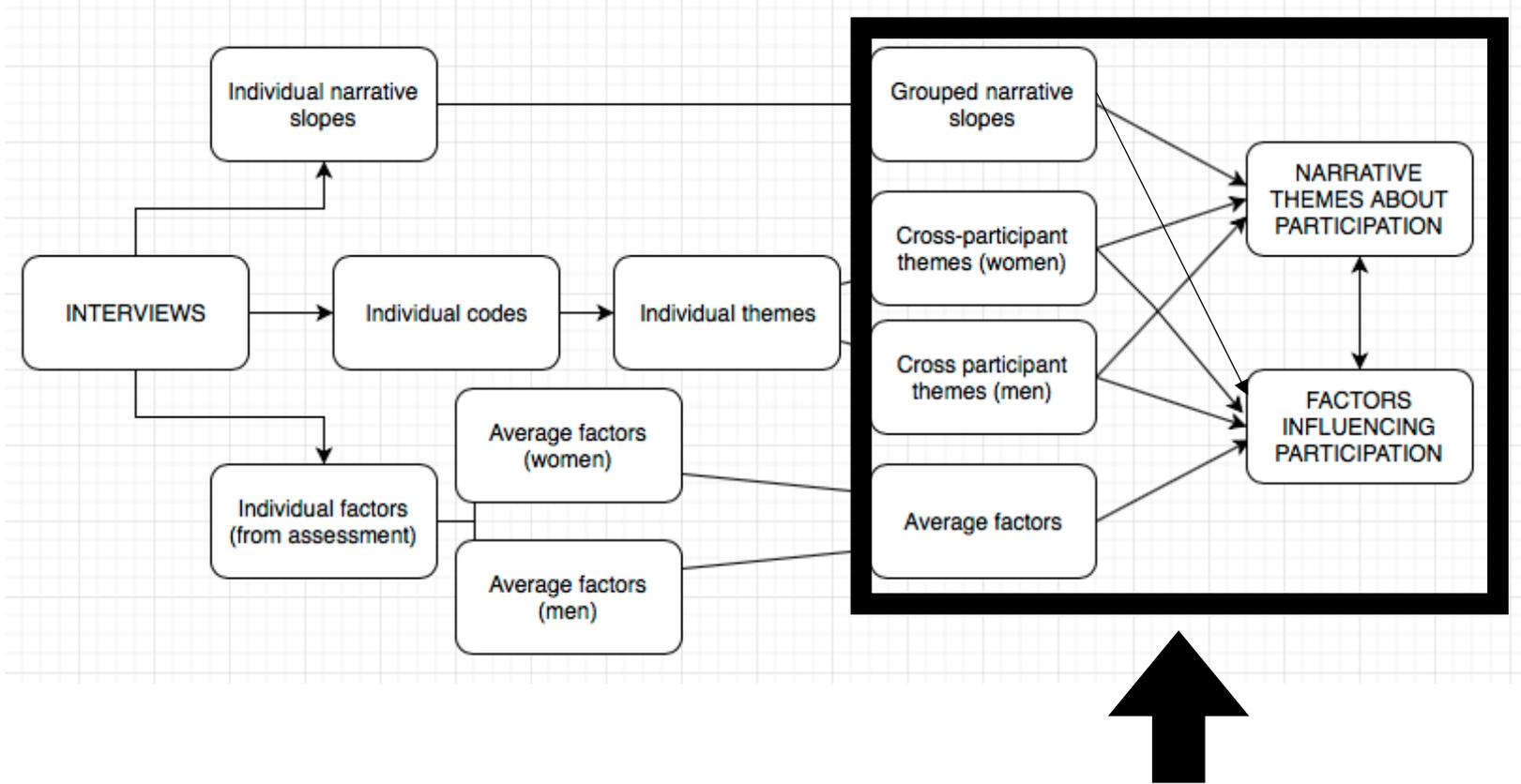
Table 7-1 Data taken into mixed-methods integration

Sub-Study	Data taken into mixed methods integration
Quantitative (Chapter Four)	Items on the OPHI-II and MOHOST assessments where the sample average was below 2.5 or above 3.5
Qualitative (Chapter Five)	21 sub-themes
Narrative slopes (Chapter Six)	3 narrative typologies

7.3.1 DATA ANALYSIS

Figure 7-1 shows the overall process of data analysis in WP2 with the analysis conducted in this sub-study highlighted. An arrow indicates where the integration process occurred.

Figure 7-1 Work Package Two analysis process: Integration process highlighted

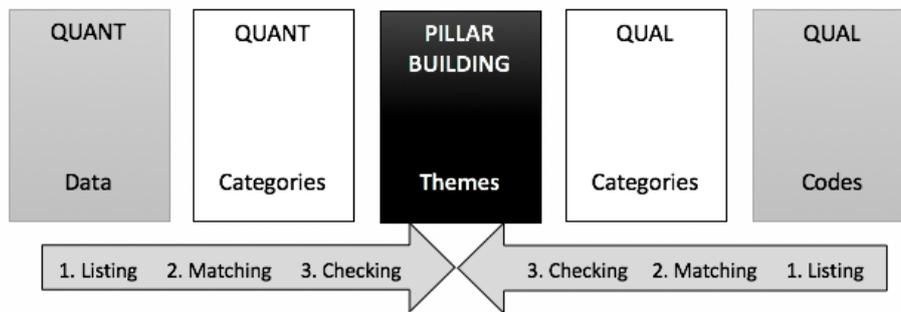


Mixed-methods integration as a specific method of analysis is beginning to be described in the literature.²⁴⁴ However, many terms are used (e.g. synthesis, triangulation, integration), often without clarification of what they are, how each is done or how they differ from one another.^{245, 246} This leaves researchers with little guidance, and open to criticism because the process lacks clarity and cannot be appraised. The 'Pillar Integration Process' was developed in response to the lack of rigorous, transparent and replicable mixed-methods approaches available the literature.²⁰⁴ As one of the few published integration methods appropriate for convergent parallel designs, and having been developed and used in complex health interventions research,^{247, 248} it was selected to structure the analysis in this sub-study.

Joint displays, commonly used in health research,²⁴⁹ are a way to visually integrate and represent findings, often in a table or matrix.²⁴⁴ The Pillar Integration Process uses a side-by-side joint display, where quantitative and qualitative results and findings are presented vertically beside one another to facilitate direct comparison and integration of different types of data describing the same phenomenon (Figure 7-2). This approach facilitated direct comparison between data from WP2, which used quantitative and qualitative methods to identify factors influencing occupational participation for PDOs in the community. Integration was conducted in four phases: listing and transformation, matching, checking and 'pillar building'

The phases are described in more detail below. Appendix E contains the full Pillar Integration Process from this sub-study to support the description.

Figure 7-2 Visual representation of Pillar Integration Process



Reproduced from Johnson et al. ²⁰⁴

TRANSFORMATION AND LISTING

Transformation is the conversion of data from quantitative to qualitative, or vice versa to permit direct comparisons.²⁵⁰ The quantitative data were transformed into qualitative data. Listing involved summarising the quantitative and qualitative data in separate ‘pillars’ on the outside of a joint display, e.g. column one and five in a five column table. The lists were then reduced and entered into pillars two and four for matching.

Quantitative data were the average scores in the PDO sample on the items of two standardised assessments. These were transformed by taking the name of the item and writing a short description using the manual criteria. This description was entered in the first ‘pillar’. The descriptions were reduced in number by merging those that were the same (resulting from using two assessments). The reduced list was entered into the second pillar.

The data listed in the opposite external pillar were the narrative typologies and the qualitative sub-themes. The narrative typologies were reflected in a number of the sub-themes and were thus subsumed into the qualitative

list. This list was entered into the fourth pillar for matching with the quantitative results.

MATCHING

Matching identified where results/findings directly related to one another or were describing the same concept in different ways. The data in each list were matched with one another where they reflected the same concept, to produce rows of matched data. If a match was not found, the list item was retained in its own row. Appendix E shows an excerpt of the results from this process.

CHECKING

Checking involved confirming that all data was matched where appropriate and identifying where there were no direct matches. The matched list was reviewed and refined. Each row on the matched list was summarised by writing a short descriptor. The matched list was compared to the four overarching narrative themes produced in Sub-Study Two as a further check on the validity of the Pillar Integration Process. Section 7.3.2. outlines the full process of validating the results with the original participants.

PILLAR BUILDING

Pillar building involved comparing, contrasting and conceptualising insights from the results. To build the final pillar, each summary descriptor was given a name and considered a factor influencing occupational

participation. Each factor was further reviewed to ensure it reflected the concepts represented by the underpinning matched data. Each factor was tabulated against the sub-systems in the Model of Human Occupation (MOHO), and the items in the associated assessments. Appendix E illustrates this process. Where factors did not match a MOHO item, this was summarised in the table with reference to the modifications required to the MOHO sub-systems discussed in Chapter Five. Finally, the factors were grouped according to the modified MOHO sub-systems to produce a list of factors that influence occupational participation for PDOs in the community, rooted in both quantitative and qualitative findings and supported by MOHO theory.

7.3.2 SYNTHESISED MEMBER CHECKING

Strategies to ensure reliability and validity of results from the quantitative sub-study are reported in Chapter Four. The strategies for ensuring credibility of the qualitative findings and narrative slopes are reported in Chapters Five and Six. In Chapters Five and Six, reference is made to the process of ‘member checking’ to validate the final results of the mixed-methods integration. This section briefly describes what this is, how it was done and why this approach was selected.

Like mixed-methods integration, in qualitative research the term ‘member checking’ is often used. It’s widespread use has been criticised as a ‘nod to validity’ with authors citing it but without describing and justifying the method, its consistency with a study’s epistemology, or the ethical implications.¹²³ To select a member checking strategy, consideration was given to the purpose of validating the synthesised results and the impact of doing so on the participants and the research.

The aim of member checking was to establish if the factors resonated with the participants after integration. This was to confirm the likely acceptability to PDOs of an intervention that was developed on the basis of the synthesised results.

To demonstrate rigour, transparency and replicability, a structured framework was applied, called Synthesised Member Checking (SMC).¹²³ SMC involved producing a visual and simplified 'map' of the factors identified after integration and meeting with the participant to discuss these.

Meeting in person, rather than posting results and seeking written responses, was determined to be more likely to be successful due to the low literacy levels, high levels of transience and fluctuating motivation in the population. In discussion, participants considered whether the synthesised results resonated with their personal experience. They were asked whether each factor made sense to them and if they had any comments. The researcher noted the comments on a prepared data collection sheet (see Appendix F). Participants could change, remove or add factors to the list. The Patient and Public Involvement Advisory Group (PPIAG) considered SMC to be beneficial if participants could recognise their experiences, but maintain control by having the opportunity to add or remove factors. The number of agreements, disagreements, changes, additions and removals were summed to reach a total across participants. The mean number of amendments per participant were calculated. Disconfirmation required a return to the analysis to ensure experiences were accurately represented.

Finally, participants identified which narrative typology best represented their experience. This was compared with the researcher's perspective and the initial slope drawn at interview (see Chapter Six). The regressive slope

that was not identified in the sample was presented to confirm its absence. Appendix F shows the documentation supporting this process.

In addition to meeting the aim of the member checking (to confirm the integrated findings were still recognisable to participants), this was also the safest and most ethical way of conducting SMC. Participants did not revisit their own interviews and some of the difficult topics raised. This was confirmed by the PPIAG as preferable, who considered it to be lower risk of causing emotional distress because it avoided re-exposure to issues discussed at interview.

The Offender Manager overseeing the case of each original participant was re-contacted to invite the person to a follow up meeting with the researcher. Some participants had completed their period of supervision and were not contacted, some offender managers did not respond, and some interviews could not be arranged at a mutually convenient time.

7.4 RESULTS

7.4.1 MIXED METHODS INTEGRATION

Table 7-2 lists the 26 factors that influence occupational participation for PDOs in the community and their relationship to the MOHO sub-systems. Appendix E shows the final results of tabulating each factor against the MOHO sub-systems and items within the associated assessments.

Table 7-2 Factors influencing occupational participation for PDOs in the community

	Factor and description	MOHO sub-system
1	Self-efficacy in social settings Perception of own competence in social settings	Volitional sub-system Personal causation (self-efficacy) operated differently depending on the social context. Need to recognise functional motivation - being driven by desire for sensory/emotional need fulfilment Past belonging, traumatic/adverse experiences and 'antisocial' occupational participation need to be recognised as influencing volition.
2	Self-efficacy in activity Belief in ability to participate in activity, overcome challenges, stay in control, and achieve outcomes	
3	Goals Willing to set goals, goals are achievable/realistic; sustains focus on goals	
4	Prosocial interests Independently pursues activities that bring pleasure, structure and purpose	
5	Emotional/sensory drive Seeking activities that perform an emotional function	
6	Past-mastery Experience of being good at something; pride	
7	Past experiences of belonging Experience of being a valued part of a social group	
8	Past experiences remain in the past Ability to separate past from present, ability to use to motivate participation	

9	Adaptability Being able to anticipate and cope with change in routine/activities/ social settings (expected); Being willing and able to learn and adjust behaviour	Habituation sub-system Adaptability separated into predicting, responding in a controlled manner, and willingness to adapt (retained in the factor 'adaptability'), and ability to tolerate change or unexpected situations (moved to performance capacity sub-system in 'emotional stability' factor) Need to recognise the impact of functional motivation and past 'antisocial' occupational participation on habit formation and internalised roles
10	Sustaining a routine Ability to maintain a balanced range of activities that meet needs	
11	Role Has a role that gives identity and meaning	
12	Responsibility Recognises what is/is not own responsibility; willing/ready to acknowledge and accept obligations and tasks; fulfilling expectations/ obligations; recognises impact on others	
13	Past experience of fulfilling a role Experience of developmentally normative roles	
14	Past experience of sustaining positive habits / routine Experience of sustaining a routine that met needs, desires and responsibilities	

15	Emotional stability Ability to predict or control responses to rapid and marked mood change	Performance capacity sub-system (emotional and relational skills) MOHO does not explicitly identify emotional and relational skills. These factors suggest an additional component should be added to the performance capacity sub-system.
16	Relating to people Able to respect and relate to others; aware of and manages own and others' needs; can offer and receive support; can balance levels of involvement with other people	
17	Perception of social judgements Beliefs about how others view them; congruence between this and current or desired future participation	
18	Conversational skills Initiates and sustains contextually appropriate conversation; manages disclosure; communicates needs and wants; adequate language ability, vocabulary and grammar to express self; clear meaning; able to take turns in interactions	Performance capacity sub-system (communication and interaction skills)
19	Non-verbal skills Able to utilise eye-contact, gestures, facial expression in communication; able to respond to others non-verbally	

20	Problem solving Able to generate workable solutions, make judgements and take decisions in response to challenges (that support positive outcome); can distance self to be objective, can use abstract thinking; able to learn from mistakes and benefit from instructions	Performance capacity sub-system (process skills) Factors could be affected differently depending on social context. Knowledge and problem solving referred to social role participation rather than activity performance.
21	Knowledge Knows what is expected of adults in society; can draw on role models	
22	Managing attentional demands Initiate and complete task using sequencing /prioritising; concentrates but attends to environment; able to cope with distractions and variable stimulation; awareness of time	
23	Physical capacity Can maintain posture, mobilise, use suitable levels of strength and effort, coordinate oneself	Performance capacity sub-system (motor skills)
24	Safe home Has a space that is their own, safe from disruptions and within their control	Environment sub-system
25	Social validation Social groups value their contribution	
26	Criminal record and disclosure requirements External requirement for occupational participation in some settings Able to judge when and how to disclose	

7.4.2 SYNTHESISED MEMBER CHECKING

SMC was completed with 50% (n=9) of the original participants. Table 7-3 shows the broad agreement with the factors identified as influencing occupational participation. Participants raised some additional factors which they felt were not reflected: finance, faith and sex. Finance was added at a later stage (discussed in Chapter Eight) as it was not widely discussed by participants at interview, sex was considered to be an example of occupational participation rather than a factor influencing it, and faith was included in roles (having a purpose). Where there was disagreement, original data and analysis was reviewed. This revealed that disagreements were where the participant felt that a factor was a strength, which was consistent with it still influencing occupational participation. No changes were therefore made to the list of factors.

Table 7-3 Synthesised member checking agreement levels

	Factors agreed	Factors disagreed	Factors removed	Factors added	Factors changed
Total statements	229.0	5.0	0.0	6.0	0.0
Average	25.4	0.6	0.0	0.7	0.0

7.5 DISCUSSION

7.5.1 SUMMARY

Twenty-six factors were produced from the mixed-methods integration. This section discusses the factors in relation to studies identified in the systematic review of the factors influencing occupational participation for PDOs in the community,²⁵¹ the literature addressing occupational participation among people with personality disorder, the items in the

assessments used in WP2, and the associated Model of Human Occupation (MOHO) sub-systems.

7.5.2 COMPARED TO SYSTEMATIC REVIEW FINDINGS

There is insufficient evidence for the factors influencing occupational participation for PDOs in the community.²⁵¹ In one of the three studies identified in the systematic literature review, assertiveness in the past and Intelligence Quotient (IQ) were associated with occupational participation in men discharged from a high security mental health facility.¹⁵⁷ For PDOs, assertiveness was evident within the factor 'relating to people' which included the ability to relate to others and assert needs appropriately. IQ was not identified as this requires specific testing.

The narrative synthesis of the systematically reviewed literature indicated that the potential relationship between prosocial identity and occupational participation, and self-efficacy and occupational participation, may be mediated by supported participation in activities and social roles.^{76, 159} Prosocial identity was clearly captured within the factors 'roles', 'past experience of fulfilling a role' and 'social validation'. However, self-efficacy was nuanced among the PDO sample. Self-efficacy had two facets: self-efficacy in activity, which included a person's belief about their ability to *perform* an activity (e.g. cook, paint); and self-efficacy in social settings, which included a person's belief about their ability to *participate* in a role (e.g. parent, worker) or an activity with even a small social component (getting a bus, using a supermarket).

One study suggested habitual destructive activities may moderate occupational participation.¹⁵⁹ In this sample, habitual patterns (destructive or otherwise) would be captured in 'adaptability', 'sustains a routine' and 'past experience of positive habits/routine'. Additionally, recognising the

‘emotional/sensory drive’ to participate in both prosocial or antisocial activities may further explain why someone habitually participates in destructive activities.

The existing literature on the factors influencing occupational participation for PDOs in the community is sparse, of poor quality and only includes men.²⁵¹ It does not contradict these results but is limited in its ability to support the findings. By identifying the factors that influence occupational participation, and including men and women, these results address a gap in the literature and make a contribution to knowledge.

7.5.3 OCCUPATIONAL PARTICIPATION FOR PEOPLE WITH A PERSONALITY DISORDER DIAGNOSIS

Very few studies examine occupational participation for people with a personality disorder diagnosis. Compared to women with no diagnosis, women with a personality disorder diagnosis participate less in work and leisure, and more in activities around the home and resting. Low participation in social activities and roles was reflected in ratings in one study, showing the women felt less able to meet their needs, engage in satisfying relationships and sustain a positive identity.²⁵² A qualitative study also identified low participation in structured social activity among women with a borderline personality disorder diagnosis. The authors conclude that this was influenced by low self-efficacy and a lack of self-image.²⁵³ Both these studies support the results of this research that self-efficacy may not be one construct, given that the women were participating in activities in the home but not social activities. This is reflected in the factors ‘self-efficacy in activity’ and ‘self-efficacy in social settings’. An alternative, critical realist, perspective could be that self-efficacy is a single factor, but the mechanism of action to influence on occupational participation differs depending on context. It is unclear what Falklöf and Haglund²⁵³ mean by

self-image, although this term is sometimes associated with sense of identity which would be captured in factors rating past or present performance of a role. Alternatively, it can be understood as a perception of how others view you, which is reflected in the factor 'perceptions of social judgements'. Neither study was explicitly focused on the factors influencing occupational participation, both only included women, and both largely represented the experience of people diagnosed with borderline personality disorder. However, the attention to self-efficacy and identity is consistent with the sparse literature focusing on male PDOs. In a mixed gender sample including people with personality disorder and other diagnoses, barriers to occupational participation following hospital discharge were identified within an explorative qualitative study.²⁵⁴ Re-establishing a routine and shame about behaviour when acutely unwell were potential influencing factors. Re-establishing a routine relies on both having experienced a routine before and having the ability to re-initiate it, which were captured in this research by the factors 'past experience of sustaining positive habits/routine' and 'sustaining a routine'. For PDOs, re-establishing a previous routine was uncommon, participants were attempting to learn and adapt to a new routine for the first time. Shame is seen within the 'perceptions of social judgements' factor. Although Birken and Harper²⁵⁴ were not explicitly exploring factors influencing occupational participation and the participants had not been in prison, they shared the experience of a period removed from society. The findings support the results of this research.

The existing evidence is limited, but factors identified in this research are reflected in the qualitative descriptions of the experiences of people with a personality disorder with and without an offending history, particularly the importance of self-efficacy in social settings, sense of identity and role, ability to establish and sustain a balanced routine, and perceptions of others' judgements. This study extends and strengthens the evidence about the factors influencing occupational participation in the community

for PDOs by including men and women in the sample and by specifically addressing this question using a robust mixed-methods design.

7.5.4 COMPARED TO ASSESSMENTS FROM WP2 AND THE MOHO SUB-SYSTEMS

The Model of Human Occupation (MOHO)²⁶ was identified a priori as an analytical lens to support abductive reasoning in this research. MOHO associated assessments^{118, 182} were used in the quantitative sub-study (Chapter Four). It is thus unsurprising that the final list of influencing factors overlaps with components of occupational participation described in MOHO and measured by these assessments. This section reviews the differences between these results and the MOHO sub-systems and associated assessments, taking one sub-system at a time. The MOHO sub-systems are understood from a critical realist perspective to be mechanisms, i.e. structures and processes that influence a phenomenon, but which are outside human awareness. Finally, this section considers implications for practitioners working with PDOs.

MOHO and the associated assessments give limited attention to functionally driven or needs-based motivation (volition), which was strongly emphasised in the 'emotional/sensory drive' factor. This led PDOs to participate in activities and roles that society may consider harmful, antisocial, criminal or inexplicable because the PDOs prioritised need fulfilment. People with borderline personality disorder have described the same process, describing self-cutting as an activity driven by a need rather than any value or interest in the activity itself.²⁰⁸ The prominence of this aspect of motivation implies that the MOHO volitional sub-system may need elaboration to incorporate it if MOHO is to retain its explanatory power with PDOs.

In qualitative literature addressing social outcomes for male PDOs, self-efficacy appears to influence occupational participation.^{76, 159} However, PDOs have clear differences in their self-efficacy depending on whether it is related to *performing* an activity alone, or to *participating* in a role or social setting. This nuanced difference is also seen for women with borderline personality disorder.^{252, 253} Studies found that the women performed activities around the home but struggled with those that were part of a role or involved a social component. This result indicates it is when a social or relational component is added, to progress from activity performance to occupational participation, that PDOs experience the most difficulty. The volitional sub-system may be a context dependent mechanism for PDOs, where self-efficacy has a differential impact depending on the social demands of a situation.

MOHOST does not explicitly address past experiences as influencing occupational participation, as it takes a snap shot in time. The OPHI-II scales include items rating past occupational participation but does not cover having experienced 'belonging in the past' and being able to 'keep the past in the past'. These may have heightened relevance for PDOs because of the high rates of past adversity and traumatic experiences among people with a personality disorder diagnosis and/or an offending history.^{3, 210} That limited attention has been given to these in MOHO and its assessments points to their development with populations whose experiences did not deviate from normative developmental trajectories in the extreme way experienced by PDOs.

Compared to the established assessment factors related to the habituation sub-system, there was a difference in the item 'adaptability'. MOHOST has adaptability as a factor which includes a person's ability to predict and tolerate change in addition to willingness and ability to respond to changes. Incorporating all these in one item potentially reduces the sensitivity of MOHOST. Among the PDOs the elements of predicting,

responding in a controlled manner, and willingness to adapt were retained in the factor 'adaptability'. Ability to tolerate change or unexpected situations was instead represented in the 'emotional stability' factor and is considered a skill within the performance capacity sub-system. The impairments in adaptability identified in the PDO sample are consistent with diagnostic descriptors of personality disorder.² An explanation is offered by the OPHI-II scales and qualitative data. Occupational adaptation is supported by occupational identity and occupational competence.³⁴ The latter two concepts are measured by the OPHI-II scales, on which the PDOs had impairments on most items.

MOHOST assesses aspects of the 'performance capacity' sub-system, including process (cognitive), motor, and communication and interaction skills. There were differences within the PDO sample. For example, MOHOST assesses a person's 'knowledge' of how to perform an activity. The PDOs often had or were able to obtain the practical knowledge they required. Instead, this factor reflected their knowledge of social norms. In MOHOST, assertiveness is considered as an aspect of vocal expression within communication and interaction skills, however for PDOs it is incorporated into 'relating to people' because they experienced difficulties asserting themselves and their needs *in relation to others*. 'Relating to people' is only partly described in the MOHOST 'relationships' item as a communication and interaction skill. For PDOs, it was more important and considered a separate influencing factor.

'Perceptions of social judgements' is another relational skill not clearly covered in MOHO or its assessments. The PDOs perceptions about how others perceived them, whether accurate or not, was a factor influencing their occupational participation. Concern about being negatively judged by others predicts lower community participation in released prisoners¹⁹² and is reflected in the qualitative experiences of people with mental illness leaving forensic psychiatric care.^{191, 255} Mentalizing (understanding the

intentional mental states of others)²²⁹ is known to be impaired among people with personality disorder²²⁹⁻²³¹ and thought to be a contributor to violent behaviour. This finding shows that mentalizing, i.e. being able to perceive the judgements of others, is also a factor influencing occupational participation.

It is evident that PDOs present with particular difficulties in emotional and relational skills, which are not well described in MOHO. Emotional and relational skills are arguably those that would allow someone to participate in a role, rather than perform an activity, again highlighting the level at which PDOs experience their difficulties. Adding emotional and relational skills is a suggested modification to the MOHO performance capacity sub-system.

Aspects of performance capacity became impaired in social settings, such as the ability to solve problems, maintain attention and maintain emotional stability. This was clearly described in the qualitative interviews and was implicitly indicated by impairments on the OPHI-II scales. However, they may be overlooked on MOHOST because it assesses factors at a point in time. This indicates that context plays an important role in the factors that influence occupational participation for PDOs and that assessment needs to take a longitudinal perspective.

Both MOHOST and OPHI-II rate factors within the environment that influence occupational participation. The factors identified among PDOs referred less to the physical environment and its resources and more to the sense of security, social support, and the risks in navigating the wider environment with a criminal history. In recognising the environment as constantly changing, the importance of context can be considered within the MOHO environment sub-system.

Comparing the factors identified as influencing occupational participation for PDOs in the community with the items in MOHOST and OPHI-II reveals that both assessments cover a number of the relevant factors, but that both have limitations for identifying the most important factors influencing occupational participation among PDOs. This result was due to the integration of qualitative data which identified factors that are not currently well accounted for by the theorised mechanisms of MOHO and thus not represented in its associated assessments. Identifying these differences further supports the selection of mixed-methods research in investigating under-researched phenomena, such as the occupational participation of PDOs in the community.

Due to the limitations in existing assessments of occupational participation, practitioners may wish to use the list of factors identified in this research to guide or complement their assessments. Doing so would allow them to gather clinically important information to enable them to intervene in a way that targets the most relevant factors. Due to the finding that social context influences the MOHO sub-systems, assessment to identify the influencing factors needs to consider the environment in which assessment takes place to determine if it reflects the realities of the natural settings where PDOs experience difficulties. Further, the limitations of making an assessment that considers a point in time suggest assessments that account for historical occupational participation may be most useful.

The list of factors is not suggested to represent all the component parts of occupational participation. It only intends to highlight those factors which are particularly relevant for PDOs. The factors are not associated with a scoring system and therefore cannot be used as a measurement tool to determine change over time in response to intervention. Practitioners should consider alternative ways to capture successful modification of these factors or intervention outcomes.

7.5.5 STRENGTHS AND LIMITATIONS

The Pillar Integration Process is a new method of mixed-methods integration that has not been widely used. However, it is one of the only published methods and is suited to convergent parallel designs. A second independent analyst could strengthen confidence in the results. However, applying this framework and reporting process transparently demonstrates the rigour and replicability of the integration process. In addition, results were validated by the participants.

Half of the original participants undertook Synthesised Member Checking and validated the findings. However, participants who could not be re-contacted may have had a different view that would have impacted upon the final results.

This research had 18 participants. It is possible that other important factors may exist that would be identified with a larger sample or with different participants. Validating the results by applying the factors to a different group of PDOs would strengthen the conclusions.

7.6 CONCLUSION

Twenty-six factors influence occupational participation for PDOs in the community. There was overlap between the factors and the items in assessments associated with the Model of Human Occupation. However, this study revealed that current assessments do not identify all the important factors, whether they focus on a point in time (Model of Human Occupation Screening Tool) or consider the influence of the past (Occupational Performance History interview – Version Two). This is because the theorised sub-systems of MOHO do not fully account for PDOs

experiences, particularly the volitional and performance capacity sub-systems. With PDOs context was important, with sub-systems triggered in a different way in social environments and when participating in roles. MOHO includes the environment as a sub-system which could be used to identify contextual differences.

Practitioners attempting to ascertain the factors influencing occupational participation for a PDO with whom they are working should pay additional attention to the factors identified in this research during assessment. This will increase the likelihood that the relevant factors are identified and can be targeted within intervention. However, this list of factors does not have an associated scoring system and thus cannot be used for measurement.

7.7 IMPLICATIONS

7.7.1 IMPLICATIONS FOR PRACTICE

- Practitioners may use the factors identified to guide assessment of occupational participation with PDOs, to ensure important factors are not overlooked when using existing assessments

7.7.2 IMPLICATIONS FOR RESEARCH

Further research should:

- Identify the components of an intervention that are likely to effectively modify the factors that influence occupational participation among PDOs in the community
- Validate the 26 factors with a larger sample of PDOs in the community

- Develop the list of factors into a valid and reliable assessment that can be used in research and/or to inform practice as a clinical outcome measure

7.8 CHAPTER CONCLUSION

This chapter concluded Work Package Two reporting the mixed-methods integration that identified the factors that influence occupational participation for PDOs in the community. Using a mixed-methods design produced results and findings that would have been overlooked had only quantitative or qualitative methods been used, demonstrating the benefits of its application. The clear list of factors directly informs Work Package Three, which is reported in the next chapter.

8 IDENTIFYING INTERVENTION COMPONENTS: A DELPHI STUDY

8.1 INTRODUCTION

Systematic literature reviews identified that very little is known about effective interventions for increasing occupational participation for people with an offending history and a personality disorder (PDOs) in the community. The interventions were not well described and did not report theoretical bases for how and why they may improve occupational participation. This chapter reports the method and results from Work Package Three (WP3) which addressed this gap in the literature. Building upon the results of Work Package Two, WP3 determined what an intervention should include given the factors found to be influential.

8.2 RESEARCH QUESTION AND OBJECTIVES

WP3 answered the question: What are the required components of an intervention to increase occupational participation for PDOs in the community, and what should these components include?

Objectives of WP3 were to:

- Identify which factors have the strongest influence on occupational participation
- Identify which factors are most likely to be modifiable through intervention
- Establish expert consensus on what should be contained in an intervention to improve occupational participation for PDOs in the community
- Group intervention content into preliminary components

8.3 METHOD

8.3.1 DESIGN

An online Delphi survey of multi-disciplinary experts was conducted over three rounds. Chapter Two details the rationale for selecting a Delphi survey.

8.3.2 PARTICIPANTS

INCLUSION CRITERIA

Participants were professionals from a health or criminal justice background with expertise in working with PDOs in the community, or academics with experience conducting research with PDOs in the community. Table 8-1 shows the pre-specified criteria used to identify potential participants.

Table 8-1 Inclusion and exclusion criteria

Participants	Target n	Inclusion	Exclusion	Justification
Health professional (e.g. occupational therapists, psychologists, doctors)	Occupational therapists 8-10 Other health professional 5-10	Hold professional qualification (e.g. BSc/MSc Occupational Therapy, DForPsych) Currently/recently (within 12 months) experience working with PDOs in community	Students/ unqualified staff Not currently/ recently working with PDOs in the community	Knowledge of intervention development and delivery in clinical/NPS context Knowledge of strategies used in practice to increase occupational participation Can hypothesise mechanisms by which intervention works. e.g. behavioural change theories Specific knowledge of PDO needs in community
Criminal justice professional (Offender managers, senior probation officers)	Offender managers/ probation officers 8-10 Other 5-10	Qualified Probation Officer/Trainee Probation Officer/Probation Services Officer in post for 12 months or more. Currently/recently (within 12 months) experience working with PDOs in community setting	Working in NPS less than 12 months Not currently/ recently working with PDOs in the community	Knowledge of intervention delivery in criminal justice settings/NPS context Knowledge of strategies used in practice to increase occupational participation Can hypothesise mechanisms by which intervention works e.g. desistance theory Specific knowledge of PDO needs in community
Academic	5-10	Published on social, health and desistance outcomes of PDOs in community	Only published on reoffending	Knowledge of the evidence base around PDOs needs and experience Can hypothesise mechanisms by which intervention works e.g. desistance theory
Other service provider (e.g. social work, third sector employment specialists)	0-5	Professional qualification or equivalent experience (min 12 months with PDOs in the community) Currently working with PDOs in community setting	No professional qualification and less than 12 months experience Not currently/ recently working with PDOs in the community	Knowledge of intervention delivery in third sector/NPS context Can hypothesise mechanisms by which intervention works. e.g. desistance theory Specific knowledge of PDO needs in community

Purposive sampling followed by snowball sampling was adopted to recruit a multidisciplinary group of participants. This approach was selected as the most appropriate way to access a small, dispersed, and hard to locate population.²⁵⁶ There was no alternative way to ascertain all the potential participants. Delphi surveys do not have optimum participant numbers. A target of 30 participants was selected. Whilst being mindful of the low number of potential expert participants, this number aimed to recruit enough participants from the same professional background to make the consensus process meaningful. For example, recruiting only one offender manager would limit the ability of the research to capture the breadth of opinion between offender managers that is likely in this developing practice area.

Purposive sampling identified participants through: authorship of publications reviewed during systematic reviews; presentation at conferences; membership of national special interest groups; the National Probation Service (NPS) personality disorder project in the West Midlands; and the national register of Offender Personality Disorder Services. Snowball sampling involved the nomination of additional participants by people in the purposive sample.

Thirty-four potential participants were approached to confirm whether they met inclusion criteria. Three did not respond to email. The initial sample consisted of 31 participants. One participant withdrew in round one, resulting in 30 participants. Participants were advised that they did not have to give consent until commencing the survey, that they could withdraw consent at any time and that participation was voluntary. Participants were informed that if they withdrew, any responses to previous rounds they had completed would be retained anonymously and used in the analysis. Participants were given full information in the form of

a study information sheet, which was also presented on commencing the online survey, and invited to contact the researcher if they required further information.

8.3.4 DATA COLLECTION AND ANALYSIS

Data were collected in three rounds via an online survey. The survey was constructed using Qualtrics software and hosted on the Qualtrics internet platform.²⁵⁷ The survey structure differed between rounds depending on participant responses, as described below. Appendix G presents the questions in each round with screen shots to illustrate how these appeared on the online platform.

Delphi rounds can continue indefinitely in attempts to achieve consensus. A four round limit was pre-determined to minimise participant burden.²⁵⁸ However, the Delphi process was concluded after three rounds to sustain a good response rate from participants from different professional backgrounds and maintain comparability with the wider literature.

Participants were contacted by email with an individual link to round one. All participants who completed a round were invited to participate in the following round, again by email with an individual link. Each survey was available for four weeks. Two standardised email reminders were sent for each round, with additional contact made with participants by email and telephone. This assertive follow up was designed to maximise participation rates and reduce attrition bias.

Response rate was determined after each round and overall. Specific methods for rounds one to three are described below. SPSS,¹⁹⁰ MAXQDA²⁰² and Microsoft Excel were used for data analysis.

PILOT

Members of the Patient and Public involvement Advisory Group (PPIAG) piloted a questionnaire including questions for round one and an example of what may be included in round two (as this was determined by round one responses). The pilot ensured that the questions elicited information relevant to identifying the content of intervention components, the questions were comprehensible and easy to answer, the software worked intuitively, and data could be exported for analysis in an appropriate format.

The data were good quality and relevant, and the survey software functioned well. Feedback informed a reduction in the length and complexity of round one questions. One person piloted the revised version and confirmed it was feasible for practitioners to complete.

ROUND ONE DATA COLLECTION

The factors identified as influencing occupational participation in WP2 were presented to the participants along with its descriptor. Participants rated how much each factor influenced occupational participation on a zero to ten Likert scale, where zero was 'no influence' and ten was 'critical influence'. Participants then rated the same factors for their potential for modification through intervention on a zero to ten Likert scale, where zero was 'impossible to change' and ten was 'simple to change'. Participants were invited to make free-text comments.

Participants then described interventions they delivered, or thought would be best practice to deliver, to address occupational participation and its influencing factors. Questions prompted participants for the details

required to standardise the intervention for practice and research (e.g. duration, practitioner skills).¹⁵⁰⁻¹⁵² Free text boxes invited additional comments.

ROUND ONE DATA ANALYSIS

Factor ratings were analysed using descriptive statistics. These were tabulated in order of most to least influential, and most to least modifiable by mean score.

Qualitative descriptions of interventions were converted into statements. Intervention content and/or components were paired with the factor/s it aimed to address. Similar statements were grouped and amalgamated where referring to the same or a similar thing, resulting in clusters of statements.

Free text responses were analysed thematically.²⁵⁹

ROUND TWO DATA COLLECTION

Factors were presented in order of influence and modifiability based on mean scores from round one. Participants were invited to comment on the results.

Participants then rated their agreement with each of the statements developed from the responses to round one using a five-point Likert scale. Options were 'strongly disagree', 'somewhat disagree', 'neither agree nor disagree', 'somewhat agree' and 'strongly agree'. Free text boxes invited comments. This served as a quality check on the round one analysis, as

participants could highlight if they felt their perspective was not represented.

ROUNDS TWO DATA ANALYSIS

Where 75% of participants agreed or strongly agreed with a statement it was removed and taken forward in the intervention development process in Work Package Four (WP4; reported in Chapter Nine). This agreement level is consistent with other intervention development Delphi studies in mental health and personality disorder.^{143, 146, 260} Statements that did not reach this consensus level were sent back to participants in round three.

Free text responses were analysed thematically²⁵⁹ to inform adaptations to statement wording, and inclusion of new statements in round three.

ROUND THREE DATA COLLECTION

For each statement which did not reach consensus in round two, participants were shown a bar chart informing them of their peers' responses. Participants then re-rated the statements that had not achieved consensus agreement on the same five-point Likert scale. Free text boxes invited additional comments.

ROUND THREE DATA ANALYSIS

Where 75% agreement was achieved for a statement it was removed and taken forward to intervention development. It was hypothesised that there may be higher agreement levels if results were analysed by participants'

professional backgrounds. Consensus agreement was compared between health and criminal justice professionals on statements that did not reach consensus overall. Nonetheless, if only one professional group reached consensus, the statement was not carried forward to WP4.

8.4 RESULTS

8.4.1 PARTICIPANTS

Table 8-2 shows the participant demographics collected at Round One.

Table 8-2 Participant demographics

	N (%)
Professional background	
Health care	13 (46)
Criminal justice	13 (46)
Clinical academic	2 (8)
Length of experience with PDOs in community	
Under 1 year	2 (7)
1 – 5 years	12 (43)
5+ years	13 (46)
Academic only	1 (4)
Gender	
Male	8 (29)
Female	19 (68)
Other	1 (3)
Age	
Under 25	0 (0)
25 – 40	9 (32)
40+	18 (64)
Decline to answer	1 (3)

8.4.2 RESPONSE RATE

Table 8-3 shows the response rate for each round. One respondent's data was not properly recorded in round one. However, they were invited to round two on the basis that they had engaged with the research.

Table 8-3 Response rates by round

Round	N (%) completion in round	N (%) completion all rounds	N (%) drop out in round	N (%) drop out overall
Round one	28/30 (93)	28/30 (93)	2 (7)	2 (7)
Round two	24/28 (86)	24/30 (80)	4 (14)	6 (20)
Round three	21/24 (88)	21/30 (70)	3 (13)	9 (30)

8.4.3 ROUND ONE RESULTS

FACTORS IDENTIFIED AS INFLUENCING PARTICIPATION

Table 8-4 shows, in descending order, the mean score for each factor for its degree of influence on occupational participation. The factor with the highest mean is considered the most influential factor by expert consensus. Participants made the ratings in general terms rather than in reference to a specific individual. For an individual PDO, the relative importance of the factors would vary.

Table 8-4 Factors influencing participation

		Mean	Std. Deviation
1	Emotional stability	8.0741	1.63909
2	Relating to people	7.8519	1.40613
3	Safe home	7.8148	1.84051
4	Perceptions of social judgement	7.3704	1.64429
5	Self-efficacy in activity	7.3704	1.59683
6	Past experiences remain in the past	7.3333	1.75412
7	Sustaining routine	7.2963	1.38160
8	Self-efficacy in social settings	7.2222	1.60128
9	Problem-solving	7.2222	1.45002
10	Role	7.1538	1.89087
11	Past experiences of belonging	7.1481	2.08850
12	Adaptability	7.0741	1.41220
13	Past mastery	6.9630	2.10277
14	Prosocial interests	6.9615	1.82166
15	Social validation	6.9259	1.66239
16	Knowledge	6.8889	1.69464
17	Responsibility	6.8889	1.31071
18	Goals	6.8519	1.70302
19	Managing attentional demands	6.6667	1.54422
20	Past experience of sustaining positive habits/routine	6.5926	2.18842
21	Conversational skills	6.5556	1.67179
22	Non-verbal skills	6.3333	1.86052
23	Past experience of fulfilling a role	6.3333	2.48069
24	Criminal record and disclosure requirements	5.8889	2.24179
25	Physical capacity	5.7037	1.81479
26	Emotional/sensory drive	5.1481	1.87501

FACTORS CONSIDERED TO BE MODIFIABLE

Table 8-5 shows, in descending order, the mean score for each factor for its ease of modifiability in intervention. The factor with the highest mean is considered the easiest to modify in intervention by expert consensus.

Participants made the ratings in general terms rather than in reference to a specific individual. For an individual PDO, the relative ease of modifying certain factors would vary.

Table 8-5 Modifiability of factors

		Mean	Std. Deviation
1	Sustaining a routine	5.8148	1.46857
2	Role	5.3846	2.11805
3	Goals	5.3704	1.64429
3	Self-efficacy in activity	5.3704	1.66752
5	Problem-solving	5.2593	1.53404
6	Adaptability	5.1852	1.44214
7	Prosocial interests	5.1111	1.57708
8	Safe home	5.1111	2.02548
9	Physical capacity	5.0000	1.94145
10	Self-efficacy in social settings	4.9630	1.53125
11	Responsibility	4.9259	1.46566
12	Conversational skills	4.9259	1.70803
13	Relating to people	4.8519	1.76948
14	Knowledge	4.8519	1.72546
15	Emotional/sensory drive	4.7407	1.89316
16	Managing attentional demands	4.7407	1.65466
17	Non-verbal skills	4.7037	1.70553
18	Emotional stability	4.5185	2.02618
19	Social validation	4.5185	1.76222
20	Past mastery	4.2963	2.09054
21	Perceptions of social judgements	4.1481	1.61015
22	Past experiences remain in the past	3.8889	1.90815
23	Criminal record and disclosure requirements	3.6296	2.18646
24	Past experience of sustaining positive habits/routine	3.2308	2.12241
25	Past experience of fulfilling a role	3.1852	2.41847
26	Past experiences of belonging	2.9259	2.21752

COMMENTS ON PART ONE

Thirteen participants added factors they felt were missed. Most could be captured in the existing list when reading the descriptor. However, local availability of opportunities and finances were not clearly captured. These themes were present in some participant interviews in Work Package Two but following the analysis and mixed-method integration were not represented in the final factors influencing occupational participation for PDOs in the community.

One participant commented that the section about modifiability was challenging due to individual variability and potential comorbid health conditions or disabilities.

SYNTHESIS INTO STATEMENTS

Participant responses to the questions about interventions were converted into statements. For example, where a participant described an intervention that targeted emotional stability as involving psychoeducation and teaching sensory modulation strategies, the following statements were produced:

- “Psychoeducation is an effective way to increase emotional stability”
- “Teaching sensory modulation strategies is an effective way to increase emotional stability”

The participant may go on to describe best practice as involving a time limited series of group skill development sessions. Thus, additional statements were produced as follows:

- “Intervention to increase emotional stability is most likely to be effective if it is delivered in a group format”

This process was completed for each respondent, producing 811 statements. Statements were then grouped according to similarity. Statements were reduced and reworded where describing the same thing, with care to use language comprehensible to a multi-disciplinary group. Groupings were considered preliminary intervention components, which were further refined in WP4.

This process produced 150 statements in groups that were carried forward to round two. Groupings were:

1. Overall intervention principles, such as the importance of having a contracted goal and end point
2. Attention to developing a therapeutic relationship
3. Assessment
4. Formulation
5. Education and goal setting
6. Strategies for increasing occupational participation
7. Ending
8. Practitioner’s behaviour

8.4.4 ROUND TWO

RESPONSE TO THE INFLUENCING AND MODIFIABLE FACTORS

Participants commented about the order of the factors, and again about factors perceived to be missing. Reanalysis of the factors recognising the

potential impact of missing data produced corrected lists (Table 8-4 and Table 8-5). These were sent in round three for comment.

