HOW DO OCCUPATIONAL THERAPISTS PRACTISING IN FORENSIC MENTAL HEALTH KNOW? A PRACTICE EPISTEMOLOGY PERSPECTIVE.

A thesis submitted for the degree of Doctor of Philosophy

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July 2015

ABSTRACT

My research explored the knowledge of occupational therapists practising in forensic mental health. There is no 'gold standard' evidence in this practice area but other forms of evidence, including experience and "intuition", are used in practice. My research aimed to identify the knowledge formed from and used in this practice area.

My research design used qualitative methodology that was informed by American pragmatist, social constructivist and post-modern theory. In particular, I used grounded theory and situational analysis to generate and to analyse the data. The practitioners were three occupational therapists working in various forensic services in one London based NHS trust. My data was generated longitudinally over eight to twelve months, where the practitioners participated in email and face-to-face interviews. The critical incident technique and the critical decision method enabled practitioners to describe and explain their knowledge about one patient with whom they were working over the interviews. The practitioners also reflected upon participating in the research.

My findings demonstrated that the practitioners' knowledge was created from practice through the interaction of three categories. First, steps of practice were structures through which knowledge was generated about the service user. Second were rules for practice where expectations had to be met. Unpredictable situations and knowledge gaps prevented meeting expectations, so new knowledge was created from practice to meet them. The third category was a blend of the practitioners' personal and professional experiences and emotions. Practitioners created a connection with service users in order to build a therapeutic relationship, alongside creating a nuanced narrative with their service users, which helped to build empathy.

In conclusion, the practitioners in my research used various forms of knowledge in practice. My thesis contributes to existing scholarship by supporting a practice epistemology approach. Thus knowledge for occupational therapy in forensic mental health is created from practice.

List of figures and tables

Acknowledgements

My PhD research experience has reinforced to me the power and value of collaborative work. These are not just my ideas, but many viewpoints that I have been able to explore and in some small way develop. Research is not interesting or possible without acknowledging that it is a collaborative endeavour with hopefully wise and critical friends.

I want to extend my sincere thanks:

To Professor Barbara Prainsack and Dr Wendy Bryant my supervisors who were so patient, supportive and flexible. They were generous with their time, ideas and good humour. They helped to make my PhD a truly memorable time in the best possible way.

To the participants who were so helpful and willing to share their practice stories with such rich examples, as well as be open to my repeated questioning and be a part of and invest in the research interviews for a year. That time spent with you was so valuable to my research.

To the forensic mental health organisation who was willing to support my research.

To my critical friends Wendy Sherwood and Sharon Morton who helped with piloting and exploring early possibilities for the methods.

For the opportunities to embed my research into pre-registration education and to the students who listened to my developing ideas in a variety of lectures.

To my colleagues who asked about my work, with whom I had 'off the cuff' discussions that could be so useful, and to those who supported me by just asking how it's all going. In particular to Anna Pratt who has supported me by freeing up time for my PhD and taking such a pro-active role when she was trying to acclimatise to her first year in BSc Occupational Therapy student level one co-leadership with me.

To Kee Hean Lim for his flexibility with my day job in the latter stages of writing up my thesis.

To Paul Hedges for his valuable insights as a health practitioner, his critical thinking, endless patience, humour and support of me; especially when he needed more support than I could provide. So much thanks is offered to you (and a limited edition Barbie).

1. SETTING THE SCENE

1.1 Preface

Prior to my current role as an occupational therapy lecturer, I practised as an occupational therapist in forensic mental health. I provide a detailed definition of occupational therapy later, however in brief, I worked with service users to identify ways in which they could and could not participate in valued activities that were affected by their mental health needs, their involvement in crime and wider social constraints. My interest in this area of practice has remained throughout my teaching and accordingly I wanted to research the area further. I was particularly interested in knowledge, otherwise known as epistemology, in occupational therapy. Richardson, Higgs and Dahlgren (2004) stated that "professional knowledge is that which is relevant to and grounded in the practice context" (p. 2). Indeed, occupational therapy as a practice can be seen as having a particular epistemology of practice, which is the production, acceptance and use of knowledge about such practice (Mitchell, 2013), discussed in detail later. Occupational therapy in the forensic setting has not previously been framed as a practice epistemology. My ultimate decision to explore occupational therapists' practice epistemology in forensic mental health (hereafter called occupational therapists) was born of a journey that incorporates my practice experiences, further training and study. It is one that occurred within a context of the United Kingdom National Health Service (NHS), an institution that has become increasingly outcome and evidence based due to its financial and market-driven focus.

I found in practice there was a persistent push from various governments, filtering through to the professional body of the College of Occupational Therapists, for occupational therapists to be evidence based in their practice. I therefore attended the Critical Appraisal Skills Programme (CASP) (http://www.casp-uk.net/, no date) to develop the skills for thinking about and identifying the evidence for my practice. Part of this training required me and two nurse colleagues to look at the evidence base on the difficulty of motivating mentally ill offenders (hereafter called service users) with a diagnosis of schizophrenia. We presented this to the other trainees and an invited group of clinicians of various disciplines. I saw the value of this process and found the feedback from the audience useful and, as a result, I tried to develop my understanding of schizophrenia, and the complex cognitive

mechanisms impacting upon motivation for occupational engagement and participation. Subsequent to CASP I pursued this inquiry further in my monthly half-day allocation of time for continuing professional development.

The content of the CASP course did not have an emphasis on using research from randomised controlled studies and meta-analyses. Indeed it also tried to incorporate research from qualitative approaches. I therefore found this process of identifying evidence for practice useful. At this time I was reading the small body of gradually developing forensic literature about occupational therapy but recognised that a great deal of it focussed on descriptions of services, general work with specific groups of service users or on specific practice areas, such as vocation. I could see that much of this literature would not be seen as appropriate for use in an evidence based practice approach which required randomised controlled trials and meta-analyses, consequently I felt uneasy with this.

My discomfort grew when hearing of colleagues in other practice areas of occupational therapy who were finding that occupational therapists faced threats if they did not develop their research base for application to practice. The view promulgated was that commissioners of health services would not see the value of occupational therapy because there were no 'gold standard' intervention studies supporting the rehabilitation of patients. This would mean occupational therapy may not be commissioned to provide services in the future, a situation potentially leading to a subsequent diminishing of the profession and possibly its demise.