Free-text response analysis resulted in the decision to seek ratings for two additional factors:

1. Financial stability – stability of sufficient income
2. Environmental resources – appropriate and accessible local physical and social environment (e.g. transport links, community opportunities)

STATEMENTS REACHING CONSENSUS

Of 150 statements, 110 statements reached consensus, with 75% of participants agreeing or strongly agreeing. These were removed to carry forward to intervention development in WP4.

Free-text response analysis informed amendment, removal and addition of some statements resulting in 38 statements being included in round three.

8.4.5 ROUND THREE

RESPONSE TO THE INFLUENCING AND MODIFIABLE FACTORS

Table 8-6 shows the relative position of the additional factors compared to the other factors. Financial stability scored mean 6.7143 for the importance of its influence on occupational participation, ranked 20th out of 28. Financial stability scored mean 4.1429 for modifiability in intervention, ranked 22nd out of 28. Environmental resources scored mean 7.4762 for the importance of its influence on occupational participation,

ranked 4th out of 28. Environmental resources scored mean 4.0000 for modifiability in intervention, ranked 23rd out of 28.

All the factors were scored above five on average for influence whereas only eight factors were scored above five on average for modifiability. Six of those were in top half for their influence on occupational participation: 'safe home', 'self-efficacy in activity', 'sustains routine', 'problem-solving', 'role' and 'adaptability'. These are highlighted in Table 8-6.

As in round one, participants made the ratings in general terms rather than in reference to a specific individual. For an individual PDO, the relative importance and modifiability of the factors would vary.

The amended list of factors (excluding financial stability and environmental resources) in order and the two new factors were acceptable to the participants. Two participants commented to indicate their agreement with the importance of the new factors, but also how challenging they could be to modify. One participant was uncertain about physical capacity, and their ability to assess its impact on occupational participation. This participant also wrote in detail about the wider environmental challenges of accommodation and criminal record disclosure for this group whose convictions were often never 'spent'.

Table 8-6 Factor mean scores and rankings

Factor	Importance (mean)	Importance (rank)	Modifiability (mean)	Modifiability (rank)
Emotional stability	8.0741	1	4.5185	18
Relating to people	7.8519	2	4.8519	13
Safe home	7.8148	3	5.1111	7
Environmental resources	7.4762	4	4.0000	23
Perceptions of social judgement	7.3704	5	4.1481	21
Self-efficacy in activity	7.3704	5	5.3704	3
Past intrudes	7.3333	7	3.8889	24
Sustains routine	7.2963	8	5.8148	1
Self-efficacy in social settings	7.2222	9	4.9630	10
Problem-solving	7.2222	9	5.2593	5
Role	7.1538	11	5.3846	2
Past belonging	7.1481	12	2.9259	28
Adaptability	7.0741	13	5.1852	6
Past mastery	6.9630	14	4.2963	20
Prosocial interests	6.9615	15	5.1111	7
Social validation	6.9259	16	4.5185	19
Knowledge	6.8889	17	4.8519	13
Responsibility	6.8889	17	4.9259	11
Goals	6.8519	19	5.3704	3
Financial stability	6.7143	20	4.1429	22
Manages attentional demands	6.6667	21	4.7407	15
Past routine	6.5926	22	3.2308	26
Conversational skills	6.5556	23	4.9259	11
Non-verbal skills	6.3333	24	4.7037	17
Past role	6.3333	24	3.1852	27
Criminal record & disclosure	5.8889	26	3.6296	25
Physical capacity	5.7037	27	5.0000	9
Emotional/sensory drive	5.1481	28	4.7407	15

STATEMENTS REACHING CONSENSUS

Eleven further statements reached consensus in round three. Table 8-7 shows the number of statements reaching consensus in each round.

Table 8-7 Statements reaching consensus in each round

Round	Number of statements presented	Number of statements reached consensus
Round two	150	110
Round three	38	11

The table in Appendix G shows all the statements presented to the panel, the level of agreement achieved and in which round consensus was achieved.

8.4.6 STATEMENTS NOT REACHING CONSENSUS

Appendix G includes those statements that did not achieve consensus. These are identifiable by a black cell where the round consensus was achieved in would be reported.

ANALYSIS BY PROFESSIONAL BACKGROUND

Appendix G shows which of the statements achieved consensus when analysed by professional background but not overall. Two further statements achieved consensus among participants from a criminal justice background, both of which referred to time limiting aspects of intervention. Four statements achieved consensus among participants from a health care background which related to individual tailoring, ways

of concluding sessions and reviewing progress against agreed goals at six weekly intervals. These were not carried forward to WP4.

To determine if there was disagreement, statements were identified on which 50% or more selected strongly disagree or somewhat disagree.

There was disagreement by 50% of participants from a criminal justice background, and 54% of participants from a health care background on the statement, “Limiting disclosure about practitioner experiences is an effective way to build a therapeutic relationship”

8.5 DISCUSSION

8.5.1 SUMMARY

Thirty multi-disciplinary experts participated in a Delphi survey to identify the content of intervention components that would be most likely to achieve an increase in occupational participation for PDOs in the community. Twenty-one (70%) participants completed all rounds resulting in consensus on 121 statements. Response rates and results are compared to those from other similar Delphi studies. The mismatch between modifiable and influencing factors is discussed followed by discussion of the generic and specific components, and then statements that did not achieve consensus. Strengths and limitations are also considered in this section.

8.5.2 RESPONSE RATE

Delphi surveys have no optimum response rate. It was not possible to compare response rates to other mental health occupational therapy and personality disorder intervention research as this is not reported in

publications.¹⁴³ In e-Delphi surveys with geographically spread professionals, akin to in this study, participation tends to drop across rounds and conclude with around 60-70% of the original participants.²⁶⁰⁻²⁶⁴ Therefore, response rate in this study is consistent with other studies that have produced credible findings.

8.5.3 COMPARED TO OTHER DELPHIS

Whilst Delphi surveys have been applied to developing interventions for multiple different populations and for multiple different outcomes, few focus on interventions with occupational participation as an outcome. In mental health occupational therapy, a Delphi was used to specify the content of an occupational therapy intervention for people with psychosis in the community, though the authors do not define the intended outcome of the intervention.¹⁴⁶ Areas of Cook's intervention specification²⁶⁵ overlap with the statements about intervention content agreed to be important in working with PDOs and the preliminary groupings into intervention components. For example, the need for assessment, goal setting, and considering endings. Therapeutic relationships are mentioned though without as much emphasis as it received among participants working with PDOs. 'Analysis' was also only a small part compared to the participants strong endorsement of statements referring to formulation when working with PDOs.

Elements within the 'action' component of Cook's specification were reflective of a number of statements agreed by participants in this study. Cook describes that the occupational therapist "reviews with the client how thinking, feeling and behavioural responses to activity engagement influence future motivation to participate in that occupational/ functional activity" (pg. 4). In this study a statement was "teaching clients to challenge their assumptions and maintain curiosity about the thoughts and

behaviours of themselves and others is an effective way to increase participation in prosocial activity". The similarities likely reflect the shared focus of mental health occupational therapists on occupational participation. The specification of the intervention for PDOs was undertaken in the final work package (WP4), reported and discussed in the next chapter.

Among people with personality disorder, a Delphi study addressed essential components to facilitate therapy engagement as a pre-requisite to therapy outcomes, but not focusing on the actual therapy outcomes.¹⁴³ The strong emphasis on the need for 'engagement' in therapy and the role of a therapeutic relationship to facilitate this when working with people with personality disorder was reflected by the participants in this research. Participants took responsibility for working on a therapeutic relationship that supported occupational participation. McMurrin et al. identified a number of staff-related competencies as important factors in engaging people with personality disorder in treatment but this was alongside a number of external considerations, such as environmental stressors like housing, or having a supportive peer group.¹⁴³ These were also identified by participants working with PDOs, although the focus here was on their impact on occupational participation rather than therapy engagement.

8.5.4 MISMATCH IN MODIFIABILITY AND INFLUENCE

Some of the factors thought most influential were rated as very difficult to change (e.g. emotional stability and relating to people were 1st and 2nd for influence, but 18th and 13th respectively for modifiability). Low ratings on modifiability may reflect the professional backgrounds of the respondents. For example, 46% (n=13) of respondents were from a criminal justice background who may have less experience or confidence in techniques to change these factors. Equally, it could be argued that people with a

criminal justice background would have a more realistic appraisal of a factor's modifiability given their experience working with PDOs on a mandatory basis. Health care professionals tend to see people on the basis that they willingly engage, and so may have seen PDOs who are more likely to respond to intervention, thus colouring their perceptions of modifiability.

Two of the five most influential factors refer to the environment. The Model of Human Occupation²⁶ emphasises the impact of the environment on occupational participation. However, free-text responses indicated that the environment was viewed as unamenable to change which was reflected in the modifiability ratings. Only 'safe home' came in the top ten for modifiability suggesting that although environmental modification is challenging, ensuring the person has a home in which they feel safe and in control may be an appropriate starting point for any intervention. This would underpin any attempts to make further changes in factors that influence occupational participation.

If a factor is highly influential yet is rated very difficult to modify, practitioners may be more effective in increasing occupational participation if they direct efforts to easier to modify factors. Six of the eight factors rated between five and six for modifiability were within the top half for how much they influenced occupational participation. These may be useful intervention targets. Nonetheless, low levels of modifiability on most factors indicates the challenges of therapeutic work with PDOs to improve occupational participation.

8.5.5 GENERIC AND SPECIFIC CONTENT

Statements relating to intervention principles, practitioner behaviours, and developing a therapeutic relationship were not specific to increasing

occupational participation, but more generic in their relation to building a good therapeutic relationship, trust and rapport with someone. The importance of a therapeutic relationship is well documented as a common factor in the effectiveness of psychotherapy²⁶⁶ and mental health occupational therapy,²⁶⁷ and has long been a valued component of probation service supervision.²⁶⁸ Some authors have argued that the similar levels of effectiveness of psychological therapies for personality disorder are attributable to what is common between them. One of these common factors is a therapeutic relationship.^{269, 270} Given the participants were health and criminal justice practitioners, it is unsurprising that this should feature strongly in the content of an intervention for PDOs.

Taylor has argued that, compared to psychotherapies, the therapeutic relationship requires different consideration in interventions to increase or modify occupational participation.²⁷¹ The relationship is used intentionally as a tool to increase occupational participation, rather than the relationship itself being the focus. Although Taylor's Intentional Relationship Model has received limited attention in UK occupational therapy, it is clear that participants from health and criminal justice were aware of the importance of continually attending to the client's emotional needs and responding appropriately so as to both strengthen the relationship and support occupational participation.

Statements relating to assessment, formulation, education and goal setting and facilitating change explicitly addressed occupational participation. The division between generic and specific components is important to consider when differentiating what is unique about the intervention developed from these results.

Statements were grouped into preliminary components, reflecting a phased intervention. However, participants often commented that these were likely to overlap and be circular rather than have clear boundaries between them. The participants preference for flexibility also resulted in statements failing to achieve consensus where they referred to time limiting aspects of the intervention. Individualised and person-centred intervention is a core value of occupational therapy²⁷² and other professions. However, intervention standardisation is required for good quality effectiveness research, which includes specification of timings.^{151,}
¹⁵² At this stage, it may be more appropriate to determine component or phase endings on the basis of observable factors or key task attainment. Estimates of timings can be made as the intervention is tested and refined in practice.

Consensus was not reached on a statement about integrating digital technology within the intervention. The majority of comments in round three related to this. Some participants felt that probation practice and a lack of digital infrastructure in probation settings made technology use impossible. This reflects current practice where most face-to-face contact is conversation based or involves completing written workbooks focused on risk behaviours (e.g. substance use). There are limited opportunities in the current organisational model to operate flexibly such as meeting off probation premises. By altering perspectives at an organisational level that intervention is safest and most efficient when conducted in the office, practitioners would be able to move to settings where internet use is possible.

Some practitioners were concerned that the person may not have the finances to engage with digital technology. However, despite relative financial hardship, most PDOs interviewed in Work Package Two referred

to internet use and owning a mobile phone, sometimes to say they hated them or could not use them effectively. Being unable to use internet-enabled technologies has been argued to increase the health, economic and social divide experienced by socially disadvantaged groups because it reduces access to the social determinants of health.²⁷³ From UK digital inclusion surveys, 93% of UK adults use the internet to communicate and connect with others via email, whilst over 70% use social media and chat sites. The internet is used by 52% of people to find employment, 85% of people to compare prices and support budgeting decisions, and 71% of people to access information about leisure. Overall, 83% state that it makes daily life easier.²⁷⁴ The pace of change in digital technology coupled with the 'digital divide' between prison and the community results in people being released from prison ill-equipped for the demands of modern society and more vulnerable to social exclusion.^{275, 276} This applies to ex-offenders who serve long sentences, who feel exposed by their lack of knowledge.²⁷⁵ It is also seen among those whose access has been disrupted for a relatively short period²⁷⁷ such as a short prison sentence. Failing to address poor digital skills may contribute to social exclusion and impaired occupational participation for PDOs. Using the internet is an essential modern life skill²⁷⁸ and despite reticence among some practitioners, it should still be considered in intervention to reduce the 'digital divide' for PDOs.

Practitioners pointed out that some PDOs, mainly those convicted of a sexual offence, were legally prevented from using the internet as a condition of their release on licence, because it is acknowledged to come with risks. The internet can facilitate criminality and other anti-social activity by offering ways to conceal ones identity or communicate outside the reach of authorities.²⁷⁹ However, rates of reported sexual offences in the Crime Survey of England and Wales show a reducing trend despite increasing internet availability (although there was a spike in 2012 followed high profile police investigations of historical sexual abuse).²⁸⁰ However,

national trends do not give an indication of individual risk and in some cases legal prevention may be a critical risk management strategy, for example where the individual previously used the internet in committing their offence and alternative risk management strategies are insufficient. Whilst restricting internet access provides an option for reducing risk, it also limits access to protective factors against offending.

Social media use has been associated with higher levels of activity and role participation amongst people with severe mental illness.²⁸¹ Despite these benefits, there is growing interest in the impact of social media use on mental health. The impact of constant identity performance and becoming reliant on others for validation of one's self-worth is particularly emphasised for youth.²⁸² Personality disorder is associated with unstable identity and unstable relationships, and its use among PDOs is inevitable. Support for PDOs to make healthy and safe use of social media should not be ignored.

As digital technology integration did not reach consensus, the intervention will not explicitly include use of the internet, mobile phones or other devices. However, the importance of digital inclusion for accessing opportunities for occupational participation indicates that it is vital to consider digital technology in intervention with PDOs. Nonetheless, this should be considered on an individual basis and with a focus on how someone can be enabled to safely use modern tools of daily living.

8.5.7 STRENGTHS AND LIMITATIONS

The sampling method used Offender Personality Disorder (OPD) Pathway networks to recruit participants. The OPD Pathway explicitly advocates a psychologically informed approach, and using formulation for case management.^{1, 89} It is likely that participants were influenced by their

working environments, which may have skewed the results toward psychological and therapeutic considerations. Expertise from practitioners who are less aware of or less receptive to psychologically-informed practice may have yielded different findings. Nonetheless, purposive sampling deliberately recruited occupational therapists, offender managers and other professionals who were not psychologists. This ensured inclusion of practitioners with different theoretical and evidence-based understandings of working with PDOs.

Delphi methods produce expert consensus, which may still be incorrect if all experts have the same inaccurate belief. However, it is a stronger method on which to base an intervention than individual case studies or a single researcher's opinion. Given the paucity of literature in this area, it provided the most pragmatic starting point to generate intervention content.

8.6 CONCLUSIONS

Multi-disciplinary experts recognised the factors from Work Package Two as influencing occupational participation for PDOs in the community and added two further factors relating to the environment, resulting in a list of 28 factors. Only six scored above five on average on a zero to ten Likert scale for modifiability *and* were among the first 14 influential factors. One hundred and twenty-one statements reached consensus about the content of an intervention to increase occupational participation for PDOs in the community. Agreement was not reached on statements pertaining to the length of meetings and duration of phases, or on the integration of digital technology within the intervention. These results provide a basis to specify the components of an intervention to increase occupational participation for PDOs in the community.

8.7 IMPLICATIONS

8.7.1 IMPLICATIONS FOR PRACTICE

- Practitioners can consider which of the 28 factors are most influential for the individual they are working with
- Practitioners may consider focusing on the factors that have been identified as easier to modify
- Decisions to incorporate digital technology into interventions should be considered on an individual basis with awareness of offending-related risks

8.7.2 IMPLICATIONS FOR RESEARCH

- Components of an intervention to increase occupational participation for PDOs in the community need to be specified
- Components and their relationship to each other within an intervention need to be modelled with consideration to the intended outcomes, a theory of change and the context of delivery

8.8 CHAPTER CONCLUSION

This chapter reported the results Work Package Three which identified the content of components of an intervention to increase occupational participation for PDOs in the community. Statements that reached agreement directly inform the intervention development and modelling process, reported in the next chapter.

9 INTERVENTION DEVELOPMENT

9.1 INTRODUCTION

This research has demonstrated that there are a range of factors influencing occupational participation for people with personality disorder and an offending history (PDOs) in the community. It has further demonstrated that in response, the content of an intervention needs to be detailed and multi-faceted. These results confirmed that developing an intervention to increase occupational participation in this population necessitated application of complex intervention development principles.

This chapter reports Work Package Four (WP4), which synthesised the research results and findings to model the intervention, its outcomes and its processes. The first output is a manualised intervention to increase occupational participation for offenders with personality disorder (PDOs) in the community. The second is a logic model to inform a feasibility study and pilot evaluation of the intervention in a natural context. These outputs demonstrate that the research aims were achieved.

9.2 QUESTION AND OBJECTIVES

WP4 answered the question: How can a new intervention to increase occupational participation for PDOs in the community be implemented in a natural context for a feasibility study and pilot evaluation?

WP4 had the following objectives:

1. Specify and describe the components of the intervention, and the theory and evidence supporting the components

2. Model the outcomes and suggest measures that can be used to evaluate the effect of the intervention by:
 - a. Identifying outcomes valued by PDOs, offenders in general, and forensic mental health service users
 - b. Operationalising the primary outcome
 - c. Identifying examples of suitable outcome measures
3. Determine how the intervention components relate to one another and the underpinning theory for the expected effects
4. Identify potential moderators and mediators of intervention delivery and the expected effects
5. Summarise the theory and evidence relating to the implementation of feasibility studies, pilot evaluations and full evaluations in community forensic mental health and probation services
6. Describe the intervention in manualised format suitable for a feasibility study and pilot evaluation
7. Generate a logic model of the intervention to inform a feasibility study and pilot evaluation

9.3 DESIGN

Sermeus¹⁴⁹ elaborated the objectives of the complex intervention modelling phase. These are translated into the WP4 objectives. Chapter Two includes the rationale for this design. For each objective the approach and results are reported together. This was determined to be clearer than separate methods and results sections.

9.4 OUTCOMES OF OBJECTIVES

The data used to address each objective were the results from the preceding work packages, additional literature searches and critical review by the Patient and Public Involvement Advisory Group (PPIAG). Each objective is reported in turn below.

9.4.1 SPECIFYING INTERVENTION COMPONENTS, SUPPORTING THEORY AND EVIDENCE

Intervention components were specified and described from the results of Work Package Three (WP3). WP3 produced a list of statements, preliminarily grouped according to their reference to different intervention components. Each group of statements was reviewed to confirm the statements referred to a distinct component with a specific function. Where the group of statements referred to more than one function, the statements were separated to form groups that described components with a distinct function. For example, statements that described education, formulation and goal setting were separated to produce one component containing goal setting and another containing education and formulation. Where statements referring to the same function were present in describing multiple components, these statements were removed and grouped into one component with that function. For example, developing a therapeutic relationship was present in all preliminary components, so was removed to form its own distinct component acting on the others. This resulted in a list of components supported by a list of statements.

Each component was described and tabulated against the:

- Statements from WP3 that underpinned its inclusion

- Factor(s) the component aimed to modify. These were identified from the list produced in Work Package Two (WP2) and added to in WP3, or theorised by applying the Model of Human Occupation (MOHO)
- Sub-system(s) of MOHO that included the factor(s) the component aimed to modify
- Theorised mechanism of change identified from MOHO and the results from WPs 1-3
- Strategies the practitioner may apply, drawn from WP3 statements
- The aim and/or function of the intervention component drawn from WP2 results and WP3 statements

Table 9-1 summarises the components, the function of each and the mechanism by which it achieves its aim. The tables containing all of the above are not included in the thesis to prevent use of the intervention in practice before its effectiveness is established.

Table 9-1 Intervention components summary

Component	Aim / function	Mechanism
<p>Safe environment Efforts are made to ensure the person has their basic needs met as a prerequisite to engaging with a challenging intervention (accommodation, finance, consistent support from services).</p>	<p>Person has settled accommodation. Person has stable source of income/ sufficient finances. Person has consistent message about the intervention and occupational participation. Person has capacity to remain safe when experiencing strong emotions.</p>	<p>The environment is a key influencer of occupational participation and occupational adaptation. Change in the environment demands a response from the person, from which people draw on habituated patterns. An unsafe or unstable environment may undermine intervention attempts to change patterns of occupational participation.</p>
<p>Contracting the intervention and behaviour Clear parameters are set about the intervention and the responsibilities of both parties in conducting it.</p>	<p>Produce an intervention contract that addresses pertinent issues such as content, form, length of intervention and review points, expectations and responsibilities of both parties, and a crisis plan.</p>	<p>It takes time to develop and embed changes in occupational participation. Maintaining engagement in an intervention to facilitate this is important, however PDOs have poorer engagement and completion rates. The person may have limited experience of transparency and trust in services. This is targeted to prevent previous patterns of relating to people re-emerging in a way that prevent a focus on occupational participation.</p>

<p>Multi-modal assessment Assessment of occupational participation using semi-structured narrative interview, observed occupational participation and a person's self-assessment.</p>	<p>Practitioner ascertains a comprehensive preliminary understanding of current occupational participation, past occupational participation and the person's perspective of/satisfaction with their occupational participation.</p>	<p>Person appraises their own occupational participation when relaying it to others. The person recognises aspects of their occupational identity that have not been considered or they themselves have forgotten. This contributes to a developing occupational identity. The person independently identifies opportunities to change, producing motivation to engage with the intervention.</p>
<p>Education and formulation Education about occupational participation and how it develops over time applied to the person's circumstances.</p>	<p>Shared understanding of the person's occupational participation and how it has developed over time. This can be written in a short description or presented visually, depending on the person's preference, to refer back to.</p>	<p>The person appraises their own occupational participation and understands how patterns have developed and are maintained, contributing to a developing occupational identity. The person recognises themselves as in control and potential ways to be different, increasing self-efficacy and motivation to engage with the intervention.</p>
<p>Collaborative goal setting Producing intervention goals with shared responsibility for achievement.</p>	<p>Identify specific intervention targets and plan for achievement through either high or low intensity intervention.</p>	<p>Motivates the person to pursue a new occupational identity and engage in intervention by: targeting issues agreed to be of relevance; demonstrating both parties are aligned; setting out achievable plans. This targets self-efficacy and emphasises developing a new occupational identity.</p>

<p>Active adaptation (high intensity) Supported occupational participation to facilitate the occupational adaptation process.</p>	<p>Ability to engage in new occupational experiences independently between sessions. Ability to balance occupational participation independently.</p>	<p>Occupational adaptation involves embedding new patterns of occupational participation. Through participation in new activities and roles the person experiences themselves as capable of different occupational participation, begins to experience self-efficacy, agency and develops an occupational identity. Person begins to develop skills that facilitate continuation of the selected activity and the developing occupational identity.</p>
<p>Active adaptation (low intensity) Guided occupational participation to facilitate the occupational adaptation process.</p>	<p>Increased occupational participation.</p>	<p>As above. Embedding new skills into a sustained pattern of occupational participation that reflects new occupational identity.</p>
<p>Homework Independent between session occupational participation.</p>	<p>Increased occupational participation.</p>	<p>As above. Embedding new skills into a sustained pattern of occupational participation that reflects new occupational identity.</p>

<p>Ending Drawing the intervention to a positive conclusion.</p>	<p>Conclude the intervention positively. Person commits to continued occupational participation. Person identifies other people who, by sharing their learning from the intervention, could support their continued progress.</p>	<p>Occupational adaptation is a process that involves embedding new patterns of occupational participation that will continue after the intervention concludes. Leaving the person with a positive ending increases the value of the intervention and any changes, motivating continued occupational participation. The environment, including social support is a key influencer of occupational participation and will be able to validate change to sustain motivation.</p>
<p>Therapeutic relationship Practitioner and person develop and sustain a relationship conducive to achieving the aims of the intervention.</p>	<p>Relationship between person and practitioner is conducive to achieving the aims intent of the intervention.</p>	<p>A therapeutic relationship facilitates the persons trust and confidence in the practitioner and intervention, commitment to and sustained engagement in the intervention, and recognition of the intervention's value.</p>
<p>Individual tailoring Adaptation for person's specific characteristics and circumstances throughout the intervention.</p>	<p>Responsive and person-centred intervention.</p>	<p>For a person to engage with the intervention it must make sense to them in the context of their lives, which is facilitated by person-specific tailoring.</p>
<p>Practitioner support and supervision Practitioners have regular support and supervision.</p>	<p>Practitioner wellbeing, confidence and competence. Quality assurance.</p>	<p>Ensuring the practitioner is supported, supervised and challenged to maintain fidelity to the intervention and not to reinforce patterns that prevent occupational adaptation.</p>

9.4.2 MODELLING OUTCOMES

IDENTIFYING OUTCOMES VALUED BY PDOS, OFFENDERS IN GENERAL, AND/OR FORENSIC MENTAL HEALTH SERVICE USERS

To inform selection of the primary outcome, literature was searched for papers reporting valued outcomes among PDOs, offenders in general and/or forensic mental health service users. These were limited to past the five years to ensure contemporary social and service issues were considered.

Web of Science was searched at title level on 12th September 2018 for papers published since 2013 using the following search string:

(TI=("forensic" OR "forensic mental health" OR "probation" OR "criminal justice social work")) AND (TI=("outcome" OR "outcome measure*" OR "goal*" OR "success*"))*

Eighty-one papers were identified. Results were screened at title and abstract level to determine whether the outcomes were identified by the service recipients. Only one paper reported the perspectives of service recipients (forensic mental health service users). No studies reported what was considered a successful or valued outcome by people who had been in the criminal justice system. No studies described participants' views on outcome measures.

Livingston²⁸³ analysed interviews with forensic mental health service users and staff in Canada to produce a description of success. Although it is unclear if different elements were more or less important to staff or service users, success was described as a life that is: (a) normal, (b) independent, (c) compliant, (d) healthy, (e) meaningful, and (f)

progressing.²⁸³ Appraising the ‘markers of success’ for each concept indicates strong overlap with occupational participation. Table 9-2 shows the ‘markers of success’ in normal life as an example.

Table 9-2 Markers of success in a normal life

Success type	Example markers of success
Normal life	Has a job or goes to school (further education in Canada) Has daily structure
Satisfies the normative expectations and rules created and imposed by society	Contributes to society Is respected by others Has own family Can afford material goods Has suitable housing

Compared to the operationalisation of occupational participation (next section) and its sub-components, the descriptions indicate that occupational participation is important for forensic mental health service users. This suggests it could be equally valued by PDOs. Although the literature on service user’s views is sparse, occupational participation was supported as the primary outcome.

OPERATIONALISING OCCUPATIONAL PARTICIPATION

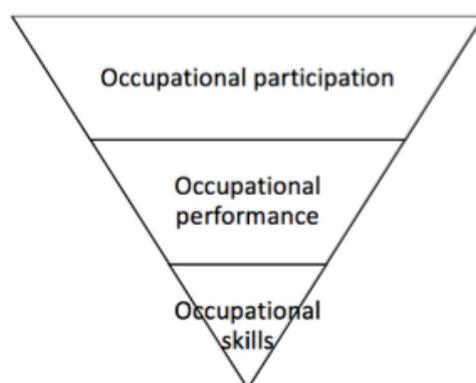
Occupational participation was operationalised by reviewing the literature discussing the World Health Organization concept of participation and MOHO concept of occupational participation. The required modifications to the MOHO sub-systems were incorporated into the review.

The World Health Organization (WHO) define participation as ‘involvement in a life situation’. This definition continues to be debated and criticised for its broad scope and lack of coherence.^{19, 284} Using WHO participation is complicated by the conflation between activities and participation in the

associated classification system, the International Classification of Functioning (ICF).¹¹² This has resulted in studies that claim to measure participation as an outcome using measures that are inconsistent with the participation definition,^{285, 286} and a proliferation of measures that all approach a slightly different understanding of participation.^{172, 285, 287} The uptake of participation in mental health research is further complicated by competing constructs such as wellbeing, recovery, quality of life, social functioning, social participation, community participation, social inclusion and others.²⁸⁸ This is reflected in research for PDOs where outcomes and their measurement are heterogenous.²⁸⁸ In discussing the distinction between participation and 'social participation' Piškur et al. argued for the inclusion of social roles within the ICF definition to better delineate how participation differs from activity.²⁸⁴ This is consistent with how occupational participation is understood in the Model of Human Occupation (MOHO).

Occupational participation from MOHO separates underpinning skills (e.g. emotional stability) from occupational performance (performing an activity) and occupational participation (participating in a role in a natural setting).³⁴ These are named 'levels of doing' (Figure 9-1). Occupational participation consists of both skills and performance but adds the element of using these to become 'involved in a life situation' through participation in roles that are valued by the person and the community in which they reside. Using occupational participation is advantageous because it is accompanied by a theory of how change is produced in occupational participation, and thus provides an explanation for how occupational participation can be modified in intervention.

Figure 9-1 Three levels of doing in occupation



The WP2 results revealed limitations in the current conceptualisation of the MOHO sub-systems. Volition was shown to have a functional component that has not previously been articulated. WP2 findings showed that people participate in activities and roles because they perform a function, often to fulfil an emotional or more complex need. Unmet needs led to disruptions in the development of a consistent pattern of socially valued occupational participation. To reflect this, the MOHO definition was modified to incorporate a reference to need fulfilment.

Occupational participation was defined as:

Undertaking activities that enable a person to meet their needs and perform a valued role/valued roles in society

For operationalisation, the main aspects to measure are:

- Undertaking activities that enable a person to meet their needs
 - Capacity to perform activities
 - Actually performing activities
 - Activities meet needs
- Participating in a personally and socially valued role/s
 - Capacity to participate in a role
 - Actually participating in a role
 - Social and personal value attributed to the role

IDENTIFYING OUTCOME MEASURES

For the purpose of research, any measure selected would need to be acceptable to research participants and comparable with other published work. Examples of measures potentially suitable for measuring change in occupational participation and/or its sub-components were identified from studies reviewed in WP1, papers reporting intervention research in community mental health settings and papers reporting service user perspectives of outcome measures.

Face validity was established by reviewing the measures against the aspects of occupational participation above. Where a measure included aspects of occupational participation among other concepts, it was only further reviewed where the aspect of occupational participation was measured on an independent scale. Further review involved establishing any psychometric testing and if the measure had been used in intervention research for people with difficulties associated with a mental disorder and/or an offending history.

This work package modelled the outcomes, but outcome *measures* identified are illustrative only. They are not based on comparative or evaluative work. In addition, further research is required to ascertain acceptability to service users.

Table 9-3 presents outcome measures found to be potentially suitable, their psychometric properties, whether they have previously been used in research, and a rationale for their selection.

Table 9-3 Selected outcome measures

Aspect of occupational participation	Selected outcome measure	Psychometric properties	Previous use in trials	Rationale
Capacity to perform activities (skills)	Work and social adjustment scale ¹⁶⁶	Yes ^{289, 290}	Yes Community forensic mental health ¹⁶⁵	Self-report. 5 items on whether the person can perform activities (and roles) in light of the 'problem'. Highest rated social functioning measure by mental health service users ²⁹¹
Actually performing activities	Time Use Survey ²⁹² Adapted for trial	N/a	Yes Early intervention for psychosis ²⁹³	Interview based review of the last month. May need adaptation to review one week, to reduce participant burden. Use by Office of National Statistics allows comparison to national average. Activity level below 30hrs indicates 'poor social function'. ²⁹⁴
Activities meet needs	Basic Psychological Need Satisfaction and Frustration Scale ²⁹⁵	Yes ^{295, 296}	No	24 items. May need simplification and amendment of negative items Reflects basic needs for autonomy, relatedness and competence from self-determination theory.

Capacity to participate in roles	Role Checklist Version Two (Quality and Value)	Limited ²⁹⁷⁻²⁹⁹	No	Flexible delivery: Self-report, computer-mediated or interview. Person rates how well they perform the role relative to their peak performance – indicative of capacity.
Actual role participation				Participant rates whether or not they participate in roles.
Social and personal value attributed to roles				Person reports whether or not they value the roles they perform/ want to perform. Includes socially valued roles and option to add <i>others</i> which could be 'antisocial' roles.

9.4.3 RELATIONSHIP BETWEEN INTERVENTION COMPONENTS AND THEORY FOR THE EXPECTED EFFECTS

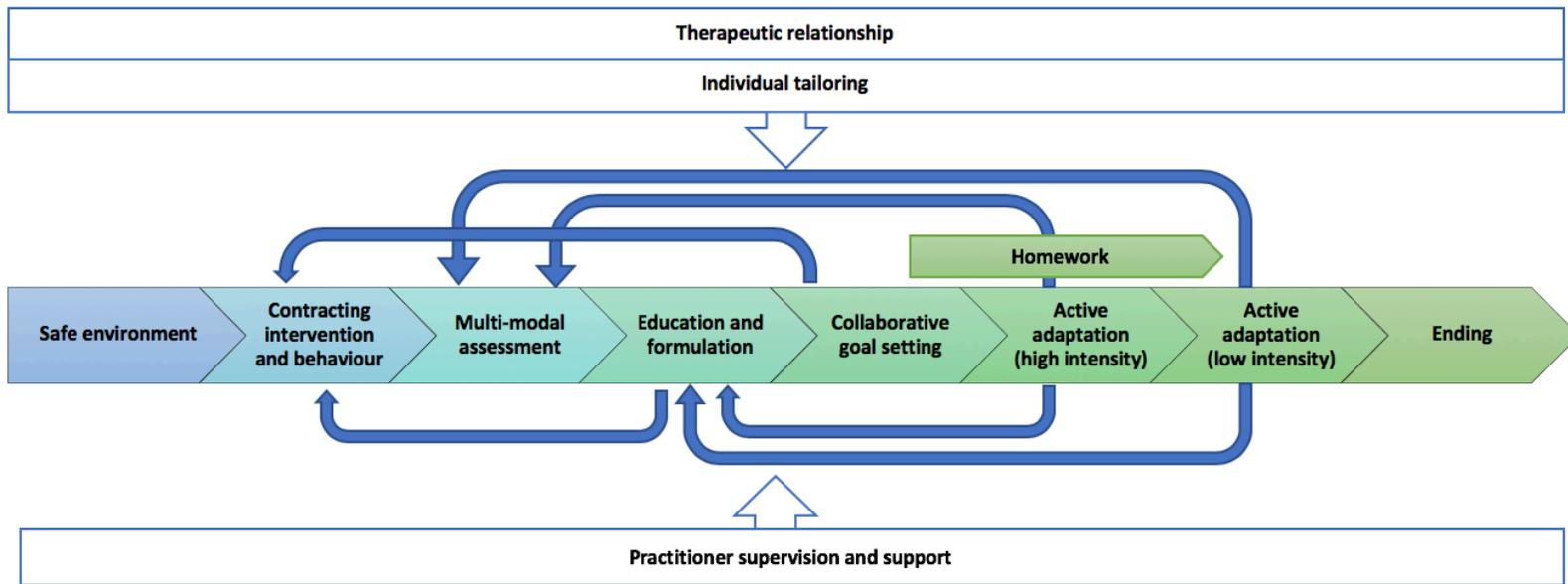
RELATIONSHIP BETWEEN INTERVENTION COMPONENTS

The components were related to one another within the intervention. Statements from WP3 were used to establish these relationships, which supported a phased intervention.

Components included those that reflected a particular phase of the intervention, and those that were active for the duration of the intervention. WP3 participants and PPIAG members emphasised that the intervention could not be rigidly linear, nor could time limits be placed on the phases. This informed a decision to model the process of moving through phases based on achieving the aim of a phase, rather than arbitrary time limits. The model reflects the possibility of the products of previous phases being reviewed as the intervention progresses.

Figure 9-2 visually represents the inter-relationship between components.

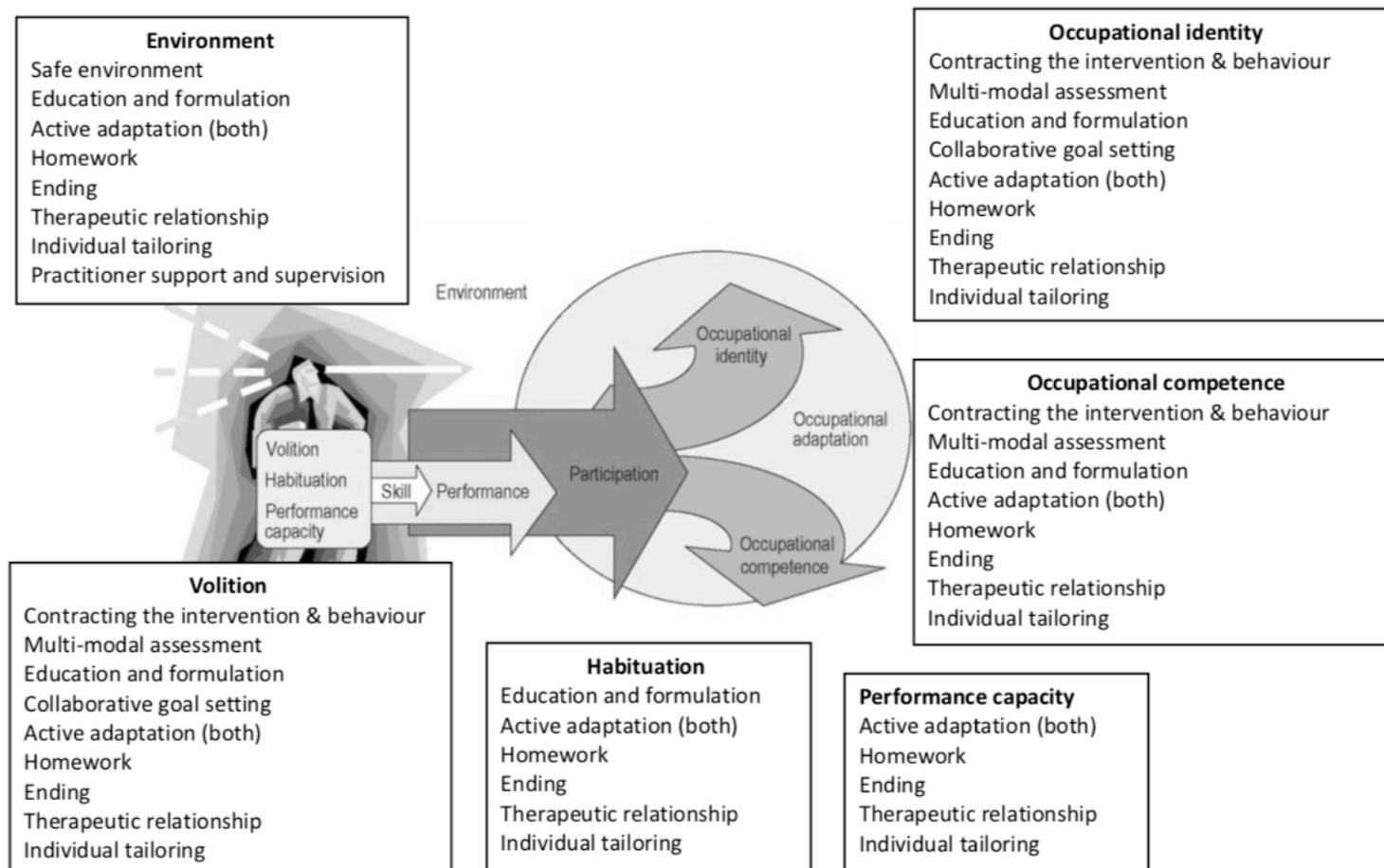
Figure 9-2 Interrelationship between components



MOHO was used throughout intervention development, consistent with the requirement of the MRC guidelines to systematically integrate of the best available theory at all stages.²⁵ MOHO was applied to explain the mechanisms of change and theorise the expected effects on each component (Table 9-1).

Figure 9-3 shows the MOHO sub-systems and which intervention components were theorised to produce change in each. Some components act on only one MOHO sub-system, but most act on volition, occupational identity and occupational competence. This is consistent with the needs of PDOs identified in WP2 where assessment scores indicated marked impairment in the latter two concepts, and qualitative findings showed that PDOs had a disrupted volitional process.

Figure 9-3 Relationship between components MOHO concepts



9.4.4 MEDIATORS AND MODERATORS

The effects of the intervention components on occupational participation may be enhanced or reduced by mediators or moderators. In statistics, mediators and moderators are quantified variables that can be incorporated into quantitative analyses. Mediators explain a relationship between two things, whilst moderators determine the strength of that relationship. Adopting a critical realist perspective, in this research mediators and moderators were not necessarily quantifiable factors, but included those mechanisms or structures within the context of the intervention which are prerequisites for its delivery (mediators), or that support or hinder its effects (moderators).

The systematic reviews identified limited evidence for moderators or mediators of occupational participation for PDOs in the community.¹¹⁴ Thus, potential moderators and mediators were identified in the results and findings from WP1-3, and review of the literature. The PPIAG developed these, drawing on their experience of receiving or working in services for PDOs in the community. Although not quantified at this stage, identifying potential moderators and mediators can inform future quantification for statistical analyses of intervention effects.

MEDIATORS

Three potential mediators were identified: law and policy on PDO rehabilitation; availability of skilled practitioners; and intervention setting commitment. These are represented in the logic model in red (Figure 9-5).

The intervention is dependent upon legal and political decisions about what services can and should be made available to PDOs. There have been two changes in England that support intervention delivery. Firstly, there has been a change in policy away from the Dangerous and Severe Personality Disorder (DSPD) programme and towards the Offender Personality Disorder (OPD) Pathway. This is summarised in Chapter One. The OPD Pathway aims to make services available to more people and to focus on pathways to the community.¹ Secondly, there has been a change in the law to abolish Imprisonment for Public Protection orders (IPPs). IPPs resulted in some high-risk offenders being detained in prison beyond tariff if they failed to make satisfactory change. Now this option is unavailable, high-risk offenders are being returned to the community. There are therefore both risk concerns and rehabilitative requirements to work effectively with PDOs on return to the community. This intervention is timely for its attention to community based rehabilitative efforts that are cognisant of risk.

Implementing the intervention requires people with the appropriate skills to be employed in services for PDOs. At the start of this research, it was intended that the intervention be delivered by practitioners from any professional background. However, the complexity of the intervention and occupational participation itself led the PPIAG to conclude that it should be delivered by experienced occupational therapists. Previously there were few occupational therapists in the community services for PDOs which would have restricted availability of skilled practitioners. However, this number is increasing. New OPD Pathway services are opening with occupational therapists within the staffing profile, including in the West Midlands. Complimenting this is the changing landscape in community forensic mental health services in England. New Care Models emphasise the importance of supporting people to transition out of secure hospitals

more quickly and of providing therapeutic interventions across the whole pathway.³⁰⁰ Because one factor in prolonged hospital admissions has been limited community based rehabilitative efforts,³⁰¹ most of the new community forensic mental health services include occupational therapists. The increase in available skilled practitioners in new settings further indicates this timeliness of the intervention.

INTERVENTION SETTING COMMITMENT AND MORALE

Policy support for intervention has to translate into commitments at regional, local and frontline service levels. A service must agree and commit to supporting the intervention evaluation process. This depends upon morale, which can be challenged repeatedly by legal and political changes.³⁰² The Transforming Rehabilitation⁶² reforms partly privatised the probation service in England and were followed in quick succession by the 'E3' reforms and the creation of Her Majesty's Prison and Probation Services (HMPPS).³⁰³ This caused disruption during WP2 as staff and PDOs moved to new agencies, offices and working practices. Feeling overwhelmed and fatigued by change may have influenced the PPIAG members who stated a preference for a specialist occupational therapy intervention they could refer into, rather than train in and provide themselves. Morale needs to be considered at an early stage for its impact on services willingness to support future research and practice changes.

MODERATORS

Moderators were grouped into those related to the intervention recipient, the environment and criminal justice factors. Table 9-4 presents these with a brief summary and examples. These are represented in the logic model in yellow (Figure 9-5).