I was aware that there seemed to be a tension between trying to provide an evidence based service and having limited research in occupational therapy generally and forensic in particular, to use as evidence. This felt a mammoth enterprise, especially when occupational therapists would compare themselves to other health care disciplines that appeared to have a much stronger research tradition. During this time I was ready to develop my academic experience and started a Master of Science degree in occupational therapy. The modules I studied included a range of practice related studies. Clinical reasoning looked at the ways in which therapists use knowledge and information in order to practice. Occupational science seemed to me to be a new way of thinking about occupation and a human's need for this, as well as a potential area for research development for the profession. Modules about theory and practice frameworks further

introduced me to the interaction between doing, thinking and knowing in practice. Despite using my practice experiences to inform my reasoning, I did not fully comprehend how experiences built from practice were a legitimate source of informing knowledge for future practice. It was all too easy to feel guilty at not having the perceived correct evidence for practice. Using practice experiences almost felt like an underground practice that was not explicitly acknowledged (Mattingly and Fleming, 1994). It was my Master's dissertation on the risk assessment of occupational therapists in forensic mental health (parts of which were published as Cordingley and Ryan 2009) that moved me more in the direction of looking at a specific aspect of their knowledge base on risk and how it was used in practice.

This doctoral research gave me the opportunity to develop this interest in knowledge and occupational therapy within a forensic setting. I saw the occupational therapy knowledge base, in terms of the published material, as slowly developing but still very limited. I felt there had to be other forms of knowledge, such as previous practice experiences and 'gut feeling', as I had used these and so wondered what other therapists used. I wondered whether material was used from other health and social care disciplines, or information from the media and arts, and if previous practice experiences were applied to their thinking and reasoning. At this stage I was not aware of the potential of thinking about a practice epistemology for occupational therapy; this became my topic for my PhD and, as such, my research question is:

How far does a practice epistemology explain occupational therapists' practise in forensic mental health?

1.2 Overview of the research

Traditionally, knowledge and practice have been seen as separate entities, and that knowledge informs and underlies practice. Historically, the separation and reification of knowledge over practice has been criticised and, as such, there are now different perspectives on what constitutes the knowledge available to professional groups of practitioners (Schön, 1991; Higgs, Andresen and Fish, 2004). Various disciplines are beginning to view practice as a form of knowledge,

that is, epistemology relevant to professional practice such as in health-care disciplines (Higgs, Andresen and Fish, 2004) and public administration (Cook and Wagenaar, 2012) that I explore in more depth later. In this research I explore practice epistemology in relation to occupational therapy as specifically practiced in a forensic mental health setting.

Occupational therapy focuses on the nature, balance, pattern and context of activities in the lives of individuals, family groups and communities. It is concerned with the meaning and purpose that people place on occupations and activities and with the impact of illness, disability or social or economic deprivation, on their ability to carry them out (Creek, 2003). Occupational therapists work in various areas of health and social care. The health-care setting of this research is in-patient forensic mental health, which is concerned with the assessment and treatment of people with mental health needs, who have committed a criminal offence or are likely to do so (Flood, 1993). Health-care is provided in a secure hospital, in prison settings and in community forensic teams. The former two include a range of levels of security (see Figure 1). These include: low security settings where people may present with challenging behaviour and need close supervision; medium security settings where service users are too dangerous for low security or general mental health units but where there is the capacity to prevent absconding and where treatment, including leave outside the hospital, can be provided; lastly, high security settings where service users pose a danger to the public or to others within the hospital and who may be associated with persistent absconding.

Increasing level of risk to others

High secure services
may include PIC

Medium secure services
may include PIC

Low secure services
may include specialist
rehabilitation and PIC

General adult inpatient services
may include PIC, rehabilitation services, acute
admissions, s136 service

Community
includes community mental health teams,
crisis & home treatment, assertive outreach,
primary care services, psychological therapies,
GP care

Criminal
justice
system

Police
custody

Court
custody

Prison

Bail hostel

Approved
premises

n.b. PIC = psychiatric intensive care

Figure 1. Adult and secure mental health system (source: Department of Health, 2012, p. 7)

It has become common practice to call those occupational therapists who work with service users in mental health and prison settings, forensic occupational therapists; a term I will not use throughout this thesis. There is an argument for simply using the discipline's title of occupational therapist. The addition of forensic makes the discipline appear very different from that practiced in other areas of mental health, when in reality it is just the increased focus on security procedures and legal requirements that make it appear so different (McNeill and Bannigan, 2014). Additionally, such a title may also compound the service users' experience of stigma, labelling and discrimination (McNeill and Bannigan, 2014). Therefore, I use occupational therapist henceforth and the term forensic only when it is required. The skills of occupational therapists in forensic settings are based on general occupational therapy knowledge. Creek (2003) delineates occupational therapists' foci on assessment and intervention, into three aspects including; enabling activities, tasks and skills. The first involves enabling a service user to enact their occupations effectively. All three of the other aspects; activities, tasks and skills, are used in order to remediate occupational participation constraints. The

therapist's attention to each of these aspects shifts back and forth during the occupational therapy process. Referral, information gathering assessment, intervention planning, evaluation and discharge of a service user (Lloyd, 1987 a, b, c and d) are all a part of the occupational therapy process. Occupational therapists believe that purposeful occupational participation is the method through which individuals develop the skills required for independent functioning in the community, and that this approach distinguishes occupational therapists from other forensic mental health professionals (Lloyd, 1987a).

Occupational participation is defined here using a summary of core characteristics created from the literature by Mary Law (2002) for her distinguished scholar lecture in America, about participation in the occupations of everyday life. She identifies the variety and complexity captured within the phrase occupational participation of which environmental, family and personal factors all have an influence. Meaningful choices linked to interests, likes and dislikes about what one does and having control over those choices form part of participation. In order to achieve mastery of an occupation there needs to be a balance between the person's skills and the 'just right' challenge. Occupational participation occurs across space and time and alters according to the person's place in their life span, gender, culture and location. The focus of any particular occupational participation needs to be clear and the goals to be met form part of that. Lastly, quick and accurate feedback whilst participating is required in order to establish the degree of mastery of an occupation. Feedback can take the form of other peoples' responses and from the person's self-awareness of their experiences and reactions to their participation (Law, 2002).

To illustrate this setting two examples from practice in this context are given. These two vignettes give an indication of how an occupational therapist typically works. The first one is an example of the types of information occupational therapists consider about John's (for confidentiality John and other service user names are pseudonyms, and the vignettes are based on various histories of service users history and presentation (see vignette 1). Embedded within this are details from occupational therapy and other disciplines from the multi-disciplinary team. Such a team can include both unqualified workers such as psychology assistants, health care assistants, occupational therapy assistants and technical instructors. Qualified workers include psychiatrists, social workers, nurses, psychologists and

various arts therapists (drama, art, music), physical activity co-ordinators and psychotherapists.

John's history demonstrates the kind of knowledge that the team members require to work with a service user. This knowledge is seen to provide a baseline or framework for each professional in this practice setting. The degree and depth into which each discipline would explore the areas in the case history differs, depending on their primary role and how much of the service user's history informs their core work. In pre-registration education the occupational therapist learns about many aspects of John's case history. This goes beyond core knowledge, but is required in order to practice within this and other mental health settings. Knowledge of crime, risk assessment and risk management in this specific setting goes beyond the core learning from occupational therapy education and may well have to be an area of additional learning for practice when working in the forensic setting.

Vignette 1. John's case history

MENTAL HEALTH HISTORY:	
Diagnosis:	Schizo-affective disorder, borderline and antisocial type personality traits.
Index offence:	Assault of a neighbour and criminal damage of the neighbour's property. Mental Health Act Sections 37/41.
Forensic History:	Various charges and convictions for different forms of assault and for disturbance of the peace.
Previous Psychiatric History:	A long history of contact with mental health services. Well known to local mental health and social services.
Substance Misuse History:	A variety of substances misused in the past, cannabis, cocaine, LSD, including injecting heroin on occasion. Alcohol, smoked cigarettes.
Medical History:	Possible risk to HIV.
SOCIAL HISTORY:	
Accommodation:	Local authority flat.
Activities of daily living :	Maintained shopping, cooking, paying bills for him-self.
Psychosexual:	Sexual abuse from one of his siblings when John was a child.
Relationships:	Little family contact.
Education/Work:	Disrupted secondary education. No formal qualifications. Short-term jobs, unemployed at admission. Receiving benefits.
PRESENTATION:	
Current mental state:	*Mood/Affect:* Swinging moods. Can become angry very quickly and has used physical aggression in different environments. He can perceive staff's intentions in a paranoid way. *Insight:* Fluctuating insight depending on mood and acute illness. Generally recognises his need to be in a secure hospital. *Appearance & behaviour:* Flirtatious with male and female staff and service users. Boundaries with staff, service users and ward rules regularly challenged. Generally presents as unkempt and unshaven.

RISK ASSESSMENT:	
Mental health	1. Antisocial traits and mood variations leading to aggression
	2. Fluctuating paranoid ideas
	3. Difficulty controlling anger
	4. Impact of sexual abuse on psychology/emotions
Social situation	1. Limited skills beyond domestic activities of daily living
	2. No consistent worker role or social activities providing a daily routine
Presentation/Behaviour	1. Capable of physical harm to others
	2. Difficulty managing personal boundaries
	3. Poly-substance misuse
	a. Possible risk to HIV if sharing dirty needles
	b. Impact on physical health
	4. Fluctuating engagement with treatment
INTERVENTION:	
Treatment 1: Medication	Reluctant to take medication other than specific types.
Treatment 2: Therapies	Engages and disengages at various points, for specific reasons, either initiated by John or the respective discipline.

The second vignette identifies my approach with Bob and activity group work that I used as an intervention with him in a forensic setting. This includes, for example, knowledge from occupational therapy theory, group-work theory and risk assessment, among others.

Bob's vignette provides an array of knowledge used in thinking about practice and the occupational therapy process, team decisions, risk and activity-based group-work. The vignette also indicates a potentially difficult communication between Bob and me, and how I was concerned about the impact this might have on a number of levels.

Bob's case history was a smaller version of John's, but indicates how, for me, this contextualised Bob's needs. The Model of Human Occupation (Kielhofner, 2008) indicated some of the concepts required to think about Bob - his interests, his performance in that environment and his routines on the ward. The occupational therapy department where I was working used that model for therapists to frame their thinking and produce reports about service user's progress.

Example of an occupational therapy group intervention

Vignette 2. Bob's activity based group requirements

The unit was an admission area for acutely unwell, male service users from London based prisons, who were predominantly on remand awaiting court proceedings. Bob had not completed his court case at his admission, and his alleged index offence was trespassing and being in possession of a knife and cannabis. Bob had a psycho-sexual history of experiencing several forms of abuse. His psychiatric history included various possible diagnoses of personality difficulties and paranoid schizophrenia. He had harmed others and self-harmed in the past, but had not attempted these since his admission. Bob had a poly-substance misuse history. Bob was presenting with a question around possibly experiencing vivid psychotic symptoms or fantasies. Bob had displayed no threatening behaviour towards others since his admission.

Within the first week of his admission Bob asked me if he could cook as he had been a chef. This was before the ward round, which meant that I did not know his history. I initially said yes he could do so, but we needed to organise a time to do this with him, and that I would get back to him with my diary. Following a review of his history, reasons for referral and discussion with the team, we decided not to allow him access to cookery sessions at that stage.

I realised I needed to be aware of Bob's potential emotional response. I may have given him the impression that a cookery session could be organised imminently. I barely knew him, and I had no sense of what his response would be to the refusal. I was concerned at what his response might be. I did not know whether he would become verbally and/or physically aggressive. I did not want to be in a position where potentially I could be harmed, but I did not want him to be put in a position where he received controls and limitations by staff if he became physically aggressive due to my unclear communication and possible mixed message to him. From the perspective of trying to build a therapeutic relationship, I had not established any trust with him, or a therapeutic rapport. To refuse him the cookery session may impede my relationship building at that early stage and hamper trying to engage him in the occupational therapy process.

My plan was to be honest with Bob about the reasons for not allowing him access to cookery at that point. I decided that it was important to tell him the team decision and also to apologise for any unclear communication on my part. If he was amenable, I would see if he was prepared to consider engaging with another activity. In our discussion, he was calm and accepted the reasoning. He also accepted the invitation to attend a 'printing group'.

I knew from the team discussion, that Bob's overall presentation on the ward, within that brief time, indicated there were no immediate risk concerns. He had been risk assessed by nurses. These included his calm responses to the vivid visual phenomena he experienced, which was seen by the team to be unusual, but did not result in any behaviour to harm him-self or others. Nurses observed no problems with his use of metal cutlery during ward meals and making toast, cereal and mugs of tea in the open access ward kitchen. He could therefore have access to some art materials in the workshop that did not involve the use of sharps (scissors, knives, needles etc.). This would mean:

1. Bob could start to develop a structure to his week
2. Bob had something meaningful and purposeful to do
3. I could start to build a therapeutic rapport and trust with Bob
4. The activity could be a bridge to encourage Bob to socialise with other service users
5. I could observe Bob's occupational participation skills
6. I could start some preliminary risk assessment of Bob's performance in activities.