Table 9-4 Moderators

Intervention recipient	Environmental	Criminal justice factors
<p>Voluntary attendance: Whether the person is legally compelled or chooses the intervention</p> <p>Life experience – narrative slope: Shapes perspective of likely usefulness of intervention and person delivering it. Experiences of traumatic ‘intrusion’</p> <p>Habituated ‘destructive’ routines and activities: Need to return to established successful strategies / no knowledge of how to do differently</p> <p>1+ supportive person outside services: Someone to encourage and support (not in a paid capacity)</p> <p>Demographic / individual characteristics: Age, ethnicity, gender identity, sexuality, cognitive ability</p> <p>Unexpected crises: Emotionally destabilising events, e.g. anniversary of offence</p>	<p>Inter-agency collaboration: Whether agencies support enabling rather than doing for, work the same way with personality disorder presentation, maintain consistent boundaries</p> <p>Housing availability: National and local quality affordable housing options</p> <p>Employment market: National and local quality employment options</p> <p>Social and service provider attitudes: Views of personality disorder, rehabilitation of offenders</p> <p>Law and policy (including social security): Non-criminal areas of law and policy, e.g. health care provision, financial support, employment options</p>	<p>Legal requirement to disclose convictions: Impact on tenancy, employment and education – convictions for some PDOs are never spent</p> <p>Licence conditions/ sentence guidelines/ sentence plan: E.g. regularity of reporting, curfews, electronic tags, mandated offending behaviour programmes. These may be outside the control of the PDO and their offender manager</p> <p>Law and policy on offender rehabilitation: Response to breaches of probation orders. Offender Personality Disorder Pathway. Transforming Rehabilitation and ongoing reforms</p>

9.4.5 EVIDENCE FOR IMPLEMENTATION

There is a growing literature on effective implementation of complex interventions in routine clinical practice, with a community of researchers naming this field of study implementation research or implementation science.³⁰⁴ Implementation needs to be considered throughout

intervention development, rather than only at the point of implementation readiness, i.e. when the intervention has been demonstrated to be effective in a robust clinical trial.³⁰⁵

At the stage of intervention development reached in this research, moving straight to a trial risks failure, and time and resource wastage.³⁰⁶

Preparatory work is first required through a feasibility study and pilot evaluation. Therefore, this objective focuses on the evidence for successfully conducting intervention research, rather than uptake of the intervention. Specifically, it attends to the UK probation and community forensic mental health context, which are the primary locations for future testing of the intervention.

Papers reporting full, feasibility or pilot evaluations of psychosocial interventions for adults in community forensic mental health or probation settings were identified. These were papers either reviewed in WP1, identified through engagement with the literature during this research, or identified through further literature searches as follows:

- i) UK Trial registers were searched using the terms “probation” OR “community forensic”.
- ii) Web of Science was searched on 12th September 2018 using the following search string:

(TI=("forensic" OR "probation" OR "criminal justice social work")) AND (TI=("trial" OR "evaluation"))

Results were limited to trials reported in the last five years to identify barriers and facilitators of contemporary UK forensic mental health and probation services.

Results from WP1 identified one paper published in 2009.¹⁶³ This was included due to the reporting of relevant process issues. Five trials were

identified from UK trials registers.^{13, 82, 307-309} Only two had reported previous piloting or feasibility work.^{13, 82} One paper was identified in the literature review,³¹⁰ and one from engagement with the literature during this research.⁹

Table 9-5 summarises the papers in publication date order. The barriers and facilitators identified in each are discussed below.

Table 9-5 Papers reporting trials

Study	Population	Intervention	Trial type	Funder
Davidson et al. ¹⁶³	Men with Antisocial Personality Disorder in community mental health services in England and Scotland	Cognitive Behavioural Therapy for Personality Disorder (psychological therapy)	Pilot RCT	Medical Research Council
Hill et al. ¹³	People with personality disorder released from prison, considered high risk, on probation in Liverpool	'Sociotherapy' delivered by health and criminal justice staff	Pilot RCT	Department of Health
Pearson et al. ³¹⁰	People whose risk of reoffending was considered high or medium risk receiving probation supervision in Teeside	'Citizenship' programme (includes CBT based motivational interviewing and community integration)	Stepped wedge cluster RCT	Regional Director of Offender Management
Khalifa et al. ⁸²	Nottingham community forensic mental health patients, including a group with personality disorder	Individual Placement and Support (support to achieve employment) delivered by trained specialists	Feasibility RCT	NIHR RfPB programme
Yakeley et al. ³⁰⁷	People with Antisocial Personality Disorder receiving probation supervision in England	Mentalization Based Treatment	Full RCT	Charitable trust, NIHR
Lennox et al. ⁹	Released prisoners with common mental illnesses. 85% co-morbid personality disorder. Southwest and Northwest England	Non-specific intervention involving strengths based, mentalization and practical support approaches.	Pilot RCT	NIHR programme grant

Thompson et al. ³⁰⁸	People on probation in Southwest and Northwest England	Health training ³¹¹ to address key areas of health and wellbeing	Pilot RCT	NIHR PHR Programme
Parkes et al. ³⁰⁹	18-24 year olds arrested at least twice for low level criminal offences in Southampton	1) Assessing and triaging health and social care needs and mentoring; 2) empathy workshops; 3) restorative justice conferencing	Full RCT	NIHR PHR Programme

Davidson et al.¹⁶³ was identified from the studies reviewed in WP1. They conducted a pilot RCT of cognitive behavioural therapy for personality disorder (CBT-PD) with men with Antisocial Personality Disorder recruited from community mental health services. Only five of the initially referred group rejected randomisation, resulting in a sample of 52. In the CBT-PD group, 44% attended 10 or more sessions. However, it is unclear what the attendance rates were in the different groups (six-month or 12-month intervention). The authors report 79% follow up at 12 months and that a full RCT would be feasible, though it has never been conducted. Although almost ten years old, the study was included due to reporting process issues relevant to working with community mental health services. The authors identified that literacy levels may preclude use of self-assessments and that economic evaluation was impeded by the men's low health service use. This suggests a need for resource intensive follow up to collect self-assessments and that economic evaluation should include the costs of criminal justice and social work service use in a feasibility study of this intervention.

An RCT of a specialist service (Resettle) for people on probation with a personality disorder and considered high-risk of reoffending, was identified on the trials register. Pilot study results, made available by the research team through personal contact, led authors to conclude that a full RCT was feasible.¹³ However, this has never been conducted. The authors recommend close collaboration and governance structures between the research and practitioner teams, having found scepticism about the need for a trial from some practitioners. Concerns among offender managers that randomisation denied people a specialist service disincentivised referral to the trial. Over 50% of people allocated to the intervention group whilst in prison declined to engage with the intervention on release. Baseline measures were taken whilst in prison and at follow up in the community, indicating that there may be some significant external influences on these ratings. Only 18% of the total people randomised

completed the outcome measures at two years from a community setting, which prevented analysis of data related to social role functioning. This suggests the need to consider when measures are taken and the number of participants required to gather sufficient data to evaluate occupational participation.

The literature search identified a stepped wedge cluster RCT of a risk focused programme delivered in probation settings.³¹⁰ Although not strictly a psychosocial intervention, the intervention did include a component of 'community integration'. Researchers selected a stepped wedge design because of its acceptability to practitioners. Practitioners were reluctant to support a traditional RCT because, similar to the Resettle pilot RCT, there were concerns about withholding a beneficial intervention. Practitioners nonetheless did not deliver the intervention as requested to all participants, with only 38% of the of the 'intention to treat' sample receiving the intervention. The authors suggest longer training and more robust monitoring and clinical supervision for the duration may have improved this. Being monitored for delivering intervention as intended, commonly referred to as fidelity, would have to be included in the evaluation of the intervention developed in this research. Further, the participants were mandated to attend the intervention as part of their licence conditions. Drop-out rates were therefore not a significant issue. Follow up was similarly not required as the primary outcome was reconviction identified from official records. The authors were therefore able to use rigorous analysis methods and demonstrate that RCT designs can be applied in probation. There are differences between a risk-focused mandatory programme evaluated from official reconviction data and the intervention developed here. This paper provides useful evidence that non-traditional RCT designs may be more acceptable in the probation context. Whilst there have been significant changes in probation structures since the time of this and the Resettle study, the reluctance of practitioners to

support traditional RCTs is worthy of consideration in a future feasibility study.

A cluster feasibility RCT of Individual Placement and Support (IPS) in community forensic mental health⁸² was identified from registered trials. The study faced time pressures, with the funders requesting the implementation period be halved. Clinical staff felt under-resourced and stretched thinly, impacting on their support for the intervention. Some staff believed this was not their core business. One cluster was a service for people with personality disorder, where some clinicians afforded the intervention lower priority than other therapy and it was challenging to maintain intervention fidelity. The evaluation identified a lack of incentive for senior management to support the research.⁸³ Making a robust case for an adequate implementation period and ensuring that service providers are willing and able to support future research into this intervention will be essential.

A full RCT of Mentalization Based Treatment (MBT) for men on probation with Antisocial Personality Disorder was identified from registered trials.³⁰⁷ It is currently recruiting participants in England from the NPS. To date the feasibility study is unpublished. Offender managers involved in the PPIAG reported some people had declined the intervention due to the cost and time to travel to the intervention site. Whilst these issues may be specific to the West Midlands, they are important to consider when continuing with the intervention developed in this research.

During this research a multi-site feasibility study and pilot RCT of a non-specialist psychosocial intervention for people leaving prison with common mental illnesses, 85% of whom had comorbid personality disorder⁹ was identified. Communication with research team members clarified that this intervention was delivered by trained staff who were external to the NHS and the criminal justice system. This avoided some of the challenges seen

in the community forensic mental health services, where existing staff felt it was extra work to support research.⁸³ The feasibility study had useful findings for informing future research of the intervention developed here. The pilot RCT recruited to time and target, had good engagement with the intervention but follow up rates were only 47% at three months. A recent publication by the same group suggests that six-month follow up rose to 66%.³¹² Some of the issues identified included: frequent unblinding, Clinical Studies Officers (external research support staff) were not as effective at recruitment as research team members; and loss to follow-up over three months. The authors identify the potential benefit of engaging with the NPS and other statutory agencies to maximise follow up. Advice from the PPIAG and experience working with the NPS in WP2 supports this conclusion. In WP2, accessing and re-contacting participants was made relatively simple by engaging with participants through their required routine attendance at NPS premises.

Two trials of probation interventions registered in 2018 are at too early a stage to have reported outcomes. One is an RCT of a mixed risk and well-being focused intervention led by the police service.³⁰⁹ The other is a pilot RCT of a health focused intervention delivered by an external provider.³⁰⁸ The latter is complete and pending a decision of the feasibility of conducting a full RCT. When published, the findings will provide useful information due to the similar intention to recruit from probation but for health practitioners to deliver the intervention.

All but one of these trials were funded by national health research organisations. This suggests that there is an interest in funding research to enable services to better meet the needs of people not traditionally in receipt of health care or who are receiving health related services in an alternative setting.

Table 9-6 summarises the considerations raised from reviewing these papers. These are grouped according to whether they are related to site practitioners, site environment or trial methods. Potential solutions are drawn from the published papers, PPIAG input and from clinical experience working in these settings.

Table 9-6 Considerations and solutions for future intervention research

	Consideration	Solutions
Site practitioners	<p>Time: Supporting (and delivering) intervention according to protocol requires training, documentation and thoughtful engagement.</p> <p>Research knowledge: Many practitioners have no or minimal research training, impacting willingness to support randomisation or the study itself.</p> <p>Support for intervention: Biasing implementation in either direction if the intervention is favoured or perceived as threatening.</p> <p>Fidelity: Not delivering the intervention as intended.</p>	<p>Intervention may be best provided by additional staff. Alternatively, practitioners may need to be relieved of other duties to provide this support. Ongoing supervision and monitoring are required.</p> <p>Information and support about what is required and why (e.g. randomisation). Consider alternative RCT designs (e.g. stepped wedge).</p> <p>Information and support about what is required and why (e.g. impartiality).</p> <p>Fidelity measures. Ongoing supervision and monitoring.</p>
Site environment	<p>Research culture: Valuing production of evidence or seeing a study as a challenge to existing practice may affect site engagement.</p> <p>Support structures: Support structures and processes need to be in place, sensitive and interested in the context.</p> <p>Managerial buy-in: Management need to value and support time given to research.</p>	<p>Select research positive sites.</p> <p>Engage research infrastructure from the start and include costing for research team time to train support staff or conduct tasks themselves.</p> <p>Incentivise and educate leadership and teams to value curiosity.</p>

Trial methods	<p>Funder requirements: May make unrealistic requests due to underestimating time and complexity in a research naïve context.</p> <p>Recruitment: Support staff less effective than study staff.</p> <p>Unblinding: Participants keen to disclose their experience to researchers.</p> <p>Retention: High loss to follow up.</p> <p>Outcome measures: Population with limited literacy, high transience and an often unpleasant experience of formal interview. Violence may not reduce if intervention is not focused on this.</p> <p>Acceptability: Participants engaged well in psychosocial interventions.</p> <p>Accessibility: Participants may have limited resource, time and capacity.</p> <p>Economic evaluation: participants likely to be low health service users.</p>	<p>Ensure funder familiar with implementation complexity in mental health/criminal justice settings and likely timescale.</p> <p>Include costings for research team to recruit or train support staff to do effectively, or for research staff to have greater role.</p> <p>Consider researchers being unblinded and using protocol for outcome measurements to minimise bias.</p> <p>Flexible, assertive follow up with multiple ways to make contact. Liaison with other statutory organisations in contact with that person. Incentivise participants. Developing a project brand. Issuing certificates. Asking the participant to problem solve ways of following up successfully. Make intervention a mandatory licence condition.</p> <p>Minimise number of measures and focus on key outcome. Deliver conversationally rather than formal interview. Focus on the outcomes targeted by the intervention.</p> <p>Intervention designed to be consistent with potential participant's ability and interest, and in a way that it is perceived as useful.</p> <p>Consider cost/ease of access if participant must travel.</p> <p>Economic evaluation should include use of criminal justice, social work and other services.</p>
----------------------	---	--

Manuals provide clear and specific guidelines for consistent intervention delivery, provide a means to measure fidelity, facilitate staff training, and allow delivery in novel contexts.³¹³ Manualising the intervention will facilitate future research into the feasibility of delivering the intervention in a natural setting and of conducting an evaluation of its effectiveness.

A psychosocial intervention at the stage of a feasibility study requires a 'stage one' manual, the purpose of which is to specify the treatment techniques, goals, format, and theoretical 'active ingredients'.¹⁵⁰ The data from this and the preceding work packages were used to produce a stage one manual.

The Template for Intervention Description and Replication (TIDieR) Checklist¹⁵¹ was integrated into the manualisation process. The TIDieR checklist provides a clear list of the information that must be included when describing an intervention. Applying this ensured that the manual included the information a practitioner would need to deliver the intervention, and also ensured that expected quality standards are easily met when reporting future research into its effectiveness.

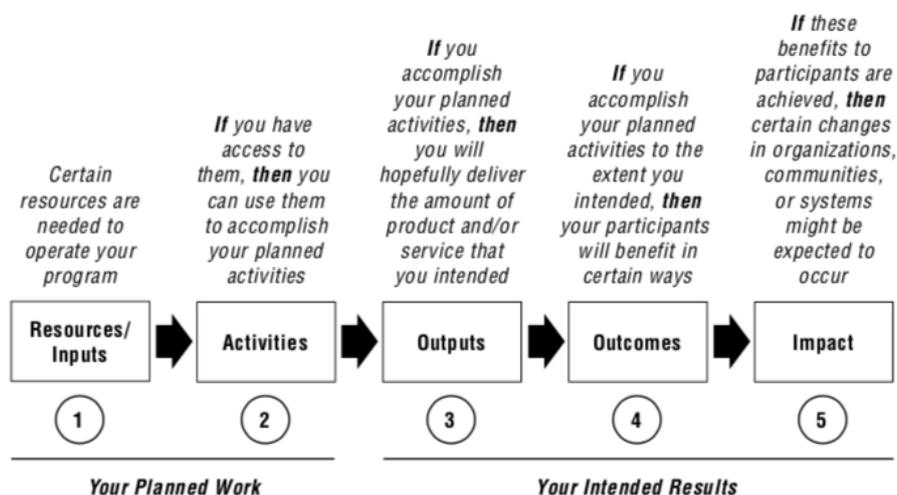
Appendix H outlines the manual content. An additional chapter on 'research considerations' was added to cover all the areas required by the TIDieR checklist and to guide practitioners delivering the intervention as part of a trial. The full manual is not included in this thesis to ensure it is not used in practice before effectiveness is established.

A logic model was developed to visually represent the relationships between the intervention components and other influencing factors, applicable to UK practice settings. It moves from a model of the intervention and how the components relate to one another within it, to considering how the intervention might work in context.

Each step in a logic model follows from the previous in a chain of reasoning that argues that if one step happens, then the next step is possible.¹⁵³

Figure 9-4 shows an example of a basic logic model, highlighting this reasoning. The example is a model for delivering a programme, akin to delivering a complex intervention.

Figure 9-4 Example of a basic logic model



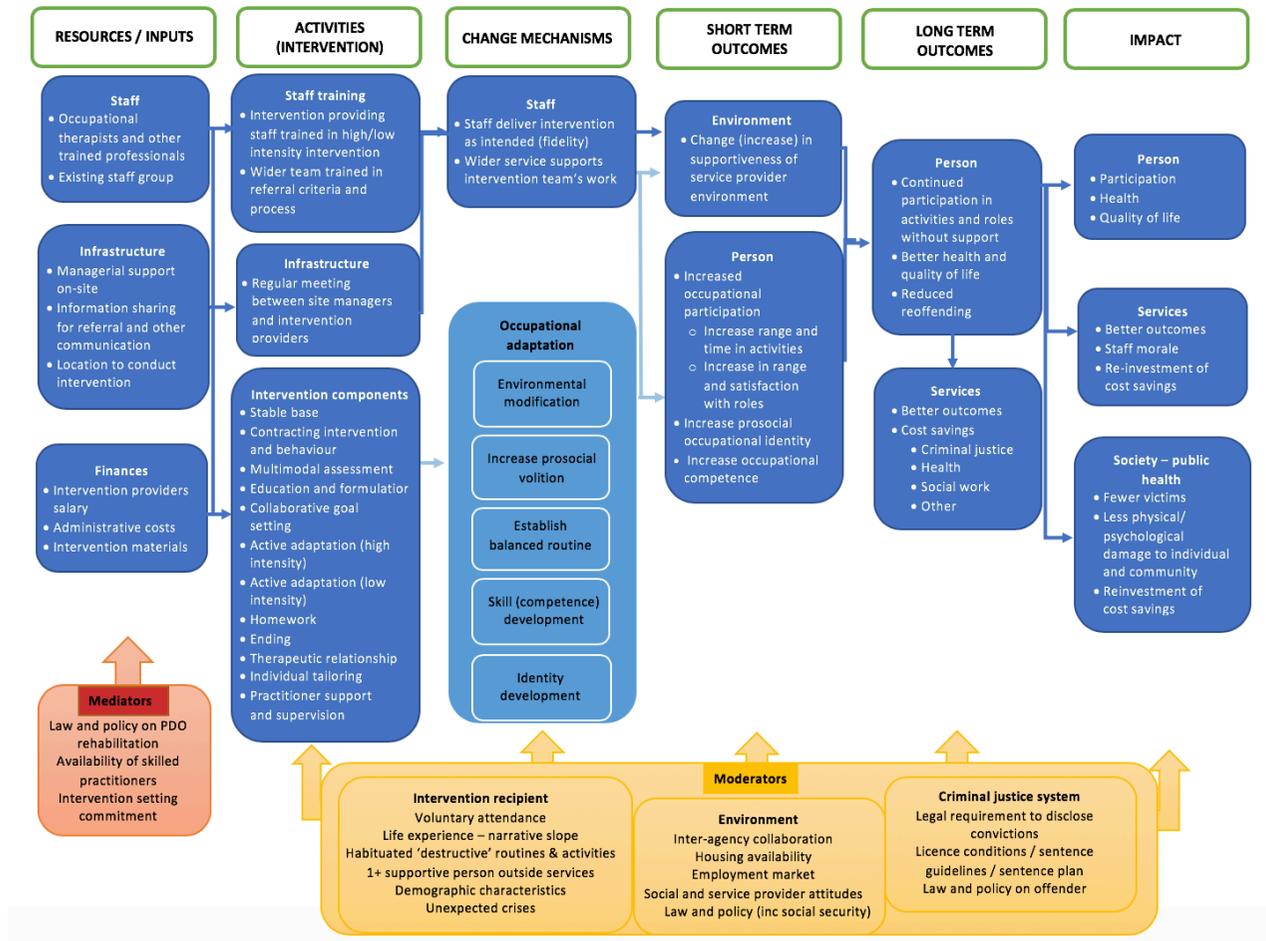
Reproduced from W.K. Kellogg Foundation¹⁵³

Logic modelling in this WP used an outcomes approach, presenting the expected outcomes of the intervention and the theoretical basis for why and how the intervention may result in these outcomes. The outcomes approach is most useful in the early stages of planning implementation and informing evaluation designs.¹⁵³

Appendix H shows how the logic model was initially created. All the items in each step were listed. Next, the relationship between individual items in one step were linked to items in the following step and drawn onto a diagram. The model was enhanced by adding representation of the mechanism of change between activities and outputs, and the potential moderators and mediators of the intervention process. PPIAG discussions informed refinement of the model and the relationships within it.

Figure 9-5 shows the preliminary logic model. Thesis formatting has reduced its size and made the text very small. If reading via a computer this can be expanded. A simplified version is included in Appendix H if reading manually.

Figure 9-5 Logic model for intervention to increase occupational for PDOs in the community



9.5 DISCUSSION

9.5.1 SUMMARY

WP4 synthesised the results and findings from previous work packages and the literature to specify, manualise and model an intervention to increase occupational participation for PDOs in the community. This section discusses the resulting intervention and its components in relation to other interventions for people with complex needs, personality disorder and in mental health occupational therapy. It discusses the results of the different stages in modelling the intervention and the gaps in the literature identified throughout this process.

9.5.2 SPECIFICATION AND RELATIONSHIP BETWEEN COMPONENTS

The overall shape of the intervention reflects what is typically seen in occupational therapy process models, moving through assessment, formulation, goal-setting, a phase of active intervention and evaluation.³¹⁴⁻
³¹⁶ It also reflects the common ‘phases’ of effective psychological therapies of first addressing safety, containment, regulation and control, before progressing to exploration and change, and integration and synthesis.³¹⁷

The first component is **‘safe environment’** which necessitates that the person referred to the intervention has their basic needs met for shelter and finances, can keep themselves safe, and receives a consistent approach from the agencies they are involved with. Housing First is an example of an intervention for people with complex needs which also focuses on securing basic needs for accommodation and stable finances before progressing to other needs. This approach is more effective than interventions sequenced in the reverse, for example asking someone to

address addiction before considering housing.³¹⁸ The safe environment component also ensures that if a person is in contact with multiple services, all give a consistent message about the intervention and the value of increasing occupational participation. Multi-agency consistency is recognised as key principle in working with people with a personality disorder diagnosis^{90, 91, 319} which would be no less important when working with people who also have an offending history. Ensuring multi-agency consistency in communicating support for the intervention intends to give the person confidence that engaging will not disrupt other service provision and thus prompt their withdrawal. It also aims to prevent one service acting (intentionally or unintentionally) to counteract the occupational adaptation process, for example by doing things for the person rather than facilitating skill development.

The '**contracting the behaviour and intervention**' component is theorised to increase occupational participation by providing a structure for identifying and addressing problematic patterns that may reduce intervention engagement and effectiveness. It is intended to give the person equal control over consequences of different actions throughout the intervention and protect both parties from harm. For example, if it is agreed that swearing at one another is not permitted and the result of this will be to stop the session and review whether to continue, neither party will then be surprised if a session is stopped if one swears at the other. Contracting is not common in the occupational therapy intervention literature, but is a typical component of psychological therapies that have been demonstrated to be effective for people with a personality disorder diagnosis.^{e.g.320,321} Its emergence here may reflect the sampling of a group of practitioners who work in a psychologically-informed style. However, there is a need to attend to predictability in relationships more closely with PDOs given the relational factors that influence occupational participation identified in Work Package Two (WP2). As the intervention continues, the

contract can be updated as the practitioner and person come to understand one another better, set the goals of the intervention and review progress.

'Multi-modal assessment' involves collecting data from a range of sources to understand the person's occupational participation and the factors that influence it. Interventions to increase occupational participation for people with psychosis include an assessment component.^{265, 322} The differences between psychosis and personality disorder and the different factors influencing occupational participation identified in WP2 indicate a different assessment process is needed to access the relevant information with people with a personality disorder diagnosis. Existing assessments which were used in WP2 had limitations in detecting all the relevant influencing factors. Therefore, no specific scored assessment is recommended at this stage. Although identified as an example trial outcome measure, the Role Checklist Version Two: Quality and Performance may provide a useful clinical outcome measure. This will need further consideration to determine which measures are most appropriate clinically, and which are best suited as trial measures.

For PDOs assessment included self-assessment, observation of occupational performance (undertaking an activity at a point in time) and assessing occupational participation over time using a narrative approach. The utility of the OPHI-II interview and narrative slopes was demonstrated in WP2 and this is suggested as a semi-structured interview schedule for the intervention. Medical and psychological practitioners use assessment to ascertain *how* a particular problem developed and how it is maintained.^{323, 324} This is not explicitly stated in occupational therapy standards.³²⁵ Use of narrative assessment emphasises understanding *how* occupational participation has developed and is sustained. It additionally focuses on how that person experiences their world and therefore participates in it. This is the first known intervention to increase

occupational participation that specifies narrative as the most important assessment method, which may reflect the particular needs of PDOs.

The **‘education and formulation’** component aims to explain to the person what occupational participation is and why it matters, before developing a shared formulation about the person’s occupational participation, how it may have developed over time and what this might mean for the future. Formulation involves making theoretical inferences about the mechanisms by which a particular problem or circumstance results, identifying treatment targets and identifying theoretically consistent approaches to modifying these.³²⁶ Formulation is included as a component of psychological therapies found to be effective for people with personality disorder.^{e.g.320, 327} It is considered a core skill for clinical psychologists.³²⁸ Formulation as a specific intervention component is under-developed in occupational therapy, with only a few references to the term in the literature.^{65, 314, 329} However, the evidence that formulation makes an additional or unique contribution to effective intervention is still lacking, including in forensic practice.^{330, 331} This has led to the development of quality checklists to rate formulations as a potential means of evaluating the relative effectiveness of interventions based on good quality (rather than absent or poor quality) formulation.^{89, 330, 332} Adaptation of these standards to focus on occupational participation are incorporated into the manual. Identifying formulation as component may reflect the emphasis on psychologically-informed formulations in the Offender Personality Disorder Pathway, but equally it may indicate a working practice suited to the needs of PDOs.

‘Collaborative goal-setting’ capitalises upon and focuses motivation to make change into relevant achievable plans, enabling the person and practitioner to identify when the intervention can be concluded. Goal-setting is common to most psychosocial mental health interventions^{e.g.265, 322, 333} and effective interventions for treating personality disorder

symptoms.^{e.g.321, 334} Systematic review and meta-analysis identified that goal setting has a small but consistent effect in interventions to achieve behavioural change ($d=0.34$).³³⁵ Some strategies for goal setting are thought to be more effective than others. Epton et al.³³⁵ found that adding some of these specific strategies to goal setting, such as feedback, had no differential effect, although they acknowledge that studies were not all sufficiently powered. Additionally, most of the included studies used non-clinical samples (67% were university students). In contrast, a systematic review and meta-analysis of a particular type of goal setting, implementation intentions, demonstrated a large effect among people with psychiatric disorders in supporting goal attainment.³³⁶ Implementation intentions involves talking through with a service user what they will do in a situation to overcome any challenges in an 'if-then' statement. This review did not include people with personality disorder. However, implementation intentions may be beneficial for preparing PDOs for potential challenges to goal achievement, anticipated on the basis of their formulation.

One of the challenges in establishing the effectiveness of goal-setting as an independent intervention component for people with personality disorder, or PDOs specifically, is the requirement that practitioners do not to support goals that may repeat harmful patterns of occupational participation. Safe goal setting therefore cannot be conducted without the preceding assessment and formulation components, as well as attending to developing a therapeutic relationship. Any testing of goal setting as a separate component would have to be by its omission from the intervention rather than only delivering that component. Additionally, results and findings in WP2 indicated that several PDOs did not perceive themselves as the agent of change in their lives and were ambivalent about setting goals. WP3 results highlighted that additional flexibility and specific approaches are required with PDOs that are less well reflected by general goal setting literature, such as repeated reorientation to goals, assertive

feedback, contingency planning (like implementation intentions) and teaching skills for reflecting on both outcomes and processes.

'Active adaptation' is the core component that directly applies occupational adaptation. It is supplemented by **'homework'**. These components are based on the theory that by undertaking new activities and roles, the person begins to re-experience their occupational identity and develop the competences that support it. This results in changes in the other MOHO sub-systems and over time the person can sustain a new pattern of occupational participation that is conducive to health and desistance outcomes.³⁴ This has been described as a 'top-down approach' in occupational therapy.³³⁷ A bottom up approach would target the factors influencing occupational participation in isolation and assume these will result in a change in occupational participation, e.g. teaching problem solving skills in the classroom or exercises to increase range of motion. Instead, the top-down approach involves participating in activities in a real-life context, like preparing a meal or catching a bus, to develop required skills to sustain occupational participation. This approach is common in UK mental health occupational therapy and has been included in interventions for people with mental disorders.^{265, 322} A Swedish mental health occupational therapy intervention combining both top-down and bottom-up approaches in a group setting demonstrated effectiveness in increasing activity participation and quality of life.³³⁸ The sample did not explicitly include people with a personality disorder, although they may have been present in a category of people with 'other' diagnoses (7%).

Participants in WP3 emphasised that working with PDOs requires particular skills that differ from the descriptions of other occupational therapy interventions. For example, rather than a skill teaching role, practitioners need to actively ensure that any activities move the person towards the agreed goals, supporting internalisation of new patterns through validation, positive reinforcement and reflecting on learning, whilst

avoiding repetition of harmful patterns or those that increase the risk of harm. Attention to the potential risk of harm likely results from the offending history of the PDO population.

Having **high and low intensity** active adaptation components reflected the differing needs and narratives among PDOs in WP2. The need for flexibility was also evident in the practitioner responses in WP3. The high intensity component is intended for people who are unable or unwilling to try new activities independently. The lower intensity component is intended for those who were willing and able to undertake new activities and roles independently but may benefit from support to make choices consistent with their goals. The latter group may be those whose narrative slope already follows a progressive trajectory. The assessment and formulation components would enable the practitioner to make a preliminary judgement on which level of intensity would be most appropriate, but the option would remain for someone to step up or down between the different intensities depending on their progress towards the agreed goals. Future research can focus on determining: who benefits most from the different intensities; whether a person's narrative slope is associated with treatment need, progress and outcome; whether a person's narrative slope can inform allocation of intensity; and to approximate an appropriate intervention 'dosage' for different people.

The '**ending**' component was important to the participants in WP3, who cited the difficulties with attachment experienced by PDOs that may make this a time that increases their risk of acting in a harmful way. Ending successfully is hypothesised to facilitate occupational participation by encouraging the ongoing occupational adaptation process after the end of the intervention. It aims to increase the value placed on the intervention by the person, motivate them to continue applying their learning and maintain changes, and to ensure that successes are shared with wider social and professional networks. Recognising the intervention as an event

in a person's unfolding life is consistent with narrative theory¹³⁶ and is emphasised by recent conceptualisation of occupational therapy interventions as situated within a complex system.³³⁹ The importance of integrating the intervention into a wider support or care system was highlighted in a study of psychoeducation and problem solving for people with personality disorder (PEPS). The study had to be concluded early due to a higher incidence of adverse events in the intervention arm. The authors hypothesised that this may be because follow up was superior, but also recognised that the intervention was not sufficiently integrated into existing care, leaving participants vulnerable when the intervention ended.³⁴⁰ This is of particular concern where harms could have implications for the individual but also exacerbate any risk posed to others. It also emphasises the importance of the ending component in ensuring the person has sufficient ongoing support.

The final three components act throughout the intervention and are consistent with generic principles of good practice in health and probation services. The component '**therapeutic relationship**' is hypothesised to increase occupational participation not of itself, but by facilitating the persons engagement in the intervention and thus the occupational adaptation process. Therapeutic alliance is one of the most commonly cited components of mental health, psychotherapeutic and probation-based intervention.²⁶⁶⁻²⁶⁸ Key to this component however, is that therapeutic alliance is essential but not sufficient to facilitate occupational adaptation. Practitioners are required to attend to the relationship *and* to maintain attention to the goals of the intervention to facilitate occupational adaptation. Taylor described this as an 'intentional relationship' in occupational therapy.²⁷¹

'Individual tailoring', reflects the WP3 results that a personalised approach sensitive to the person's unique characteristics is essential. The need to be person-centred is central to therapeutic practice. This does not negate the

application of evidence-based practice, which is explicit about the practitioners skill in applying the best evidence to a person and their unique circumstances.³⁴¹ Complex interventions allow for tailoring provided the active ingredients of an intervention are not changed. Attending to a person's unique experience is facilitated by narrative approaches when working cross-culturally.²⁴³ It ensures the intervention makes sense to the person in the context of their life and thus facilitates engagement with it.¹³⁶ Whilst the effectiveness of highly individualised occupational therapy interventions has been suggested by some to be impossible to establish,³⁴² this view has been largely rejected³⁴³ as more and more researchers, including mental health occupational therapists, utilise the MRC guidelines in their work to allow for tailoring.^{322, 344}

The final generic component is '**practitioner support and supervision**'. Recent systematic review of the challenges to practitioners when working with people with a personality disorder diagnosis found only descriptive papers but identified stress and burnout, hardening of attitudes, negative emotional responses and fear of violence.³⁴⁵ Supervision is cited as a buffer against these, although it is acknowledged in the review that there is little clarity about what supervision should consist of and that evaluation of its effectiveness is still required. This component ensures that the person delivering the intervention is supported in their own wellbeing when working with often emotionally disturbing stories and interactions. It also acts as a quality control to ensure fidelity is maintained. It facilitates occupational participation by maximising the practitioner's ability to deliver an intervention that is likely to be effective.

Specifying the intervention components and their content highlighted that a level of knowledge and skill is required to work in a way that is likely to be effective to increase occupational participation for PDOs in the community. Reviewing the detail of the components suggested that it may not be feasible to expect people from any disciplinary background to be

able to deliver it. The complexity in the population and the intervention indicate that the intervention in its current form would be best delivered by experienced occupational therapists. This conclusion was reached by the PPIAG on account of the underpinning theoretical background to the intervention, requirement to assess and formulate occupational participation, the need to be able to work with activity as a therapeutic medium, and the requirement to individualise the goals and strategies. All of these are core aspects of occupational therapy practice.³²⁵

The original intent in developing the intervention was for it to be deliverable by any practitioner in order to increase its reach. At the start of this research, specifying it's delivery by occupational therapists would have limited the feasibility of the intervention itself because there were few occupational therapists in forensic community mental health or probation services in England. However, there has been a recent expansion of community intervention services within the Offender Personality Disorder Pathway and community forensic mental health services within the NHS England New Care Models initiative.³⁰⁰ This expansion has created roles for occupational therapists. The intervention is timely in its production, providing these occupational therapists with a structured, manualised and evidence-based intervention to apply when working with service users with a personality disorder diagnosis.

9.5.3 OUTCOME MEASURES

There is increasing evidence that people who have experience of the criminal justice system and/or forensic mental health services can be involved in research as partners.^{346, 347} However, there is still a gap in the literature regarding what outcomes are important to PDOs and offenders in general, and what measures are acceptable to them. Future work should establish what matters to PDOs and appraise the face validity of existing

measures from PDOs' perspectives. This can inform selection of trial outcome measures to enhance the acceptability and perceived utility of the research and intervention to PDOs.

Perspectives of general mental health services users of outcome measures used in research have been studied. The most commonly used measures were not highly rated, with some participants feeling the measures are too short and superficial.²⁹¹ This has led efforts to involve service users in developing reliable and valid assessments of valued outcomes in mental health.³⁴⁸ People with personality disorder and experienced practitioners value the inclusion of measures of social functioning, though only one measure has been appraised. The Social Functioning Questionnaire¹⁶⁴ had a mixed response but was better received than lengthy symptom-related measures. The authors raise the impact of emotive content in a measure altering a person's emotional state and thus influencing their ratings.³⁴⁹ It is thus important that measures selected in future research are considered by PDOs in advance of any trial to ascertain if there are any unforeseen effects from completing the measure.

In identifying suitable measures for the component parts of occupational participation, there were more psychometrically evaluated measures used in intervention trials for activity performance than for role participation. The Role Checklist Version Two – Quality and Value (RCv2:QP)²⁹⁸ is suggested as a potential measure of occupational participation because it allows the person to identify the roles they participate in, which roles they value regardless of participation in them, and the quality of their performance. A recent revision into Version Three³⁵⁰ was not selected because the changes mean that only roles performed are rated for satisfaction and those not performed are rated for interest, which no longer reflects the operationalisation of occupational participation produced in this research. Version Three also removes the time delineations of the past one week which are useful for research purposes,

and the option to add an 'other' role which is important for validating the experiences of a population whose access to socially valued roles may have been limited. Both these critiques were raised in a study of the utility and feasibility of the RCv2:QP.³⁵¹ North American language is included in both versions (for example referring to school rather than college or higher education). This may need attention as American language was identified as a negative by people with personality disorder in their appraisal of outcome measures.³⁴⁹ There may be cultural differences reflected within measures derived in America that could be addressed to enhance the acceptability in the UK, particularly in a group whose experiences have deviated so markedly from socially valued American norms.

Psychometric properties for the RCv2:QP have only been investigated on a small scale. Test-retest reliability was established with a sample of 100 people in a study that also confirmed the reliability of online administration. Demographics of the participants are not reported but are unlikely to include PDOs.³⁵² Some limitations were identified in a cross-cultural study of construct validity to determine if the RCv2:QP was consistent with occupational participation as defined in the Model of Human Occupation (MOHO). Several raters gave examples of occupational performance rather than occupational participation, which the authors suggest indicates that the measure does not exclusively tap occupational participation. However, the study was flawed by asking people for examples of an 'activity performed for the role' which equates to asking for an example of occupational performance. This study was also unlikely to include practitioners working with PDOs. In a study of the concurrent validity with another MOHO associated assessment, the Occupational Circumstances Interview and Rating Scales (OCAIRS), RCv2:QP had an interclass correlation co-efficient on the 'internalised roles' subscale of OCAIRS of $r = 0.95$.²⁹⁹ This is good indicator, but the sample was 20 liver transplant patients and the psychometric properties of the OCAIRS are still relatively understudied. The RCv2:Q2 has not been used in intervention

research, although clinical examples suggest sensitivity to change.^{298, 353}

Despite the few studies of the psychometric properties of the RCv2:QP and that it is yet to be used in clinical trials, this measure had good face validity when compared to the operationalisation of occupational participation. It was selected as a potential outcome measure but will require appraisal by PDOs for whether they consider it valid, useful and acceptable and how best to support completion given potentially limited literacy and digital literacy skills.

The RCv2:QP is a clinical tool that in itself may facilitate change in occupational participation by increasing awareness in the participant about discrepancies between their values and their current role participation. This may be problematic for use in a trial, because if the measure itself has an impact on occupational participation it may produce change in the control group and therefore mask the true effect size. This could be explored in a feasibility study or pilot evaluation, for example with a subgroup in each arm of a trial receiving a different measure or excluding the RCv2:QP to determine if an effect is achieved by the measure alone. If the RCv2:QP does prove problematic for trials, it may be useful as clinical assessment within the intervention, with an alternative sought for trial purposes. If the RCv2:QP does produce change of itself, it could be applied for people with a low level of needs without further intervention.

9.5.4 MEDIATORS AND MODERATORS

Mediators and moderators could only be hypothesised from the research informing the intervention development process and input from the PPIAG. A feasibility study could include detailed monitoring and scoring of the presence or absence of different moderators and mediators in different settings. This could assist in identifying where the intervention can have its greatest effect, or what modifications are required to enhance its

effectiveness. Additionally, it would inform future analysis of trial results by allowing statistical modelling of the impact of moderators and mediators on the outcome.

9.5.5 IMPLEMENTATION

The manual and the logic model provide a basis for a future feasibility study and pilot evaluation of intervention effectiveness. Using the intervention in practice settings for the purpose of a feasibility study and pilot evaluation is likely to require a change in practitioner behaviour and a change in the knowledge and support in the wider practice setting infrastructure. In a detailed process evaluation as part of a large multi-site RCT, Rycroft-Malone et al. found that even where the evidence for practice change was uncontested at the sites, challenges to shifting established practice remained. Particularly important within this were the relationships in the care setting between different professions, teams and individual practitioners, and wider organisational support for change.³⁵⁴ These findings led to the development of the i-PARIHS (integrated - Promoting Action on Research Implementation in Health Services) for designing process evaluations. In England, there are complex structures of health and criminal justice services working in partnership to deliver services for PDOs, with multiple practitioners who at times have competing agendas. Given the complexity and limited knowledge of implementation contexts, a feasibility study would benefit from including a process evaluation using a framework such as i-PARIHS,³⁵⁵ paying particular attention to individual, interagency and cross-site differences in working between health and criminal justice that may impact on implementation success. Process evaluation will support identification of sites that have the ability to partake in a full evaluation of the intervention, and what tailoring will be required to enhance successful implementation in different contexts.

Intervention development and evaluation is iterative, thus changes and enhancements to the intervention and the logic model will be expected as the process continues.³⁵⁶ However, a clear road map to continued research and development has been set out here.

9.5.6 STRENGTHS AND LIMITATIONS

Literature reviews were undertaken to identify supporting or contradictory evidence for aspects of the intervention and logic model. Systematic reviews were only available in some cases. Further systematic reviews would strengthen the conclusions, although there is little literature in the area to review. Finding literature gaps is expected in the iterative intervention development process.³⁵⁶ The intervention and logic model thus provide a starting point for primary research to address gaps and answer further questions.

9.6 CONCLUSIONS

This work package synthesised the data from the research to model the intervention, and its outcomes and processes. It produced two outputs. The first output is a stage one intervention manual to increase occupational participation for PDOs in the community. At this stage the intervention should be delivered by an experienced occupational therapist. The second output is a logic model to inform a feasibility study and process evaluation. Producing the logic model highlighted further gaps in the evidence, indicating that detailed process evaluation of implementation would be advantageous to inform continued intervention development and evaluation.

9.7 IMPLICATIONS

9.7.1 IMPLICATIONS FOR PRACTICE

- The complexity of occupational participation and intervention to increase it suggests services for PDOs in the community should include experienced occupational therapists in their staffing profile

9.7.2 IMPLICATIONS FOR RESEARCH

The manual and the logic model provide a basis for a future research. This should include:

- Identifying the outcomes important to PDOs and other stakeholders
- Identifying acceptable, valid and reliable measures of those outcomes
- A feasibility study in varied practice settings to determine:
 - Whether the intervention can be delivered as intended
 - The acceptability of the intervention to practitioners and recipients
 - The most appropriate and feasible trial design to test effectiveness
- A process evaluation within the feasibility study to strengthen the understanding of site-specific implementation considerations, and moderators and mediators that may need to be measured and/or addressed
- Once feasibility is established, the intervention can be tested for whether it is effective in increasing occupational participation for PDOs in the community

9.8 CHAPTER CONCLUSION

This chapter concludes the results from the research, describing the process that resulted in the two intended primary outputs. It demonstrates that the research questions have been answered and that the research achieved its aims.

10 DISCUSSION AND CONCLUSION

10.1 INTRODUCTION

This research developed an intervention to increase occupational participation for people with an offending history and a personality disorder (PDOs) in the community. Occupational participation involves undertaking activities and roles valued by society, and that meet a person's needs. The decision to focus on occupational participation was informed by theory and evidence that occupational participation is integral to health,¹⁷ associated with a reduced risk of reoffending³⁵⁷ and implicated in the desistance process.^{42, 44} These are all key aims of health and criminal justice services working with PDOs in the community. In addition, service providers and service recipients valued occupational participation as an important outcome of their work together. The specific attention to developing an intervention to increase occupational participation was in response to practitioners' desires to better address the rehabilitative needs of PDOs, and in light of the lack of evidence available to inform their practice.

Chapter One, which introduces the thesis, and Chapter Three, which reports results from two systematic literature reviews, demonstrate that evidence for effective interventions to increase occupational participation for PDOs in the community is largely absent.^{113, 114} Before a trial to demonstrate the effectiveness of any intervention to increase occupational participation for PDOs in the community could be considered, it was essential that attention was given to developing an intervention that is supported by theory and evidence and thus likely to be effective. Intervention development was therefore the focus of this research. As such, the research had three aims:

- 1) Identify the factors that influence occupational participation for PDOs in the community
- 2) Identify the required components of an intervention to increase occupational participation for PDOs in the community, and what these components should include
- 3) Identify how a new intervention to increase occupational participation for PDOs in the community can be implemented in a natural setting for a future feasibility study and pilot evaluation

Due to the complexity of the population, services and outcomes, this research applied the Medical Research Council (MRC) guidelines for developing and evaluating complex interventions.²⁵ Chapter Two describes how the MRC guidelines were applied to inform the work packages in this research. Chapter Two also explains how critical realist philosophy and the Model of Human Occupation²⁶ were applied throughout to ensure the intervention developed was theoretically coherent.

Each work package used a different research method to address the above aims, building on the results and findings of the previous work packages. A full discussion of methods, results and findings, and strengths and limitations of each study are reported in Chapters Three to Nine.

The primary outputs of the research are:

1. A stage one manualised intervention to increase occupational participation for PDOs in the community
2. A logic model to inform a future feasibility study and pilot evaluation in a natural context

These outputs indicate the aims of the research were achieved, making a unique contribution to knowledge.

This chapter discusses the main findings that demonstrate the achievement of the above aims. It considers these in relation to advancing the evidence base in intervention research for PDOs in the community. The chapter considers the strengths and limitations of the thesis as a whole, and highlights implications for research and practice.

10.2 DISCUSSION OF MAIN FINDINGS

10.2.1 GAPS IN EVIDENCE FILLED BY THIS RESEARCH

FACTORS INFLUENCING OCCUPATIONAL PARTICIPATION

The first aim of this research was to identify the factors that influence occupational participation for PDOs in the community. This research identified 28 factors. These were determined by integrating qualitative and quantitative data collected at interview with PDOs, which were added to and confirmed by an expert panel in a Delphi study. The panel rated all 28 factors above five for their degree of influence on a zero to ten Likert scale. It is the first time that the contemporary factors influencing occupational participation in the community have been studied with PDOs, making a clear contribution to the evidence.

Previously, only one study has sought to identify predictors of a 'good social outcome', a construct similar to occupational participation, for PDOs.¹⁵⁷ Intelligence Quotient (IQ) and assertiveness on admission to a high secure psychiatric facility were associated with a good social outcome to a statistically significant degree. Other factors tested or any theory behind selecting them are not reported. As static and historical factors respectively, these cannot be modified in an intervention. Therefore, this

research has advanced understandings by identifying distal, proximal and modifiable influencing factors associated with a theory of how they may be changed. The factors' association with or prediction of occupational participation was not tested statistically. Future research can use these results to guide attention to relevant factors when testing associations with or prediction of occupational participation in the community for PDOs.

Combining both quantitative and qualitative approaches in this research strengthened the results. Quantitative data demonstrated that existing measures derived from the Model of Human Occupation are sensitive to identifying some areas of impairment for PDOs that influence occupational participation in the community. The areas of impairment were broadly consistent with what would be expected based on the criteria used to diagnose personality disorder with the ICD-10.² In the recent release of the ICD-11, the conceptualisation of personality disorder has changed from categories with different (but often overlapping) diagnostic criteria, to a single disorder on a continuum of severity.³⁵⁸ The overall description of difficulties experienced by people with a personality disorder diagnosis is unchanged and thus the revision into ICD-11 does not change the significance of these research findings.

Lower scores in communication and interaction skills on the Model of Human Occupation Screening Tool¹⁸² differentiated PDOs from people with personality disorder but no offending history. This could be explained by the additional stigma associated with having an offending history, which may impact on PDOs self-efficacy in social settings and decision to avoid interpersonal situations. Self-imposed restrictions on occupational participation, because of a fear of stigma or failure, was evident in the qualitative data in this research. This finding has been replicated in qualitative studies exploring recovery and community engagement among people leaving secure psychiatric facilities in the UK and Canada.^{191, 255}

Scores on the Occupational Performance History Interview – Version Two (OPHI-II) scales differentiated PDOs from people with a physical disability and people with no diagnoses. PDOs scored markedly lower than both groups on occupational identity and occupational competence, and lower than people with no diagnosis on the occupational settings (environment scale). Using the OPHI-II scales was problematic as the PDOs scores deviated from ‘expected’ patterns, which according to the manual should be adjusted. However, doing so undermined the construct validity of the scales and produced inflated scores in occupational identity and occupational competence. The unexpected scores resulted from the assumption of the assessment, which was that people are assessed on entering therapy following a deterioration in occupational participation. In contrast, despite the level of impairment experienced by PDOs, their life histories revealed that coming into contact with the probation service could not be viewed as a time of deterioration. The narrative typologies, developed from participants’ collaboratively drawn visual representations of their lives (reported in Chapter Six) further revealed how current occupational participation was at worst, a continuation of the difficulties they had always experienced. In addition, the narrative typologies themselves influenced occupational participation and how a PDO may view an intervention. This has implications for situating the intervention developed in this research within an individual PDOs unfolding life narrative.

Integrating the themes and sub-themes from the qualitative analysis, narrative typologies and scores based on factors found to be influential in other populations produced a list of 28 factors that influence occupational participation for PDOs in the community that takes account of the specific difficulties experienced by PDOs. Chapter Seven discusses the factors in relation to the sparse literature identified during systematic reviews^{76, 157, 159} and on occupational participation among women with personality

disorder.^{252, 253} It is evident that the PDOs did not experience their greatest difficulties in occupational performance, for which they were well equipped with cognitive and physical capabilities. Where difficulties were most apparent was when moving from activity performance to occupational participation, i.e. participating in socially valued roles. This involves social, relational and emotional capacities, in which the PDOs experienced more impairments. However, these capacities are not well described in MOHO and its associated assessments. PDOs were further disadvantaged by: the absence of historical 'success' in occupational participation on which to model their behaviour; the development of habitual patterns of responding to immediate needs by selecting activities or roles that functioned to do so; and experiences of adversity or traumatic events that coloured their experience of other people and intruded into their present.

In Chapter Five, the qualitative data were used to examine the factors found to influence occupational participation in relation to the sub-systems of the Model of Human Occupation (MOHO). This revealed two additional findings. Firstly, the mechanisms that influence occupational participation for PDOs are not fully accounted for by MOHO. This could be addressed by modifications to the existing MOHO volitional and performance capacity sub-systems. Secondly, when these modifications are made, the MOHO sub-systems equally explained the PDOs participation in activities and roles that society would consider 'antisocial,' deviant, inexplicable or harmful. Occupational participation in MOHO only considers those activities and roles which are socially valued (i.e. productive, leisure and activities of daily living). The focus of this research was to identify the factors that influence occupational participation in those socially valued activities and roles, because of their importance in health, risk reduction and desistance.^{17, 42,}
³⁵⁷ However, the findings resulting from the application of MOHO suggest that failing to consider current and past participation in activities and roles that society views as deviant will lead to important influencers being

overlooked. I further discuss the merits of the dichotomy between socially valued and socially deviant occupational participation, and the findings relating to the MOHO sub-systems in the additional findings section below.

Despite the need for modifications to the MOHO subsystems, the theorised mechanism of change, occupational adaptation, was confirmed. This is an important result as it supports the use of MOHO in developing the intervention in this research. The qualitative data analysis demonstrated that the PDOs could learn and adapt to new ways of living in the community. This was achieved with variable levels of success, as adaptability is an area of impairment indicated by the quantitative findings and the diagnostic criteria for personality disorder. Nonetheless, some participants described how they achieved change through undertaking new activities and roles that gradually became part of a new personally and socially valued pattern of occupational participation.

Identifying the factors that influence occupational participation for PDOs in the community makes a unique contribution to knowledge by addressing a gap in the literature. Previously, there was insufficient evidence and no theoretical direction in studies that aimed to identify moderating or mediating factors influencing occupational participation.²⁵¹ These factors can now be built upon to ascertain the nature and degree of influence of each factor on occupational participation for PDOs in the community. This will require quantification of each factor and testing its association with occupational participation.

The results emphasise the benefit of conducting additional qualitative research when applying existing frameworks to a new population. The important differences between these factors and those routinely measured in standardised assessments have implications for practitioners. Applying existing assessments may overlook factors of critical importance for understanding what is influencing occupational participation for PDOs, and

therefore the factors identified in this research may better guide practitioners in their assessments. As there has been no statistical investigation of these factors, they cannot be used to score someone or as a clinical outcome measure. The use of narrative principles in data collection demonstrates how a narrative approach could be integrated into practice resulting in a better appreciation of the influences of occupational participation and highlighting potential targets for intervention.

INTERVENTION CONTENT

The second research aim was to identify and describe the content of the components of an intervention to increase occupational participation for PDOs in the community. A national sample of multi-disciplinary experts rated the importance of the 28 factors and the relative ease with which they could be modified. They agreed 121 statements describing intervention content. These were grouped according to similarities, resulting in the specification of twelve intervention components intended to achieve a particular aim. Nine intervention components related to intervention phases that progressed in a sequential nature, and three components described overarching intervention principles. Component specification is reported in Chapter Nine.

Statements that did not achieve consensus mostly related to timing, such as the duration or frequency of sessions, with participants emphasising that they prioritised maintaining a responsive and individualised approach. At this early stage of development, it was determined to be more appropriate to use task completion or observable phenomena to ascertain when a session or phase of intervention is complete. However, for reporting trials of complex interventions it is essential to include timing, frequency and dosage.^{151, 152} A future feasibility study will need to collect

data to make an approximation of session length and frequency, and overall intervention length for standardisation purposes that will allow the results of a future trial to be fully appraised.

The participants failed to reach consensus on integrating technology in the intervention, yet digital literacy is critically important for occupational participation in modern society.^{274, 278} Digital technology and internet use has risks through connecting people,^{281, 282} which is one reason some PDOs are legally prevented from using the internet as part of their licence conditions. However, failure to address digital literacy will leave some PDOs facing barriers to occupational participation and other protective factors,²⁷³ and potentially leave them vulnerable in the online space.

Practitioners may have expressed hesitance about technology use due to an unfamiliarity with incorporating it with their work to date. Almost half the participants (46%) were from a criminal justice background where intervention is rarely conducted outside the consulting room and interventions often use paper and pencil workbooks. A proportion of the expert panel were occupational therapists who may be more used to delivering intervention in less conventional settings. Despite the lack of consensus, the importance of safe technology use for access to occupational participation and other protective factors informed a decision to retain it in the intervention as an optional consideration, recognising the need for individualised risk management.

Chapter Nine illustrates how the agreed statements were grouped to specify the intervention components and determine how each component related to the factors identified in Work Package Two, MOHO sub-systems, the hypothesised mechanism of change and suggested practitioner actions. These data were converted into a manual suitable for a feasibility study. The Patient and Public Involvement Advisory Group (PPIAG) was critical at this stage for establishing whether the intervention would be acceptable to

PDOs and whether it could feasibly be delivered by a multi-disciplinary workforce. They agreed that it was likely to be acceptable to PDOs but had two primary comments on its feasibility. The first was the view that the intervention required too high a level of knowledge and skill to realistically be delivered after brief training by any practitioner. This was particularly commented upon in relation to assessment and formulation skills, as well as using live settings to produce change in the target factors. As working in this way is a core skill of occupational therapists, the PPIAG suggested it should be delivered by experienced occupational therapists. The second comment on feasibility was expressed by people working in criminal justice settings, who advised that their preference would be to have a specialist intervention which they could refer PDOs into, rather than to have to learn a new intervention on top of their current responsibilities.

Whilst the arguments made by the PPIAG are supported by the relative complexity of the intervention, restricting its delivery to experienced occupational therapists limits the workforce capable of delivering it to a smaller group of professionals. It could be argued that this outcome resulted from my stance as an occupational therapist with specific expertise in this area, and a conscious or unconscious desire to justify this specialism. However, on commencing this research there were few occupational therapists working with PDOs in the community and the intention was to produce a widely applicable intervention that would benefit as many PDOs as possible. Finding that the intervention is too complex to deliver without significant knowledge, skills and training more accurately reflects the complexity of occupational participation and the challenges of intervention with PDOs.

There has recently been expansion of multi-disciplinary community forensic mental health services and collaboration between these and criminal justice services for PDOs.³⁰⁰ The available occupational therapy workforce is therefore expanding with potential to use some of these

services as sites for a future feasibility study. Producing this intervention is timely as, if found to be effective, it will provide the occupational therapists in these new services with a structured, manualised and evidence-based intervention to apply.

Developing and evaluating a complex intervention is an iterative process.³⁵⁶ One area that may warrant future attention is whether the intervention can be simplified for use by multi-disciplinary practitioners with a short training package. For example, the qualitative findings in Work Package Two demonstrated that the interview itself was highly motivational for some PDOs. This may be enough to initiate an increase in occupational participation in some cases and could be delivered following brief training in narrative interviewing. This research identified three narrative typologies (Chapter Six): progressive, consistent instability and restrained. Previous research has suggested that those with a progressive slope and sense of agency about their future may be more likely to do well in an intervention.¹²⁸ An initial screening using co-production of a narrative slope could inform the intensity of the intervention, with those reporting an unstable or regressive slope receiving a higher intensity of intervention and those reporting a progressive narrative being more suitable for a multi-disciplinary intervention based on brief training. These questions can be addressed in a future feasibility study.

INTERVENTION MODELLING

The third research aim was to identify how a new intervention to increase occupational participation for PDOs in the community could be implemented in a natural context for a future feasibility study. In Chapter Nine, the final logic model is discussed. As is expected at this stage of developing and evaluating a complex intervention, further gaps in the

evidence were identified that will need to be addressed in future research.³⁵⁶

As demonstrated in the systematic review findings there is a lack of consensus about which participation-related outcomes are relevant for PDOs in the community, and how they are operationalised for measurement in research.^{113, 114} There are several potential explanations for this, including: the overall lack of research into interventions and outcomes for PDOs; the understandable prioritisation of risk reduction; multiple competing constructs considered 'social outcomes' such as recovery, wellbeing, participation, employment, prosocial behaviour and social inclusion; and the ongoing debate about how participation is operationalised.

The World Health Organization concept of participation is recognised internationally in physical disability and paediatric research but is minimally used in mental health research. Its lack of conceptual clarity, the conflation of activities and participation in its associated classification system, and the lack of a theoretical mechanism of change informed the decision to use occupational participation, as conceptualised in the Model of Human Occupation (MOHO), as the intended intervention outcome. MOHO occupational participation is analogous with the WHO concept of participation but is supported by a theory of change and has a number of associated assessment tools validated in mental health settings. With modifications to reflect the findings in this research, occupational participation was redefined and operationalised.

Occupational participation is defined here as 'undertaking activities that enable a person to meet their needs and perform a valued role/valued roles in society'. It does not have an associated reliable and valid outcome measure. Separating occupational participation into component parts informed the presentation of illustrative outcome measures in Chapter

Nine. However, these will need further scrutiny before being considered for use in a trial. Two specific areas should be prioritised. Firstly, the perspectives of PDOs should be ascertained with regards to the acceptability of different valid and reliable measures of occupational participation. This is important because selecting an acceptable measure will increase the likelihood of completion, whether in trials or practice. Considerations have to be given to time to complete, perceived relevance, a person's literacy levels and the potential for emotive content to influence responses.³⁴⁹ Ascertaining PDOs perspectives of how best to measure occupational participation could be completed as part of a future feasibility study.

Secondly, consensus should be established in the multi-disciplinary academic community on which outcomes and outcome measures should be used in intervention research for PDOs, including PDOs in this process. Occupational participation is often the focus of occupational therapists and other allied health professionals, but social outcomes are increasingly of concern to most services. The protective effect of occupational participation on both health and reoffending^{17, 359} indicates it should be considered as an intervention outcome for PDOs. Including an agreed measure of occupational participation in a core outcome set would enable the wide range of clinical and academic disciplines to effectively communicate and compare the outcomes of their research between one-another, stakeholders, commissioners, practitioners and PDOs. Achieving consensus across the professions and disciplines who work with PDOs, who often have different theoretical approaches and intervention foci, is a challenge. However, a core outcome set is being developed for trials involving people with schizophrenia or bipolar disorder in the community, including service users throughout.³⁶⁰ Producing a core outcome set for trials involving PDOs in the community could be approached in a similar way.

This intervention is intended to be delivered in any setting or service accessed by PDOs, but primarily probation and community forensic mental health. Probation and community forensic mental health are different services, but there are also marked variation between sites and the individuals working with them. The limited evidence of moderators, mediators and documented trial experiences in these settings suggest a prospectively designed process evaluation should be integrated into any future feasibility study or trial of the intervention. The i-PARIHS³⁵⁵ specifically addresses relational issues within and between professions and could be applied in planning this additional aspect of evaluation. Learning from a process evaluation would ensure that if progressing to a full trial, risk of implementation failure is minimised so that it does not invalidate its results.

This research produced a logic model to inform a future feasibility study and process evaluation. It therefore considerably advances the literature from when this research commenced. It lays the groundwork for a continued body of research to test the effectiveness of the intervention in a trial. Identifying further gaps in the literature is expected in the iterative complex intervention development and evaluation process.³⁵⁶ The logic model also provides a starting point for primary research to address gaps in the literature to further enhance intervention research with PDOs in the community.

10.2.2 ADDITIONAL FINDINGS

Findings from analysing the qualitative data indicated that that modifications are required to the Model of Human Occupation (MOHO) to account for the experiences of PDOs in the community. The volitional and performance capacity sub-systems require elaboration. The dominance of need fulfilment within the volitional sub-system for PDOs needs to be

reflected in the operationalisation of occupational participation. This section further argues that the focus of MOHO on explaining *social valued* occupational participation is an unnecessary limitation in its scope. Further, the failure to consider the impact of past (and current) participation in activities and roles considered socially deviant (antisocial occupational participation) restricts its explanatory power with PDOs.

MOHO SUB-SYSTEMS

The Model of Human Occupation (MOHO) was applied to facilitate the abductive reasoning process. The MOHO sub-systems were conceptualised from a critical realist perspective as mechanisms that produce the phenomenon of occupational participation. All the sub-systems influence one another; however, the modifications proposed lie in the volitional and performance capacity subsystems.

The volitional sub-system incorporates values, interests and personal causation which develop over time through our ability to anticipate, chose, experience and interpret occupation.²¹⁷ Whilst these concepts were evident for the PDOs, a finding in the qualitative work was that one of the main influences of occupational participation was the *function* a particular activity or role performed. The value or interest in the activity was secondary to a person's motivation to meet a need. This led to PDOs sometimes meeting their needs through antisocial occupational participation (antisocial activities and roles). In a study using narratives Morris et al. observed the same phenomenon.²⁰⁸ People with personality disorder participated in self-cutting because it met an emotional need, despite being disliked by the participants themselves and considered harmful by society. In contrast to MOHO, The Good Lives Model highlights that humans have innate needs and strive to attain these through the

pursuit of 'human goods'. If someone cannot attain human goods that meet their needs by prosocial means, they may partake in antisocial activities as an alternative.¹⁶⁰ This reflects the motivational process in PDOs.

Functional motivation had implications for all the MOHO sub-systems. It resulted in disrupted routines and identity development, and habitual participation in activities considered socially deviant because of their past effectiveness. The habituation of antisocial activities was supported by Morris et al.²⁰⁸ Functional motivation also disrupted performance capacity by directing capacities to need fulfilment at the expense of applying cognitive skills. Functional motivation impacted the environment sub-system because it resulted in PDOs prioritising their own need fulfilment above the needs of others. This contributed to tensions within the social environment, conflicts, relationship strain and involvement of the criminal justice system. Incorporating functional motivation into the volitional sub-system resulted in need fulfilment being included in the modified operationalisation of occupational participation. To fully understand occupational participation, this data supports the modification.

The performance capacity sub-system also requires consideration with PDOs. This sub-system is currently described as consisting of motor, process and communication and interaction skills. However, emotional and relational skills (such as anticipating, coping with and responding to emotion, or relating to people and accurately perceiving their views) emerged as important influencers of occupational participation for PDOs. Impairments in these aspects of performance capacity may be considered unsurprising given their relevance to a personality disorder diagnosis.² Emotional and relational skills should be recognised within the performance capacity subsystem, as their impact on occupational participation is clear.

Further, the performance capacity sub-system was not consistently impaired. Performing activities alone, such as in the home, was generally unaffected. The PDOs reported good skills maintaining their environments, preparing meals or in leisure activities. However, when moving from occupational performance to occupational participation, PDOs described considerable difficulties. Occupational participation requires emotional and relational skills, in which the PDOs experienced more impairments. Similar variation has been reported, but not considered any further, in studies with women with personality disorder.^{252, 253} This research suggests that the performance capacity sub-system may operate differently in different contexts. The difference between impairment in performing activities and impairment in occupational participation is instrumental in understanding apparently fluctuating presentation of PDOs and must be considered in future research and practice

This research demonstrated that despite the required modifications in the MOHO sub-systems, the mechanism of change in occupational participation, occupational adaptation, is supported. Similarly, with modification to the operationalisation of occupational participation to include need fulfilment, it can still be used as an intervention outcome.

DICHOTOMISING OCCUPATIONAL PARTICIPATION

Occupational participation, as described within MOHO, involves undertaking activities and roles that are *valued by society*, or that are at least within societal norms. For clarity of argument and brevity, this section uses the term 'prosocial occupational participation' to describe this phenomenon. However, the PDOs often undertook activities and roles that were socially deviant, antisocial, harmful or apparently inexplicable, such as serious self-injury, criminal activity, substance misuse or gang

participation. For clarity of argument and brevity, these types of activities and roles are referred to in this section as 'antisocial occupational participation'. The qualitative findings demonstrated that antisocial occupational participation and prosocial occupational participation could equally be explained by the interacting sub-systems of the Model of Human Occupation (MOHO). However, there are only two brief mentions in contemporary MOHO texts regarding antisocial occupational participation. First in discussion volition there is a reference to a 'failure of interests.' Substance use, sedentary lifestyles or antisocial activity are described as a preference and deliberate choice.²¹⁷ It is clear from the findings in this research that there are more complex reasons than this for why PDOs participated in antisocial activities in the past and may continue to do so. The second reference is to 'dysfunctional habits'. This term is not elaborated but dysfunctional habits are understood as a barrier to prosocial occupational participation.²²⁰ From these brief mentions, there appears to be an implicit assumption that antisocial occupational participation is a barrier to prosocial occupational participation as defined in MOHO. However, the findings of this research suggest an alternative perspective. Occupational participation, whether antisocial or prosocial, is influenced by the same factors and may occur simultaneously. Thus, if value judgements on social acceptability are suspended, they are the same phenomenon.

It is mostly within the discipline of occupational science where the commonly held belief that occupation is health-promoting is being challenged.^{32, 361} However, this theoretical argument has yet to result in adaptations to the models used in occupational therapy practice. In contemporary forensic occupational therapy, MOHO is the most commonly used model.²⁹ It is used to assess and explain antisocial occupational participation, and to inform interventions. Forensic occupational therapists aim to modify the MOHO sub-systems to direct a person towards prosocial occupational participation, because of its association with health and

reduced risk.²⁹ In the same study of forensic occupational therapists, the Good Lives Model was also commonly cited. This model draws on the theory that people are driven to achieve certain goods, which can be achieved in prosocial or antisocial ways. Recognition of the Good Lives Model suggests that forensic occupational therapists are aware that need fulfilment is an important influencer of occupational participation and recognise that people meet their needs through whatever opportunities are available to them. The ability of MOHO to fully explain occupational participation appears limited by its focus on socially valued activities and roles. Dispensing with this dichotomy would enhance its explanatory power, especially in forensic services.

Recognising that occupational participation can be both prosocial and antisocial presents problems for practice and research. Arguably, practitioners are looking to increase the prosocial without facilitating the antisocial, yet I suggest both are produced by the same mechanisms. There may be unintended consequences of intervention to increase prosocial occupational participation. Modifying the mechanisms that increase prosocial occupational participation may simultaneously increase someone's effectiveness in antisocial occupational participation. There is increasing precedence for incorporating theoretically possible yet undesirable outcomes within logic models.³⁶² A future feasibility study should use this theory to identify and measure theoretically possible unintended outcomes, as well as unexpected adverse effects.

For research it may be necessary to maintain the dichotomy between antisocial occupational participation and prosocial occupational participation. In this research, it ensured the relevant mechanisms were targeted in designing an intervention to produce an outcome consistent with the aims of practitioners, services and most PDOs, i.e. increased prosocial occupational participation. Therefore, the focus throughout on integrating the MOHO theory of change, occupational adaptation, has

resulted in the production of a theoretically coherent intervention. The final outputs of the research are this intervention, which has been written into a manual, and a logic model for implementing and evaluating the intervention in a future feasibility study.

10.3 STRENGTHS AND LIMITATIONS OF THE THESIS

The strengths and limitations of each work package and the sub-studies are discussed in the chapter reporting their respective results. This section considers strengths and limitations of the thesis as a whole.

10.3.1 LIMITATIONS

People with lived experience of personality disorder diagnosis and/or other mental disorders were included in the Patient and Public Involvement Advisory Group (PPIAG) throughout. However, involvement was more problematic among both people supervised by probation services and probation-based practitioners. People with lived experience of probation could not be invited to participate in the PPIAG via the National Probation Service, who considered this inappropriate. However, alternative engagement was conducted by meeting with PDOs as a visiting academic to other services nationally. Probation-based practitioners were unable to attend the PPIAG despite interest and contributed by email. Other stakeholder involvement activities were undertaken, including presentations and email participation, to maximise their involvement.

The research supporting the development of the intervention used non-random samples of 18 PDOs in Work Package Two, and 30 multi-disciplinary experts in Work Package Three. Whilst both are acceptable

sample sizes for the methods used in each work package, it is nevertheless a small proportion of the PDOs in receipt of services and the practitioners working with them. It is possible that the intervention may have developed differently with a larger sample of PDOs or practitioners.

10.3.2 STRENGTHS

This research was conducted to address a gap in the evidence informing practitioners working with PDOs in the community. It is the first to apply a theory to identify the influencing factors and ascertain what is likely to work and how. The outputs include the first manualised intervention focused on increasing occupational participation in the community for PDOs. Occupational therapists are increasingly being employed in services working with PDOs, either in community forensic mental health or probation settings, indicating the level of need among PDOs is being recognised. As such, this research is timely.

The research was conducted in accordance with the Medical Research Council Guidelines for Developing and Evaluating Complex Interventions.²⁵ Applying these guidelines ensured that the intervention developed has a coherent theoretical basis, is based on the best available evidence and has been developed with consideration to real world implementation.

Mixed-methods were applied to establishing the evidence on which to base the intervention, consistent with the critical realist philosophy underpinning this research. Utilising different methods to approach the same question in Work Package Two resulted in a potentially more accurate understanding of the factors influencing occupational participation in the community than if using only one method. The different approaches identified different factors that could then be considered as a whole. This approach also permitted the interrogation of

the assumptions of MOHO, to ensure that the theory which informed the intervention was supported with PDOs.

Patient and Public Involvement was integrated throughout via the Patient and Public Involvement Advisory Group, which included practitioners from different settings, people with lived experience, a magistrate and university educators. This ensured that real world application was always considered. It strengthens the likelihood that the intervention will be acceptable to PDOs and can be feasibly delivered in different settings.

The outputs of this research are not an end in themselves. Because of the robust attention to developing the intervention and modelling its implementation, there is a clear trajectory for how this research can progress to a feasibility study. Questions identified throughout the research are all relevant to increasing the likely success of an intervention and could contribute towards a significant body of work. Continuing research on the basis of a well-developed intervention has potential to make a meaningful difference to the lives of people with a history of offending and a personality disorder, people who may be victims of offences, the communities to which PDOs return, and society as a whole which meets the cost of health, social and criminal justice services for PDOs.

10.4 IMPLICATIONS FOR FUTURE RESEARCH

10.4.1 FEASIBILITY STUDY

The intervention needs to be evaluated to determine if it is effective. However, progressing immediately to a trial risks failure and resource wastage as there are outstanding questions that first need to be answered.

Little is known about implementing an intervention for trial purposes in community forensic mental health and probation services. Therefore, a feasibility study incorporating a process evaluation should be conducted with the following aims:

1. Identify if the intervention itself is feasible

This intervention has not yet been applied in practice. It needs to be used by a small group of occupational therapists to determine if it is deliverable in its current format in the different settings in which they work, and if and how it may need to be tailored. A mixed-methods approach could be applied including measures of how often, how much and why the occupational therapists deviate from the intervention as specified in the manual. Focus groups or interviews could be conducted with the occupational therapists and service managers as to their experience of delivering the intervention, exploring aspects that need modification and considering how it could be situated in their service for a trial.

2. Identify which evaluation design is most appropriate to establish whether the intervention is effective

This could include requiring referral to the occupational therapists delivering the intervention, and using this data to ascertain referral, recruitment, retention and follow up rates. Service users, occupational therapists and service managers could be asked to participate in interviews and focus groups to identify attitudes to randomisation and other trial procedures, different outcomes measures, and experiences of delivering or receiving the intervention.

10.4.2 INFLUENCING FACTORS

The 28 influencing factors identified in this research can be examined to establish if there are existing valid and reliable measures of each factor.

Where there is a measure, research could establish whether there is a statistically significant association with the factor and occupational participation, and whether change in these factors predicts a change in occupational participation. However, as discussed below, a measure of occupational participation first needs to be agreed.

10.4.3 OUTCOME MEASURES

Systematic reviews revealed that there is currently a lack of clarity around valued outcomes for PDOs and how they are measured. This research argues for the importance of occupational participation because of its association with health, desistance and the avoidance of reoffending. This research operationalised occupational participation but has only given examples of potential measures. The outcomes valued by PDOs, service providers and other stakeholders need to be identified before consensus is established among the academic community on which outcomes are sufficiently valid and reliable for use in a trial. Establishing the minimal clinically important difference on these measures would also be beneficial for determining whether there is a noticeable 'real world' change.

10.4.4 MODEL OF HUMAN OCCUPATION

This research suggests that there needs to be modifications to the volitional and performance capacity sub-systems of the Model of Human Occupation (MOHO) to fully explain occupational participation for PDOs. Further empirical and theoretical studies will be required to determine if these modifications can be incorporated within MOHO whilst maintaining its coherence, and to determine if the findings here are replicated in other samples and other populations.

It is proposed that antisocial occupational participation is influenced by the same mechanisms as prosocial occupational participation. By dispensing with social judgements of occupational participation, MOHO could expand its explanatory power and scope to describe all human occupation. However, this also needs further theoretical and empirical scrutiny to establish if this is the case and whether occupational participation needs to be defined differently.

10.5 IMPLICATIONS FOR PRACTICE

The intervention developed here cannot be used in clinical practice until it is demonstrated to be effective in a robust evaluation. When this is complete, it will enable practitioners to deliver an evidence-based intervention that is likely to be effective in increasing occupational participation for PDOs in the community. Nonetheless, there are implications for practice arising from this research.

Work Package Two demonstrated that two interviewer-rated scales associated with the Model of Human Occupation (the Model of Human Occupation Screening Tool¹⁸² and the Occupational Performance History Interview – Version Two Scales¹¹⁸) do not assess all the factors that influence occupational participation for PDOs in the community. There were also limitations in the psychometric properties and the construct validity of the OPHI-II. Whilst there is no alternative scored assessment at present, a more complete understanding can be obtained using the narratively informed semi-structured interview designed as part of the Occupational Performance History Interview – Version Two. The list of influencing factors produced in this research can be used to guide attention relevant factors.

Practitioners should be cognisant that most PDOs have not experienced a developmentally normative trajectory and their patterns of occupational participation may only be comprehensible when placed in the context of their narrative slopes. Using a narrative assessment can additionally assist practitioners to understand how someone may respond to intervention, and to present intervention in a way that makes sense in the context of their life experiences.

10.6 CONCLUSION

This research achieved its aim, to develop a complex intervention to increase occupational participation for PDOs in the community. Accordingly, the research makes a unique contribution to knowledge in this field. To achieve this aim, the research first addressed gaps in the literature about what influences occupational participation for PDOs in the community. It secondly identified what is likely to work to increase occupational participation. Finally, it modelled the intervention, its outcomes and processes for the purposes of a feasibility study and process evaluation.

These research findings were used to produce two primary outputs: a fully specified manualised intervention suitable for a future feasibility study; and a preliminary logic model to inform a process evaluation of implementing the intervention in different natural settings.

The research has also generated a clear trajectory for continuing this research to produce clinically useful results that can be applied to make a meaningful difference in the lives of people with a history of offending and a diagnosis of personality disorder, their communities and society as a whole.

11 ABBREVIATIONS

Abbreviation	Full term
ASPD	Antisocial Personality Disorder
BPD	Borderline Personality Disorder
CBT	Cognitive Behavioural Therapy
HMPPS	Her Majesty's Prison and Probation Service
ICD-10	International Classification of Diseases - Version Ten
ICF	International Classification of Functioning
LSU	Low Secure Unit
MOHO	Model of Human Occupation
MOHOST	Model of Human Occupation Screening Tool
MRC	Medical Research Council
MSU	Medium Secure Unit
NHS	National Health Service
NPS	National Probation Service
OPD	Offender Personality Disorder. The OPD pathway is the name given to services co-commissioned by NHS England and Her Majesty's Prison and Probation Service for people at risk of reoffending linked to a personality disorder
OPHI-II	Occupational Performance History Interview – Version Two
PD	Personality disorder
PDO	Personality Disordered Offender: A person with a history of offending and diagnosis of personality disorder (or a likely diagnosis based on screening)
PPI	Patient and Public Involvement
PPIAG	Patient and Public Involvement Advisory Group
RCT	Randomised Controlled Trial
WHO	World Health Organization
WP	Work Package

12 REFERENCES

1. Skett S. *Offender Personality Disorder Pathway strategy 2015*. London: National Offender Management Service; NHS England, 2015.
2. World Health Organization. *International Statistical Classification of Diseases and Related Health Problems 10th Revision (ICD-10)*. Geneva: World Health Organization 1992.
3. Singleton N, Meltzer H and Gatward R. *Psychiatric morbidity among prisoners in England and Wales*. London: Office for National Statistics, 1998.
4. Stewart D. *The problems and needs of newly sentenced prisoners: results from a national survey*. London: Ministry of Justice, 2008.
5. Blackburn R, Logan C, Donnelly J and Renwick S. Personality disorders, psychopathy and other mental disorders: co-morbidity among patients at English and Scottish high-security hospitals. *The Journal of Forensic Psychiatry and Psychology*. 2003; 14: 111-37.
6. Lorangar AW, Sartorius N and Janca A. *Assessment and diagnosis of personality disorders: The International Personality Disorder Examination (IPDE)*. New York: Cambridge University Press, 1997.
7. Brooker C, Sirdifield C, Blizzard R, Denney D and Pluck G. Probation and mental illness. *Journal of Forensic Psychiatry and Psychology*. 2012; 23: 522-37.
8. Pluck G, Sirdifield C, Brooker C and Moran P. Screening for personality disorder in probationers: Validation of the Standardised Assessment of Personality—Abbreviated Scale (SAPAS). *Personality and Mental Health*. 2012; 6: 61-8.
9. Lennox C, Kirkpatrick T, Taylor RS, et al. Pilot randomised controlled trial of the ENGAGER collaborative care intervention for prisoners with common mental health problems, near to and after release. *Pilot and Feasibility Studies*. 2017; 4: 15.
10. Black DW, Gunter T, Loveless P, Allen J and Sieleni B. Antisocial personality disorder in incarcerated offenders: Psychiatric comorbidity and quality of life. *Annals of Clinical Psychiatry*. 2010; 22: 113-20.
11. Yu R, Geddes JR and Fazel S. Personality disorders, violence, and antisocial behavior: A systematic review and meta-regression analysis. *Journal of Personality Disorders* 2012; 26: 775-92.

12. West L. Personality disorder and serious further offending [DForPsych Thesis]. *Division of Psychiatry and Applied Psychology, School of Medicine*. Nottingham: University of Nottingham 2013.
13. Hill J, Nathan R and Shattock L. Report of a pilot randomized controlled trial of an intensive psychosocial intervention for high risk personality disordered offenders (the 'Resettle' programme). Unpublished: University of Manchester, 2013.
14. Hill J, Pilkonis P, Morse J, et al. Social domain dysfunction and disorganization in borderline personality disorder. *Psychological Medicine*. 2008; 38: 135-46.
15. Heeks M, Reed S, Tafsiri M and Prince S. *The economic and social costs of crime. Research report 99*. 2nd ed. Home Office: London, 2018.
16. Dustmann C and Fasani F. The effect of local area crime on mental health. *The Economic Journal*. 2014; 126: 978-1017.
17. World Health Organization. *Towards a common language for functioning, disability and health: ICF* Geneva: World Health Organization, 2002.
18. World Health Organization. ICF Checklist. Geneva: World Health Organization, 2003.
19. Arvidsson P, Granlund M and Thyberg M. How are the activity and participation aspects of the ICF used? Examples from studies of people with intellectual disability. *NeuroRehabilitation*. 2015; 36: 45-9.
20. Esquirol Y, Perret B, Ruidavets JB, et al. Shift work and cardiovascular risk factors: New knowledge from the past decade. *Archives of Cardiovascular Diseases*. 2011; 104: 636-68.
21. Cheng W-J and Cheng Y. Night shift and rotating shift in association with sleep problems, burnout and minor mental disorder in male and female employees. *Occupational and Environmental Medicine*. 2017; 74: 483.
22. Centre for Social Justice. *Dying to belong: An in-depth review of street gangs in Britain*. London: Centre for Social Justice, 2009.
23. Gilman AB, Hill KG and Hawkins JD. Long-term consequences of adolescent gang membership for adult functioning. *American Journal of Public Health*. 2014; 104: 938-45.
24. Albarracín D, Gillette JC, Earl AN, Glasman LR, Durantini MR and Ho M-H. A test of major assumptions about behavior change: A comprehensive look at the effects of passive and active HIV-prevention interventions since the beginning of the epidemic. *Psychological Bulletin*. 2005; 131: 856-97.

25. Medical Research Council. *Developing and evaluating complex interventions: New guidance*. London: Medical Research Council, 2008.
26. Taylor RR. *Kielhofner's Model of Human Occupation: Theory and application*. 5th ed. Philadelphia: Wolters Kluwer, 2017.
27. Taylor RR and Kielhofner G. Introduction to the Model of Human Occupation. *Kielhofner's Model of Human Occupation: Theory and Application*. 5th ed. Philadelphia: Wolters Kluwer, 2017, p. 3-10.
28. Royal College of Occupational Therapists. What is occupational therapy? London: Royal College of Occupational Therapists, 2017.
29. Connell C. Forensic occupational therapy to reduce risk of reoffending: A survey of practice in the United Kingdom. *Journal of Forensic Psychiatry and Psychology*. 2016; 27: 907-28.
30. Helbig K and McKay E. An exploration of addictive behaviours from an occupational perspective. *Journal of Occupational Science*. 2003; 10: 140-5.
31. Russell E. Writing on the wall: The form, function and meaning of tagging. *Journal of Occupational Science*. 2008; 15: 87-97.
32. Kiepek NC, Beagan B, Laliberte Rudman D and Phelan S. Silences around occupations framed as unhealthy, illegal, and deviant. *Journal of Occupational Science*. 2018: 1-13.
33. Stamm TA, Cieza A, Machold K, Smolen JS and Stucki G. Exploration of the link between conceptual occupational therapy models and the International Classification of Functioning, Disability and Health. *Australian Occupational Therapy Journal*. 2006; 53: 9-17.
34. de las Heras de Pablo C. Dimensions of doing. In: Taylor RR, (ed.). *Kielhofner's Model of Human Occupation: Theory and application* 5th ed. Philadelphia: Wolters Kluwer, 2017.
35. Kielhofner G. A model of human occupation, part 2. Ontogenesis from the perspective of temporal adaptation. *American Journal of Occupational Therapy*. 1980; 34: 657-63.
36. Kielhofner G. A model of human occupation, part 3. Benign and vicious cycles. *American Journal of Occupational Therapy*. 1980; 34: 731-7.
37. Kielhofner G and Burke JP. A model of human occupation, part 1. Conceptual framework and content. *American Journal of Occupational Therapy*. 1980; 34: 572-81.
38. Thelen E. Dynamic Systems Theory and the complexity of change. *Psychoanalytic Dialogues*. 2005; 15: 255-83.

39. McNeill F, Farrall S, Lightowler C and Maruna S. *How and why people stop offending: Discovering desistance*. Glasgow: Institute for Research and Innovation in Social Services, 2012.
40. Cornish DB and Clarke RV. *The reasoning criminal: Rational choice perspectives on offending*. New York: Springer-Verlag, 1986.
41. Gottfredson M and Hirschi T. *A general theory of crime*. Stanford, CA: Stanford University Press, 1990.
42. Maruna S. *Making good: How ex-convicts reform and rebuild their lives*. Washington, DC: American Psychological Association, 2001.
43. Giordano PC, Cernkovich SA and Rudolph JL. Gender, crime, and desistance: Toward a theory of cognitive transformation. *American Journal of Sociology*. 2002; 107: 990-1064.
44. Sampson R and Laub J. *Crime in the making: Pathways and turning points through life*. Cambridge, MA: Harvard University Press, 1993.
45. Farrall S, Hunter B, Sharpe G and Calverley A. Integrating structural and individual-level processes in criminal careers research. *Criminal careers in transition: The social context of desistance from crime*. Oxford: Oxford University Press 2014, p. 39-69.
46. Laub JH and Sampson RJ. Understanding desistance from crime. *Crime and Justice*. 2001; 28: 1-69.
47. Uggen C. Work as a turning point in the life course of criminals: A duration model of age, employment, and recidivism. *American Sociological Review*. 2000; 65: 529-46.
48. Cebulla A and Tomaszewski W. The demise of certainty: Shifts in aspirations and achievement at the turn of the century. *International Journal of Adolescence and Youth*. 2013; 18: 141-57.
49. Paternoster R and Bushway S. Desistance and the "feared self": Toward an identity theory of criminal desistance. *Journal of Criminal Law and Criminology*. 2009; 99: 1103-56.
50. Stone R. Desistance and identity repair: Redemption narratives as resistance to stigma. *British Journal of Criminology*. 2015; 56: 956-75.
51. Herrschaft BA, Veysey BM, Tubman-Carbone HR and Christian J. Gender differences in the transformation narrative: Implications for revised reentry strategies for female offenders. *Journal of Offender Rehabilitation*. 2009; 48: 463-82.
52. Liem M and Richardson NJ. The role of transformation narratives in desistance among released lifers. *Criminal Justice and Behavior*. 2014; 41: 692-712.

53. National Offender Management Service. *Kaizen: An introduction to the Kaizen programme*. London: National Offender Management Service, 2016.
54. Scottish Government. *National outcomes and standards for social work services in the criminal justice system*. Edinburgh: Scottish Government, 2010.
55. Andrews, D.A. and Bonta J. *The psychology of criminal conduct*. 5th ed. New Providence, NJ: LexisNexis Group, 2010.
56. Douglas KS, Hart SD, Webster CD and Belfrage H. *HCR-20V3: Assessing risk of violence. User guide*. Burnaby: Mental Health Law and Policy Institute, 2013.
57. Boer DP, Hart SD, Kropp PR and Webster CD. *Manual for the Sexual Violence Risk-20: Professional guidelines for assessing risk of sexual violence*. Vancouver: Mental Health, Law, and Policy Institute, 1997.
58. Kropp PR, Hart SD, Webster CD and Eaves D. *Manual for the Spousal Assault Risk Assessment Guide*. 3 ed. Toronto: Multi-Health Systems, 1999.
59. de Vogel V, de Ruiter C, Bouman Y and de Vries Robbé M. *SAPROF. Guidelines for the assessment of protective factors for violence risk. English version*. Utrecht: Forum Educatief, 2009.
60. Sentencing Council. *Life sentences*. Sentencing Council, 2018.
61. NHS England and National Offender Management Service. *Intensive Intervention and Risk Management Service specification. Draft V6_24.10.13*. London: NHS England; National Offender Management Service, 2013.
62. Ministry of Justice. *Transforming rehabilitation: A strategy for reform*. London: Ministry of Justice, 2013.
63. Shaw J and Edelmann R. Personality disorder, treatment readiness and dropout from treatment in three community-based cognitive skills and violence reduction programmes. *Journal of Forensic Practice*. 2017; 19: 247-57.
64. Bennett AL. Personality factors related to treatment discontinuation in a high secure personality disorder treatment service. *Journal of Criminological Research, Policy and Practice*. 2015; 1: 29-36.
65. Connell C. An integrated case formulation approach in forensic practice: the contribution of Occupational Therapy to risk assessment and formulation. *Journal of Forensic Psychiatry and Psychology*. 2015; 26: 94-106.

66. Department for Work and Pensions. *Work Programme official statistics to December 2015*. London: Department of Work and Pensions, 2016.
67. Department of Work and Pensions. *Work Programme statistics to December 2017*. London: Department of Work and Pensions, 2018.
68. Bouffard JA, Mackenzie DL and Hickman LJ. Effectiveness of vocational education and employment programs for adult offenders. *Journal of Offender Rehabilitation*. 2000; 31: 1-41.
69. Visher C, Coggeshall MB and Winterfield L. Systematic review of non-custodial employment programs: Impact on recidivism rates of ex-offenders. 2006.
70. Moran P. Offender Personality Disorder Pathway. National evaluation. Health Research Authority, 2016.
71. Turley C, Payne C and Webster S. *Enabling features of Psychologically Informed Planned Environments*. London: National Offender Management Service 2013.
72. Royal College of Psychiatrists. *Enabling Environments Standards*. London: Royal College of Psychiatrists Centre for Quality Improvement, 2013.
73. Ryan S, Benefield N and Baker V. Socially creative activities in Psychologically Informed Planned Environments: engaging and relating in the Offender Personality Disorder Pathway. *The Journal of Forensic Practice*. 2018; 20: 202-10.
74. Baker V, Johnson D and Oluonye S. Resettle: A significant new step in an emerging pathway that manages risk and addresses need in high-risk personality disordered offenders on their release into the community. *Psychology Crime and Law*. 2013; 19: 449-60.
75. Bruce M, Crowley S, Jeffcote N and Coulston B. Community DSPD pilot services in South London: Rates of reconviction and impact of supported housing on reducing recidivism. *Criminal Behaviour and Mental Health*. 2014; 24: 129-40.
76. Jacobs B, Bruce M, Sonigra K and Blakesley J. Service user experiences of a community forensic personality disorder service: A qualitative survey. *Journal of Forensic Practice*. 2010; 12: 47-56.
77. Jolliffe D, Cattell J, Raza A and Minoudis P. Evaluating the impact of the London Pathway Project. *Criminal Behaviour and Mental Health*. 2017; 27: 238-53.