It was clear from the discussion of Bob's history that he had a couple of key interests; one was his previous role as a chef and the other was that he had some artistic ability. Also at this early stage nurses observed that his routine on the ward consisted of using the ward smoking room and lounge, but he did not socialise much with other service users, only with staff. It was possible to use his interest in art where he had some skills and was confident, to engage him in other activities in order to start the assessment of his occupational participation skills. The group was based in the occupational therapy workshop on the ward. This group was open to all service users regardless of the degree of mental health problem. The group lasted up to 90 minutes but most service users could be accommodated for even a few minutes.

Both a new-graduate occupational therapist and I ran this group. I took the initial lead in the group; however, facilitation of the service users' engagement was a fluid approach depending on who arrived to the session and which of the therapists were available. This enabled us to engage service users with minimal concentration to those who could participate for the entire time, as long as they had an interest in the projects available. We created a flexible group that enabled us to work in an acute environment, meeting a service users' wish to engage at that time.

The various forms of printing available allowed for the grading of activities from simple to complex within the group itself, hence being able to engage a range of service user abilities. Silk-screen printing on t-shirts for example, which the service users would create and take away to wear. The projects ranged from using pens with integral shapes, various pre-cut stamps and coloured pads of ink. There were pre-cut stencils for use with acrylic and water-based paints on paper and card and fabric pens and paints for textiles. The more complex projects for the service users included patterns to cut new stencils from plastic, or they could design their own stencil and cut it out. The stencils could be used with brushes and Bob's participation initially focussed on printing t-shirts with pre-cut stencils and brushing on fabric paint. He was not permitted access to the craft knives or scissors to cut his own stencils at this point. Indeed, about 10 weeks into attending the group, with no risk behaviours observed, I offered Bob a small pair of scissors to cut a stencil. He stated that he was not permitted to use them. Bob seemed to have internalised the particular risk issues related to activities in that group. From that point he cut his own stencils and used this with silk-screen printing techniques on t-shirts. All items and materials that could be used for risky behaviours, such as solvent based glues and pens, pencils, paint brushes, scissors and craft knives were kept in a locked cabinet at the far end of the workshop.

This was at the opposite end to the panic alarm button and the only door to the workshop. Whenever Bob used a knife he had to sit nearest the cabinet and he had to remain sitting whilst using the knife. He could only stand up or walk briefly around the workshop after he called me or my colleague to monitor the knife placed on the table. If he was to leave the room the knife was locked away in the cabinet. If he tried to use a sharp to harm others or him-self, then others in the room could exit more easily as they were closest to the door. Such close attention to sharps meant it was difficult for him to secrete these to take away from the room.

Risk assessment was required for physical objects that could be used to harm one-self or others and that were immediately accessible and the physical environment. This was considered by the nurses, me, and the team in relation to Bob's history. This related to the teams' and my decisions on what further access he could have to objects that could be used to inflict damage, such as knives. Yet, ultimately, any item accessible to service users, such as a compact disc, or a chair, could be used to harm one-self or others. His emotional responses were also considered within this risk assessment both before and during his participation.

The knowledge required for me to think about Bob and his participation in the printing group included the need to know the purpose of the group and how it would be structured Also my use of occupational therapy core skills to analyse, grade and adjust the activities according to his abilities and the abilities of other service users in the group at any given time was required. The structure of the printing group and the flexibility in its facilitation allowed me and my colleague to meet a range of service user needs in that acute remand forensic context. The context coupled with my experience of running various activity groups, with different levels of service users' abilities allowed me to offer opportunities to service users and observe, as well as assess, a greater range of their skills. If I had relied purely upon the literature to organise the group, the structure and level of flexibility would have only been codified in more abstract terms, and could not include the specific contextual aspects.

The physical interior of the workshop and location of the storage for sharps and the arrangement of the service users' activities within the workshop was important for risk management. The sharps cabinet had been in that location before I started

working in the unit, however, I was able to organise the activities for effective risk management. There was no literature to tell me how to risk manage in such a specific context. The location of security items, my core skills of environmental analysis and adaptation allowed me to work out a viable workable plan that enabled service users to engage in activities rather than be restricted from participation.

Summary

These vignettes introduce the range of sources of knowledge the practitioner draws upon to work with service users in occupational therapy in forensic mental health. What is partially captured in Bob's vignette is some of my practice experience and knowledge within a specific context and how I used that knowledge to develop my practice to improve access to activities for service users.

Occupational therapists' practice decisions and actions are expected to be informed by what is learnt in pre-registration study (COT, 2015) and for expectations of lifelong learning and keeping knowledge and skills up to date over the course of the therapist's professional working life (Health and Care Professions Council, 2013 & COT, 2015). There is very little of the so called 'gold standard' research method in occupational therapy. Consequently, the limitations in the evidence for occupational therapists are a challenge. Therapists must however, base their clinical decisions and actions upon other forms of evidence, practice experiences, and a range of other forms of knowledge about forensic and other related practice areas. Certainly there are some examples of my knowledge created from practice in Bob's vignette, such as risk assessment and risk management strategies, my structuring of the group and the grading of complex activities within the group. The following literature review further illustrates the issues raised in the discussion above.

1.3 Literature review strategy

I now clarify how and where I located the literature. Since the start of my PhD I have made an on-going systematic literature search and review that included hand searches, receiving monthly notifications by email and database searches. The literature searches conducted were from core occupational therapy journals (paper

and e-journals) including: Occupational Therapy International, Occupational Therapy in Healthcare, Occupational Therapy and Mental Health, American Journal of Occupational Therapy, British Journal of Occupational Therapy, Canadian Journal of Occupational Therapy, Mental Health Occupational Therapy, Scandinavian Journal of Occupational Therapy, Australian Journal of Occupational Therapy, Journal of Occupational Science. Practice based experiences are often discussed in non-academic publications such as Occupational Therapy News in the UK and Occupational Therapy Practice in the USA. My existing collection of published occupational therapy in forensic mental health articles provided an initial basis for that literature search and I also collected references from literature that I had read. I also incorporated general mental health literature.

Database searches were conducted using: Academic Search Complete, AMED (Allied and Complementary Medicine), Google, Google Scholar, JSTOR (Journal Storage). The following search terms were used in the databases: practice knowledge health care, professional knowledge health care, practice epistemology, practice epistemology and/or professional practice, professional knowledge, practice knowledge, practice theory, evidence based practice, evidence based practice and occupational therapy, and further qualifiers including mental health, psychiatry, forensic mental health, and forensic psychiatry.

1.3.1 Evidence based practice in health care

Evidence based practice and its limitations, along with concerns about the dominant discourse that evidence based practice has become in health care are problematic for occupational therapists. This next section is a review of the development of evidence based practice (EBP) and its relationship to occupational therapy and knowledge in practice. The following aspects about evidence based practice are discussed: the paradigm upon which it is based, the assumptions underlying it and the hierarchy of evidence associated with it, as well as the conflation of evidence with research.