78. Joint Commissioning Panel for Mental Health Services. Guidance for commissioners of forensic mental health services. London: Joint Commissioning Panel for Mental Health Services, 2013.
79. Royal College of Psychiatrists Centre for Quality Improvement. *Standards for forensic mental health services: Low and medium secure care*. London: Royal College of Psychiatrists Centre for Quality Improvement, 2016.
80. Royal College of Occupational Therapists. *Occupational therapists' use of occupation-focused practice in secure hospitals: Practice guideline*. London: Royal College of Occupational Therapists, 2017.
81. Spearing C, Wastenev V and Morgan P. Offenders with severe personality disorder and 'Lifestyle Paralleling Behaviours'. In: Daffern M, Jones L and Shine J, (eds.). *Offence paralleling behaviour*. Chichester: John Wiley & Sons Ltd, 2010, p. 261-74.
82. Khalifa N, Talbot E, Schneider J, et al. Individual placement and support (IPS) for patients with offending histories: The IPSOH feasibility cluster randomised trial protocol. *BMJ Open*. 2016; 6.
83. Talbot E, Bird Y, Russell J, Sahota K, Schneider J and Khalifa N. Implementation of individual placement and support (IPS) into community forensic mental health settings: Lessons learned. *British Journal of Occupational Therapy*. 2018; 81: 338-47.
84. National Offender Management Service. *An introduction to NOMS offender services co-commissioning*. London: National Offender Management Service, 2014.
85. Joseph N and Benefield N. A joint offender personality disorder pathway strategy: An outline summary. *Criminal Behaviour and Mental Health*. 2012; 22: 210-7.
86. Tyrer P, Duggan C, Cooper S, et al. The successes and failures of the DSPD experiment: The assessment and management of severe personality disorder. *Medicine, Science and the Law*. 2010; 50: 95-9.
87. Barrett B and Tyrer P. The cost-effectiveness of the dangerous and severe personality disorder programme. *Criminal Behaviour and Mental Health*. 2012; 22: 202-9.
88. O'Loughlin A. The Offender Personality Disorder Pathway: Expansion in the face of failure? *The Howard Journal of Criminal Justice*. 2014; 53: 173-92.
89. Craissati J, Joseph N and Skett S. Working with personality disordered offenders: A practitioners guide. 2nd ed. London: National Offender Management Service and NHS England, 2015.

90. National Institute for Health and Care Excellence. *Antisocial Personality Disorder: Treatment, management and prevention. Clinical guideline 77*. Manchester: NICE, 2009.
91. National Collaborating Centre for Mental Health. *Borderline Personality Disorder: Recognition and management. Clinical guideline CG78*. London: British Psychological Society; Royal College of Psychiatrists, 2009.
92. Creswell JW and Plano Clark VL. *Designing and conducting mixed methods research*. 3rd ed. Thousand Oaks, CA: SAGE Publications Inc, 2018.
93. Richards DA and Hallberg IR. *Complex interventions in health: An overview of research methods*. Oxon: Routledge, 2015.
94. Tyrer P, Mitchard S, Methuen C and Ranger M. Treatment rejecting and treatment seeking personality disorders: Type R and Type S. *Journal of Personality Disorders*. 2003; 17: 263-8.
95. Crawford MJ, Sahib L, Bratton H, Tyrer P and Davidson K. Service provision for men with antisocial personality disorder who make contact with mental health services. *Personality and Mental Health*. 2009; 3: 165-71.
96. INVOLVE. Briefing note two: What is public involvement in research? London: INVOLVE, 2018.
97. Ennis L and Wykes T. Impact of patient involvement in mental health research: Longitudinal study. *British Journal of Psychiatry*. 2013; 203: 381-6.
98. Staley K. *Exploring impact: Public involvement in NHS, public health and social care research*. Eastleigh: INVOLVE, 2009.
99. Danermark B, Ekstrom M, Jakobsen L and Karlsson JC. *Explaining society: An introduction to critical realism in the social sciences*. Oxon: Routledge, 2002.
100. Lipscomb M. Mixed method nursing studies: A critical realist critique. *Nursing Philosophy*. 2008; 9: 32-45.
101. Duncan EAS and Nicol MM. Subtle realism and occupational therapy: An alternative approach to knowledge generation and evaluation. *British Journal of Occupational Therapy*. 2004; 67: 453-6.
102. Bhaskar R. *A realist theory of science*. Leeds: Leeds Books, 1975.
103. Johnson RB and Onwuegbuzie AJ. Mixed methods research: A research paradigm whose time has come. *Educational Researcher*. 2004; 33: 14-26.

104. Hall JN. Pragmatism, evidence, and mixed methods evaluation. *New Directions for Evaluation*. 2013; 138: 15-26.
105. Lipton P. *Inference to the best explanation*. London: Routledge, 1991.
106. Lee J. Achieving best practice: A review of evidence linked to occupation-focused practice models. *Occupational Therapy in Health Care*. 2010; 24: 206-22.
107. Higgins JPT and Green S. *Cochrane handbook for systematic reviews of interventions*. London: Cochrane Collaboration 2011.
108. Ryan R. *Data synthesis and analysis*. Cochrane Consumers and Communication Review Group, 2013.
109. Liberati A, Altman DG, Tetzlaff J, et al. The PRISMA statement for reporting systematic reviews and meta-analyses of studies that evaluate healthcare interventions: Explanation and elaboration. *British Medical Journal Online*. 2009; 339: b2700.
110. Connell C, Furtado V, McKay EA and Singh SP. What is known about the factors influencing participation in prosocial occupation among personality disordered offenders released to/on license in the community? York: Centre for Reviews Dissemination 2016.
111. Connell C, Furtado V, McKay EA and Singh SP. A systematic review of the effectiveness of interventions to improve participation in prosocial occupation in offenders with personality disorder when released to/on license in the community. York: Centre for Reviews Dissemination 2016.
112. World Health Organization. *International Classification of Functioning, Disability and Health (ICF)*. Geneva: World Health Organization, 2001.
113. Connell C, Furtado V, McKay EA and Singh SP. How effective are interventions to improve social outcomes among offenders with personality disorder: A systematic review. *BMC Psychiatry*. 2017; 17: 368.
114. Connell C, Furtado V, McKay EA and Singh SP. What influences social outcomes among offenders with personality disorder: A systematic review. *Criminal Behaviour and Mental Health*. 2018; 28: 390-6.
115. Connell C, Furtado V, McKay EA and Singh SP. What influences participation in prosocial occupation among offenders with personality disorder in the community, and how effective are current interventions? Two systematic reviews. *British and Irish Group for the Study of Personality Disorder (BIGSPD) Annual Conference*. Inverness 2017.
116. Connell C, Furtado V, McKay EA and Singh S. What influences participation in prosocial occupation among offenders with personality

disorder in the community, and how effective are current interventions?
Two systematic reviews. *College of Occupational Therapists Annual
Conference and Exhibition*. Birmingham 2017.

117. Squire C, Davis M, Esin C, et al. *What is narrative research*. London:
Bloomsbury Publishing Plc, 2014.

118. Kielhofner G, Mallinson T, Crawford C, et al. *Occupational
Performance History Interview II (OPHI-II) Version 2.1*. Chicago: Model of
Occupational Therapy Clearinghouse, 2004.

119. Robson C. *Real world research*. Chichester: John Wiley and Sons Ltd,
2011.

120. Corbin J and Strauss A. *Basics of qualitative research: Techniques
and procedures for developing grounded theory*. 3 ed. Thousand Oaks, CA:
Sage, 2008.

121. Glaser B and Straus SE. *The discovery of grounded theory: Strategies
for qualitative research*. New York: Aldine DeGruyter, 1967.

122. Riessman CK. *Narrative methods for human sciences*. Los Angeles:
Sage Publications, 2008.

123. Birt L, Scott S, Cavers D, Campbell C and Walter F. Member
checking: A tool to enhance trustworthiness or merely a nod to validation?
Qualitative Health Research. 2016; 26: 1802-11.

124. Braveman B and Helfrich CA. Occupational identity: Exploring the
narratives of three men living with AIDS. *Journal of Occupational Science*.
2001; 8: 25-31.

125. Braveman B, Kielhofner G, Albrecht G and Helfrich C. Occupational
identity, occupational competence and occupational settings
(environment): influences on return to work in men living with HIV/AIDS.
Work (Reading, Mass). 2006; 27: 267-76.

126. Finlay L. From 'gibbering idiot' to 'iceman', Kenny's story: A critical
analysis of an occupational narrative. *British Journal of Occupational
Therapy*. 2004; 67: 474-80.

127. Heuchemer B and Josephsson S. Leaving homelessness and
addiction: Narratives of an occupational transition. *Scandinavian Journal of
Occupational Therapy*. 2006; 13: 160-9.

128. Levin M, Kielhofner G, Braveman B and Fogg L. Narrative slope as a
predictor of work and other occupational participation. *Scandinavian
Journal of Occupational Therapy*. 2007; 14: 258-64.

129. McIntosh J and McKeganey N. Addicts' narratives of recovery from drug use: Constructing a non-addict identity. *Social Science and Medicine*. 2000; 50: 1501-10.
130. Wisdom JP, Bruce K, Auzeen Saedi G, Weis T and Green CA. 'Stealing me from myself': Identity and recovery in personal accounts of mental illness. *Australian and New Zealand Journal of Psychiatry*. 2008; 42: 489-95.
131. Ricoeur P. *Time and narrative. Volume 1*. Chicago: University of Chicago Press, 1984.
132. Melton J, Holzmueller RP, Keponen R, Nygard L, Munger K and Kielhofner G. Crafting occupational life In: Taylor RR, (ed.). *Kielhofner's Model of Human Occupation: Theory and application* 5th ed. Philadelphia: Wolters Kluwer, 2017, p. 123-39.
133. Kielhofner G. *Model of Human Occupation: Theory and application*. 4th ed. Philadelphia, PA: Lippincott, Williams and Wilkins, 2008.
134. Gergen KJ and Gergen MM. Narrative and the self as relationship. In: Berkowitz L, (ed.). *Advances in Experimental Social Psychology*. Academic Press, 1988, p. 17-56.
135. Goldstein K, Kielhofner G and Paul-Ward A. Occupational narratives and the therapeutic process. *Australian Occupational Therapy Journal*. 2004; 51: 119-24.
136. Mattingly C. The concept of therapeutic 'employment'. *Social Science and Medicine*. 1994; 38: 811-22.
137. Connell C, McKay EA, Furtado V and Singh SP. Occupational narratives to explore participation among offenders with personality disorder. *College of Occupational Therapists Annual Conference and Exhibition*. Birmingham2017.
138. Connell C, Furtado V, McKay EA and Singh SP. Improving positive community outcomes among offenders with personality disorder: The POPPED Project. *British and Irish Group for the Study of Personality Disorder (BIGSPD) Annual Conference*. Inverness2017.
139. Connell C, Furtado V, McKay EA and Singh SP. Improving social outcomes among offenders with personality disorder: An intervention development study. *FNRSIG Annual Research Conference* Falkirk2017.
140. Connell C. An occupational approach to intervention development. *Delivering occupational therapy for people with "personality disorder"*. Middlesbrough2018.

141. Gill FJ, Leslie GD, Grech C and Latour JM. Using a web-based survey tool to undertake a Delphi study: Application for nurse education research. *Nurse education today*. 2013; 33: 1322-8.
142. Keeney S, McKenna H and Hasson F. *The Delphi technique in nursing and health research*. Chichester: Wiley, 2010.
143. Tetley A, Jinks M, Huband N, Howells K and McMurrin M. Barriers to and facilitators of treatment engagement for clients with personality disorder: A Delphi survey. *Personality and Mental Health*. 2012; 6: 97-110.
144. Atwal A and Caldwell K. Profiting from consensus methods in occupational therapy: Using a Delphi study to achieve consensus on multiprofessional discharge planning. *British Journal of Occupational Therapy*. 2003; 66: 65-70.
145. Deane KHO, Ellis-Hill C, Dekker K, Davies P and Clarke CE. A delphi survey of best practice occupational therapy for parkinson's disease in the United Kingdom. *British Journal of Occupational Therapy*. 2003; 66: 247-54.
146. Cook S and Birrell M. Defining an occupational therapy intervention for people with psychosis. *British Journal of Occupational Therapy*. 2007; 70: 96-106.
147. Connell C, Furtado V, McKay EA and Singh SP. Increasing community participation for offenders with personality disorder: Manualising and modelling a complex intervention. *FNRSIG Annual Research Conference Falkirk2018*.
148. Connell C, Furtado V, McKay EA and Singh SP. Increasing community participation for offenders with personality disorder: Manualising and modelling a complex intervention. *Paper presented at British and Irish Group for the Study of Personality Disorder Annual Conference*. Durham2019.
149. Sermeus W. Modelling process and outcomes in complex interventions. In: Richards DA and Hallberg IR, (eds.). *Complex interventions in health: An overview of research methods*. Oxon: Routledge, 2015, p. 111-20.
150. Carroll KM and Nuro KF. One size cannot fit all: A stage model for psychotherapy manual development. *Clinical Psychology: Science and Practice*. 2002; 9: 396-406.
151. Hoffmann TC, Glasziou PP, Boutron I, Milne R, Perera R and Moher D. Better reporting of interventions: Template for intervention description and replication (TIDieR) checklist and guide. *BMJ (Clinical research ed)*. 2014; 348.

152. Möhler R, Köpke S and Meyer G. Criteria for Reporting the Development and Evaluation of Complex Interventions in healthcare: Revised guideline (CReDECI 2). *Trials*. 2015; 16: 204.
153. W.K. Kellogg Foundation. *Logic model development guide*. Battle Creek, MI: W.K. Kellogg Foundation. , 2004.
154. National Institute for Health Research. NIHR Research for Patient Benefit (RfPB) programme guidance on applying for feasibility studies. London: National Institute for Health Research 2017.
155. Critical Appraisal Skills Programme. CASP qualitative checklist. Oxford Critical Appraisal Skills Programme, 2019.
156. Downs SH and Black N. The feasibility of creating a checklist for the assessment of the methodological quality both of randomised and non-randomised studies of health care interventions. *Journal of Epidemiology and Community Health*. 1998; 52: 377-84.
157. Reiss D, Grubin D and Meux C. Young 'psychopaths' in special hospital: Treatment and outcome. *British Journal of Psychiatry*. 1996; 168: 99-104.
158. American Psychiatric Association. *Diagnostic and statistical manual of mental disorders. 3rd edition. Revised*. Arlington, VA: American Psychiatric Association, 1987.
159. Whitehead PR, Ward T and Collie RM. Time for a change: Applying the good lives model of rehabilitation to a high-risk violent offender. *International Journal of Offender Therapy and Comparative Criminology*. 2007; 51: 578-98.
160. Ward T and Stewart C. Criminogenic needs and human needs: A theoretical model. *Psychology, Crime and Law*. 2003; 9: 125-43.
161. Higgins JPT, Altman DG, Gøtzsche PC, et al. The Cochrane Collaboration's tool for assessing risk of bias in randomised trials. *BMJ (Clinical research ed)*. 2011; 343:d5928.
162. Öhlin L, Fridell M and Nyhlen A. Buprenorphine maintenance program with contracted work/education and low tolerance for non-prescribed drug use: A cohort study of outcome for women and men after seven years. *BMC Psychiatry*. 2015; 15: 56-69.
163. Davidson KM, Tyrer P, Tata P, et al. Cognitive behaviour therapy for violent men with antisocial personality disorder in the community: An exploratory randomized controlled trial. *Psychological Medicine*. 2009; 39: 569-77.

164. Tyrer P, Nur U, Crawford M, et al. The Social Functioning Questionnaire: A rapid and robust measure of perceived functioning. *International Journal of Social Psychiatry*. 2005; 51: 265-75.
165. Fortune Z, Barrett B, Armstrong D, et al. Clinical and economic outcomes from the UK pilot psychiatric services for personality-disordered offenders. *International Review of Psychiatry*. 2011; 23: 61-9.
166. Mundt JC, Marks IM, Shear MK and Greist JM. The Work and Social Adjustment Scale: A simple measure of impairment in functioning. *British Journal of Psychiatry*. 2002; 180: 461-4.
167. Krampen G. Psychotherapeutic processes and outcomes in outpatient treatment of antisocial behavior: An integrative psychotherapy approach. *Journal of Psychotherapy Integration*. 2009; 19: 213-30.
168. Ward T and Brown M. The Good Lives Model and conceptual issues in offender rehabilitation. *Psychology, Crime and Law*. 2004; 10: 243-57.
169. Hart SD, Cox DN and Hare RD. *The Hare PCL:SV. Psychopathy Checklist Screening Version*. Toronto: Multi-Health Systems 1999.
170. Davidson KM. *Cognitive therapy for personality disorders: A guide for clinicians*. 2nd ed. Hove: Routledge, 2007.
171. Bouman YHA, de Ruiter C and Schene AH. Recent life events and subjective well-being of personality disordered forensic outpatients. *International Journal of Law and Psychiatry*. 2009; 32: 348-54.
172. Ballert CS, Hopfe M, Kus S, Mader L and Proding B. Using the refined ICF Linking Rules to compare the content of existing instruments and assessments: A systematic review and exemplary analysis of instruments measuring participation. *Disability Rehabilitation*. 2016; 14: 1-17.
173. Leamy M, Bird V, Le Boutillier C, Williams J and Slade M. Conceptual framework for personal recovery in mental health: Systematic review and narrative synthesis. *British Journal of Psychiatry*. 2011; 199: 445-52.
174. Blank AA, Harries P and Reynolds F. 'Without occupation you don't exist': Occupational engagement and mental illness. *Journal of Occupational Science*. 2014: 1-13.
175. McMurrin M, Egan V and Duggan C. Stop & Think! Social problem-solving therapy with personality-disordered offenders. In: McMurrin M and McGuire J, (eds.). *Social problem solving and offending: Evidence, evaluation and evolution*. New York, NY: John Wiley & Sons Ltd, 2005, p. 207-20.
176. Looman J and Abracen J. The risk need responsivity model of offender rehabilitation: Is there really a need for a paradigm shift?

- International Journal of Behavioral Consultation and Therapy*. 2013; 8: 30-6.
177. Kinoshita Y, Furukawa TA, Kinoshita K, et al. Supported employment for adults with severe mental illness. *Cochrane Database of Systematic Reviews*. 2013.
178. Connell C. Forensic occupational therapy in Europe: A comparative evaluation. *COTEC-ENOTHE Congress*. Galway2016.
179. Lindstedt H, Grann M and Söderlund A. Mentally disordered offenders' daily occupations after one year of forensic care. *Scandinavian Journal of Occupational Therapy*. 2011; 18: 302-11.
180. Patton MQ. *Qualitative research in and evaluation methods* 3rd ed. Thousand Oaks, CA: SAGE Publications Inc, 2002.
181. Daniel J. *Sampling essentials : practical guidelines for making sampling choices*. London: Sage, 2011.
182. Parkinson S, Forsyth K and Kielhofner G. *The Model of Human Occupation Screening Tool (MOHOST): Version 2.0*. Chicago, IL: Model of Human Occupation Clearinghouse, 2006.
183. Kielhofner G, Fan C-W, Morley M, et al. A psychometric study of the Model of Human Occupation Screening Tool (MOHOST). *Hong Kong Journal of Occupational Therapy*. 2010; 20: 63-70.
184. Fan C-W, Morley M, Garnham M, Heasman D and Taylor R. Examining changes in occupational participation in forensic patients using the Model of Human Occupation Screening Tool. *British Journal of Occupational Therapy*. 2016; 79: 727-33.
185. Kielhofner G, Mallinson T, Forsyth K and Lai J. Psychometric properties of the second version of the Occupational Performance History Interview (OPHI-II). *American Journal of Occupational Therapy* 2001; 55: 260-7.
186. Lee SW, Morley M, Taylor RR, et al. The development of care pathways and packages in mental health based on the Model of Human Occupation Screening Tool. *British Journal of Occupational Therapy*. 2011; 74: 284-94.
187. NHS England. Mental health clustering booklet (V5.0) (2016/2017). NHS England, 2016.
188. Jaeschke R, Singer J and Guyatt GH. Measurement of health status. Ascertaining the minimal clinically important difference. *Contemporary Clinical Trials*. 1989; 10: 407-15.

189. McQueen R and Knussen C. Introducing inferential statistics and tests of difference. In: McQueen R and Knussen C, (eds.). *Introduction to research methods and statistics*. 2nd ed. Harlow: Pearson Education Limited, 2013, p. 283-362.
190. IBM Corp. IBM SPSS Statistics for Macintosh. Version 24.0. Armonk, NY: IBM Corp, Released 2016.
191. Alred D. Service user perspectives of preparation for living in the community following discharge from a secure mental health unit [PhD thesis]. University of Brighton, 2018.
192. Moore KE, Stuewig JB and Tangney JP. The effect of stigma on criminal offenders' functioning: A longitudinal mediational model. *Deviant Behavior*. 2016; 37: 196-218.
193. Department of Work and Pensions. Official statistics: Disability facts and figures. London: UK Government, 2014.
194. UK Government. Ethnicity facts and figures. London: UK Government, 2018.
195. Moffitt TE. Life-course-persistent versus adolescence-limited antisocial behavior. *Developmental psychopathology Volume 3: Risk, disorder, and adaptation*. 2nd ed. Hoboken, NJ: John Wiley & Sons Inc, 2006, p. 570-98.
196. Farrington DP. Age and crime. In: Tonry M and Morris NA, (eds.). *Crime and justice: An annual review of research Volume seven*. Chicago: Chicago University Press, 1986, p. 189–250.
197. Black DW. The natural history of antisocial personality disorder. *Canadian Journal of Psychiatry*. 2015; 60: 309-14.
198. Zanarini MC, Frankenburg FR, Reich DB and Fitzmaurice G. Attainment and stability of sustained symptomatic remission and recovery among patients with borderline personality disorder and axis II comparison subjects: A 16-year prospective follow-up study. *American Journal of Psychiatry*. 2012; 169: 476-83.
199. Grossi LM. Sexual offenders, violent offenders, and community reentry: Challenges and treatment considerations. *Aggression and Violent Behavior*. 2017; 34: 59-67.
200. Mingus W and Burchfield KB. From prison to integration: Applying modified labeling theory to sex offenders. *Criminal Justice Studies*. 2012; 25: 97-109.
201. Targum SD. The distinction between clinical and research interviews in psychiatry. *Innovations in Clinical Neuroscience*. 2011; 8: 40-4.

202. VERBI Software. *MAXQDA Software for qualitative data analysis. 1989-2017*. Berlin: VERBI Software GmbH, 2017.
203. Lincoln YS and Guba EG. *Naturalistic inquiry*. Newbury Park, CA: Sage, 1985.
204. Johnson RE, Grove AL and Clarke A. Pillar Integration Process: A joint display technique to integrate data in mixed methods research. *Journal of Mixed Methods Research*. 2017; [online]: 1-20.
205. City-REDI. *West Midlands databook 2017*. Birmingham: University of Birmingham 2017.
206. Office for National Statistics. Time series: Unemployment rate (aged 16 and over, seasonally adjusted). London: Office for National Statistics 2018.
207. Office for National Statistics. Ethnicity and national identity in England and Wales: 2011. London: Office for National Statistics, 2012.
208. Morris C, Simpson J, Sampson M and Beesley F. Emotion and self-cutting: Narratives of service users referred to a personality disorder service. *Clinical Psychology and Psychotherapy*. 2013; 22: 125-32.
209. Hughes K, Bellis MA, Hardcastle KA, et al. The effect of multiple adverse childhood experiences on health: A systematic review and meta-analysis. *Lancet Public Health*. 2017; 2: e356-e66.
210. Cloitre M, Garvert DW, Weiss B, Carlson EB and Bryant RA. Distinguishing PTSD, Complex PTSD, and Borderline Personality Disorder: A latent class analysis. *European Journal of Psychotraumatology*. 2014; 5: 10.3402/ejpt.v5.25097.
211. Treasure J. Motivational interviewing. *Advances in Psychiatric Treatment*. 2004; 10: 331-7.
212. McMurrin M. Motivational interviewing with offenders: A systematic review. *Legal and Criminological Psychology*. 2011; 14: 83-100.
213. Adler JM, Chin ED, Kolisetty AP and Oltmanns TF. The distinguishing characteristics of narrative identity in adults with features of Borderline Personality Disorder: An empirical investigation. *Journal of Personality Disorders*. 2012; 26: 498-512.
214. Stickley T and Wright N. The British research evidence for recovery, papers published between 2006 and 2009 (inclusive). Part One: A review of the peer-reviewed literature using a systematic approach. *Journal of Psychiatric and Mental Health Nursing*. 2011; 18: 247-56.
215. Drennan G and Alred D. *Secure recovery: Approaches to recovery in forensic mental health settings* London: Routledge, 2012.

216. Drennan G, Wooldridge J, Aiyegbusi A, et al. *Making recovery a reality in forensic settings*. London: Centre for Mental Health and Mental Health Network, NHS Confederation, 2014.
217. Lee SW and Kielhofner G. Volition. In: Taylor RR, (ed.). *Kielhofner's Model of Human Occupation: Theory and application*. 5th ed. Philadelphia, PA: Wolters Kluwer, 2017, p. 38-56.
218. Helfrich C, Kielhofner G and Mattingly C. Volition as narrative: Understanding motivation in chronic illness. *American Journal of Occupational Therapy*. 1994; 48: 311-7.
219. Sturmey P. *Behavioral case formulation and intervention: A functional analytic approach*. Chichester: John Wiley & Sons Ltd, 2008.
220. Lee SW and Kielhofner G. Habituation: Patterns of daily occupation. In: Taylor RR, (ed.). *Kielhofner's Model of Human Occupation: Theory and application*. 5th ed. Philadelphia: Wolters Kluwer, 2017.
221. Erikson EH. Youth: Change and challenge. New York: Basic Books, 1963.
222. Walder K and Molineux M. Occupational adaptation and identity reconstruction: A grounded theory synthesis of qualitative studies exploring adults' experiences of adjustment to chronic disease, major illness or injury. *Journal of Occupational Science*. 2017; 24: 225-43.
223. Levanon-Erez N, Cohen M, Traub Bar-Ilan R and Maeir A. Occupational identity of adolescents with ADHD: A mixed methods study. *Scandinavian Journal of Occupational Therapy*. 2017; 24: 32-40.
224. Nygren U, Sandlund M, Bernspang B and Fisher AG. Exploring perceptions of occupational competence among participants in Individual Placement and Support (IPS). *Scandinavian Journal of Occupational Therapy*. 2013; 20: 429-37.
225. Jonsson H, Borell L and Sadlo G. Retirement: An occupational transition with consequences for temporality, balance and meaning of occupations. *Journal of Occupational Science*. 2000; 7: 29-37.
226. Kielhofner G and Barrett L. Meaning and misunderstanding in occupational forms: A study of therapeutic goal setting. *American Journal of Occupational Therapy*. 1998; 52: 345-53.
227. Shaw J, Minoudis P and Craissati J. A comparison of the Standardised Assessment of Personality – Abbreviated Scale and the Offender Assessment System Personality Disorder Screen in a probation community sample. *Journal of Forensic Psychiatry and Psychology*. 2012; 23: 156-67.

228. Mallinson T, Kielhofner G and Mattingly C. Metaphor and meaning in a clinical interview. *American Journal of Occupational Therapy*. 1996; 50: 338-46.
229. Fonagy P, Leigh T, Steele M, et al. The relation of attachment status, psychiatric classification, and response to psychotherapy. *Journal of Consulting and Clinical Psychology*. 1996; 64: 22-31.
230. Allen JG, Fonagy P and Bateman A. *Mentalizing in clinical practice*. Washington, Dc: American Psychiatric Press, 2008
231. Chiesa M and Fonagy P. Reflective function as a mediator between childhood adversity, personality disorder and symptom distress. *Personality and Mental Health*. 2014; 8: 52-66.
232. Bly EM, Wright AJ and Tuber SB. Unemployed and poor in New York: The impact of mentalization and Axis II psychopathology on job outcome. *Bulletin of the Menninger Clinic*. 2012; 76: 101-29.
233. Hyvärinen M. Towards a conceptual history of narrative. In: Hyvärinen M, Korhonen A and Mykkanen J, (eds.). *The travelling concept of narrative*. Helsinki: Collegium, 2006.
234. Canter D and Youngs D. Narratives of criminal action and forensic psychology. *Legal and Criminological Psychology*. 2012; 17: 262-75.
235. Youngs D and Canter DV. Narrative roles in criminal action: An integrative framework for differentiating offenders. *Legal and Criminological Psychology*. 2012; 17: 233-49.
236. Kielhofner G, Braveman B, Finlayson M, Paul-Ward A, Goldbaum L and Goldstein K. Outcomes of a vocational program for persons with AIDS. *American Journal of Occupational Therapy*. 2004; 58: 64-72.
237. Thylstrup B, Hesse M, Thomsen M and Heerwagen L. Experiences and narratives – Drug users with antisocial personality disorder retelling the process of treatment and change. *Drugs: Education, Prevention and Policy*. 2015; 22: 293-300.
238. Barrett L, Beer D and Kielhofner G. The importance of volitional narrative in treatment: An ethnographic case study in a work program. *Work (Reading, Mass)*. 1999; 12: 79-92.
239. McMurrin M, Huband N and Overton E. Non-completion of personality disorder treatments: A systematic review of correlates, consequences, and interventions. *Clinical Psychology Review*. 2010; 30: 277-87.
240. De Silva D. Helping people help themselves The Health Foundation, 2011.

241. Horne R, Chapman SCE, Parham R, Freemantle N, Forbes A and Cooper V. Understanding patients' adherence-related beliefs about medicines prescribed for long-term conditions: a meta-analytic review of the Necessity-Concerns Framework. *PloS one*. 2013; 8: e80633-e.
242. Mental Health Taskforce. *The five year forward view for mental health* London: The Mental Health Taskforce, 2016.
243. Mattingly C and Lawlor M. Learning from stories: Narrative interviewing in cross-cultural research. *Scandinavian Journal of Occupational Therapy*. 2000; 7: 4-14.
244. Fetters MD, Curry LA and Creswell JW. Achieving Integration in Mixed Methods Designs—Principles and Practices. *Health Services Research*. 2013; 48: 2134-56.
245. Fetters MD and Molina-Azorin JF. The Journal of Mixed Methods Research starts a new decade: Principles for bringing in the new and divesting of the old language of the field. *Journal of Mixed Methods Research*. 2016; 11: 3-10.
246. Wisdom JP, Cavaleri MA, Onwuegbuzie AJ and Green CA. Methodological reporting in qualitative, quantitative, and mixed methods health services research articles. *Health Services Research*. 2012; 47: 721-45.
247. Johnson RE. Practicalities of public health practice and evaluation: The case of mental wellbeing in Coventry. *Warwick Medical School*. Coventry: University of Warwick, 2013.
248. Grove A, Johnson RE, Clarke A and Currie G. Evidence and the drivers of variation in orthopaedic surgical work: A mixed method systematic review. *Health Systems and Policy Research*. 2016; 3.
249. Guetterman TC, Fetters MD and Creswell JW. Integrating quantitative and qualitative results in health science mixed methods research through joint displays. *Annals of family medicine*. 2015; 13: 554-61.
250. Creswell JW. *Research design: Qualitative, quantitative, and mixed methods approaches*. 3rd ed. Los Angeles: SAGE Publications Inc, 2009.
251. Connell C, Furtado V, McKay EA and Singh SP. What influences social outcomes among offenders with personality disorder: A systematic review. *Criminal Behaviour and Mental Health*. 2018; 0.
252. Larivière N, Denis C, Payeur A, Ferron A, Levesque S and Rivard G. Comparison of objective and subjective life balance between women with and without a personality disorder. *Psychiatric Quarterly*. 2016; 87: 663-73.

253. Falklöf I and Haglund L. Daily occupations and adaptation to daily life described by women suffering from Borderline Personality Disorder. *Occupational Therapy in Mental Health*. 2010; 26: 354-74.
254. Birken M and Harper S. Experiences of people with a personality disorder or mood disorder regarding carrying out daily activities following discharge from hospital. *British Journal of Occupational Therapy*. 2017; 80: 409-16.
255. Lin N, Kirsh B, Polatajko H and Seto M. The nature and meaning of occupational engagement for forensic clients living in the community. *Journal of Occupational Science*. 2009; 16: 110-9.
256. Given LM. *The Sage encyclopedia of qualitative research methods*. London: Sage, 2008.
257. Qualtrics. *Qualtrics*. Utah: Qualtrics, 2018.
258. Hasson F, Keeney S and McKenna H. Research guidelines for the Delphi survey technique. *Journal of Advanced Nursing*. 2000; 32.
259. Braun V and Clarke V. Using thematic analysis in psychology. *Qualitative Research in Psychology*. 2006; 3: 77-101.
260. Kelly CM, Jorm AF and Kitchener BA. Development of mental health first aid guidelines on how a member of the public can support a person affected by a traumatic event: a Delphi study. *BMC Psychiatry*. 2010; 10: 49.
261. Kelly CM, Jorm AF, Kitchener BA and Langlands RL. Development of mental health first aid guidelines for non-suicidal self-injury: A Delphi study. *BMC Psychiatry*. 2008; 8.
262. Langlands RL, Jorm AF, Kelly CM and Kitchener BA. First aid for depression: A Delphi consensus study with consumers, carers and clinicians. *Journal of Affective Disorders*. 2008; 105.
263. Kelly CM, Jorm AF and Kitchener BA. Development of mental health first aid guidelines for panic attacks: a Delphi study. *BMC Psychiatry*. 2009; 9.
264. Santos O, Lopes E, Virgolino A, et al. Defining a brief intervention for the promotion of psychological well-being among unemployed individuals through expert consensus. *Frontiers in Psychiatry*. 2018; 9: 13.
265. Cook S. *Intervention schedule, occupational therapy for people with psychotic conditions in community settings. Manual*. Sheffield: Sheffield Hallam University, 2006.
266. Wampold BE. How important are the common factors in psychotherapy? An update. *World Psychiatry*. 2015; 14: 270-7.

267. Wimpenny K, Savin-Baden M and Cook C. A qualitative research synthesis examining the effectiveness of interventions used by occupational therapists in mental health. *British Journal of Occupational Therapy*. 2014; 77: 276-88.
268. Burnett R and McNeill F. The place of the officer-offender relationship in assisting offenders to desist from crime. *Probation Journal*. 2005; 52: 221-42.
269. Livesley WJ. An integrated approach to the treatment of personality disorder. *Journal of Mental Health*. 2007; 16: 131-48.
270. Bateman AW and Fonagy P. Effectiveness of psychotherapeutic treatment of personality disorder. *British Journal of Psychiatry*. 2000; 177: 138-43.
271. Taylor RR. *The intentional relationship: Occupational therapy and use of self*. Philadelphia, PA: FA Davis, 2008.
272. College of Occupational Therapists. Code of Ethics and Professional Conduct. London: College of Occupational Therapists, 2015.
273. Farooq S, Taylor CDJ, Gire N, Riley M, Caton N and Husain N. Digital inclusion: The concept and strategies for people with mental health difficulties. *Australian & New Zealand Journal of Psychiatry*. 2015; 49: 772-3.
274. UK Government. Digital inclusion. London: UK Government, 2018.
275. Reisdorf BC and Jewkes Y. (B)Locked sites: cases of Internet use in three British prisons. *Information, Communication & Society*. 2016; 19: 771-86.
276. Reisdorf BC and Rikard RV. Digital rehabilitation: A model of reentry into the digital age. *American Behavioral Scientist*. 2018; 62: 1273-90.
277. Enyon R and Geniets A. *On the periphery? Understanding low and discontinued internet use amongst young people in Britain*. Oxford: Oxford Internet Institute, University of Oxford, 2012.
278. Larsson-Lund M. The digital society: Occupational therapists need to act proactively to meet the growing demands of digital competence. *British Journal of Occupational Therapy*. 2018; 81: 733-5.
279. Stalans LJ and Finn MA. Understanding how the internet facilitates crime and deviance. *Victims and Offenders*. 2016; 11: 501-8.
280. Office for National Statistics. Domestic abuse, sexual assault and stalking. In: Office for National Statistics, (ed.). *Compendium: Focus on violent crime and sexual offences England and Wales: Year ending March 2016*. London: Office for National Statistics, 2017.

281. Brusilovskiy E, Townley G, Snethen G and Salzer MS. Social media use, community participation and psychological well-being among individuals with serious mental illnesses. *Computers in Human Behavior*. 2016; 65: 232-40.
282. Shapiro LAS and Margolin G. Growing up wired: Social networking sites and adolescent psychosocial development. *Clinical, Child and Family Psychology Review*. 2014; 17: 1-18.
283. Livingston JD. What does success look like in the forensic mental health system? Perspectives of service users and service providers. *International Journal of Offender Therapy and Comparative Criminology*. 2016; 62: 208-28.
284. Piškur B, Daniēls R, Jongmans MJ, et al. Participation and social participation: are they distinct concepts? *Clinical Rehabilitation*. 2014; 28: 211-20.
285. Eyssen IC, Steultjens MP, Dekker J and Terwee CB. A systematic review of instruments assessing participation: challenges in defining participation. *Archives of Physical Medicine and Rehabilitation*. 2011; 92: 983-97.
286. Imms C, Adair B, Keen D, Ullenhag A, Rosenbaum P and Granlund M. 'Participation': a systematic review of language, definitions, and constructs used in intervention research with children with disabilities. *Developmental Medicine and Child Neurology*. 2016; 58: 29-38.
287. Resnik L and Plow MA. Measuring participation as defined by the International Classification of Functioning, Disability and Health: An evaluation of existing measures. *Archives of Physical Medicine and Rehabilitation*. 2009; 90: 856-66.
288. Connell C, Birken M and Inman J. The World Health Organization's concept of participation: A proposal for assessing mental health and evaluating outcomes in real world settings. *Conceptualising, measuring and influencing context in mental health care: From the individual to society*. Groningen 2017.
289. Zahra D, Qureshi A, Henley W, et al. The work and social adjustment scale: Reliability, sensitivity and value. *International Journal of Psychiatry in Clinical Practice*. 2014; 18: 131-8.
290. Mataix-Cols D, Cowley AJ, Hankins M, et al. Reliability and validity of the work and social adjustment scale in phobic disorders. *Comprehensive Psychiatry*. 2005; 46: 223-8.
291. Crawford MJ, Robotham D, Thana L, et al. Selecting outcome measures in mental health: the views of service users. *Journal of Mental Health*. 2011; 20: 336-46.

292. Gershuny J. *Time-use surveys and the measurement of national well-being*. Oxford: Centre for Time Use Research, 2011.
293. Fowler D, Hodgekins J, French P, et al. Social recovery therapy in combination with early intervention services for enhancement of social recovery in patients with first-episode psychosis (SUPEREDEN3): a single-blind, randomised controlled trial. *The Lancet Psychiatry*. 2018; 5: 41-50.
294. Hodgekins J, French P, Birchwood M, et al. Comparing time use in individuals at different stages of psychosis and a non-clinical comparison group. *Schizophrenia Research*. 2015; 161: 188-93.
295. Chen B, Vansteenkiste M, Beyers W, et al. Basic psychological need satisfaction, need frustration, and need strength across four cultures. *Motivation and Emotion*. 2015; 39: 216-36.
296. Costa S, Ingoglia S, Inguglia C, Liga F, Lo Coco A and Larcan R. Psychometric evaluation of the Basic Psychological Need Satisfaction and Frustration Scale (BPNSFS) in Italy. *Measurement and Evaluation in Counseling and Development*. 2018; 51: 193-206.
297. Scott J, McFadden R, Yates K, Baker S and McSoley S. The Role Checklist V2: QP: Establishment of reliability and validation of electronic administration. *British Journal of Occupational Therapy*. 2014; 77: 96-102.
298. Scott PJ. Measuring participation outcomes following life-saving medical interventions: The Role Checklist Version 2: Quality of Performance. *Disability and Rehabilitation*. 2014; 36: 1108-12.
299. Scott PJ, Cacich D, Fulk M, Michel K and Whiffen K. Establishing concurrent validity of the Role Checklist Version 2 with the OCAIRS in measurement of participation: A pilot study. *Occupational Therapy International*. 2017; 2017: 6.
300. NHS England. Testing New Care Models in tertiary mental health services. London: NHS England 2017.
301. Connell C, Seppänen A, Scarpa F, Gosek P, Heitzman J and Furtado V. External factors influencing length of stay in forensic services: A European evaluation *Psychiatria Polska*. 2019; In press.
302. Tangen J and Briah RK. The revolving door of reform: Professionalism and the future of probation services in England and Wales. *Probation Journal*. 2018; 65: 135-51.
303. HM Prison and Probation Service. *HM Prison and Probation Service: Business plan 2017/18*. London: HMPPS Communications, 2017.
304. Eccles MP and Mittman BS. Welcome to Implementation Science. *Implementation science : IS*. 2006; 1: 1-.

305. Eccles M, Grimshaw J, Campbell M and Ramsay C. Research designs for studies evaluating the effectiveness of change and improvement strategies. *Quality & safety in health care*. 2003; 12: 47.
306. Chalmers I and Glasziou P. Avoidable waste in the production and reporting of research evidence. *The Lancet*. 2009; 374: 86-9.
307. Yakeley J, Williams A, Blumenthal S, Bateman A and Fonagy P. Mentalization-based therapy (MBT) for individuals with antisocial personality disorder ISRCTN32309003 ISRCTN Registry: BMC, 2016.
308. Thompson TP, Callaghan L, Hazeldine E, et al. Health trainer-led motivational intervention plus usual care for people under community supervision compared with usual care alone: a study protocol for a parallel-group pilot randomised controlled trial (STRENGTHEN). *BMJ Open*. 2018; 8.
309. Parkes J, Scantlebury A, Morgan S, et al. ISRCTN: 11888938. A randomised control trial, economic and qualitative evaluation to examine the effectiveness of an out-of-court community-based Gateway intervention programme aimed at improving health and well-being for youth offenders; victim satisfaction and reducing recidivism. ISRCTN, 2018.
310. Pearson DAS, McDougall C, Kanaan M, Torgerson DJ and Bowles RA. Evaluation of the citizenship evidence-based probation supervision program using a stepped wedge cluster randomized controlled trial. *Crime & Delinquency*. 2014; 62: 899-924.
311. Michie S, Rumsey N, Fussell A, et al. *Improving health: Changing behaviour. NHS health trainer handbook*. London: Department of Health and British Psychological Society, 2008.
312. Quinn C, Byng R, Shenton D, et al. The feasibility of following up prisoners, with mental health problems, after release: a pilot trial employing an innovative system, for engagement and retention in research, with a harder-to-engage population. *Trials*. 2018; 19: 530.
313. McMurrin M and Duggan C. The manualization of a treatment programme for personality disorder. *Criminal Behaviour and Mental Health*. 2005; 15: 17-27.
314. Duncan EAS. Skills and processes in occupational therapy. In: Duncan EAS, (ed.). *Foundations for practice in occupational therapy*. 5th ed. Edinburgh: Churchill Livingstone Elsevier, 2013, p. 33-42.
315. Creek J. *Occupational therapy defined as a complex intervention*. London: College of Occupational Therapists, 2003.
316. Fisher AG. *Occupational Therapy Intervention Process Model: A model for planning and implementing top-down, client-centered, and occupation-based interventions*. Ft. Collins, CO: Three Star Press, 2009.

317. Livesley WJ. Principles and strategies for treating personality disorder. *Canadian Journal of Psychiatry*. 2005; 50: 442-50.
318. Busch-Geertsema V. Housing First Europe. Final report Bremen/ Brussels: GISS, 2013.
319. Royal College of Psychiatrists. *College report CR214. Personality disorder in Scotland: Raising awareness, raising expectations, raising hope*. London: Royal College of Psychiatrists, 2018.
320. Linehan MM. *Cognitive behavioral treatment of borderline personality disorder*. New York, NY: The Guildford Press, 1993.
321. Beck AT, Freeman A, Davis DD and Associates. *Cognitive therapy of personality disorders*. 2nd ed. New York: The Guildford Press, 2004.
322. Birken M, Henderson C and Slade M. The development of an occupational therapy intervention for adults with a diagnosed psychotic disorder following discharge from hospital. *Pilot and Feasibility Studies*. 2018; 4: 81.
323. Royal College of Psychiatrists. *College report CR154: Good psychiatric practice*. 3rd ed. London: Royal College of Psychiatrists, 2009.
324. British Psychological Society. *Practice guidelines*. 3rd ed. Leicester: British Psychological Society, 2017.
325. College of Occupational Therapists. *Professional standards for occupational therapy practice*. London: College of Occupational Therapists, 2017.
326. Eells TD. Step 3: Develop an explanatory hypothesis. *Psychotherapy case formulation*. American Psychological Association, Washington, DC, 2015, p. 107-47.
327. Arntz A and van Genderen H. *Schema therapy for borderline personality disorder*. Chichester: John Wiley and Sons Ltd., 2009.
328. Johnstone L, Whomsley S, Cole S and Oliver N. *Good practice guidelines on the use of psychological formulation*. Leicester: British Psychological Society, 2011.
329. Brooks R and Parkinson S. Occupational formulation: A three-part structure. *British Journal of Occupational Therapy*. 2018; 81: 177-9.
330. Hart S, Sturmey P, Logan C and McMurrin M. Forensic Case Formulation. *International Journal of Forensic Mental Health*. 2011; 10: 118-26.
331. Logan C. Formulation for forensic practitioners. In: Roesch R and Cook A, (eds.). *Handbook of forensic mental health*. New York: Routledge, 2017, p. 153-78.

332. Bruford S and McMurrin M. Case formulation quality checklist: a revision based upon clinicians' views. *The Journal of Forensic Practice*. 2015; 18: 31-8.
333. Morrison AP and Barratt S. What are the components of CBT for psychosis? A Delphi study. *Schizophrenia Bulletin*. 2010; 36: 136-42.
334. Blum N, Pfohl B, John DS, Monahan P and Black DW. STEPPS: a cognitive-behavioral systems-based group treatment for outpatients with borderline personality disorder--a preliminary report. *Comprehensive Psychiatry*. 2002; 43: 301-10.
335. Epton T, Currie S and Armitage CJ. Unique effects of setting goals on behavior change: Systematic review and meta-analysis. *Journal of Consulting and Clinical Psychology*. 2017; 85: 1182-98.
336. Toli A, Webb TL and Hardy GE. Does forming implementation intentions help people with mental health problems to achieve goals? A meta-analysis of experimental studies with clinical and analogue samples. *British Journal of Clinical Psychology*. 2015; 55: 69-90.
337. Weinstock-Zlotnick G and Hinojosa J. Bottom-up or top-down evaluation: Is one better than the other? *American Journal of Occupational Therapy*. 2004; 58: 594-9.
338. Eklund M, Tjörnstrand C, Sandlund M and Argentzell E. Effectiveness of Balancing Everyday Life (BEL) versus standard occupational therapy for activity engagement and functioning among people with mental illness – a cluster RCT study. *BMC Psychiatry*. 2017; 17: 363.
339. Pentland D, Kantartzis S, Clausen MG and Witemyre K. *Occupational therapy and complexity: defining and describing practice*. London: Royal College of Occupational Therapists, 2018.
340. McMurrin M, Crawford MJ, Reilly J, et al. Psychoeducation with problem-solving (PEPS) therapy for adults with personality disorder: a pragmatic randomised controlled trial to determine the clinical effectiveness and cost-effectiveness of a manualised intervention to improve social functioning. *Health Technology Assessment*. 2016; 20: 1-7.
341. Sackett DL, Rosenberg WMC, Gray JAM, Haynes RB and Richardson WS. Evidence based medicine: what it is and what it isn't. *BMJ*. 1996; 312: 71-2.
342. Creek J, Ilott I, Cook S and Munday C. Valuing occupational therapy as a complex intervention. *British Journal of Occupational Therapy*. 2005; 68: 281-4.
343. Duncan EAS, Paley J and Eva G. Complex interventions and complex systems in Occupational Therapy: An alternative perspective. *British Journal of Occupational Therapy*. 2007; 70: 199-206.

344. Inman J. Occupational therapy intervention development, for individuals with a diagnosis of psychosis living in the community, to improve participation in activities of everyday life: a feasibility study for a pragmatic randomised controlled trial. [PhD thesis]. *Faculty of Health and Human Sciences Plymouth: Plymouth University* 2017.
345. Freestone MC, Wilson K, Jones R, et al. The impact on staff of working with personality disordered offenders: A systematic review. *PLoS ONE*. 2015; 10.
346. Völlm B, Foster S, Bates P and Huband N. How best to engage users of forensic services in research: Literature review and recommendations. *International Journal of Forensic Mental Health*. 2017; 16: 183-95.
347. Awenat YF, Moore C, Gooding PA, Ulph F, Mirza A and Pratt D. Improving the quality of prison research: A qualitative study of ex-offender service user involvement in prison suicide prevention research. *Health Expectations*. 2017; 21: 100-9.
348. Connell J, Carlton J, Grundy A, et al. The importance of content and face validity in instrument development: lessons learnt from service users when developing the Recovering Quality of Life measure (ReQoL). *Quality of Life Research*. 2018; 27: 1893-902.
349. Blount C, Evans C, Birch S, Warren F and Norton K. The properties of self-report research measures: Beyond psychometrics. *Psychology and Psychotherapy: Theory, Research and Practice*. 2002; 75: 151-64.
350. Scott PJ, McKinney K, Perron J, Ruff E. and Smiley J. Measurement of participation: The Role Checklist Version 3: Satisfaction and Performance. In: Huri M, (ed.). *Occupational Therapy: Occupation focused holistic practice in rehabilitation*. London: IntechOpen, 2017.
351. Scott PJ, McKinney KG, Perron JM, Ruff EG and Smiley JL. The revised Role Checklist: Improved utility, feasibility, and reliability. *OTJR: Occupation, Participation and Health*. 2019; 39: 56-63.
352. Scott PJ, McFadden R, Yates K, Baker S and McSoley S. The Role Checklist V2: QP: Establishment of reliability and validation of electronic administration. *British Journal of Occupational Therapy*. 2014; 77: 96-102.
353. Aslaksen M, Scott PJ, Haglund L, Ellingham B and Bonsaksen T. Occupational therapy process in a psychiatric hospital: Using the Role Checklist Version 2: Quality of Performance. *Ergoterapeuten*. 2014; 57: 38-45.
354. Rycroft-Malone J, Seers K, Chandler J, et al. The role of evidence, context, and facilitation in an implementation trial: implications for the development of the PARIHS framework. *Implementation science : IS*. 2013; 8: 28.

355. Harvey G and Kitson A. PARIHS revisited: From heuristic to integrated framework for the successful implementation of knowledge into practice. *Implementation science : IS*. 2016; 11: 33.
356. Bleijenberg N, de Man-van Ginkel JM, Trappenburg JCA, et al. Increasing value and reducing waste by optimizing the development of complex interventions: Enriching the development phase of the Medical Research Council (MRC) Framework. *International journal of nursing studies*. 2018; 79: 86-93.
357. de Vries Robbé M, de Vogel V and de Spa E. Protective factors for violence risk in forensic psychiatric patients: A retrospective validation study of the SAPROF. *International Journal of Forensic Mental Health*. 2011; 10: 178-86.
358. World Health Organization. *International Statistical Classification of Diseases and Related Health Problems 11th Revision (ICD-11)*. Geneva: World Health Organization, 2018.
359. de Vries Robbe M, de Vogel V, Douglas KS and Nijman HLI. Changes in dynamic risk and protective factors for violence during inpatient forensic psychiatric treatment: Predicting reductions in postdischarge community recidivism. *Law & Human Behavior*. 2015; 39: 53-61.
360. Keeley T, Khan H, Pinfold V, et al. Core outcome sets for use in effectiveness trials involving people with bipolar and schizophrenia in a community-based setting (PARTNERS2): study protocol for the development of two core outcome sets. *Trials*. 2015; 16: 47.
361. Twinley R. The dark side of occupation: A concept for consideration. *Australian Occupational Therapy Journal*. 2013; 60: 301-3.
362. Bonell C, Jamal F, Melendez-Torres GJ and Cummins S. 'Dark logic': theorising the harmful consequences of public health interventions. *Journal of Epidemiology and Community Health*. 2015; 69: 95.

13 APPENDICES

APPENDIX A – SYSTEMATIC REVIEWS: DATA EXTRACTION AND SYNTHESIS

REVIEW ONE: DATA EXTRACTION

Author/s	Year data collected	Country	Aim/hypothesis	Study design	Inclusion criteria	Sample demographics	PD diagnosis method	PD prevalence	Offender status
Reiss, Grubin and Meux ¹⁵⁷	Patients admitted 1972-89, discharged by 1993	England	Report background details, treatment and outcomes for offenders held at high security hospital. Also reports larger group with men held on other units	Retro-spective cohort	Admitted to YPU Jan 1972-December 1989 and discharged by Jan 1993 Treated on YPU for at least one year Legally classified psychopathic disorder (inc comorbidity) Detained on	Age: YPU group = mean 19.2, (sd 1.9) at admission Combined group = mean difference in age 2.9 years, t = 6.39, P <0.0005; 95% CI = 2.0-3.8 years Gender: Male	DSM-III Legal classification of 'psychopathic disorder' PCL-R (results not reported)	61% of YPU group, 60% of matched group. All legal classification of psychopathic disorder.	Discharged from high security forensic psychiatric hospital on restriction order.

					hospital order with restrictions or transferred from prison on a life sentence No previous high security /YPU admission.	Ethnicity: YPU group 96% Caucasian Matched group = Not reported. Whole sample = not reported. (No sig dif reported in ethnicity)			
Whitehead, Ward and Collie ¹⁵⁹	Not reported	New Zealand	Illustrate application of the Good Lives Model with a high risk, psychopathic, violent offender	Case study	Not reported	Age: 28 Gender: Male Ethnicity: Maori	PCL-R: SV	PCL-R psychopathy 100%	Parole
Jacobs et al. ⁷⁶	2009	England	Present service users' views of engaging with a community forensic PD service	Qual-itative	Within service for one year	Age 30-64 Gender: Male Ethnicity: 9/12 British, 1/12 African, 1/12 Caribbean 1/12 Other	ICD-10	100%	All under forensic community services for PDOs

REVIEW ONE: DATA EXTRACTION (CONTINUED)

Author/s	Participation outcome of interest	Factors investigated for influencing	Analysis method	Results	Limitations
Reiss, Grubin and Meux ¹⁵⁷	<p>Overall social outcome reported to be 'good' if a good was awarded on all four categories, meeting the following criteria:</p> <p>Social interaction (having friends or intimate relationship)</p> <p>Employment (held a job at least 6 months, had not been continuously unemployed for 6 months, was not fired)</p> <p>Accommodation (never of no-fixed abode, remained in one residence for 6 months, not evicted, either lived with family or own</p>	'All recorded background and treatment factors' - not clear if this includes participation in certain interventions.	Univariate analysis to determine relationship between all recorded background and treatment factors to social outcome.	<p>For the YPU group, no significant associations were found. 61% of YPU group discharged to community. 28 followed up 10 had overall good social outcome. In the matched group only 4 had good overall social outcome.</p> <p>In combined group - 36% of those followed up (n=54) had a 'good' social outcome.</p> <p>Positively related to: Adequate or improved assertiveness rated by Broadmoor staff during first 18 months of admission (OR 6.0, 95% CI = 1.3-28.2) .</p> <p>Higher IQ (good outcome mean=107.6 poor mean=98.5, mean diff 9.0, t=2.3, p<0.03)</p>	<p>All factors tested were not reported</p> <p>How assertiveness of IQ were measured is not reported</p> <p>Not all participants received the same treatment whilst in hospital.</p> <p>Quality: Low</p> <p>Risk of bias: High</p>

	<p>residence)</p> <p>Substance abuse (drank social or in moderation, cannabis only socially and in small amounts, no illicit drugs)</p>				
Whitehead, Ward and Collie ¹⁵⁹	<p>A 'good life' including activities, experiences, or situations sought for their own sake and that benefit individuals by increasing fulfillment and happiness</p> <p>In this case: attending college, learning to drive, sustaining an intimate relationship, and being a family member.</p>	<p>Describes treatment using GLM reported in five phases goal setting, enhancing cognitive dissonance, formulation, objective setting and support.</p> <p>Working with strengths to enhance positive identity linked to spiritual values/culturally relevant support, developing skills, practical support.</p> <p>Establishing a prosocial vision of self, understanding barriers to success, develop formulation of behaviour patterns, establish plan</p>	Psychological formulation	<p>Authors frame intervention as a success.</p> <p>Participant commenced but did not complete college or driving qualification. Transport difficulties impacted success at college. They suggest self-belief was essential to achieving these outcomes.</p> <p>Participant reported to be in an intimate relationship and have had success in establishing a new peer group, but not what impacted upon this.</p> <p>The authors suggest certain barriers based on a case formulation, describing the habitual pattern of meeting his</p>	<p>Single case deliberately selected to demonstrate utility of GLM.</p> <p>Quality: Low</p> <p>Risk of bias: High</p>

		(only talks about safety plan), enlisted support to provide opportunity and external press for socially acceptable behaviour.		needs through destructive means.	
Jacobs et al. ⁷⁶	Return to work and independence	Exploratory – qualitative study	<p>Principles of grounded theory</p> <p>Interviews systematically analysed, with each data item coded according to axial coding framework</p> <p>The items were integrated into categories of meaning, where similarities within transcripts formed ‘themes</p>	<p>Within theme on employment, authors attribute increased independence and employment seeking to confidence. The service user viewed independence as a result of a process of growing and maturing.</p> <p><i>‘I feel that I’ve grown and matured in the last four years that I’ve been with FIPTS to the point where I am now in full independence. I’ve been doing a bit of part-time work also which I never thought I’d get back into, I’m looking to go into college in September to do medical administration and my future is a lot more brighter and there is a lot more hope now than there was four years ago.’</i></p>	<p>Minimal attention to the factors associated with success in employment.</p> <p>Findings can only be tentative as factors influencing success in employment/independence were not the focus of the study.</p> <p>Quality: Low</p> <p>Risk of bias: High</p>

REVIEW TWO: DATA EXTRACTION

Author/s	Year data collected	Country	Aim/ hypothesis	Study design	Inclusion criteria	Demographics	Diagnosis method	Prevalence	Offender status
Davidson et al. ¹⁶³	Not reported	Two UK sites England and Scotland	Compare effect of cognitive behavioural therapy (CBT) to treatment as usual (TAU) on violence, alcohol misuse, mental health and social functioning for violent men with ASPD in a community setting. Test RCT feasibility in this setting.	Feasibility RCT	Men 18 - 65 years ASPD Living in the community Endorsement of any item on MacArthur Community Violence Screening Instrument (MCVSI) Interview in the 6 months prior to baseline Written informed consent.	Age in years M(SD): TAU= 36.5 (10.9), CBT= 39.3 (9.9), All= 37.9 (10.4) Gender: Male 100% Ethnicity: Only proportion white reported, TAU 66.7%, CBT 68%, All 67.3%	Structured Clinical Interview for DSM-IV Axis II Personality Disorders (SCID-II)	100%	Unclear. First involvement with the law given as mean age. Not reported if all participants were involved with the law.

Fortune et al. ¹⁶⁵	2005-06 Follow up: 2007-08	UK	Follow up patients for 2 years to determine clinical and economic outcomes of non-high secure (medium, community and residential) services for offenders with personality disorder.	Prospective cohort	All service users in three non-high secure forensic services treating adults with PD and IQ above 70	Age in years (M, S.D.) for whole sample (not given for community group) 36.8(8.3) Gender: Male Ethnicity for community group: White 92% Black 8% Ethnicity for whole sample: White 80% Black: 15% Other: 5%	International Personality Disorder Examination (IPDE)	100%	All in receipt of forensic mental health services Violent offence 80% Sexual offence 31% Acquisitive offence 74% Drug offence 28%
-------------------------------	-----------------------------------	----	---	--------------------	--	---	---	------	---

Krampen ¹⁶⁷	Not reported. Measures indicate post 2002	Germany	Follow up patients for 5 years to determine long-term effects of integrative psychotherapy on: criminal and police records, occupational adjustment, social integration, frequency of relaxation exercises used in everyday life	Cohort	Male Dominant symptoms of violence and acting out against intimates Referred/self-referred to psychotherapy for treatment of this	For whole sample (not given for ASPD group) Age in yrs M(SD): 34.3 (6.6). Range 25-56 yrs Gender: Male Ethnicity: Not reported	SCID-II	ASPD = 61% at start of treatment Results for ASPD group reported separately	All had history of criminal involvement
------------------------	--	---------	--	--------	---	--	---------	--	---

<p>Öhlin, Fridell and Nyhlen¹⁶²</p>	<p>2004 – 2011</p>	<p>Sweden</p>	<p>Evaluate 7-year outcome of buprenorphine assisted treatment with contracted work/ education, combined with low tolerance for non-prescribed drug use.</p> <p>Analyse influence of gender, psychiatric disorder on outcome of drug use, social situation and criminal activity</p>	<p>Cohort</p>	<p>Age 20+</p> <p>At least 1 year documented heroin addiction</p> <p>Not expelled from another program in previous 3 months</p> <p>Contact with social services</p> <p>Current drug-free living environment</p> <p>Employment contract on starting treatment</p> <p>Agree to expulsion if use non-prescribed drugs.</p>	<p>Age: Men: 22–62, M=34.29 Women: 20–52, M=32.23 All: 21–62, M=33.76</p> <p>Gender: Male 77.7% Female 22.3%</p> <p>Ethnicity: Not reported</p>	<p>SCID-II</p>	<p>84% *results not reported separately for PDOs.</p>	<p>73% history of probation 54.1% history of prison 40.5% current probation</p>
--	--------------------	---------------	--	---------------	---	---	----------------	---	---

Whitehead, Ward and Collie ¹⁵⁹	Not reported	New Zealand	Demonstrate application of the Good Lives Model to treatment with a high risk, psychopathic, violent offender	Case study	Not reported	Age: 28 Gender: Male Ethnicity: Maori	Psychopathy Checklist Screening Version (PCL: SV)	100%	Parole following prison for 'most of adult life'
---	--------------	-------------	---	------------	--------------	---------------------------------------	---	------	--

REVIEW TWO: DATA EXTRACTION (CONTINUED)

Author/s	Occupational participation outcome	Intervention	Analysis method	Results	Limitations
Davidson et al. ¹⁶³	Social functioning measured using Social Functioning Questionnaire (SFQ)	<p>Cognitive Behavioural Therapy for BPD and ASPD.</p> <p>Described as: <i>Participants encouraged to engage in treatment through a cognitive formulation of their problems. Therapy focuses on beliefs about self and others and behaviours that impair social and adaptive functioning.</i></p> <p>Participants randomized to either 15x 1hr sessions over 6 months or 30x 1hr sessions over 12 months</p>	<p>Participants randomized to CBT 15x1hr over 6 months or 30x 1hr over 12 months or TAU.</p> <p>Change on SFQ from baseline to last time of follow up (6 or 12 months) adjusted for baseline levels.</p> <p>Treatment difference and estimate 95% confidence intervals (CIs) estimated from an analysis of covariance of the changes from baseline adjusted for baseline levels.</p> <p>All analyses intention-to-treat.</p>	<p>No differences in social functioning between CBT and TAU groups at 12 months: Mean difference = -0.7 (95% CI = -3.3 to 1.8), p=0.54.</p> <p>Trend for those who received 6 months of CBT to have improved social functioning compared to TAU (p=0.08, data not shown).</p>	<p>Did not explicitly investigate factors within CBT that may influence social functioning.</p> <p>Small-scale feasibility study, underpowered to detect clinically important differences between groups.</p> <p>TAU is not defined</p> <p>Medium risk of bias</p>

<p>Fortune et al.¹⁶⁵</p>	<p>Social functioning Measured using Work and Social Adjustment Scale</p>	<p>Service described as 'UK pilot psychiatric services for personality disordered offenders'.</p> <p>Three different non-high secure services (providing inpatient and community service), with stated aims to provide treatments to reduce the risk of re-offending, address mental health needs and improve social functioning</p> <p>The community services: 1. Residential service provided by local housing organisation that provided social care for eight residents. Residents were assisted in exploring local opportunities for education, employment and other activities 2. Community team offering assessment and treatment programme aimed at reducing risk of harm to others 3. Community team and two hostels (10 beds) providing continuation of Violence Reduction Programme.</p>	<p>Paired t-test to detect statistically significant change in social functioning</p>	<p>No significant difference in social functioning at 6 months or 24 months. 29/55 lost to follow up. Initially 24/54 in community group.</p> <p>For the community group: Mean WSAS at baseline =20.42 (12.12), mean at 6 months 19.53(10.97). T=0.81, p=0.43. Mean WSAS at 24 months=14.5(8.3), T=1.04, p=0.33.</p>	<p>Unclear: i) How representative of the population the sample is (refusal 39%) ii) How many patients were followed up in the community group and thus the validity of the findings</p>
-------------------------------------	---	--	---	---	---

<p>Krampen¹⁶⁷</p>	<p>Occupational adjustment described as: <i>"Being on the job' for two or more years"</i> Social adjustment not clearly defined, denoted as: <i>"peers' data about non-deviant social network"</i></p>	<p>Long-term integrative psychotherapy including progressive relaxation and autogenous training.</p> <p>Four components described:</p> <p>(1) Enhance social-emotional skills, empathy and morality. Techniques include modelling, operant and respondent techniques, role playing, therapeutic homework, moral dilemma techniques, mirroring, free association, and guided imagery.</p> <p>(2) Reduced psychophysiological arousal in favour of impulse control and mastery. Techniques included relaxation therapy, self-control techniques, distraction techniques, thought stop, delayed negative feedback.</p> <p>(3) Developing adaptive self-statements, using techniques such as cognitive restructuring of self-defeating thought patterns and social-cognitive biases and anger control training.</p> <p>(4) Reconstructing attachment abilities, trust, and social</p>	<p>Pre-and post frequency counts and percentages</p>	<p>For antisocial personality disorder group:</p> <p>Occupational adjustment Increase from 7-12 (25%-43%)</p> <p>Social adjustment There is no pre-test score. Only post test score of 13 (46%) which the authors report is positive</p>	<p>Statistical measures not used to compare significant change or with other groups within the sample. Small sample, potentially limited representativeness given the majority were not mandated to therapy. Inadequate articulation of social adjustment and attribution of change to factors targeted through treatment. Authors not explicit about how intervention may influence occupational / social adjustment outcomes. High risk of bias</p>
------------------------------	--	---	--	--	---

		relationships. Techniques included resource activation, focusing, behaviour and problem analyses, biographical analyses, development of life projects, role play, and therapeutic homework.			
--	--	---	--	--	--

<p>Öhlin, Fridell and Nyhlen¹⁶²</p>	<p>Employment -either 'regular' job or subsidised wages during studies</p>	<p>Multi-modal treatment with five basic elements:</p> <p>(1) Pharmacological treatment with buprenorphine to manage opioid addiction.</p> <p>(2) Prohibition of misuse of drugs.</p> <p>(3) Access to drug-free accommodation, although no further detail is given.</p> <p>(4) Achieving structured employment (work or studies)</p> <p>(5) Psychosocial treatment sessions to modify drug use and 'prevent passivity'.</p>	<p>Employment rates pre- and post</p> <p>Statistical comparisons were based on 148 patients who stayed in the program for a minimum of 30 days and started buprenorphine maintenance treatment.</p> <p>Analysis of variance and t-test to compare interval data or data with higher metrical properties. Bivariate regression analysis to investigate possible differences in the study group.</p> <p>Raw score in the tests converted to linear T-scores corrected for age and sex differences. χ^2-test to compare proportions</p>	<p>69% in regular job at 7 years compared to 22% at outset. Proportionally more women than men in work or education (70% vs 60%). 30% improvement for both in movement from precarious to regular labour market work.</p> <p>Drop outs lost employment and did not resume.</p> <p>29% earned living by subsidized wage compensation compared to 9.5% at baseline. Subsidized wage compensation increased by 19% during the first 2 years of follow-up. 2% did academic studies</p> <p>Throughout program patients started vocational courses / advanced studies.</p>	<p>Assumption made that PDOs were a sufficient proportion to justify inclusion</p> <p>Unclear what specifically was considered the factor that increased employment rate.</p> <p>Statistical significance of change in employment rates not reported.</p> <p>High risk of bias</p>
--	--	--	--	--	--

<p>Whitehead, Ward and Collie¹⁵⁹</p>	<p>A 'good life' including activities, experiences, or situations sought for their own sake and that benefit individuals by increasing fulfilment and happiness In this case: attending college, learning to drive, sustaining an intimate relationship, and being a family member.</p>	<p>Exploratory –Describes treatment using GLM reported in five phases 1) Identifying life goals and the motivation for pursuing them. 2) Defining desired identity and determining the barriers/opportunities to achieving this. 3) Producing a good lives informed formulation. 4) Developing a plan to equip offender with values, attitudes, skills and resources to achieve their goals in a prosocial way. 5) Enacting the plan, including undertaking any interventions to address criminogenic barriers such as substance use or attitudes towards violence.</p>	<p>Psychological formulation</p>	<p>Authors frame intervention as a success. Participant commenced but did not complete college or diving qualification, started learning to drive but completion not reported. Identify that transport difficulties impacted success at college They suggest self-belief was essential to achieving these outcomes.Participant reported to be in an intimate relationship and have had success in establishing a new peer group, but not what impacted upon this.The authors suggest certain barriers based on a case formulation, describing the habitual pattern of meeting his needs through destructive means.</p>	<p>Single case deliberately selected to demonstrate utility of GLM. High risk of bias</p>
---	---	---	----------------------------------	--	---

REVIEW TWO: DATA SYNTHESIS

Study	Participation outcome	Intervention	How intervention may impact participation	Effectiveness
Davidson et al. ¹⁶³	Social functioning measured with SFQ	CBT for personality disorder	Therapy focuses on beliefs about self and others, and behaviours that impair social and adaptive functioning Attitude and behaviour that blocks successful participation 'challenged' and reduced, which may result in improved social functioning.	No significant difference
Fortune et al. ¹⁶⁵	Social functioning measured using WSAS	MSU and community treatment in 3 teams. One service helped explore local opportunities for participation (education, employment, other activities).	Unclear Practical assistance/support to overcome barriers to accessing real world experiences of participation. Real world experiences allow for developing skills and abilities in response to challenges in live settings that can be continued in future participation.	No significant difference
Krampen ¹⁶⁷	Employment defined as being 'on the job' for at least two years	Long-term integrative psychotherapy Including: Resource activating interventions, mastery-oriented interventions and consciousness-creating interventions	Not explicit which interventions (see additional file 1 for full detail) or treatment objectives relate to employment specifically. Overall therapy objectives included enhanced social emotional skills, empathy and morality; increased impulse control and mastery; producing adaptive self-statements; reconstructed attachment ability, trust and social relationships and developing prosocial peer networks. The above may build capacities to better cope with the social and emotional challenges of a work environment, and solve problems modelling behaviour from prosocial networks.	Increased employment rate. Difference can't be attributed to intervention

Öhlin, Fridell and Nyhlen ¹⁶²	Employment Either in competitive employment or 'subsidised wage compensation'	Multi-modal treatment including employment advisors 'Support radical lifestyle change'	Unclear how the intervention got participants into a job, and what role was played in sustaining this during and post intervention. If participants were provided with practical assistance to gain and sustain employment this may involve embedding a new routine, experiencing work and learning adaptive skills to sustain this role.	Increased employment rate. Difference can't be attributed to intervention
Whitehead, Ward and Collie ¹⁵⁹	Mixed University, prosocial leisure and relationship	Psychologist and other team members (e.g. Maori mentor) using Good Lives Model	Motivation to engage and sustain change in participation is enhanced by producing cognitive dissonance between desired identity and current situation. Interventions orientated around imparting values, attitudes, skills resources needed to make most of opportunities and overcome barriers Staff practical support, information giving (e.g. finding course information). and orchestrating positive life events may enable the offender to initiate participation and then develop competences/identity to continue independently and generalise to other activities	Began participating Difference can't be attributed to intervention

APPENDIX B – PROCESS DOCUMENTS FROM WORK PACKAGE TWO:
ETHICAL APPROVAL, SAMPLING FRAMEWORK, INTERVIEW SCHEDULE

ETHICAL APPROVAL



WARWICK
THE UNIVERSITY OF WARWICK

PRIVATE

Ms Catriona Connell
Mental Health and Wellbeing
Warwick Medical School
University of Warwick
Coventry
CV4 7AL

30 September 2016

Dear Ms Connell,

Study Title and BSREC Reference: *Experiences of participation among offenders with personality disorder/difficulties in a Community setting* REGO-2016-1822

Thank you for submitting the above-named project to the University of Warwick Biomedical and Scientific Research Ethics Committee for research ethical review.

I am pleased to advise that research ethical approval is granted.

In undertaking your study, you are required to comply with the University of Warwick's *Research Data Management Policy*, details of which may be found on the Research and Impact Services' webpages, under "Codes of Practice & Policies" » "Research Code of Practice" » "Data & Records" » "Research Data Management Policy", at: http://www2.warwick.ac.uk/services/ris/research_integrity/code_of_practice_and_policies/research_code_of_practice/datacollection_retention/research_data_mgt_policy

You are also required to comply with the University of Warwick's *Information Classification and Handling Procedure*, details of which may be found on the University's Governance webpages, under "Governance" » "Information Security" » "Information Classification and Handling Procedure", at:

<http://www2.warwick.ac.uk/services/gov/informationsecurity/handling>.

Investigators should familiarise themselves with the classifications of information defined therein, and the requirements for the storage and transportation of information within the different classifications:

Information Classifications:

<http://www2.warwick.ac.uk/services/gov/informationsecurity/handling/classifications>

Handling Electronic Information:

<http://www2.warwick.ac.uk/services/gov/informationsecurity/handling/electronic/>

Handling Paper or other media

<http://www2.warwick.ac.uk/services/gov/informationsecurity/handling/paper/>.

Please also be aware that BSREC grants **ethical approval** for studies. **The seeking and obtaining of all other necessary approvals is the responsibility of the investigator**



These other approvals may include, but are not limited to:

1. Any necessary agreements, approvals, or permissions required in order to comply with the University of Warwick's Financial Regulations and Procedures.
2. Any necessary approval or permission required in order to comply with the University of Warwick's Quality Management System and Standard Operating Procedures for the governance, acquisition, storage, use, and disposal of human samples for research.
3. All relevant University, Faculty, and Divisional/Departmental approvals, if an employee or student of the University of Warwick.
4. Approval from the applicant's academic supervisor and course/module leader (as appropriate), if a student of the University of Warwick.
5. NHS Trust R&D Management Approval, for research studies undertaken in NHS Trusts.
6. NHS Trust Clinical Audit Approval, for clinical audit studies undertaken in NHS Trusts.
7. Approval from Departmental or Divisional Heads, as required under local procedures, within Health and Social Care organisations hosting the study.
8. Local ethical approval for studies undertaken overseas, or in other HE institutions in the UK.
9. Approval from Heads (or delegates thereof) of UK Medical Schools, for studies involving medical students as participants.
10. Permission from Warwick Medical School to access medical students or medical student data for research or evaluation purposes.
11. NHS Trust Caldicott Guardian Approval, for studies where identifiable data is being transferred outside of the direct clinical care team. Individual NHS Trust procedures vary in their implementation of Caldicott guidance, and local guidance must be sought.
12. Any other approval required by the institution hosting the study, or by the applicant's employer.

There is no requirement to supply documentary evidence of any of the above to BSREC, but applicants should hold such evidence in their Study Master File for University of Warwick auditing and monitoring purposes. You may be required to supply evidence of any necessary approvals to other University functions, e.g. The Finance Office, Research & Impact Services (RIS), or your Department/School.

May I take this opportunity to wish you success with your study, and to remind you that any Substantial Amendments to your study require approval from BSREC before they may be implemented.

Yours sincerely



Professor John Davey
Chair
Biomedical and Scientific
Research Ethics Sub-Committee

**Biomedical and Scientific
Research Ethics Sub-Committee**
Research & Impact Services
University of Warwick
Coventry, CV4 8UW.
E: BSREC@Warwick.ac.uk

http://www2.warwick.ac.uk/services/ris/research_integrity/researchethicscommittees/biomed

Aim

Purposive sampling aimed to select twenty participants, to achieve range and diversity in the sample, rather than statistical representation. The total number would depend upon data saturation being achieved and recruitment rate.

Recruiting site

The National Probation Service in the West Midlands was selected as recruiting site because:

- High risk offenders with suspected personality disorder are all supervised by the National Probation Service
- To complete the study within the timescales and resource limitations of a PhD project, a single geographical area was feasible
- The limited community provision to offenders with personality disorder in comparison to some other areas of the country. In some areas of the country (e.g. Liverpool, Yorkshire and Humber, London), OPD provision in the community includes intervention by health clinicians and specialist approved premises. By sampling a population that does not have such provisions, the research will identify factors influencing participation without the complicating effects of intervention services. This will also have comparative value when considering if what is currently provided elsewhere would be applicable to the West Midlands, and has potential to identify unmet needs in other geographical locations
- The diverse West Midlands population (Birmingham, Coventry, Walsall, Wolverhampton, Sandwell and Dudley) in relation to age, ethnicity, deprivation levels, that may provide a degree of generalisability

Variables

Participants were sampled based upon pre-defined primary and secondary variables. These were selected for their relevance to the research question, in response to emergent findings from systematic literatures reviews, and because of theoretical relevance to the outcome of interest. Cases were stratified using two primary variables (gender and a proxy for successful participation), with case selection proceeding on the basis that range and diversity will need to be achieved in terms of the chosen secondary variables.

Primary variables

1. Sex/Gender – Man or woman

The experiences of participation are likely to differ markedly between male and female PDOs. There very limited literature on occupational participation among women in the community, as identified in the systematic reviews reported in Chapter Three.^{113, 114} However, there is also much lower proportion of female PDOs (5% of NPS caseload). To identify if there are important differences that are unexplored due to the limited literature I will oversample the women to allow comparisons, aiming to recruit 5 women (25% of the sample).

2. Successful participation – employed or unemployed.

Employment is not the only indication of participation. However, background literature review reported in Chapter One demonstrated that it is the most often reported in the literature, is a valued element of occupational participation in the UK, is an indicator of health, and is associated with desistance. It was adopted as a proxy for successful occupational participation in the sampling framework. A target was set to recruit employed people as 50% of the sample to allow comparison and to identify the factors associated with increased occupational participation.

Male (n=15)		Female (n=5)	
Unemployed (8)	Employed (7)	Unemployed (3)	Employed (2)

Secondary variables

3. Age – under 35 vs 35+

The activities and roles in which people participate in and the values associated with them change with age. There is also potential for both individual (e.g. skills) and environmental (social networks) influences on participation to change depending on a person’s age/stage of life.

The well documented ‘age-crime’ curve suggests that most offenders cease criminal activity after a peak in late adolescence. However, there are a group of persistent offenders who continue to offend at high rates into adulthood.^{195, 196} It is the latter ‘high-risk’ group that are under the supervision of the National Probation Service, and for whom this intervention is designed.

The problematic traits of Cluster B personality disorders (antisocial and borderline personality disorder) are typically what results in screening into the OPD Pathway. There is evidence for a symptomatic recovery from personality disorder over time.^{197, 198} However, despite symptomatic remission for 78% of people with borderline personality disorder after eight years, only 40% achieve good social and vocational functioning.¹⁹⁸

Recruiting participants of different ages was intended to identify if there are different experiences of occupational participation, and whether the expected improvement in personality symptoms and offending behaviour facilitate occupational participation.

4. Ethnicity – Caucasian and BAME

Most PDOs are reported to be Caucasian. However, there may be important differences to consider that influence occupational participation for people from a different ethnic background. The West Midlands includes areas of high ethnic diversity and an intervention for this area should consider the appropriateness of interventions developed on the basis of research with only Caucasian samples. The sample was intended to recruit 25% of participants from a Black, Asian or Minority Ethnic (BAME) background.

5. Offence type – violent vs sexual

Barriers and opportunities to occupational participation may be influenced by individual differences linked to committing different offence types, and societies reaction to them. For example, barriers to occupational participation for sexual offenders can be particularly high due to societal attitudes and associated shame.^{199, 200} The majority of people under probation supervision are persistent violent offenders although the high-risk group targeted in this research includes more people with a sexual offending history. I aimed for 33% of both the men and women recruited to have committed a sexual offence.

1. Daily routine

Current routines

Describe a typical day during the week.

Can you tell me about something that happened recently that typifies what this routine is really like for you?

Is the weekend any different? Describe it.

Are you satisfied with this routine?

[if yes] What do you like about it?

[If No] What do you dislike about it?

If you were having a really good or really bad day, what would that day be like?

What are the most important things in your routine?

Does your routine allow you to get done the things that are most important?

[If No] What important things are you not able to do?

Do you have any ongoing hobbies/projects that are part of your current routine?

Tell me about _____.

How often do you do it?

How did you get started?

What do you like about it?

How long has this been a part of your routine?

Historical perspective

Was your daily routine ever different? When?

How was your routine different when _____?

How would you compare these routines? Which was better for you?

Did you have any hobbies or projects that were part of your routine in the past?

Desired change

What is the most important thing to keep the same about your routine?

What would you most like to change about your routine?

2. Occupational Roles – exploring the participant's life roles

[pursue line of questioning for all current roles]

Identify current life roles – (productivity)

Do you currently work/study/take care of anyone?

[Or] I understand that you are a _____?

How did you come to [have this job/ _____]?

What do(es) your work/studies/caretaking involve?

[Or] What kind of [responsibilities do you have/things do you have to do] as a__?

How well do you handle these responsibilities/tasks?

Do you like doing them?

What would you say is the main thing you get out of your work/studies?

[Or] What is the main reason that you do this?

What kind of worker/student/caretaker would you say you are?

Can you give me an example of something that shows how this is so?

[Or] Tell me something that happened recently that would show what kind of worker/____ you are.

[Or] Tell me something that you did recently as a worker/parent/partner/son/daughter that you are proud of.

Identify historical role performance (productivity)

Have you worked/studied/cared for someone in the past?

How did you come to [have this job/choose this line of work or study]?

[And/or] What kind of worker would you say you were?

How much of your time/energy did your work take?

Was work difficult for you?

What would you say is the main thing you got out of your work?

Why did you quit [working/this line of work/this job]?

Has anything particular affected your work? Why do you think it is that you have not worked?

What about your past student/caretaker experiences?

What kind of a student would you say you were? How much of your time/energy did your studies take? Was school difficult for you? What would you say is the main thing you got out of your studies? How far did you go in school? Has anything particular affected your studies?

Identify current leisure/social roles

Friend, volunteer, amateur, hobbyist and other roles

In addition to your work/studies/other responsibilities is there anything else that takes up a lot of your time and energy that is really important to you?

[Or] Is there any special thing that you do a lot?

How did you come to have this role?

What do(es) it involve? [Or] What kind of [responsibilities do you have/things do you have to do as a _____]?

How well do you handle these responsibilities/tasks? Do you like doing them?

What would you say is the main thing you get out of your ...?

[Or] What is the main reason that you do this?

What kind of ... would you say you are?

Can you give me an example of something that shows how this is so?

[Or] Tell me something that happened recently that would show what kind of ____ you are. [Or] Tell me something that you did recently as a ____ that you are really proud of.

Home-maintenance role

Do you live in an apartment/home/dormitory/nursing home/other?

Who else do you live with?

What kind of responsibilities do you have to keep up your home/apartment/room?

[Or] How do you divide up the responsibilities to keep up your home/apartment/room?

How well do you handle these responsibilities/tasks?

Do you like doing them?

What would you say is the main thing you get out of it? [Or] What is the main reason that you do this?

Religious/organization participation

Do you actively participate in any organizations or in church/temple groups?
Tell me about it.

How did you come to _____?

What do(es) it involve?

[Or] What kind of [responsibilities do you have/things do you have to do] as a _____?

How well do you handle these responsibilities/tasks?

Do you like doing them?

What would you say is the main thing you get out of it?

[Or] What is the main reason that you do this?

What kind of religious person would you say you are?

Can you give me an example of something that shows how this is so?

[Or] Tell me something that happened recently that would show what kind of /-
___ you are. [Or] Tell me something that you did recently as a ___ that you are
really proud of.

3. Occupational Settings (Environment)

Home

Tell me about where you live [Or] I understand you live _____.

Is your home/apartment/room/dorm comfortable?

Do you have enough privacy?

Can you get around in your home/apartment/room/dorm?

Do you have the things there that you need in order to do what you want?

Are you ever bored there?

Do you like your surroundings? Are they stimulating for you?

What do you have to do to keep up your home/apartment/room/dorm?

Do you like doing this?

Are you able to do it okay?

[overlaps with the caretaker role/responsibilities questions in the role section and
may not need to be repeated if that section is done first]

Who do you live with? [Or] Who are the important people in your life? [Or] I
understand you live with _____?

How do you get along?

What kind of things do you do together?

How would you describe things where you live/living with this person/people?

(For instance, which of the following describes your home/living situation: loving,
fighting, stressful, calm, chaotic, busy, boring?)

[Or] Tell me about something that happened at home recently that would show
me what things are like where you live.

Is there anyone at home/in your family who makes life stressful or difficult for
you?

If you need help with something, can you expect your ___ to give you a hand?

Can you give me an example?

If you were feeling depressed or upset, could you expect your ___ to give you
support? Can you give me an example?

How is this different/the same as other places you have lived?

Major productive role – if different from above

Tell me about the place where you work/go to school. What is it like?

Is it well suited for you to get your studies/work done?
Do you have enough privacy?
Can you get around okay?
Do you have the things there that you need in order to do what you want?
Are you ever bored there?
Are you ever stressed there?
Do you like your work surroundings?
How would you describe things where you work?
(For instance, which of the following describes your work situation: loving, fighting, stressful, calm, chaotic, busy, boring?)
[Or] Tell me about something that happened at work recently that would show me what things are like where you work.
Who are the people you interact with most [on the job/as a student]?
How do you get along with your colleagues/coworkers/boss/fellow students/teachers?
Is there anyone at work who makes work difficult or stressful for you?
If you need help with something can you expect your colleagues/coworker/ boss to give you a hand? Can you give me an example?
If you were feeling depressed or upset, could you expect your boss or coworkers to give you advice or support? Can you give me an example?
How does this compare to other places you have worked?

Leisure

What are the main things you do to recreate and relax?
Where do you go for that?
Is it a good place to be?
Do you like the facilities/atmosphere?
Do they suit you well?
Do you really have the places you want for relaxation or recreation?
Who are the people you relax/recreate with most?
How do you get along with them?
Is there anyone at work who makes this activity difficult or stressful for you?
Tell me about something you did recently that would show me what kind of atmosphere you are in when you relax or recreate
How does this compare to other leisure activities/hobbies you have done in the past?

4. Activity/Occupational Choices

Values

What are some of the things that are really important to you?
How did you come to [have this job/choose this line of work or study/have responsibilities for your parents]?
Can you tell me about those things you don't get to do, and why? [Or] What are the things you can't do? Can you give me an example?
Can you tell me about a recent situation in which you weren't able to do something you really value?
Have you been able to choose the things in your life that are important to you?
Is there anything that routinely interferes with what you want to do?
Do you feel you have enough time to do the things you enjoy?

Do you have free time?
What are you likely to spend it doing? [or] Why do you think you don't have the time?
Can you give an example of a time when you felt you did not have enough time to do the things you enjoy?
What do you do for fun/do you have fun?
Can you tell me about the most recent time when you really had a lot of fun?
[If Can't Answer] Why don't you think you have fun anymore?

Volition / goals

Do you ever [set goals for yourself/plan for the future]?
[If yes] Are you able to follow through?
[If Yes] Can you give me an example of a time when you had a goal and followed through with it?
[If No] Can you give me an example of a time when you had a goal and were not able to follow through with it?
[If no] Have you ever had something you looked forward to or really wanted to accomplish?
How do you make decisions to get things done?
When you run into obstacles or difficulties, how do you handle it?
Can you give me an example?
What do you think is the biggest challenge you are facing now?
How do you think you will [adjust to/handle] _____?
Can you give me an example of some decisions you've already made that illustrate this?

5. Critical Life Events

Neutral past

What were the events or experiences that most shaped or changed your life?
[or] When did things really change for you?
Have things changed since coming under probation?
[Ask for each event]
Tell me about _____.
What happened? What changes did it bring about?

Success and failure

If you think about your life, what do you consider the time when you were doing best? Tell me about this period. What made it so good?
What do you consider your biggest success in life? [Or] Tell me about a time when you felt successful
What do you consider the worst period in your life? Tell me about this period. What made it so bad?
What do you consider your biggest failure in life? [Or] Tell me about something where you felt especially unsuccessful.

Ambitions

If you could make your future turn out as you wanted, what would you be doing?
What do you think you will be doing in the future? [Or] What do you see yourself doing in the future?
Is that how you'd like it to be?