History of the evidence based medicine and practice approaches

A brief history of evidence based practice emerged from the work of Archie Cochrane, a doctor and epidemiologist in the UK, who was an early proponent of

evaluating health interventions (Cochrane, 1972/1999). Cochrane was a supporter of using the randomised controlled trial as a high quality method to establish the effectiveness and lowest cost of those medical treatments with equitable access (Cochrane, 1972/1999) and which had a rational, scientific foundation (Macleod, 2007). These were the bases for establishing evidence based medicine.

The government of the mid 1990s had committed itself to an evidence based health service (NHS Executive, 1996, cited in Bannigan, 1997, p.479). The finances of the NHS were reviewed and, in order to function, the NHS' internal market required evidence of effectiveness in terms of treatments offered and their cost, and additionally, required health outcomes to be measurable (Lloyd-Smith, 1997). The evidence based medicine approach had been adopted to provide accountable and cost-effective services across the NHS (Ballinger and Wiles, 2001).

Evidence based practice developed from evidence based medicine to incorporate a range of health and social care disciplines. This development necessitated a review of the definition for this variant in a number of disciplines including occupational therapy (Taylor, 2007). Hinojosa (2013) raises a concern that since its inception, evidence based practice and its assumptions have been rapidly and unquestioningly accepted by occupational therapists.

Providing evidence to support the interventions used in health care through evidence based practice appears to be a sensible and ethical approach to patient care (Higgs et al, 2004). Evidence based practice is seen as a clearly defined structure that can be utilised to inform decisions about treatment approaches, which has some face validity for use in contentious health situations (Sim and Richardson, 2004). For Taylor (1997) it is potentially a perfect blend of theory and practice to demonstrate the benefits and effectiveness of occupational therapy.

Evidence based practice has a hierarchy of evidence of what constitutes what are seen by adherents as the best form of evidence in the form of the 'gold standard' (see table 1) (Whiteford, 2005). The hierarchy lists a range of research methods, the top of which is regarded as the best evidence. Expert and respected opinion are placed as types of evidence at the lowest and subordinate position in the hierarchy of evidence (Whiteford, 2005). These latter two are not research methods

as the higher levels are, but they are seen as a form of evidence in this conceptualisation of a hierarchy of evidence.

Table 1. Hierarchy of evidence (Source: Taylor, 2000, p. 19)

Systematic reviews and meta-analyses of randomised controlled trials
Randomised controlled trials
Non-randomised experimental studies
Non-experimental studies
Descriptive studies
Respected opinion, expert discussion

There are implications of placing respected opinion and expert discussion at the bottom of the hierarchy of valued evidence. Such evidence is seen to be suspect, appearing to be no more than anecdotal and thus not seen as a valid form of evidence. The hierarchy is a series of research methods thus there is a question then about how opinions about practice and expert discussion about practice experiences, even at the lowest position, can form part of evidence, which is considered further.

There is often little differentiation in the occupational therapy literature between the terms evidence and research. In an opinion piece about occupational therapy evidence based practice in the USA, Hinojosa (2013) identifies that 'evidence based' often refers to the best available evidence from research. More broadly, evidence based practice is equated with scientific practice, but this depends on who is defining it and therefore the meaning attributed to the terms science and scientific (Reagon, Bellin and Boniface, 2010). In their review of occupational therapy literature about the use of research and evidence based practice Thomas and Law (2013) use an amalgam of 'research evidence'. They do not define this, but on the face of it, it is a reflection that research is used for evidence in practice.

Occupational therapists in the UK are required to see "research as the basis of the profession's evidence base." (COT, 2015, p.37) The term evidence is therefore equated with research. It is not stated which form of research is acceptable, or whether a specific adherence to the 'gold standard' is required. It can therefore be assumed various research methods are acceptable for practice. Therapists should incorporate research into "practice where appropriate" (COT 2015, p. 37), thus the therapist is required to decide what research is appropriate for use in practice.

Occupational therapists are still using a terminology from other disciplines, considered next.

There are some other ways of seeing what counts as evidence and research and their relationship to practice. It is more accurate to say research is a form of knowledge, some of which can be used for evidence to use in practice. In any event, this needs to be clarified as, until then, the occupational therapy profession is using borrowed terms and philosophical approaches to evidence based practice that are not entirely relevant to the profession's goals and values. This also brings occupational therapy closer to medicine, having previously successfully distanced itself from the medical model (Hinojosa, 2013). Indeed, as the philosophers Hutchison and Rogers (2012) note in their exploration of evidence based medicine, evidence based practice may not have set out to become an epistemology of medicine, but it has become an epistemology of clinical (medical) practice in general, even if not officially recognised as so. Discounting research, other than that identified as the best in the hierarchy of evidence, may have serious implications for developing a comprehensive epistemology of medicine (Hutchison and Rogers, 2012), which occupational therapy does not need to emulate.

The primacy of experimental research from which evidence based practice is derived is too narrow, ignoring qualitative and hermeneutic forms of evidence (Hyde, 2004; Stiwne and Abrandt Dahlgren, 2004). The occupational therapy profession does not have a strong tradition of the research methodologies used in evidence based practice and so therapists have struggled with this. If evidence based practice is used to measure the degree of effectiveness of occupational therapy through research, this places therapists in a challenging position (Taylor, 2000). This is potentially an ethical issue as evidence based practice is required in the profession's code of practice and professional conduct.

An issue of greater concern however, is that the current emphasis on evidence based practice may be misleading to both health professionals and the individuals to whom they offer a service. It is argued that quantitative science does not take account of the complexity of humans and their social conditions (Whiteford, 2005; Richardson, Higgs and Dahlgren, 2004; Ballinger and Wiles, 2001). Evidence based practice creates the expectation of a concrete answer, or a clear-cut 'best practice'. This may be misleading in its apparent simplicity and in many areas of

healthcare the patients' needs could often be much more complex (Whiteford, 2005). A narrative interpretative approach would be suitable, unlike the patho-physiological explanations used by medicine (Whiteford, 2005).

Meta-analyses and systematic reviews of randomised controlled trials are one form of knowledge created from research that can be utilised as evidence for practice in health care. Qualitative research used as evidence does not need to be perceived as subordinate to quantitative evidence. It is different to, but a no less useful form of evidence, providing answers to questions that are different to those posed in quantitative research (Whiteford, 2005). A key point from Gustavsson (2004) is "that different forms of knowledge have different characteristics and criteria of truth verification" (p.36). Therefore qualitative evidence cannot be judged by quantitative concepts of validity and reliability which are seen as key concepts in randomised controlled trial research.