APPENDIX C – FURTHER DATA FROM CHAPTER FOUR

MOHOST AREAS OF IMPAIRMENT, INDICATORS OF LOW SCORE AND COMPARISON TO ICD-10 DESCRIPTIONS OF DISSOCIAL AND EMOTIONALLY UNSTABLE PERSONALITY DISORDER

Item and key concepts	Indicators of low score	Dissocial personality disorder	Emotionally unstable personality disorder
<p>Adaptability</p> <p>Anticipation of change Habitual response to change Tolerance of change Response to changes in routine Willingness to adapt Reaction to adversity/obstacles</p>	<p>Desires immediate satisfaction lacks patience despite all attempts to support change May be extremely anxious or fearful, avoidant of change Poor response to boundaries or pushes boundaries causing distress to others Resists suggestions, intolerant, reacts inappropriately to change Volatile, explosive, aggressive, physically violent or verbally abusive in relationship to change</p>	<p>Very low tolerance to frustration and a low threshold for discharge of aggression, including violence</p>	<p>Marked tendency to act impulsively without consideration of the consequences, together with affective instability Outbursts of intense anger may often lead to violence or "behavioural explosions"; these are easily precipitated when impulsive acts are criticised or thwarted by others</p>

<p>Roles Role identity Role variety Belonging Involvement Social acceptability</p>	<p>Withdrawn from all previous roles Unable to maintain self-care, leisure or productive roles despite support Can become over-involved in the lives of others Clear roles but poor sense of belonging Limited access to long-term roles but shows role behaviour in structured environments Limited role behaviour, playing e.g. the joker, or e.g. mother figure, but little else Requires support to meet expectations and obligations</p>	<p>Gross and persistent attitude of irresponsibility and disregard for social norms, rules and obligations</p>	<p>Self-image, aims, and internal preferences (including sexual) are often unclear or disturbed Usually chronic feelings of emptiness. Liability to become involved in intense and unstable relationships may cause repeated emotional crises and may be associated with excessive efforts to avoid abandonment and a series of suicidal threats or acts of self-harm (although these may occur without obvious precipitants)</p>
<p>Responsibility Role competence Meeting expectations Fulfilling obligations Delivering responsibilities Willingness/ readiness to acknowledge/ accept role obligations and assigned tasks</p>	<p>Consistently hostile or highly defensive when required to face responsibilities Denies or disputes feedback, refuses to accept feedback or takes no responsibility Difficulty disassociating self from other people's problems, despite support Lacks awareness — seems unaware of how failure to handle responsibilities affects others May attribute actions solely to illness or external situations and doesn't take responsibility. Overwhelming guilt feelings expressed about responsibility Unpredictable acceptance of responsibilities</p>	<p>Gross and persistent attitude of irresponsibility and disregard for social norms, rules and obligations Marked proneness to blame others, or to offer plausible rationalisations, for the behaviour that has brought the patient into conflict with society</p>	<p>Tendency to quarrel-some behaviour and conflicts with others, especially when impulsive acts are thwarted or censored Outbursts of intense anger may often lead to violence / "behavioural explosions", easily precipitated when impulsive acts criticised or thwarted by others Liability to become involved in intense and unstable relationships may cause repeated emotional crises and may be associated with excessive efforts to avoid abandonment and a series of suicidal threats or acts of self-harm (these may occur without obvious precipitants)</p>

<p>Relationships Co-operation Collaboration Rapport Respect Helpfulness Ability to relate Dyadic and group interaction Sociability</p>	<p>Does not get involved, unresponsive, does not display concern for others Extremely withdrawn or isolative, may ignore others Hostile or suspicious, may sabotage interventions or otherwise be destructive Inattentive, appears to be out of touch with occupational situation Intolerant of others, possibly malicious or provocative Obstructive, demanding, interfering within occupational situations Offensive, may provoke disgust in others Unaware of boundaries, extremely vulnerable despite support</p>	<p>Callous unconcern for the feelings of others Incapacity to maintain enduring relationships, though having no difficulty in establishing them</p>	<p>Tendency to quarrelsome behaviour and to conflicts with others, especially when impulsive acts are thwarted or censored Liability to become involved in intense and unstable relationships may cause repeated emotional crises and may be associated with excessive efforts to avoid abandonment and a series of suicidal threats or acts of self-harm (although these may occur without obvious precipitants)</p>
<p>Problem solving Judgement Adaptation Decision-making Responsiveness Objectivity — ability to distance self Concrete v. abstract thinking Ability to generate workable solutions Ability to learn from mistakes and benefit from instructions</p>	<p>Avoidant, does not seek information and fails to respond to feedback Fails to overcome problems or to make appropriate changes. Frequently resorts to inappropriate or anti-social coping strategies Highly dependent/reliant on others, extremely vulnerable Irrational, makes random or inappropriate decisions, unamenable to reason Makes unsuccessful attempts to solve problems</p>	<p>Very low tolerance to frustration and a low threshold for discharge of aggression, including violence Incapacity to experience guilt or to profit from experience, particularly punishment Marked proneness to blame others, or to offer plausible rationalisations, for the behaviour that has brought the patient into conflict with society</p>	<p>The ability to plan ahead may be minimal Tendency to act impulsively and without consideration of the consequences; Tendency to self-destructive behaviour, including suicide gestures and attempts Liability to become involved in intense and unstable relationships may cause repeated emotional crises and may be associated with excessive efforts to avoid abandonment and a series of suicidal threats or acts of self-harm (although these may occur without obvious precipitants)</p>

<p>Social groups Family dynamics Friends and social support Work climate Expectations and involvement</p>	<p>Emotional or practical climate contributes to maladaptive functioning Has major difficulties getting along with colleagues or family Interaction or collaboration is non-existent or impossibly demanding/conflicting Skills, contributions or efforts are ignored or devalued</p>	<p>Incapacity to maintain enduring relationships, though having no difficulty in establishing them</p>	<p>Tendency to quarrelsome behaviour and to conflicts with others, especially when impulsive acts are thwarted or censored Liability to become involved in intense and unstable relationships may cause repeated emotional crises and may be associated with excessive efforts to avoid abandonment and a series of suicidal threats or acts of self-harm (may occur without obvious precipitants)</p>
<p>Occupational demands Activity demands (self-care, productivity, leisure) Cultural conventions Activity construction</p>	<p>Poorly suited Result in over or under stimulation, excessive stress or boredom Self-care activities severely challenge personal capacity</p>	<p>Generic descriptor: Extreme or significant deviations from the way the average individual in a given culture perceives, thinks, feels, and particularly relates to others. ... frequently, but not always, associated with various degrees of subjective distress and problems in social functioning and performance</p>	<p>Generic descriptor: Extreme or significant deviations from the way the average individual in a given culture perceives, thinks, feels, and particularly relates to others. ... frequently, but not always, associated with various degrees of subjective distress and problems in social functioning and performance</p>

OPHI-II AREAS OF IMPAIRMENT, INDICATORS OF LOW SCORE AND COMPARISON TO ICD-10 DESCRIPTIONS OF DISSOCIAL AND EMOTIONALLY UNSTABLE PERSONALITY DISORDER

Item	Example indicators of low score	Dissocial personality disorder	Emotionally unstable personality disorder
Expects success	Pessimistic view of own potential to perform Feels helpless Feels unable to control self Feels helpless in the ability to influence outcomes Gives up in the face of obstacles/ limitations/ failures	Marked proneness to blame others, or to offer plausible rationalisations, for the behaviour that has brought the patient into conflict with society	General theme of impulsiveness and lack of self-control Self-image, aims, and internal preferences (including sexual) are often unclear or disturbed A liability to become involved in intense and unstable relationships may cause repeated emotional crises and may be associated with excessive efforts to avoid abandonment and a series of suicidal threats or acts of self-harm (although these may occur without obvious precipitants)
Accepts responsibility	Takes little/no responsibility for personal failure Chronically self-deprecating Avoids/ cannot use feedback effectively Chronically uses others/circumstances to avoid responsibilities	Gross and persistent attitude of irresponsibility and disregard for social norms, rules and obligations Marked proneness to blame others, or to offer plausible rationalisations for the behaviour that has brought the patient into conflict with society	There is a tendency to quarrelsome behaviour and to conflicts with others, especially when impulsive acts are thwarted or censored Outbursts of intense anger may often lead to violence or "behavioural explosions"; these are easily precipitated when impulsive acts are criticized or thwarted by others
Appraises abilities and limitations	Fails to realistically estimate own abilities Difficulty recognising/compensating for limitations with abilities	Marked proneness to blame others, or to offer plausible rationalisations for the behaviour that has brought the patient into conflict with society	Not clear

Recognises identity and obligations	Does not identify with any occupational role Identifies with deviant role Lacks role commitment	Not clear	Self-image, aims, and internal preferences (including sexual) are often unclear or disturbed. Usually chronic feelings of emptiness
Felt effective (past)	Lacked a sense of responsibility Felt hopeless	Callous unconcern for the feelings of others Marked proneness to blame others, or to offer plausible rationalisations for the behaviour that has brought the patient into conflict with society	Self-image, aims, and internal preferences (including sexual) are often unclear or disturbed. There are usually chronic feelings of emptiness
Found meaning and satisfaction in life (past)	Was extremely unhappy with lifestyle/ life roles Was unable to identify interests Was unable to find meaning in life	Generic criteria: Considerable personal distress but this may only become apparent late in its course	Self-image, aims, and internal preferences (including sexual) are often unclear or disturbed. There are usually chronic feelings of emptiness Generic criteria: Considerable personal distress but this may only become apparent late in its course
Made occupational choices (past)	Life story was not motivating (e.g. tragic, portrayed self as a victim). Was unable to envision a life story. Avoided/ made very poor occupational choices.	Generic criteria: Usually, but not invariably, associated with significant problems in occupational and social performance	General theme of impulsiveness and lack of self-control. The ability to plan ahead may be minimal Self-image, aims, and internal preferences (including sexual) are often unclear or disturbed Generic criteria: Usually, but not invariably, associated with significant problems in occupational and social performance

Maintains a satisfying lifestyle	Overwhelmed with responsibilities related to roles/personal projects Consistent failure in roles/personal projects Major lack of roles/personal projects/responsibilities to fill lifestyle Lifestyle shows no direction/meaning	Generic criteria: Usually, but not invariably, associated with significant problems in occupational and social performance	Generic criteria: Usually, but not invariably, associated with significant problems in occupational and social performance
Fulfills role expectations	Unable to meet demands of major life roles Completely lost major life roles due to disability Negligible/no role demands with little opportunity for achievement	Gross and persistent attitude of irresponsibility and disregard for social norms, rules and obligation Incapacity to maintain enduring relationships, though having no difficulty in establishing them	A liability to become involved in intense and unstable relationships may cause repeated emotional crises and may be associated with excessive efforts to avoid abandonment and a series of suicidal threats or acts of self-harm (although these may occur without obvious precipitants)
Works towards goals	Illness/trauma invalidated goals Cannot stay focussed on goals/sustain effort toward goals over time. Abandons goals. Struggles toward unattainable goals resulting in chronic failure	Generic criteria: Usually, but not invariably, associated with significant problems in occupational and social performance	Generic criteria: Usually, but not invariably, associated with significant problems in occupational and social performance
Meets personal performance standards	Chronic difficulty meeting completely unrealistic personal expectations Major loss of capacity preventing achievement of performance standards	Not clear	Not clear

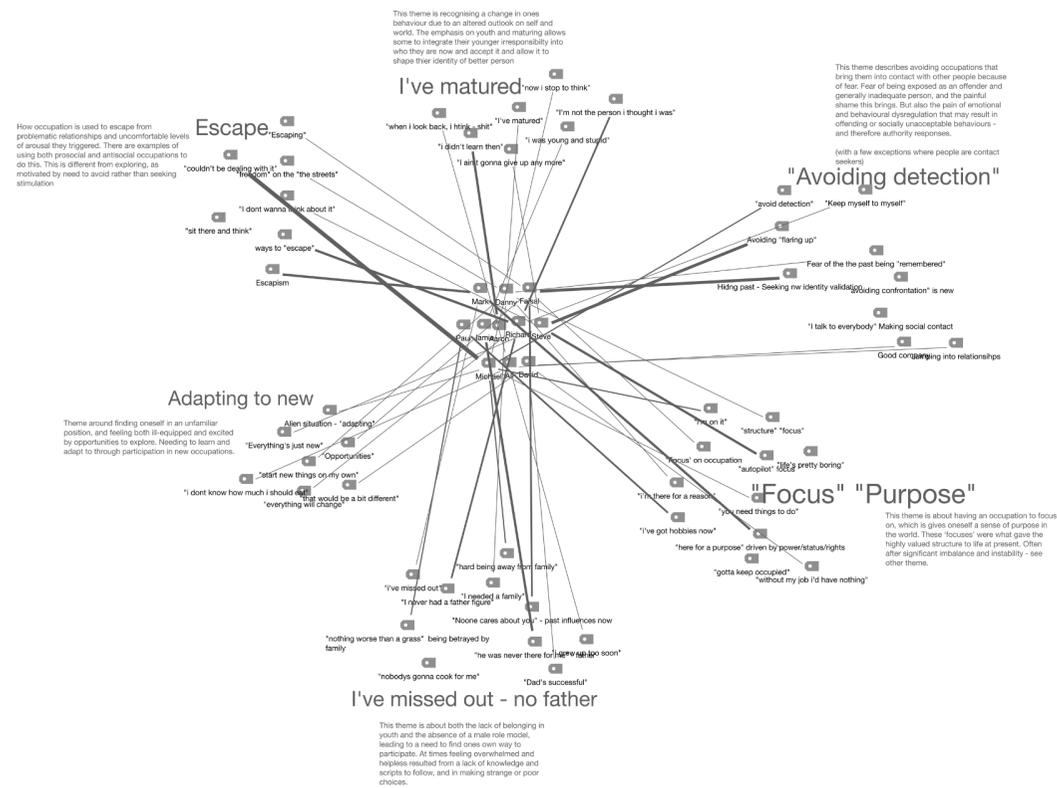
Organises time for responsibilities	Totally disorganised/ chaotic routine Unable to organise routine for basic self-care tasks Unable to adapt routine to new circumstances Routine expresses highly maladaptive behaviour such as substance abuse/negative coping strategies	Generic criteria: Usually, but not invariably, associated with significant problems in occupational and social performance.	General theme of impulsiveness and lack of self-control Marked tendency to act impulsively without consideration of the consequences Generic criteria: Usually, but not invariably, associated with significant problems in occupational and social performance
Fulfilled roles (past)	Had significant failure in one or more major life roles Had absence of roles Had major difficulty in several/ all roles	Gross and persistent attitude of irresponsibility and disregard for social norms, rules and obligations Generic criteria: Usually, but not invariably, associated with significant problems in occupational and social performance	Self-image, aims, and internal preferences (including sexual) are often unclear or disturbed Usually chronic feelings of emptiness Liability to become involved in intense and unstable relationships may cause repeated emotional crises and may be associated with excessive efforts to avoid abandonment and a series of suicidal threats or acts of self-harm (although these may occur without obvious precipitants) Generic criteria: Usually, but not invariably, associated with significant problems in occupational and social performance
Maintained habits (past)	Had significant problems maintaining routine Routine pattern failed to match developmental stage/goals Had chaotic life pattern in relation to appropriate developmental stage/goals Had an inactive routine Had markedly deviant life pattern	Gross and persistent attitude of irresponsibility and disregard for social norms, rules and obligations Generic criteria: Usually, but not invariably, associated with significant problems in occupational and social performance	General theme of impulsiveness and lack of self-control Marked tendency to act impulsively without consideration of the consequences Generic criteria: Usually, but not invariably, associated with significant problems in occupational and social performance

<p>Achieved satisfaction (past)</p>	<p>Illness/trauma significantly hindered/prevented the pursuit/achievement of goals/interests Had strong sense of failure/dissatisfaction with lifestyle Had significant failure leading to dissatisfaction Had poor balance of work, rest, and play</p>	<p>Generic criteria: Usually, but not invariably, associated with significant problems in occupational and social performance</p> <p>Leads to considerable personal distress but this may only become apparent late in its course</p>	<p>Self-image, aims, and internal preferences (including sexual) are often unclear or disturbed Usually chronic feelings of emptiness</p> <p>Generic criteria: Usually, but not invariably, associated with significant problems in occupational and social performance Leads to considerable personal distress but may only become apparent late in its course</p>
<p>Major productive role occupational forms (tasks)</p>	<p>Physical, cognitive and/or emotional demands/opportunities poorly match interests and abilities Time/effort required well suit available time/energy</p>	<p>Generic criteria: Usually, but not invariably, associated with significant problems in occupational and social performance</p> <p>Assessment of personality disorder made in the context of general social and cultural norms but does not assess match between capacity and demands of social environment</p>	<p>Generic criteria: Usually, but not invariably, associated with significant problems in occupational and social performance</p> <p>Assessment of personality disorder made in the context of general social and cultural norms but does not assess match between capacity and demands of social environment</p>

Home life social group	Interaction/collaboration either non-existent/impossibly demanding/conflicting Emotional/practical climate contributes to extremely maladaptive functioning/coping Others ignore/devalue skills/contributions/efforts Feels helpless in own ability to influence outcomes	Marked proneness to blame others, or to offer plausible rationalisations for the behaviour that has brought the patient into conflict with society Assessment of personality disorder made in the context of general social and cultural norms but does not assess match between capacity and demands of social environment	General theme of impulsiveness and lack of self-control Assessment of personality disorder made in the context of general social and cultural norms but does not assess match between capacity and demands of the social environment
Major productive role social group	As above	As above	As above
Leisure social group	As above	As above	As above

APPENDIX D – FURTHER DATA FROM CHAPTER FIVE

EXAMPLE THEMATIC MAP



APPENDIX E – FURTHER DATA FROM CHAPTER SEVEN

PILLAR INTEGRATION PROCESS

Quantitative	Quantitative	Pillar building	Qualitative	Qualitative
<p>Data</p> <p><i>Items rated as a strength or limitation on MOHOST and OPHI-II</i></p>	<p>Categories</p> <p><i>Over-lapping constructs determined by manual definition – list reduced and short description added</i></p>	<p>Matching and checking</p> <p><i>Qualitative categories were ‘matched’ with quantitative category to produce rows of in a matrix table / joint display. Each was related to final narrative themes from qualitative sub-study (example in next table)</i></p>	<p>Categories</p> <p><i>Codes and slopes reduced and presented with propositional statement</i></p>	<p>Data (Codes)</p> <p><i>Codes and slopes produced using grounded theory informed approach to analysis of participant narratives and narrative slopes</i></p>
<p>Adaptability</p> <p>Roles</p> <p>Responsibilities</p> <p>Relationships</p>	<p>Adaptability / Organises time for responsibilities</p> <p>Roles / Fulfils role expectations / Organises time for responsibilities / Recognises identity and obligations</p>	<p>Adaptability</p> <p>Being able to anticipate and cope with change in routine/activities/social settings (expected and unexpected)</p> <p>Being willing and able to learn</p>	<p>Adapting to new</p> <p>Finding self in an unfamiliar position; Ill-equipped/excited to explore; Need/desire to learn</p> <p>Seeing things differently</p>	<p>Put a fire in me</p> <p>Seeing things differently</p> <p>People to be on top of it</p> <p>Like a yo-yo</p> <p>What the drink does to me</p> <p>Pride</p> <p>Clean</p>

Problem solving	Responsibilities / Fulfils role expectations / Organises time for responsibilities	and adjust behaviour	Recognising need to learn	Safe home
Non-verbal skills		Responsibility Recognises what is/is not own responsibility; willing/ready to acknowledge and accept obligations and tasks; fulfilling expectations/ obligations; recognises impact on others	Probation recognition Fear of losing support	Hangs over me
Conversation	Maintains satisfying lifestyle / Participates in interests / Meets personal performance standards		What the drink does to me Losing control and making poor choices	Keep myself to myself
Timing				Managing intruding past
Physical capacities	Relationships	Problem solving Able to generate workable solutions, make judgements and take decisions in response to challenges (that support positive outcome); Can distance self to be objective, can use abstract thinking; Able to learn from mistakes and benefit from instructions	I've matured / Progressing Change in identity and outlook Level past self is integrated into self	Doing things I've never done
Social groups	Problem solving			Occupational roles
Occupational demands	Non-verbal skills		Generative activity Sharing their experience and this valued by others Including parenthood	Faith
Expects success	Conversation			Dependable social support
Recognises identity and obligations	Social groups / Home life social group / Major productive role social group / Leisure social group	Emotional stability Ability to predict or control responses to rapid and marked mood change	Three bastards / Can't do nothing about it / Consistent instability Barriers that seem out with individuals control	Probation recognition
Felt effective (past)				Escape
Found meaning and satisfaction (past)	Occupational demands / Major productive role occupational forms / Leisure occupational forms / Major productive role	Relating to people	People to be on top of it	I've matured
				Avoiding detection
				Focus – purpose
				I've missed out – no father figure
				Adapting to new
				Goals
				Controlling home environment
				Consistent occupations
				Buzz
				Generative activity
				Instability
				Three bastards
				Validation of new identity
				Legacy

Made occupational choices (past)	physical space, objects and resources / Leisure physical space, objects and resources	Able to respect and relate to others; aware of and manages own and others' needs; can offer and receive support; can balance levels of involvement with other people	Abdicating responsibility for occupational choices	Sorted it out for me Can't do nothing about it I don't deserve it
Maintains satisfying lifestyle	Expects success / Works towards goals		Escape Occupations to escape relationship strain, emotional discomfort	Liminality Progressing Consistent instability Restrained
Fulfils role expectations	Fulfilled roles (past)	Self-efficacy (relating) Perception of own competence in social settings (see below for competence in occupation)	Avoiding detection / keep myself to myself Avoiding occupations that involve others because of fear of judgement, and fear of losing self-control and doing something socially unacceptable	
Works towards goals	Maintained habits (past)	Self-efficacy (activity) Belief in ability to participate, overcome challenges, stay in control, and achieve	Sorted it out for me / Dependable social support Connections that assist	
Meets personal performance standards	Achieved satisfaction (past) / Found meaning and satisfaction (past)		Like a yo-yo / Consistent instability Theme about the influence of mood on choices, a sense of unpredictability/lack of control over emotions. Women desired	
Organises time for responsibilities	Felt effective (past)	Perception of social judgements Beliefs about how others view them; congruence between this and current or desired future participation		
Participates in interests	Made occupational choices (past)			
Fulfilled roles (past)				
Maintained habits (past)				
Achieved satisfaction (past)				
Major productive role occupational forms		Sustaining a routine Ability to maintain a balanced range of activities that meet		

<p>Leisure occupational forms</p> <p>Home life social group</p> <p>Major productive role social group</p> <p>Leisure social group</p> <p>Major productive role physical space, objects and resources</p> <p>Leisure physical space, objects and resources</p>		<p>needs</p> <p>Goals Willing to set goals, goals are achievable/realistic; sustains focus on goals</p> <p>Prosocial interests Independently pursues activities that bring pleasure, structure and purpose</p> <p>Emotional/sensory drive Chooses activities that give high adrenaline or high physical exertion</p> <p>Prosocial roles Has a role that gives meaning, identity, belonging</p> <p>Physical capacity Can maintain posture, mobilise, use suitable levels of strength and effort, coordinate oneself</p>	<p>stability.</p> <p>Put a fire in me / Progressing How a negative interaction with authority had the result of driving a change in choices.</p> <p>Liminality / Consistent instability Need to use activity to cope with absence of meaning. Having an activity that gives a sense of purpose and structure to/in the world</p> <p>Hangs over me / Restrained Stigma and realities of rejections</p> <p>Managing intruding past / I don't deserve it / Consistent instability Uncontrollable recall disrupts occupational participation and brings fear. Sense of shame, guilt and unworthiness from the past influencing current</p>	
---	--	---	--	--

		<p>Knowledge Knows what is expected of adults in society; can draw on role models</p> <p>Managing attentional demands Initiate and complete task using sequencing /prioritising; Concentrates but attends to environment; Able to cope with distractions and variable stimulation; awareness of time</p> <p>Non-verbal skills Using eye-contact, gestures, facial expressions, tone of voice to give and respond to communications</p> <p>Conversational skills Initiates and sustains contextually appropriate conversations; can take turns; manages disclosure; has the language to express self; meaning is clear</p>	<p>choices</p> <p>Focus – purpose / Faith / Occupational roles Having an activity that gives a sense of purpose and structure to/in the world</p> <p>Goals Willing to set goals Setting achievable goals Having a plan</p> <p>Buzz Seeking highs/excitement/ status akin to that achieved in past (potentially antisocial activities)</p> <p>I've missed out Lack of youth belonging and achievement to base current performance on. No father figure.</p> <p>Doing things I've never done</p>	
--	--	---	---	--

		<p>Safe home Has a space that is their own, safe from disruptions and within their control Social validation – social groups value their contribution</p> <p>Criminal record and disclosure requirements</p> <p>Past-mastery Experience of being good at something; pride</p> <p>Past experiences of belonging Learned to value self and relationships</p> <p>Past experience of fulfilling a role Participated in developmentally normative / socially acceptable role</p> <p>Past experience of sustaining</p>	<p>(absent past meaning) / Progressing Valuing opportunity to do things that either had never been done or because the things have intrinsic value, rather than being undertaken for survival or other reasons</p> <p>Safe home / clean Place I can call my own and be safe from any hostility. Where the environment is within my control Being personally clean and having a clean environment.</p> <p>Validation of new identity / Progressing Other people recognise my progress</p> <p>Pride Activities proud of, motivate to partake. Defends me from negative judgements by myself and others</p>	
--	--	--	--	--

		<p>positive habits / routine Sustained a prosocial routine</p> <p>Past experiences remain in the past Ability to separate past from present, ability to use to motivate participation</p>	<p>Consistent occupations Repeating activities that served a useful purpose.</p> <p>Instability / Consistent instability Frequent disruptions prevent competency development</p>	
--	--	---	--	--

EXAMPLE OF THE MATCHING AND CHECKING PROCESS

Factor	MOHOST	OPHI-II	Qualitative findings	Definition	Narrative theme
Adaptability	<p>Adaptability</p> <p>Anticipation of change</p> <p>Willingness to adapt</p> <p>Adjusts to cope with change</p> <p>Reaction to adversity/obstacles</p>	<p>Organising time for responsibilities</p> <p>Maintains a routine</p> <p>Meets demands and responsibilities</p> <p>Copes with change</p>	<p>Adapting to new</p> <p>Finding self in an unfamiliar position</p> <p>Ill-equipped/excited to explore</p> <p>Need/desire to learn</p> <p>Seeing things differently</p> <p>Recognising need to learn</p> <p>Probation recognition</p> <p>Fear of losing</p> <p>What the drink does to me</p> <p>Losing control and making poor choices</p>	<p>Adaptability</p> <p>Being able to anticipate and cope with change in routine/ activities/ social settings (expected and unexpected)</p> <p>Being willing and able to learn and adjust behaviour</p>	<p>‘Learning and adapting’</p> <p>How participation is a slow process, influenced by the time and capacity it takes to learn new skills</p>

<p>Responsibility</p>	<p>Responsibility Recognises what is/is not own responsibility Willingness/readiness to acknowledge/accept role obligations and assigned tasks Fulfilling expectations / obligations Response to feedback Aware of impact on others</p>	<p>Recognition of identity and obligations (overlap above) Range of roles Prosocial/ antisocial roles Sense of identity emanating from roles Commitment to roles</p> <p>Organising time for responsibilities Maintains a routine Meets demands and responsibilities Copes with change</p> <p>Fulfilling role expectations</p>	<p>I've matured Change in identity and outlook Level past self is integrated into self</p> <p>Generative activity Sharing their experience and this valued by others Inc parenthood</p> <p>Three bastards Barriers that seem out with individual's control</p> <p>What the drink does to me Losing control and making poor choices</p> <p>People to be on top of it Abdicating responsibility for occupational choices</p>	<p>Responsibility Recognises what is/is not own responsibility; willing/ready to acknowledge and accept obligations and tasks; fulfilling expectations/ obligations; recognises impact on others</p>	<p>External forces Persons externalisation of responsibility to mood, other people, unpredictable circumstances</p>
-----------------------	---	---	--	--	---

<p>Problem solving</p>	<p>Problem solving Judgement Adaptation Decision-making Responsiveness Level of objectivity - ability to distance self Concrete v. abstract thinking Ability to generate workable solutions Ability to learn from mistakes and benefit from instructions</p>		<p>Adapting to new Finding self in an unfamiliar position Ill-equipped/excited to explore Need/desire to learn Seeing things differently Recognising need to learn Escape Occupations to escape relationship strain, emotional discomfort What the drink does to me Managing an intruding past Avoiding detection Avoiding occupations that involve others because of fear of judgement, and fear of losing self-control and doing something socially unacceptable Keep myself to myself Three bastards Barriers that seem out with individuals control What the drink does to me</p>	<p>Problem solving in activities Able to generate workable solutions, make judgements and take decisions in response to challenges (that support positive outcome); Can distance self to be objective, can use abstract thinking; Able to learn from mistakes and benefit from instructions</p>	<p>Learning and adapting People learning to solve problems in prosocial ways not resort to antisocial strategies. Function Solving the problem of emotional discomfort External forces When relying on other people to solve problems, 'rescuers'</p>
------------------------	---	--	---	---	---

			Losing control and making poor choices Sorted it out for me – connections that assist People to be on top of it Abdicating responsibility for occupational choices		
--	--	--	--	--	--

FACTORS TABULATED AGAINST MOHO SUB-SYSTEMS AND ITEMS IN ASSOCIATED ASSESSMENT TOOLS

Factor and description	MOHO sub-system(s)	Assessment items
<p>Self-efficacy in social setting Perception of own competence in social settings (see below for competence in occupation)</p>	<p>Volition Occupational identity</p>	<p>MOHOST 'Appraisal of ability', 'Expectation of success'</p> <p>OPHI-II Occupational identity: 'Expects success'. 'Appraises abilities and limitations' Occupational competence: 'Meets personal performance standards'</p> <p><i>Does not permit separation at different 'levels of doing', i.e. performing and activity, participating in a role</i></p>
<p>Self-efficacy in activity Belief in ability to participate in activity, overcome challenges, stay in control, and achieve outcomes</p>	<p>Volition Occupational identity</p>	<p>MOHOST 'Appraisal of ability', 'Expectation of success'</p> <p>OPHI-II Occupational identity: 'Expects success'. 'Appraises abilities and limitations'</p> <p><i>Does not permit separation at different 'levels of doing', i.e. performing and activity, participating in a role</i></p>
<p>Goals Willing to set goals, goals are achievable/realistic; sustains focus on goals</p>	<p>Volition Occupational identity Occupational competence</p>	<p>MOHOST Included in 'choices'</p> <p>OPHI-II Occupational identity: 'Has personal goals and projects' Occupational competence: 'Works towards goals'</p>

<p>Prosocial interests Independently pursues activities that bring pleasure, structure and purpose</p>	<p>Volition Occupational identity and occupational competence</p>	<p>MOHOST 'Interests'</p> <p>OPHI-II Occupational identity: 'Identifies desired occupational lifestyle', 'Has commitments and values', 'Has interests' Occupational competence: 'Participates in interests'</p>
<p>Emotional/sensory drive Seeking activities that perform an emotional function</p>	<p><i>Not reflected – limited explanation of non-cognitive motivations.</i> <i>Suggestion/s:</i> <i>Volition and habituation</i></p>	<p>MOHOST Included in one sub-component of motivation, 'choices', as an impairment, where goal-based choices are the ideal and 'impulsivity' a limitation.</p> <p><i>This was a far more prevalent issue for PDOs</i></p>
<p>Past-mastery Experience of being good at something; pride</p>	<p>Contributes to present volition, occupational identity and occupational competence</p>	<p>MOHOST <i>Not included</i></p> <p>OPHI-II Occupational identity: 'Felt effective (past)' Occupational competence: 'Achieved satisfaction (past)'.</p>
<p>Past experiences of belonging Experience of being a valued part of a social group</p>	<p><i>Not addressed explicitly</i> <i>Suggestion/s:</i> <i>Contributes to present volition, occupational identity</i></p>	<p>MOHOST <i>Not included</i></p> <p>OPHI-II <i>Not included – 'Found meaning and satisfaction in lifestyle (past)' touches on occupational identity, but not belonging.</i></p>

<p>Past experiences remain in the past Ability to separate past from present, ability to use to motivate participation</p>	<p><i>Although past acknowledged as shaping present, the ability to differentiate is overlooked. For PDOs intrusions and instability disrupted occupational participation.</i> <i>Suggestion/s:</i> <i>Contributes to present volition, habituation, performance capacity, occupational identity, and occupational competence</i></p>	<p>MOHOST Not included</p> <p>OPHI-II <i>Not included – ‘Made occupational choices (past)’ touches on trajectory but attributes this to poor/good choices.</i></p>
<p>Adaptability Being able to anticipate and cope with change in routine/ activities/ social settings (expected and unexpected); Being willing and able to learn and adjust behaviour</p>	<p>Habituation Occupational competence</p>	<p>MOHOST <i>‘Adaptability’ - includes ability to predict, tolerate and respond - however having as one item does not permit separation of ability to anticipate, cope, and willingness to adapt (deliberate and controlled) from habitual response and tolerance (immediate and uncontrolled) (see 15)</i></p> <p>OPHI-II Occupational competence: ‘Organises time for responsibilities’</p>
<p>Sustaining a routine Ability to maintain a balanced range of activities that meet needs</p>	<p>Habituation Occupational competence</p>	<p>MOHOST <i>‘Routine’</i> <i>‘Energy’ is included in motor skills which is better situated here for PDOs</i></p> <p>OPHI-II Occupational competence: ‘Maintains satisfying lifestyle’ Occupational competence: ‘Organises time for responsibilities’</p>

<p>Role Has a role that gives identity and meaning</p>	<p>Habituation Occupational identity</p>	<p>MOHOST 'Roles'</p> <p>OPHI-II Occupational identity: 'Recognises identity and obligations' Occupational competence: 'Fulfil role expectations'.</p>
<p>Responsibility Recognises what is/is not own responsibility; willing/ready to acknowledge and accept obligations and tasks; fulfilling expectations/ obligations; recognises impact on others</p>	<p>Habituation Occupational competence</p>	<p>MOHOST Responsibility</p> <p>OPHI-II Occupational identity: 'Accepts responsibility', 'Recognises identity and obligations' Occupational competence: 'Fulfil role expectations'.</p>
<p>Past experience of fulfilling a role Experience of developmentally normative roles</p>	<p>Contributes to present volition and habituation, occupational competence and occupational identity</p>	<p>MOHOST <i>Not included</i></p> <p>OPHI-II Occupational competence: 'Fulfilled roles (past)'.</p>
<p>Past experience of sustaining positive habits/routine Experience of sustaining a routine that met needs, desires, responsibilities</p>	<p>Contributes to present volition and habituation</p> <p>Contributes to occupational competence and occupational identity</p>	<p>MOHOST <i>Not included</i></p> <p>OPHI-II Occupational competence: 'Maintained habits (past)', 'Achieved satisfaction (past)'.</p>

<p>Emotional stability Ability to predict or control responses to rapid and marked mood change</p>	<p><i>Minimally mentioned, except from in small children</i> <i>Suggestion:</i> <i>Performance capacity (emotional skills)</i></p>	<p>MOHOST <i>Not included – though ‘impulsivity’ referenced in adaptability, having as one item does not permit separation of ability to anticipate, cope, and willingness to adapt (deliberate and controlled) from habitual response and tolerance (immediate and uncontrolled) (see 9)</i></p> <p>OPHI-II <i>Not included</i></p>
<p>Relating to people Able to respect and relate to others; aware of and manages own and others’ needs; can offer and receive support; can balance levels of involvement with other people</p>	<p><i>MOHO includes this in performance capacity as part ‘communication and interaction’ but this is a significant area for PDOs, different from their ability to hold a conversation for example.</i> <i>Suggestion:</i> <i>Performance capacity (social and relationship skills)</i></p>	<p>MOHOST Vocal expression includes ‘assertiveness’ which for PDOs is better reflected here in their ability to assert in relation to another’s needs ‘Relationships’</p> <p>OPHI-II <i>Not included</i></p>
<p>Perception of social judgements Beliefs about how others view them; congruence between this and current or desired future participation</p>	<p><i>Recognises subjectivity as an influencer on skills but not explicit about perceptions of others</i> <i>Suggestion:</i> <i>Performance capacity (social and relationship skills)</i> <i>Occupational identity</i></p>	<p>MOHOST <i>Doesn’t include – looks at actual supportiveness, but not perception / misperception and its impact</i></p> <p>OPHI-II <i>Not included</i></p>

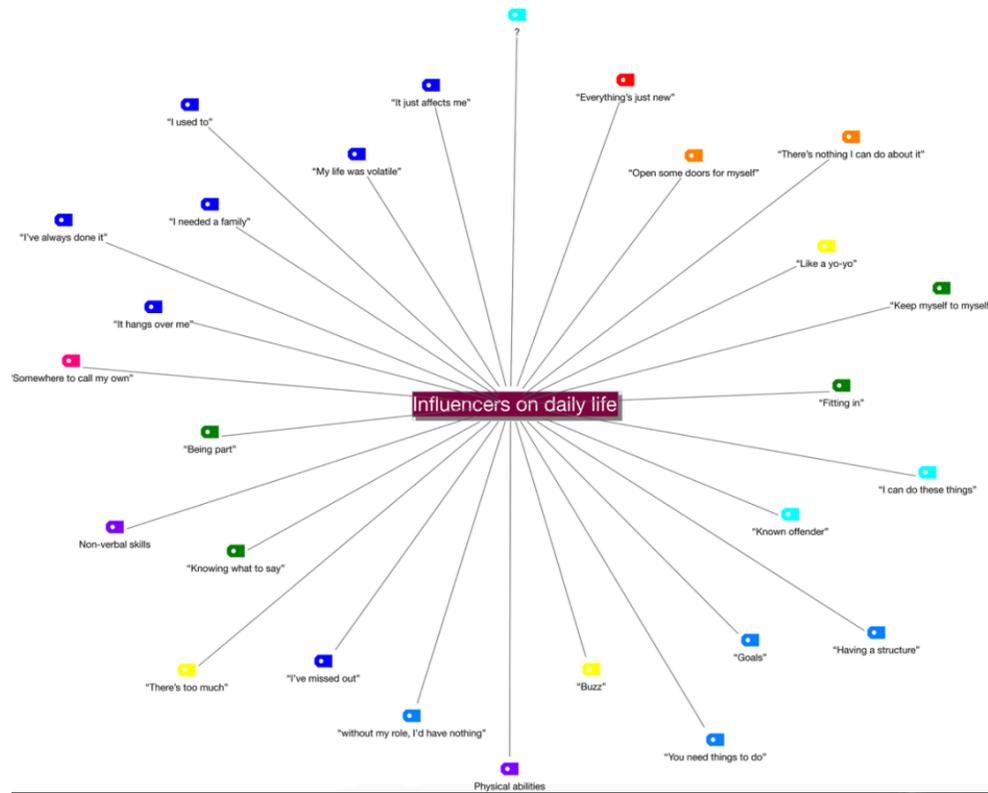
<p>Conversational skills Initiates and sustains contextually appropriate conversation; manages disclosure; communicates needs and wants; adequate language ability, vocabulary and grammar to express self; clear meaning; able to take turns in interactions</p>	<p>Performance capacity (communiation and interaction skills)</p>	<p>MOHOST Conversation skills</p>
<p>Non-verbal skills Able to utilise eye-contact, gestures, facial expression in communication; able to respond to others non-verbally</p>	<p>Performance capacity (communiation and interaction skills)</p>	<p>MOHOST Non-verbal skills</p>
<p>Problem solving Able to generate workable solutions, make judgements and take decisions in response to challenges (that support positive outcome); Can distance self to be objective, can use abstract thinking; Able to learn from mistakes and benefit from instructions</p>	<p>Performance capacity (process skills)</p>	<p>MOHOST Problem-solving – <i>does not specify if it is within activities or roles, the latter causing most difficulty for PDOs</i></p>

<p>Knowledge Knows what is expected of adults in society; can draw on role models</p>	<p><i>Only included in relation to task performance. Suggest expanding performance capacity (process skills), occupational competence</i></p>	<p>MOHOST Includes but focuses on knowledge of an activity rather than of role participation. This is different for PDOs</p>
<p>Managing attentional demands Initiate and complete task using sequencing /prioritising; Concentrates but attends to environment; Able to cope with distractions and variable stimulation; awareness of time</p>	<p>Performance capacity (process skills)</p>	<p>MOHOST Describes this as ‘timing’</p>
<p>Physical capacity Can maintain posture, mobilise, use suitable levels of strength and effort, coordinate oneself</p>	<p>Performance capacity (motor skills)</p>	<p>MOHOST Includes four elements: posture and mobility; coordination; strength and effort; and energy. <i>The latter is excluded among PDOs as better captured in routine</i></p>
<p>Safe home Has a space that is their own, safe from disruptions and within their control</p>	<p>Social environment and physical environment (immediate)</p>	<p>MOHOST Environment has four elements <i>The focus on physical space and resource was less of a concern as the sense of safety that it provided.</i></p> <p>OPHI-II Occupational settings: ‘Home life occupational forms’, ‘Home life social groups’, ‘Home life physical space, objects, and resources’</p>

<p>Social validation Social groups value their contribution</p>	<p>Social environment (global, local and immediate)</p>	<p>MOHOST Social groups</p> <p>OPHI-II Occupational settings: 'Home life social group', 'Major productive role social group', 'Leisure social group'</p>
<p>Criminal record and disclosure requirements External requirement for occupational participation in some settings Able to judge when and how to disclose</p>	<p>Social environment (global, local and immediate) Contributes to occupational identity</p>	<p>MOHOST <i>Does not include wider environmental, could be included in 'occupational demands'</i></p> <p>OPHI-II Occupational settings: 'Major productive role occupational forms', 'Leisure occupational forms'</p>

APPENDIX F - MEMBER CHECKING DOCUMENTS

SIMPLIFIED VISUAL PRESENTATION PROVIDED TO PARTICIPANTS



PARTICIPANT FEEDBACK FORM

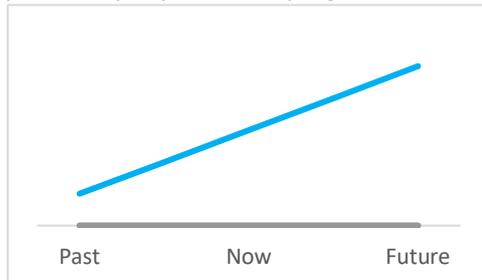
	Comments
<p>“Everything’s just new” Predicting and coping with change in what I need and want to do. Learning new ways to take part in life</p>	
<p>“Open some doors for myself” Getting the balance between taking responsibility for getting involved in life/activities, and being able to meet the expectations</p>	
<p>“There’s nothing I can do about it” Being able to find solutions to challenges that bring a positive outcome.</p>	
<p>“Like a yo-yo” Being able to predict or control changes in mood – so I can still do what I want/need to do</p>	
<p>“Keep myself to myself” Relating to people is hard and it’s easier sometimes to reduce contact with people</p>	
<p>“Fitting in” Being confident that I can act how people expect in social situations</p>	
<p>“I can do these things” Being confident in my abilities - that I can do the tasks I want and need to do.</p>	
<p>“Known offender” Thinking/knowing that the authorities or other people view me negatively – and that’s not fair</p>	
<p>“Having a structure” Being able to keep a balanced routine of activities that meet all my needs and interests</p>	
<p>“Goals” Being able to work towards something and stick to my plans</p>	
<p>“You need things to do” Having a meaningful activity like work or a hobby to bring pleasure, purpose and structure</p>	
<p>“Buzz” Doing things because they give me a good feeling</p>	
<p>“Without my role, I’d have nothing” Having a role in life</p>	

Physical abilities Being physically able to do things	
“I’ve missed out” Having the knowledge of what to do depended on getting experiences when younger	
“There’s too much” Being able to keep track of all the things going on at once, and keep calm when it’s difficult	
“Knowing what to say” Conversation skills	
Non-verbal skills Being able to manage eye-contact, gestures and tone of voice	
“Somewhere to call my own” Having a safe home where I can manage the environment	
“Being part” Having people around me that recognise my contribution	
“It hangs over me” Criminal record gets in the way of me moving on.	
“I’ve always done it” Doing things that I know I’m good at	
“I needed a family” Having a place where I belong and feel successful	
“I used to” Roles I had and activities I did in the past affect how I think and what I do now	
“My life was volatile” Having a routine in the past that included positive habits makes it easier to keep them going	
“It just affects me” What happens in the past still affects me	
?	

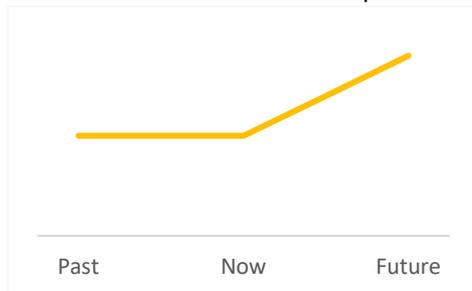
NARRATIVE SLOPE CONFIRMATION

Participants were reminded of the part of the interview where narrative slopes were co-created. The grouped narrative slopes were explained, and participants were asked which reflected their perception of their life trajectory looking at the slopes below (presented on a single page).

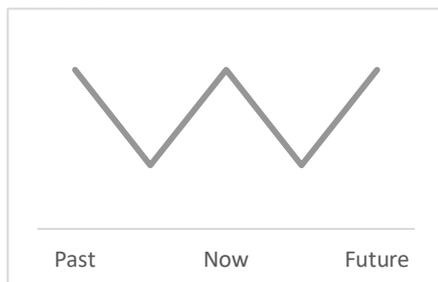
Blue – Things are getting better for me. I am leaving behind bad times from the past and people are helping me move forward. The future is going to be good.



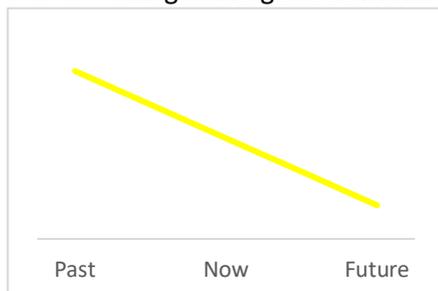
Orange – Things were OK. But people are slowing me down from getting where I want to be. Once I am free of probation, things will be much better.



Grey - Things have been up and down all of my life. I can't imagine things being different



Yellow – Things have gone downhill in my life. I don't think my life will get better



APPENDIX G – FURTHER DATA AND QUESTIONNAIRES FROM CHAPTER
EIGHT

ETHICAL APPROVAL

Excerpt from full letter:

PRIVATE
Miss Catriona Connell
WMS
University of Warwick
Coventry
CV4 7AL

22 December 2017

Dear Miss Connell,

Study Title and BSREC Reference: *What works to improve participation and social outcomes among offenders with personality disorder/difficulties* REGO-2017-2132

Thank you for submitting the above-named project to the University of Warwick Biomedical and Scientific Research Ethics Committee for research ethical review.

I am pleased to advise that research ethical approval is granted.

In undertaking your study, you are required to comply with the University of Warwick's *Research Data Management Policy*, details of which may be found on the Research and

DELPHI QUESTIONS

Round one

Please indicate your professional background

- Offender manager / probation officer / probation service officer / trainee probation officer (1)
Specialist probation officer (2)
Other criminal justice (3) _____
Social worker (4)
Occupational therapist (5)
Psychologist (6)
Psychiatrist (7)
Nurse (8)
Other healthcare (9) _____
Academic (10)
Decline to answer (8)

Please indicate the length of time you have worked with offenders with personality disorder/difficulties in the community

- Less than 1 year (1) / 1-5 years (2) / 5+ years (3) / Academic only (4) Decline to answer (5)

Gender

- Male (1) / Female (2) / Other (3) _____ / Decline to answer (4)

Age

- Under 25 (1) / 25-40 (2) / 40+ (3) / Decline to answer (4)

A number of factors have been identified as potentially influencing participation in prosocial activities among offenders with personality disorder.

(Prosocial activities are activities the person finds meaningful but are also viewed positively by society, like a leisure activity, a job, or family role).

You will see each factor with a definition. Underneath you can rate it for how much you think it influences participation.

Please slide the scale to show how much you think each factor influences participation in prosocial activity (0 = "no influence", 10 = "critical influence")

No influence 0 1 2 3 4 5 6 7 8 9 10 Critical influence

Adaptability - Able to anticipate and cope with change in routine/activities/social settings (expected and unexpected); Able and willing to learn and adjust behaviour



Recognises what is/is not own responsibility; Able/willing to acknowledge, accept and fulfil obligations and tasks; recognises impact on others



The sliding scales continued for each of the factors identified in Work Package Two (reported in Chapter Seven)

You will now see the same factors again with their definition. This time, you will be asked to rate how easy they are to change.

Please slide the scale to show how easy you think each factor is to change (0 = "impossible", 10 = "simple to change")

Impossible 0 1 2 3 4 5 6 7 8 9 10 Simple to change

Adaptability - Able to anticipate and cope with change in routine/activities/social settings (expected and unexpected); Able and willing to learn and adjust behaviour



Responsibility - Recognises what is/is not own responsibility; Able/willing to acknowledge, accept and fulfil obligations and tasks; recognises impact on others



Problem solving - Able to generate workable solutions, make judgements and take decisions in response to challenges (that support positive outcome); Can be objective, use abstract thinking; Learns from mistakes and benefits from instructions



Emotional stability - Able to predict or control responses to rapid and marked mood change



The sliding scales continued for each of the factors identified in Work Package Two (reported in Chapter Seven)

Are there any factors that influence participation in prosocial activities that you think are missing?

If yes, please provide a summary of why you think it's important for improving participation in prosocial activities. Please suggest how easy you think it would be to change.

Reference table provided

Do you have any other comments?

The following questions will ask you about **interventions to improve participation in prosocial activities, for offenders with personality disorder/difficulties.**

You can describe up to three different interventions. Please start with the one you think is most likely to be effective. Please describe what you think is, or would be, **best practice.** It does not have to be what you currently do.

What does 'intervention' mean in this survey?

An intervention is any action you perform with or for someone that aims to change a particular outcome. In this survey, the **interventions of interest are those with the purpose of improving participation in prosocial activities.** These may be single acts (e.g. giving a leaflet, making a phone call on behalf of someone), or a series of actions that together make up an intervention (e.g. a group programme).

Throughout the survey the following **terms** are used:

Client - the person/s who benefits from the intervention

Practitioner - the intervention provider, who may work in a health, criminal justice, third sector or other setting.

Prosocial activities - these are activities and roles people perform that are personally meaningful AND socially valued. For example, a leisure activity, a job or family role.



Please give a name or phrase for the first intervention you think is/is likely to be effective at improving participation in prosocial activities.

e.g. accompanied leisure activities

What is/are the desired outcome/s of the intervention?

Daily life skills (financial management, household chores, meal preparation, shopping)	Social activities
Employment	Civic / community activities (local committees, political involvement)
Education or volunteering	Leisure

(other outcome not visible is other and free text response)

Please describe what this intervention involves, focusing on what **the practitioner does/should do**.

For example: any techniques, strategies, or specific components at different stages. There may be several elements you wish to detail.

Are there any things the practitioner should avoid during the intervention? Please say why.

Which (if any) of the factors does this intervention target?

Table of factors presented to select from

Please describe the timing and duration of the intervention.

This may include some of the following. If this not applicable, please indicate this.

Time of day / day of week
Number of sessions
Time between sessions
Duration of session
Intensity
Overall length
Whether parts are repeated

How does the intervention finish? Does it have an endpoint?

Please describe any theory or rationale for why this intervention is likely to be effective.

i.e. Why do you do this, why does/should it work?

Does the intervention need to be personalised or adapted for individuals or groups of individuals? E.g. age, ethnicity, gender, offence type, literacy, other factors.

Please describe how.

Have there been/could there be any adverse events associated with the intervention?

None (1)

Deterioration in mental wellbeing (2)

Deterioration in physical wellbeing (3)

Reduced participation in positive activity (4)

Harm to self (5)

Offending behaviour (6)

Serious further offence (7)

Other (8) _____

Do you provide another intervention to improve participation in prosocial activities?

Or is there another intervention you think could be effective?

Next (1)

No (2)

Optional blocks (repeats questions on intervention a second and third time if the person answered 'next' in the above question)

Round Two

What works to improve participation among offenders with personality disorder/difficulties in the community?

This is a follow up survey based on your invaluable contribution in round one. It requires you to rate your agreement with a number of statements. Throughout, there are opportunities for you to add comments if you think there is anything missing or important to add.

The survey is structured as follows:

1. A presentation of which factors people considered the most **influential** on participation in prosocial activities and which factors people thought were most **changeable** in intervention.

2. You will be asked to rate statements in the following sections:

- Overarching intervention principles
- Therapeutic relationship
- Assessment
- Formulation
- Education and goal setting
- Increasing participation in prosocial activity
- Ending sessions
- Practitioner behaviour

The estimated time to complete is about 15 minutes

Completion of all the rounds will result in a CPD certificate and you are welcome to contact me at any time with questions or for further information on c.connell.1@warwick.ac.uk

Factors influencing participation from most to least influential	The factors that are easiest to change from most to least modifiable
Ability to relate to people	Prosocial goals
Self-efficacy in social settings	Physical capacity
Criminal record and disclosure requirement	Prosocial interest
Sustaining a routine	Perceptions of social judgements
Perception of social judgements	Problem solving
Prosocial goals	Adaptability
Self-efficacy in activities	Choice of activity for emotional/sensory feedback
Problem solving ability	Criminal record and disclosure requirement
Physical capacity	Knowledge
Past routine	Self-efficacy in activity
Adaptability	Responsibility
Past experience of roles	Non-verbal skills
Choice of activity for emotional/sensory feedback	Self-efficacy in social settings
Past experience of mastery / achievement	Maintaining attention
Maintaining attention	Prosocial roles
Responsibilities	Conversational skills
Prosocial interest	Social validation
Conversational skills	Ability to relate to people
Non-verbal skills	Past experience of mastery / achievement
Social validation	Past experience of roles
Intruding past	Sustaining a routine
Past experience of belonging	Past experience of belonging
Knowledge	Intruding past
Prosocial roles	Past experience of routine

Do you have any comments about the order of the most influential and changeable factors?

These statements all refer to overarching principles of the intervention. Please rate your level of agreement with each statement from strongly disagree to strongly agree.

	Strongly disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Strongly agree
Intervention to increase participation in prosocial activity should be considered when a person has safe accommodation and financial stability	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Intervention should not be delivered in isolation from support from additional services, supportive people or peer support services	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Where a client is engaged with other support services, practitioners should liaise as closely as possible to encourage those services to do things with the client, teaching them sustainable skills, rather than doing things for the client	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

The rating continued for all 121 statements grouped into the preliminary intervention components. At the end of each group of statements, participants were given the space to make a free text response to the question.

Do you have any comments about the [grouped statements]?

Round three

What works to improve participation among offenders with personality disorder/difficulties in the community?

This is the final follow up survey, based on your responses in round two. It will take 5-10 minutes to complete.

After completing this round, you will receive a certificate.

The survey covers:

1. The factors people thought the most **influential** on participation in prosocial activities, and which factors people thought were most **changeable**.
2. You will see the responses of the other participants on statements from the last round and you are asked to rate a much smaller number of statements where people did not agree before.

You are welcome get in touch at any time with questions or for further information on c.connell.1@warwick.ac.uk

Remember you can also check your participant information sheet if there is anything you're not sure about.



Below you can see the factors considered most influential, next to the ones thought to be most changeable. In reality, the difference between each was very small and all were thought to be influential.

Your feedback has informed the wider descriptions of these factors and a change in the order.

Two additional factors were highlighted – you will be asked to rate these.

Factors that influence participation from most to least influential	Factors that can be changed from easiest to hardest to change
Emotional stability	Sustains a routine
Relating to people	Role
Safe home	Goals
Perceptions of social judgements	Self-efficacy in activity
Self-efficacy in activity	Problem-solving
Past intrudes	Adaptability
Sustains routine	Prosocial interests
Self-efficacy in social settings	Safe home
Problem-solving	Physical capacity
Role	Self-efficacy in social settings
Past experience of belonging	Responsibility
Adaptability	Conversational skills
Past experience of mastery	Relating to people
Prosocial interests	Knowledge
Social validation	Emotional/sensory feedback
Knowledge	Manages attentional demands
Responsibility	Non-verbal skills
Goals	Emotional stability
Manages attentional demands	Social validation
Past experience of routine	Past experience of mastery
Conversational skills	Perceptions of social judgements
Non-verbal skills	Past intrudes
Past experience of roles	Criminal record & disclosure
Criminal record & disclosure	Past experience of routine
Physical capacity	Past experience of roles
Emotional/sensory feedback	Past experience of belonging

Please rate these factors according to how influential you think they are on a client's ability to participate in prosocial activities.

No influence
0 1 2 3 4 5 6 7 8 9 10
Critical influence

Finances - stability of sufficient income



Environmental resources – appropriate and accessible local physical and social environment (e.g. transport links, community opportunities)



Now please rate these same factors according to how easy they are to change

Impossible to change Simple to change
0 1 2 3 4 5 6 7 8 9 10

Finances - stability of sufficient income



Environmental resources – appropriate and accessible local physical and social environment (e.g. transport links, community opportunities)

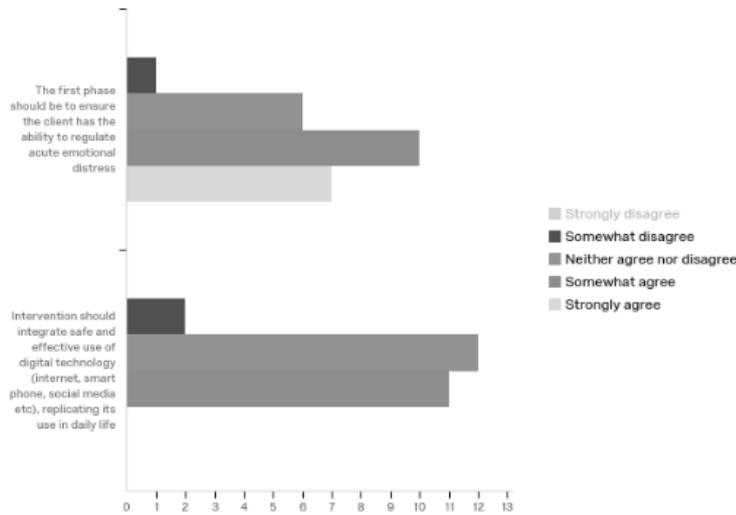


Do you have any comments about the revised order of the most influential and changeable factors? Or the new factors added?

For each of the preliminary intervention components, previous consensus was presented as stacked bar charts and participants asked to re-rate statements that had not reached consensus. Below is an example from the 'overarching intervention principles' component

Two out of twenty-three statements about the over-arching intervention principles did not reach agreement.

You can see how other participants responded before you consider the statements again. Wording has been amended in response to your feedback.



Please rate your level of agreement with the revised statements about over-arching intervention principles.

	Strongly disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Strongly agree
The first phase should be to ensure the client has the ability to regulate acute emotional distress	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Intervention should integrate safe and effective use of digital technology (internet, smart phone, social media etc), replicating its use in daily life and consistent with licence conditions	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Do you have any comments about the overarching intervention principles?

At the end of each round, participants were thanked and reminded how to get in touch.

You reached the end!!

Thank you for giving your time to complete this survey and support research to identify what works to increase participation in prosocial activity among people with offending histories and personality difficulties/disorder.

We really appreciate your input.

If you have any questions, feel free to get in contact on c.connell.1@warwick.ac.uk

We will be sending a CPD certificate to you on the email address you provided.



FINAL LIST OF STATEMENTS, AGREEMENT LEVEL AND ROUND CONSENSUS ACHIEVED

Statement	Consensus level (%)	Round agreed
Intervention principles		
Intervention to increase participation in prosocial activity should be considered when a person has safe accommodation and financial stability	91.7	2
Intervention should not be delivered in isolation from support from additional services, supportive people or peer support services	87.5	2
Where a client is engaged with other support services, practitioners should liaise as closely as possible to encourage those services to do things with the client, teaching them sustainable skills, rather than doing things for the client	100	2
Practitioners should advocate for social and cultural attitudinal change where it acts as a barrier to a client's participation in prosocial activity	95.8	2
Practitioners should have a base in which they are part of a team	95.8	2
Practitioners must have support and supervision from a suitably experienced and qualified professional	100.0	2
Practitioner and client should agree a 'contract' which is regularly revisited and includes expectations and responsibilities of each party, including a crisis plan	91.7	2
Practitioners must be mindful that intervention to change a person's patterns of participating has potential to contribute to reduced participation in prosocial activity, deterioration in mental or physical health, or increased risk of behaviour that is harmful to self or others	75.0	2
Intervention should have agreed goals	95.8	2
Intervention should have a pre-defined review points and end-point	91.7	2
Intervention sessions should have an agreed aim and pre-defined start and finish time	87.5	2
Intervention to increase participation in prosocial activity may be delivered at different levels of intensity for clients with varied levels of need	100.0	2

An intervention to increase participation in prosocial activity must be underpinned by a therapeutic relationship with a consistent practitioner/s throughout	95.7	2
Practitioners should encourage clients to share responsibility for the intervention and the wider support they receive	100.0	2
Awareness of and attention to the ending of the intervention should be held in mind and discussed throughout the intervention	100.0	2
An intervention to increase participation in prosocial activity should consist of phases that build on one another and can be revisited	95.7	2
The first phase should be to ensure the client has the ability to regulate acute emotional distress	81.0	3
An intervention doesn't have to depend on a person having ability to fully regulate their emotions	83.3	2
An intervention should have a phase focused on assessment of a client's strengths and difficulties in participating in prosocial activity over time	87.5	2
An intervention should have a phase of collaborative formulation of a client's strengths and difficulties in participating in prosocial activity over time	95.8	2
An intervention should have a phase of actively undertaking prosocial activity with a practitioner to target the needs identified in assessment and formulation	91.7	2
Intervention should integrate safe and effective use of digital technology (internet, smart phone, social media etc), replicating its use in daily life <i>Amended to: Intervention should integrate safe and effective use of digital technology (internet, smart phone, social media etc), replicating its use in daily life and consistent with licence conditions</i>	57.1	
At each stage of the intervention the practitioner should explicitly consider the implications and potential need for adaptation due to age, gender identity, ethnicity or cultural background, sexuality, educational level and literacy, cognitive ability, co-morbid conditions, sensory preferences, offence type, triggers for distress and/or traumatic memories and/or aggression, and any other individual characteristics that may influence engagement with the intervention	100.0	2
Therapeutic relationship		
Initial sessions should attend to the development of the therapeutic relationship	100.0	2
Initial sessions to develop a therapeutic relationship should be delivered at least weekly	83.3	2

Initial sessions to develop a therapeutic relationship should last approximately one hour <i>Amended to: Initial sessions to develop a therapeutic relationship should last approximately one hour, depending on the client's ability to stay with the sessions</i>	52.4	
Practitioners should consider undertaking an activity in the initial sessions to develop a therapeutic relationship <i>Amended to: Practitioners should consider undertaking an activity, appropriate to setting, in the initial sessions to develop a therapeutic relationship</i>	61.9	
Initial sessions to develop a therapeutic relationship should be structured around developing the intervention 'contract' and initial education about the intervention	81.0	3
Genuine, empathic, non-judgemental attention to the client's narrative is an effective way to build a therapeutic relationship that supports participation in prosocial activity	100.0	2
Being explicit about the responsibility to hold in mind both client risk and vulnerability for immediate and community safety is an effective way to develop a therapeutic relationship	95.8	2
Difference in practitioner and client characteristics should not preclude development of a therapeutic relationship	87.5	2
Aiming to understand the client as a whole person, not a collection of risk factors or symptoms, is an effective way to build a therapeutic relationship	100.0	2
Attending to the client's emotional experience is an effective way to build a therapeutic relationship	100.0	2
Limiting disclosure about practitioner experiences is an effective way to build a therapeutic relationship	14.3	
Mandating what a client needs or privileging the practitioner's opinion over the client's is not an effective way to build a therapeutic relationship	95.8	2
Being organised, consistent, reliable, patient and understanding is an effective way to build a therapeutic relationship	100.0	2
Being flexible, within limits, relating to unreliable attendance or challenging interactions is an effective way to build a therapeutic	91.7	2
Collaboration with 'experts by experience' in development and delivery of an intervention is an effective way to increase a therapeutic relationship	91.7	2
Validating past experiences of success and difficulty throughout the intervention is an effective way to build a therapeutic relationship	100.0	2

Allowing the client time to process discussions about the past during and between sessions is an effective way to build a therapeutic relationship	95.8	2
Ensuring the client is aware they can express themselves in a safe space but with clear boundaries is an effective way to build a therapeutic relationship	100.0	2
Reminding the client that things will be OK even if they are 'unsuccessful' is an effective way to build a therapeutic relationship <i>Amended to: Reminding the client that you will still work with them, even if they are 'unsuccessful' is an effective way to build a therapeutic relationship</i>	85.7	3
Maintaining clear boundaries relating to where and with whom certain behaviours (particularly offending) can be discussed, is an effective way to build a therapeutic relationship	87.5	2
Making power dynamics explicit and discussing these with the client are an effective way to build a therapeutic relationship <i>Amended to: Practitioners should consider power dynamics. Discussing these with the client at an appropriate stage is an effective way to build a therapeutic relationship</i>	95.2	3
Maintaining accurate records, and sharing these as openly as possible with the client is an effective way to build a therapeutic relationship	82.6	2
Assessment		
A semi-structured narrative assessment of participation in activity over time is an effective way to develop an initial understanding of a client's participation in activity	83.3	2
Through narrative assessment, identification of past mastery experiences is an effective way to increase participation in prosocial activity	83.3	2
Through narrative assessment, identification of past experiences of success and enjoyment is an effective way to increase participation in prosocial activity	83.3	2
Through narrative assessment, identification of past experiences of belonging to a community is an effective way to increase participation in prosocial activity	75.0	2
Through narrative assessment, identification of past role performance is an effective way to increase participation in prosocial activity	79.2	2
Through narrative assessment, identification of past routines and habits is an effective way to increase participation in prosocial activity	95.2	3
Assessment should include consideration of the client's means to attend sessions, e.g. due to transportation	87.5	2

Assessment should include the client's environment, including risks and opportunities for participation in their local area	91.7	2
Assessment should identify if the client has access to a supportive person unconnected to the service (e.g. friend, partner, mentor)	95.8	2
Assessment sessions may include undertaking a 'real world' activity with the practitioner on an individual basis where questions may feel more natural to the client	79.2	2
Self-assessment of ability, current participation levels, satisfaction with this and priorities for change is an effective way to increase participation in prosocial activity	75.0	2
Self-assessment with a structured checklist of different activities is an effective way to increase participation in prosocial activity <i>Amended to: Supported self-assessment with a structured checklist of different activities is an effective way to increase participation in prosocial activity</i>	47.6	
Self-assessment of the nature and function of time use is an effective way to increase participation in prosocial activity <i>Amended to: Supported self-assessment of the nature and function of time use is an effective way to increase participation in prosocial activity</i>	81.0	3
Assessment sessions should occur weekly	61.9	
Assessment sessions should last approximately one hour <i>Amended to: Assessment sessions should last approximately one hour depending on the client's ability to stay with the session</i>	61.9	
Assessment sessions should be time limited up to a maximum of six sessions <i>Amended to: Assessment sessions should be reviewed after six sessions and extended until a sufficient understanding of participation is developed</i>	52.4	
Assessment sessions should be delivered on an individual basis	61.9	
Additional needs should be identified and the appropriate support engaged collaboratively with the client, e.g. peer support, mentorship or a support worker to aid with attending appointments	91.7	2
<i>New statement: Practitioners should collaborate with the client to integrate assessment findings from narrative, self-assessment, individual and group observations, with other documented or team information.</i>	81.0	3

Formulation		
Supporting the client to understand how their past participation influences current participation is an effective way to increase participation in prosocial activity	83.3	2
Including narrative approaches to assessment and formulation is an effective way to increase a client's sense of identity	91.7	2
Including narrative approaches to assessment and formulation is an effective way to increase a client's sense of agency	87.5	2
Including narrative approaches to assessment and formulation is an effective way to increase self-efficacy in activity	87.5	2
Including narrative approaches to assessment and formulation is an effective way to increase self-efficacy in social settings	83.3	2
Formulation should follow standards adapted to focus on participation in prosocial activity	79.2	2
Formulation should attend to the influences of past and current emotion and behaviour on current participation and future-focus	95.8	2
Formulation sessions should occur weekly	42.9	
Formulation sessions should last approximately one hour <i>Amended to: Formulation sessions should last approximately one hour depending on a client's ability to stay with the sessions</i>	76.2	3
Formulation sessions should be time limited up to a maximum of six sessions <i>Amended to: Formulation sessions should be reviewed after 6 sessions. Sessions may be extended until an adequate understanding of participation is shared between client and practitioner.</i>	61.9	
Formulation sessions should be delivered on an individual basis	71.4	
Formulation should be regularly re-visited and adapted as the intervention continues	91.7	2
Education and goal setting		
Education about distress, anxiety and depression is an effective way to increase participation in prosocial activities	91.7	2
Education about the nature of participation in activity and its different functions is an effective way to increase participation in prosocial activity	91.7	2

Education about how the client's experiences relate to the nature of participation based on their assessment and formulation is an effective way to increase participation in prosocial activity	95.8	2
Collaborative goal setting based on the outcome of assessment and formulation, in the context of understanding participation, is an effective way to increase participation in prosocial activity	87.5	2
Asking the client how they could address their ability to meet their needs, current participation levels, satisfaction with this and priorities for change is an effective way to engage a client in goal setting	87.5	2
Asking the client what steps they can take to engage/re-engage with participation in an activity is an effective way to engage a client in goal setting	95.8	2
Increasing participation		
Developing skills required for community living is an effective way to increase participation in prosocial activity	91.7	2
Developing a new (prosocial) identity through participation is an effective way to increase participation in prosocial activity	95.8	2
Prompting, encouraging and supporting the client to participate in 'real world' activity independently is an effective way to increase participation in prosocial activity	95.8	2
Prompting, encouraging and supporting the client to participate in 'real world' activity with another person (e.g. mentor, volunteer, family member, friend, spouse) is an effective way to increase participation in prosocial activity	91.7	2
Supporting the client to manage their time to participate in a balance of 'real world' activity is an effective way to increase participation in prosocial activity	95.8	2
Teaching new or compensatory strategies for areas of skill deficit, identified as most relevant in assessment and formulation, is an effective way to increase participation in prosocial activity	83.3	2
Applying skills acquired with a practitioner independently between sessions is an effective way to increase participation in prosocial activity	95.8	2
Teaching clients to challenge their assumptions and maintain curiosity about the thoughts and behaviours of themselves and others is an effective way to increase participation in prosocial activity	95.8	2
Role modelling and encouraging a continued focus on a goal is an effective way to increase participation in prosocial activity	95.8	2

Positively reinforcing prosocial activity participation and use of new skills is an effective way to increase participation in prosocial activity	100.0	2
Understanding and applying sensory strategies in 'real world' activities is an effective way to increase participation in prosocial activity	81.0	3
Undertaking a 'real world' activity in collaboration with a practitioner is an effective way to increase participation in prosocial activity	95.8	2
Sessions involving undertaking a 'real world' activity should be collaboratively planned as far as possible, to ensure the client is aware of the aims, content and skills they are developing	91.7	2
Raising the client's awareness of their skills and areas to develop during 'real world' activity is an effective way to increase participation in prosocial activity	87.5	2
Encouraging the client to listen, focus and follow instruction is an effective way to increase participation in prosocial activity	82.6	2
Reflecting on undertaking a 'real world' activity in collaboration with a practitioner is an effective way to increase participation in prosocial activity	95.8	2
Providing clear feedback that may challenge a client's perceptions of their past and present ability is an effective way to increase participation in prosocial activity	91.7	2
Challenging a client's assumption about themselves, others and the world with evidence from shared 'real world' experiences is an effective way to increase participation in prosocial activity	87.5	2
Minimising unnecessary rules when undertaking 'real world' activity sessions is an effective way to increase participation in prosocial activity	75.0	2
Undertaking a 'real world' activity in collaboration with a practitioner can be delivered on an individual basis	77.3	2
Undertaking a 'real world' activity in collaboration with a practitioner can be delivered on a group basis	79.2	2
In group 'real world' activities, teaching why and how to tolerate others is an effective way to increase participation in prosocial activity	100.0	2
In group 'real world' activities, supporting clients to maintain their independence (not depend upon or be influenced by others) is an effective way to increase participation in prosocial activity	91.7	2
Sessions involving undertaking a 'real world' activity in collaboration with a practitioner should conclude with acknowledgement of an achievement within the session	87.5	2
Sessions involving undertaking a 'real world' activity in collaboration with a practitioner should conclude with the accomplishment of a task	71.4	

Sessions involving undertaking a 'real world' activity in collaboration with a practitioner should conclude at a logical point for continuation at the next session	81.0	3
Sessions involving undertaking a 'real world' activity in collaboration with a practitioner should conclude with a plan to apply any new learning between sessions	79.2	2
Sessions involving undertaking a 'real world' activity in collaboration with a practitioner should be approximately 2-3 hours long, depending on the activity	9.5	
Undertaking a 'real world' activity in collaboration with a practitioner should be delivered weekly	47.6	
Undertaking a 'real world' activity in collaboration with a practitioner should be delivered for a maximum of 6 sessions <i>Amended to: Sessions undertaking a 'real world' activity in collaboration with a practitioner should be reviewed every 6 sessions to determine if there is continued need, based on assessment formulation, intervention goals and intervention contract</i>	66.7	
Undertaking a 'real world' activity in collaboration with a practitioner should be delivered for approximately 8-10 sessions <i>Amended to: Sessions undertaking a 'real world' activity in collaboration with a practitioner should be reviewed every 8-10 sessions to determine if there is continued need, based on assessment formulation, intervention goals and intervention contract.</i>	52.4	
Sessions involving undertaking a 'real world' activity in collaboration with a practitioner should be supplemented by between session telephone contact	30.0	
Sessions involving undertaking a 'real world' activity can be followed by a period of consolidation in the 'consulting room'	75.0	2
Sessions in the consulting room promoting and consolidating a change in participation, or teaching new skills for participation, should be delivered individually <i>ERROR – not included in R3</i>	41.7 (R2 only)	-
Sessions in the consulting room promoting and consolidating a change in participation, or teaching new skills for participation, should be delivered as a group <i>ERROR – not included in R3. NB in R2 more people actively disagreed.</i>	12.5 (R2 only)	-
Sessions in the consulting room promoting and consolidating a change in participation, or teaching new skills for participation, should run weekly	57.1	

Sessions in the consulting room promoting and consolidating a change in participation, or teaching new skills for participation, should for 60-90 minutes	28.6	
Sessions in the consulting room promoting and consolidating a change in participation, or teaching new skills for participation, should be delivered for approximately 6-12 weeks <i>Amended to: Sessions in the consulting room promoting and consolidating a change in participation, or teaching new skills for participation, should be reviewed every reviewed every 8-10 sessions to determine if there is continued need, based on assessment formulation, intervention goals and intervention contract.</i>	57.1	
Sessions in the consulting room promoting and consolidating a change in participation, or teaching new skills for participation, should be delivered for approximately 6 months <i>REMOVED (incorporated into above)</i>	-	-
Sessions in the consulting room promoting and consolidating a change in participation, or teaching new skills for participation, should be delivered for approximately 12 months <i>REMOVED (incorporated into above)</i>	-	-
Group sessions in the consulting room promoting and consolidating a change in participation, or teaching new skills for participation, should be supplemented by individual sessions	78.3	2
Sessions in the consulting room focused on teaching a specific skill or strategy (e.g. budgeting) should focus on a specific skill for a maximum of two weeks before moving on <i>Amended to: Sessions in the consulting room focused on teaching a specific skill or strategy (e.g. budgeting) should focus on a specific skill for approximately two weeks before moving on</i>	14.3	
Sessions in the consulting room focused on teaching a specific skill or strategy should conclude with a logical continuation planned for the next session	71.4	
Sessions in the consulting room focused on teaching a specific skill or strategy should conclude with a goal to apply new learning in the 'real world'	75.0	2
Each session should conclude with an acknowledgement of an achievement in the time between the last session	83.3	2

Any session delivered as a group must consider the individual clients characteristics, personality traits and offence type, and how these may interact in a group setting	91.7	2
Endings		
Ending sessions should focus on change in participation during the intervention as an effective way to sustain change in participation in prosocial activity	95.8	2
Ending sessions should revisit the client's original self-assessments	100.0	2
Ending sessions should focus on revising the client's formulation as an effective way to sustain change in participation in prosocial activity	91.7	2
Validation of the client's efforts throughout the intervention is an effective way to sustain change in participation in prosocial activity	100.0	2
Client's should be encouraged to take their formulation with them in continued work with other services as an effective way to sustain change in prosocial activity	87.5	2
Ending sessions should last one hour <i>Amended to: Ending sessions should last approximately one hour, depending on the client's ability to stay with the session</i>	71.4	
Ending sessions should be delivered weekly	28.6	
Ending sessions should run for a maximum of three weeks <i>Amended to: The number of ending sessions should run for the time estimated to cover the material needed and be attentive to the client's needs</i>	71.4	
<i>ADDED: By estimating the overall length of the intervention, practitioners and clients can consider the ending throughout the intervention</i>	90.5	3
Practitioner behaviours		
Encouraging future-focus to an improved quality of life is an effective way to increase participation in prosocial activity	83.3	2
Providing encouragement and reassurance is an effective way to increase participation in prosocial activity	100.0	2
Reminding a client that the process is as important as successfully achieving a goal is an effective way to increase participation in prosocial activity	95.8	2
Practitioners should role model the skills involved in participation in prosocial activity	95.8	2

Practitioners should maintain an awareness of unhelpful patterns of relating to people being enacted between themselves and the client	100.0	2
Practitioners should strive for cultural competence and be aware of different privileges afforded to them and the client by society	100.0	2
Practitioners must remain responsive to a client's presentation on the day whilst maintaining the logic and structure of the intervention	100.0	2
Practitioners should consider the client's potential responses to perceived successes and failures in different components of the intervention	95.8	2
Adopting a pace of engagement and change tolerable to the client is an effective way to build trust in the practitioner	100.0	2
Practitioners should attempt to avoid collusion with reports or memories that may be idealised/unrealistic	91.7	2
Intervention using particular approaches should only be delivered by practitioners with the professional competence to do so	95.8	2
Practitioners should aim to develop a high support- high challenge relationship	80.1	3
Practitioners should actively attend to their own biases throughout the intervention	100.0	2
Practitioners should ensure any support service working with a client can work effectively and maintain boundaries	95.8	2
Practitioners must uphold professional standards of their respective professional body at all times	100.0	2

STATEMENTS REACHING CONSENSUS WHEN ANALYSED BY PROFESSIONAL BACKGROUND

Statement	Agreement among health professionals (%)	Agreement among criminal justice professionals (%)
Initial sessions to develop a therapeutic relationship should last approximately one hour, and be responsive to the client's ability to stay with the sessions	38.46	75
Formulation sessions should be delivered on an individual basis	76.92	62.5
Sessions involving undertaking a 'real world' activity in collaboration with a practitioner should conclude with the accomplishment of a task	76.92	62.5
Sessions undertaking a 'real world' activity in collaboration with a practitioner should be reviewed every 6 sessions to determine if there is continued need, based on assessment formulation, intervention goals and intervention contract.	76.92	50
Sessions in the consulting room focused on teaching a specific skill or strategy should conclude with a logical continuation planned for the next session	76.92	62.5
Ending sessions should last approximately one hour, depending on the client's ability to stay with the session	76.92	62.5
The number of ending sessions should run for the time estimated to cover the material needed and be attentive to the client's needs	69.23	75

APPENDIX H – MANUALISATION AND BASIC LOGIC MODELLING

OVERVIEW OF MANUAL CONTENT

Section and content (TIDieR Checklist number)	Issues to be addressed	Summary
Introduction (1) A. Orientation to the manual	Name of intervention Aims of the manual How manual is set out	Name of the intervention Overview of aim of manual Summary of the sections
I. Overview, description, and rationale (2) A. General description of the approach B. Background and rationale for the treatment C. Theoretical mechanism of action	Overview of treatment and goals Theoretical rationale Empirical underpinnings of treatment Rationale for application of this treatment to this population Brief summary of hypothesized mechanisms of action, and critical “active ingredients”	Description of occupational participation Background information about relationships to reduced risk, improved wellbeing/health. Relevance to PDOs Summary of Model of Human Occupation (MOHO) with focus on occupational adaptation. Signpost to Section V

<p>II. Conception of the disorder or problem (2)</p> <p>A. Etiological factors</p> <p>B. Factors believed to be associated with change</p> <p>C. Agent of change</p> <p>D. Case formulation</p> <p>How are the disorder/symptoms assessed by the therapist?</p>	<p>Summary of concepts and factors that lead to development of the problem</p> <p>According to treatment/theory, the factors or processes associated with change or improvement</p> <p>Hypothesized agent of change – Who, or what, is responsible for change?</p> <p>Conceptual framework around which cases are formulated and understood?</p> <p>Therapist strategy for assessing disorder/problem</p> <p>Specify any standardised assessment</p>	<p>Occupational participation and how problems may develop</p> <p>Summary of the factors that influence occupational participation and their development over time.</p> <p>Description of the factors that influence occupational participation for PDOs from research.</p> <p>Explanation of occupational adaptation as change mechanism, and change barriers and facilitators</p> <p>MOHO as formulation framework with example</p> <p>Multi-modal assessment explained</p>
<p>III. Treatment goals (2, 4, 9)</p> <p>A. Specification determination of treatment goals</p> <p>B. Evaluation of patient goals</p> <p>C. Identification of other target behaviours and goals</p> <p>D. Negotiation of change in goals</p>	<p>Specification of principal treatment goals. Determination of primary versus secondary goals</p> <p>How to prioritise goals, goal-setting with person</p> <p>Strategies therapist uses to identify/evaluate goals</p> <p>Clarification of other problem areas that can be targeted as secondary goals of the treatment versus those that must be handled outside of the treatment</p> <p>Strategies for renegotiating goals as treatment progresses</p>	<p>Description of intervention goals (participation, health/wellbeing, risk reduction)</p> <p>Example of potential participant goals. Example of primary/secondary goals and how to address</p> <p>Goals that should be directed to other places</p> <p>Reference to intervention component: ‘collaborative goal setting’</p> <p>When and how goals are reviewed. Reference to intervention components:</p> <p>‘contracting intervention and behaviour’ and ‘ending’</p>

<p>IV. Contrast to other approaches (2,5)</p> <p>A. Similar approaches B. Dissimilar approaches</p>	<p>What are the available treatments for the disorder or problem that are most similar to this treatment? How do these differ from this treatment? What treatments for the disorder or problem are most dissimilar to this approach?</p>	<p>No other treatments focussed on occupational participation. Comparison with those identified in WP1 that looked at social function. Comparison with Good Lives Model, interventions available on probation: indicating difference in goals and modality. Comparison with interventions available in community mental health: indicating difference in goals and modality. Reference to specific skills needed to provide this intervention.</p>
<p>V. Specification of defining interventions (2,4,6,9)</p> <p>A. Unique and essential elements B. Essential but not unique elements C. Recommended elements D. Proscribed elements</p>	<p>Of active ingredients, which are unique and essential? Which are essential but unique? Which are recommended but not essential or unique? What ingredients or processes are prohibited or not characteristic of this treatment? What may be harmful or countertherapeutic in the context of this treatment?</p>	<p>Details of each component in order but with visualisation to indicate not strict linearity including supporting documentation Summary of the unique elements and their relationship with generic elements. Examples of areas for caution.</p>
<p>VI. Session content (3,4,6,7,8,9,11)</p>	<p>Where appropriate, detailed, session-by-session content with examples and vignettes</p>	<p>Session content tailored to the persons progress and abilities. Phases presented with what they aim to achieve and the strategies to get there. Reminder to document content/fidelity/modification</p>

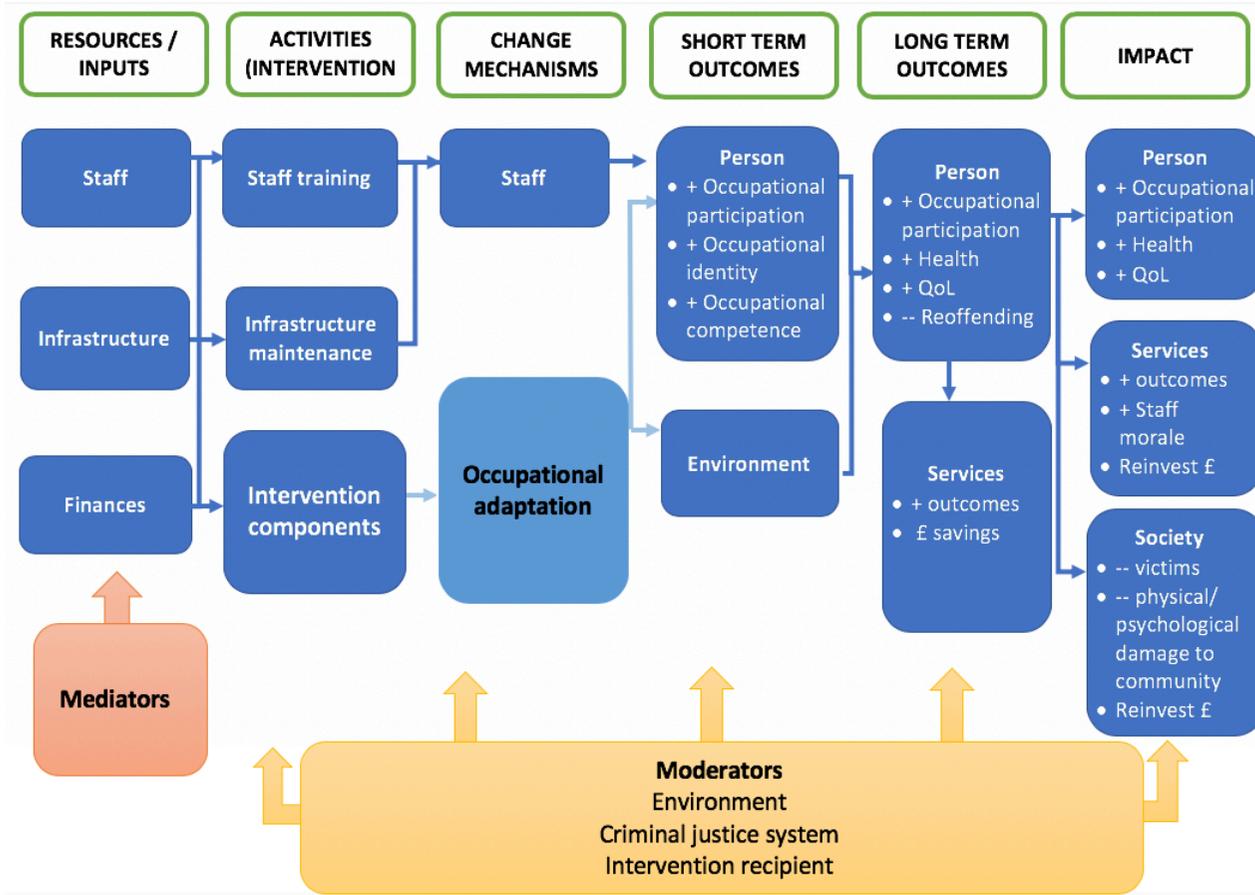
<p>VII. General format (2,3,4,5,6,7,8,9)</p> <p>A. Format for delivery</p> <p>B. Frequency and intensity of sessions</p> <p>C. Flexibility in content</p> <p>D. Session format</p> <p>E. Level of structure</p> <p>F. Extra-session tasks</p> <p>G. Therapist behaviour and overarching principles</p>	<p>Mode: individual, group, family, mixed? If group, closed- or open-ended format?</p> <p>Frequency, length of sessions, duration.</p> <p>Essential versus “elective” content.</p> <p>Flexibility in sequencing sessions/content.</p> <p>Who sets the agenda for each session? How structured are sessions and what determines this? Who talks more?</p> <p>Is there extra-session (e.g. homework)? What is its purpose? How are tasks selected? How does the present a rationale for the tasks? How does the therapist assess patient implementation of tasks? How is it integrated into the intervention? Response to completion/ non-completion of assignments.</p>	<p>Summary of formatting (also referred to in Section VI)</p> <p>Suggested session length and frequency with emphasis on indicators for moving to next phase rather than time.</p> <p>Estimation of whole intervention length.</p> <p>Explanation of how session content is decided and structured with tailoring to degree of responsibility and ownership divided between parties.</p> <p>Revision of rationale and conduct of homework component, and response to completion/non-completion.</p> <p>Guidance for therapist behaviours and response to challenges throughout.</p> <p>Overarching principles.</p>
<p>VIII. Research considerations (3,4,8,10,11,12)</p> <p>A. Strategies for research appropriate documentation</p> <p>B. Framework for establishing deviations from manual</p> <p>C. When and how to contact research team</p>	<p>How to document sessions that occur, are cancelled.</p> <p>How to document individual tailoring consistent/ inconsistent with manual parameters</p> <p>Description of adverse events.</p> <p>When and how to notify research team.</p> <p>Maintaining blinding and confidentiality.</p> <p>Submitting final documents.</p>	<p>Templates for documents</p> <p>Explanation for why this is important.</p> <p>Explanation and indicative list of adverse events.</p> <p>When and how to contact the research team.</p> <p>When and how to send data to the research team.</p>
<p>APPENDICES (3)</p>	<p>Supporting documentation for intervention delivery and supervision</p>	<p>Documents including assessment guide, formulation checklist</p>

BASIC LOGIC MODELLING

Assumptions	Resources/ inputs and barriers	Intervention activities	Outputs	Outcomes (Short term)	Outcomes (longer term)	Impact
<i>Theoretical assumptions informing the intervention</i>	<i>Human, financial, organisational, and community resources available to direct toward intervention</i>	<i>What is done with the resources. Activities are the intentional parts of the intervention used to bring about changes and outcomes</i>	<i>Direct products of program activities</i>	<i>Changes in participants' behaviour, knowledge, skills, status and level of functioning - attainable in 1 to 3 years</i>	<i>Changes in participants' behaviour, knowledge, skills, status and level of functioning - attainable in 4 to 6 years</i>	<i>Fundamental intended or unintended change occurring in organizations, communities or systems in 7 to 10 years</i>

<p>Occupational participation is: A complex social phenomenon Integral to good health Integral to desistance</p> <p>Occupational adaptation Occupational adaptation is the process of change in occupational participation Occupational adaptation, occupational identity and occupational competence reciprocally influence one another over time Occupational adaptation towards prosocial participation may be impaired in PDOs because: i) past experiences impact occupational competence and occupational identity ii) emotional drivers influence occupational participation</p>	<p>Staff: Occupational therapists and/or other practitioners Existing staff group</p> <p>Funding: Staff wages Intervention costs</p> <p>Infrastructure: Managerial liaison for support Referral process</p> <p>Person factors: Demographic characteristics Life experience</p> <p>Wider influences: Law and policy Social attitudes Environmental opportunities/ infrastructure</p>	<p>Staff trained in intervention delivery Wider team trained in intervention aims and how to refer. Ongoing liaison for managerial support Intervention delivered with all 12 components</p>	<p>Increase staff skills and knowledge Number of people referred & starting intervention Number of people completing Number of sessions provided per person per component Number of hours provided per person (face-to-face and non-contact hour) per component Increase in person's volition, habituation, performance capacity, occupational identity, occupational competence Environment responds to efforts</p>	<p>Changes in volition, habituation, performance capacity, occupational identity and occupational competence, and the persons environment Increased occupational participation</p>	<p>Better health and/or QoL Reduced reoffending Cost savings Public health</p>	<p>Increased focus on occupational participation in wider staff group results in more good outcomes Money saved is re-invested in other services for public health</p>
---	--	--	--	--	--	---

SIMPLIFIED LOGIC MODEL



APPENDIX I - PPIAG MEETINGS SUMMARY

Meeting one: 14th September 2016

Attendees: Expert by experience, Magistrate, 2x Educator/lay persons, 3x Clinicians

Agenda items:

- Aims and project background
- Importance of PPI
- Participant feedback
- Establishing group terms of reference
- Project update – overview and systematic review proposals
- Going forward

Key feedback: Practitioners assisted with ensuring participant facing documents minimised risk to all parties and emotional distress to participants.

Meeting two: 11th May 2017

Attendees: 4x Clinicians

Agenda items were:

- Presentation - Project update
- Discussion - Future project work
- Dissemination
- Stakeholder updates
- Future opportunities

Key feedback: Potential participants for Delphi identified

Meeting three: 11th December 2017

Attendees: 3x Clinicians, CJS practitioner

Agenda items:

- Project update
- Discussion - Future project work
- Dissemination
- Stakeholder updates
- Involvement opportunities

Key feedback: CJS practitioners want to refer into an intervention not be trained to deliver an additional intervention. Absent restrained slope in women consistent with CJS experience.

Meeting four: 10th July 2018 / 16th July 2018

Attendees: 2x Clinicians, Magistrate, Expert by experience, Complex intervention researcher

Agenda items:

- Project update
- Discussion - Models
- Dissemination
- Stakeholder updates

Key feedback: Addition of sentence plan and personal anniversaries (high distress circumstances) as mediator and moderator respectively. View it should be delivered by experienced occupational therapists