Greenhalgh (1999), a general practitioner and academic who writes from a medical perspective, notes that from a social constructionist perspective so-called objective facts are theoretically laden themselves. So, one's viewpoint of what constitutes objective knowledge is an artefact. In this situation this means that knowledge used in evidence based medicine comes from the technical rational (Schön, 1991) and positivist epistemology (Hinojosa, 2013), which is viewed as the only way of producing appropriate research, RCTs, for evidence on which to base practice. Greenhalgh (1999) highlighted, as part of the physician's clinical method, doctors must use patients' narratives in order to understand each patient's unique illness experience, culture and context, all of which must be taken into account in medical diagnosis and treatment.

In a recent paper, Greenhalgh et al (2014) highlighted their concerns about evidence based medicine and physical health needs and made a recent call for a review of how it is currently viewed, how the research is conducted and funded, and how it is used in medical practice. Some points are relevant to occupational therapy and includes a concern for how guidelines and protocols are being used to drive the management of health conditions rather than client-centred practice. There is little or no value placed on the practitioner's judgement, which has to be used in various situations. For example when guidelines do not map well to multi-morbidity, when there is uncertainty about the health condition/s, for which the

research evidence (the term used by Greenhalgh et al) does not exist or is limited. Also the relationship to the service user's context and the individual's illness experience along with the relationship between them and the practitioner is not considered (Greenhalgh et al, 2014). Their suggestion is that these aspects should be a combined discussion between the physician and patients (the term used in the medical context of their work) (Greenhalgh et al, 2014). Of relevance to occupational therapists is that this suggestion fits with a client-centred approach and the value placed on service users' experiences. It also takes into account any relevant research related to the service user's health condition, thus moving beyond the focus on intervention based studies as the only form of research evidence. Lastly this combination of aspects makes practice more individually relevant and can facilitate an open dialogue about the advantages and disadvantages of taking a particular approach to occupational therapy.

There has been an attempt made by a multidisciplinary and international group of health-care disciplines to broaden the conceptualisation of evidence based practice, its definition and the knowledge and evidence considered appropriate to be used in practice.

> Evidence based practice requires that decisions about health care are based on the best available, current, valid and relevant evidence. These decisions should be made by those receiving care, informed by the tacit and explicit knowledge of those providing care, within the context of available resources (Dawes et al., 2005, p. 1).

This quotation indicates that there is another way to view how the evidence base can be defined, one that is more inclusive. A range of healthcare disciplines as well as medicine and the service user perspective are included as forms of evidence. Other forms of knowledge that form part of practitioners' explicit and tacit knowledge, including practice experiences, are also seen as forms of evidence that can be considered part of the evidence for practice. The differentiation between evidence and research is not made explicit, but there is more flexibility in what evidence might be used, which goes beyond that seen as the hierarchy of evidence.

It is possible to have a different way of thinking about evidence for practice in occupational therapy. A way of conceptualising evidence from various research methods incorporated into a range of hierarchy of evidence, moving beyond the current single hierarchy of evidence, has been created by Tomlin, an occupational therapist and academic and Borgetto, a health prevention and promotion academic (2011). A pyramid of evidence based on Borgetto's work, incorporates three sides that include quantitative, qualitative and outcome measure research methods that converge for meta-analyses in their respective side of the pyramid (see Figure 2). The base consists of descriptive research, also in a hierarchy:

1. Systematic reviews of related descriptive studies (highest);
2. Association, correlational studies;
3. Multiple-case studies (series), normative studies, descriptive surveys and
4. Individual case studies (lowest).
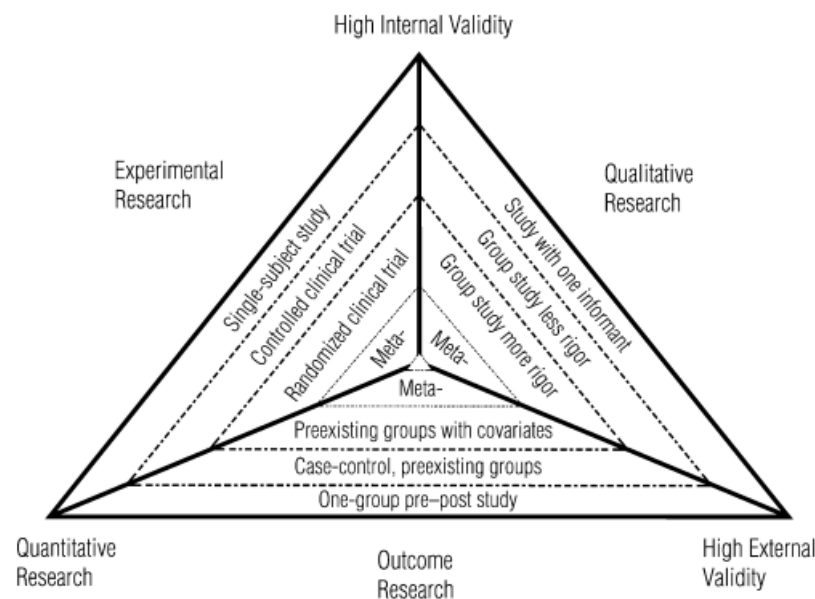
Figure 2. Research Pyramid (source: Tomlin and Borgetto, 2011, p. 191)

n.b. meta- = meta-analyses

This approach to an evidence hierarchy offers occupational therapists a way to deal with a complex array of research methods that is better than a single hierarchy. Tomlin and Borgetto (2011) however, still conflate research and evidence and additionally, knowledge is equated with evidence. The research Pyramid hierarchy, albeit now incorporating qualitative research, still reifies some

research methods over others. Tomlin and Borgetto (2011) however, stated that they aimed to keep the 'gold standard' for evaluating evidence, but build on this in order to create a best-balanced 'alloy' between their hierarchies.

The context of evidence based practice for occupational therapists in the UK, along with NHS and government directives, is also determined by The College of Occupational Therapists. The meaning of best practice is not explained in the code, it does however suggest that best practice could be formed from practice experience. This is unless practice is assumed to be evidence based as conceptualised in the hierarchy of evidence, in which case practice based on systematic reviews would be seen as best. The National Institute for Health and Care Excellence (NICE) (2013) established in 1999, state their guidelines represent best practice, based upon various aspects including the best available research evidence and expert consensus (NICE, 2013). Unfortunately, very few NICE guidelines include occupational therapy research as evidence, or the practice experience of therapists that is developed into a consensus. In a national body that is endorsed as providing a key source of guidance for clinical and social care matters, NICE does not seem to value practice experiences as expert consensus. Also it is unclear how best practice fits with the reified view of the hierarchy of evidence in evidence based practice or within a practice epistemology. Having considered evidence based practice, it is now pertinent to consider what forms of research exist as possible forms of evidence from occupational therapists working in the forensic context.

1.3.2 A brief overview of the recent history of the development of occupational therapy in forensic mental health

In order to provide some context as to the development of occupational therapy in the forensic setting it is important to note that as a profession, occupational therapy in the UK is less than 100 years old (Wilcock, 2002). It is difficult to date the start of occupational therapy in the forensic setting. The wider development of forensic services has been identified, and gives some indication of a pathway into forensic mental health for occupational therapy.

A large gap in provision of forensic care was identified prior to 1975, and it was the Interim Report of the Committee on Mentally Abnormal Offenders (the Butler Committee) (1974, cited in Stone et al, 2000, p. 12), that recommended that medium secure units should be developed, as many patients did not require the levels of maximum security provided by special hospitals. Some patients were not cared for and others were diverted inappropriately to prisons (Nolan, 2005; Stone, et al, 2000). Regional health authorities were urged to build medium secure units, and as a result three were opened in the late 1970s, with twelve opened in fourteen regions of England by 1989 (Stone et al, 2000). The need for occupational therapy was made clear in the Review of Health and Social Services for Mentally Disordered Offenders and Others Requiring Similar Services (Department of Health [DH], 1992; aka the Reed Report). There was a recommendation to expand therapy posts in special hospitals and medium secure services with an early priority towards developing a more effective core service. Principles of care were proposed, with one being particularly relevant to occupational therapy services in "providing opportunities for rehabilitation and generalisation of skills, to ensure that mentally disordered offenders (sic) reach their maximum level of independence" (cited in Flood, 1993 p. 293). This is a core aspect of occupational therapy in any practice setting, so the specific knowledge about practice in forensic work is now considered.

1.3.3 Synopsis of the occupational therapy in forensic mental health literature

Conceptual understandings in occupational therapy literature have developed from observations and stories from accumulated practice experiences, noted by Gary Kielhofner (2009), a prominent academic and occupational therapist in the United States of America (USA). From discovery through practice, to systematic attempts at explanation through formal theory and research, the profession's conceptual foundations are constituted (Kielhofner, 2009). Understanding the ways different forms of knowledge arise from, and become integrated into practice knowledge, can help to identify the sources of knowledge that are relevant to practice, research and education of a health care profession (Richardson, Higgs and Dahlgren, 2004). The occupational therapy literature about forensic practice is reviewed to illustrate how practice can be represented in a codified form. Occupational therapists

recognise practice needs to be described and some have done so in a variety of publications (Chacksfield, 2003; McQue, 2003).

In this review I look at three key areas in the literature on occupational therapy in forensic settings (hereon called the literature). Firstly I look at evidence based practice and the occupational therapy in forensic mental health literature. Secondly, I provide brief examples of how practice has been codified in the literature about practice experience and the occupational therapy process. The third section considers theory in practice. Later, the discussion will provide more detail about these topics in relation to the findings in order to further clarify their relationship.

Before I move onto the remaining topics I need to highlight the work of Chris Lloyd, an occupational therapist and academic who worked in forensic mental health. She was an author of early work in the area from the mid-1980s onwards. Her work is prolific and spans many of the early discussions about forensic practice; such as theory and practice, descriptive work on various practice areas and some empirical work. She remains a key figure in the early development of the literature and so for that reason is used a lot in my research. Some of her work has not been explored fully or reviewed for how current practice reflects her stance. My research therefore considers some of her work in light of how it reflects current practice and knowledge.

Evidence based practice literature

Three reviews of the literature by Mountain (1998), O'Connell and Farnworth (2007) and particularly COT (2012) are associated with an evidence based approach. Mountain stressed the need to look at evidence to support practice and in her conclusion stated the need for "determining the efficacy of specific interventions" (p16) which implies randomised controlled trials are required. Therefore Mountain supports the 'gold standard' as an evidence base. O'Connell and Farnworth (2007) state "research should be the basis for interventions in evidence based occupational therapy practice" (p189). The inference here is that they are referring to intervention studies and thus the 'gold standard'; however, research is a term that can also include qualitative and mixed methodologies. Indeed, O'Connell and Farnworth (2007) indicated that examples of practice

interventions in the form of case studies can be useful for practitioners, for example Kromm et al (1982), which also suggests a more inclusive view about what counts as research for evidence.

The review most firmly rooted in an evidence based practice approach is the COT (2012) practice guideline. The review of the literature included categorising the literature against criteria of the quality of the research into high, moderate, low and very low using the Grading of Recommendations Assessment, Development and Evaluation (GRADE) approach (http://www.gradeworkinggroup.org/index.htm, 2013). These criteria are similar to Taylor (2000), except that the high criteria in GRADE that COT (2012) has adopted includes randomised controlled trials, but does not include systematic reviews or analyses. There is still the reification of the randomised controlled trial, as research such as case studies, or expert opinion is in the very low criteria. Despite this reification, 24 of the 34 papers are categorised into the low criteria which included cohort and qualitative studies in the practice guideline.

Lloyd (1995) and Forward, Lloyd, Trevan-Hawke (1999) review some of the literature, but include no discussion about developing research for an evidence based approach and moreover, they do not take into account the value and place of practice experience. The literature however, includes research that uses quantitative, qualitative and mixed methodologies, which is possible to use in practice if the 'gold standard' is not seen as the only way to conceptualise what research can be used in practice, which is briefly summarised now. Occupational therapy standardised assessments are used to measure the functional performance of service users (Lloyd, 1987d) and measure the therapeutic outcomes of an Interactional Life Skills group intervention, but not using a randomised controlled trial (Jones and McColl, 1991). There is research correlating background factors, personality traits, occupational and social participation and life satisfaction (Lindstedt, Ivarsson and Soderlunde, 2006, Lindstedt et al, 2005; Lindstedt et al, 2004). The time use of service users has been investigated (Farnworth 2000, Stewart and Craik, 2007, O'Connell, Farnworth, Hanson, 2010), as well as an exploration of the experiences of life in forensic settings (Farnworth, Nikitin, and Fossey, 2004, Craik et al 2010) and risk assessment (Cordingley and Ryan, 2009). The value of this body of research is the variety of methods used to provide research on a range of topics of interest to how occupational therapists

would work in the forensic context.

This snapshot of the literature from the late 1980s shows that there is no work that fits within the 'gold standard' of randomised controlled trials, systematic reviews and meta-analyses. There is clearly a small, but developing body of research that uses a range of experimental and non-experimental research methods. From this perspective occupational therapists are trying to engage in research but it does not fit the 'gold standard' evidence based approach. The literature does not identify and explore the knowledge that arises from practice. Indeed in terms of the hierarchy, practice experiences would be considered respected opinion and the lowest form of evidence for practice.

Practice experiences

Theory and research are explicit ways in which practice experiences are discussed in the literature. Mountain (1998) identified the importance of practice experience and that occupational therapists' knowledge and practice base are well developed due to the use of models of practice, also supported by Lloyd (1995), to underpin assessment and treatment. These perspectives however, assume that theory comes before practice and underpins and informs practice. Research is seen as a way by which occupational therapists clarify their role, but this does not include research of practice experiences in the forensic literature (Forward et al, 1999).

The literature used in the guideline (COT 2012) includes studies that garner practitioners' views, which can represent an aspect of their practice experiences. The review includes: surveys (Baker and McKay 2001), focus groups (Cordingley and Ryan 2009), and interviews with both service users and occupational therapists (Clarke, 2003a; Cronin-Davis, 2010) in a formalised approach following a research process. Such research is important to occupational therapists as a method by which to develop their knowledge about service users' perspectives and to find ways of codifying their practice experiences. Occupational therapists therefore value a range of research methods to provide various forms of evidence about their practice.

The first British and international edited textbook about occupational therapy in forensic mental health (Couldrick and Alred, 2003) provides glimpses of some

authors' practice experiences. This book was comprehensive in its range of chapters presenting descriptions of various forensic settings of occupational therapy. It was not, however, relevant and specific in relation to forms of knowledge used and created within practice. There were some case examples of occupational therapists' practice with service users. Cases were used for practice examples of their discussion; as a specific illustration, highlighted below, within a more traditional approach of applying research and literature to their discussion.

There were various case examples used throughout the book, some of which provided hints into occupational therapists' practice experience, two are presented here. One of three brief case examples of particular occupational therapy interventions and the service users' responses are provided by McQue (2003). Here McQue did not expect a particular positive therapeutic consequence of an intervention that she had used. This may indicate a new practice experience that could be used in future therapeutic situations; however this is not discussed by McQue. There was also a more detailed case study providing an example of Chacksfield's (2003) organisation and categorisation of a service user's history from an occupational therapy perspective. This included an analysis of performance areas where Chacksfield (2003) made an analogy between the service user's drug dealing activities and how this followed a pattern like regular employment. This suggests Chacksfield was using his and/or others' life experience to interpret how a criminal activity was being used for a form of occupation that created a financial benefit for the service user.

In the codified work then, therapists cannot discuss their practice without examples that come from experience in practice. The value of practice experience however, as a form of knowledge is rarely, if ever, recognised. This maintains only a partial view of what knowledge is used in and as part of practice, creating the impression that only propositional knowledge is required for practice.

Experiences and how they relate to practice are formed through an interaction between various aspects. Experiences in practice are a complex arrangement of observation, interpretation and action that make up a fluid process and are not a simple matter of pattern recognition and problem-solving for and with the service user (Mattingly and Fleming, 1994). Such experiential knowledge influences therapists' thoughts and actions continually, and form the tacit knowledge of the

therapist (Mattingly and Fleming, 1994). Therefore experiences that emerge from practice become a form of knowledge that can, in turn, be used in practice.

Mattingly and Fleming draw on Dewey's concept of experience (1929 cited in Mattingly and Fleming, 1994 p. 30), which comprised, not only the process of doing something, but also the process of reflection, which, in turn, contributed to making meaning out of the experience. Experience is therefore more than the time spent in a particular area of practice, but furthermore, can be the intention to do something, doing it and then reflecting on it (Mattingly and Fleming, 1994).

There is a mixed picture in the professional requirement for reflection upon practice experiences. The Care and Health Professions Council (HCPC) (2013) standards of proficiency for occupational therapists in standard 11 emphasise the requirement to reflect on and review practice. The College of Occupational Therapists does not identify reflection in its Code of Ethics and Professional Conduct (2010). Such a lack of connection between two key documents for occupational therapists' expectations of practice and the way in which their practice experience is valued creates a disjuncture between how reflection on practice experience can form part of an explicit acknowledgement that there is practice knowledge. A core feature to practice in the codified literature is the occupational therapy process, which will be discussed in the next section.

The occupational therapy process

The textbook version of the occupational therapy process in forensic mental health includes what Lloyd (1985) calls the process of treatment (see figure 3 below), which is similar to how the occupational therapy process is represented. There is a referral, following which a range of information is collected using various methods, this is then analysed in order to identify treatment goals and a plan is collated to achieve these. In the subsequent re-evaluation process the occupational therapist compares the service user's occupational participation following treatment, with the data collection following referral. Should the areas of need and goals not have been met, then a revised treatment plan may be required (Lloyd, 1985). The process as presented by Lloyd is an over simplified version compared to actual practice, however all occupational therapists, regardless of their clinical speciality, are required to follow this process (COT, 2015) and

moreover, the literature indicates that the process in the forensic setting is similar to that used in many other areas of occupational therapy and mental health (Forward et al, 1999, Hunter and McKay 2008, Flood 1997) and prison-based services (Eggers et al, 2006). Creek (2014), from general mental health, provides a more detailed figure 4 of the process (see below).
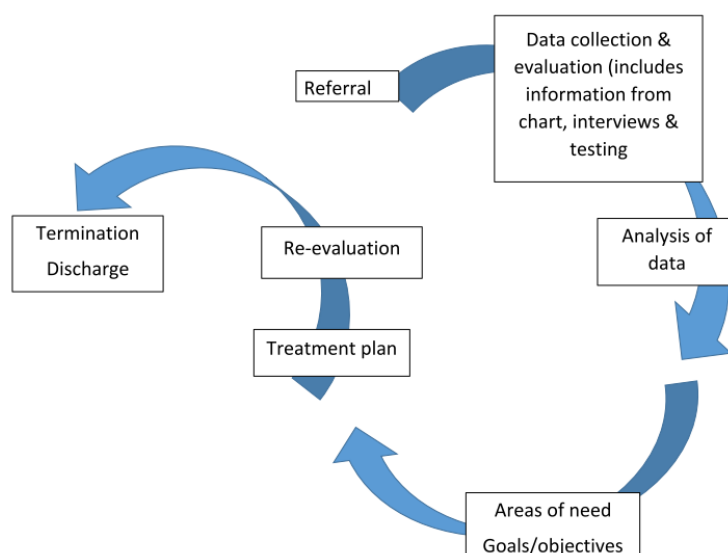
Figure 3. The process of treatment (source: Lloyd, 1985, p.138)

Creek's (2014) figure (4) indicates the process of a hierarchical sequence that all occupational therapists would recognise in mental health and other practice areas such as physical health and social care (Rogers and Holm, 2009). The process is often presented and described as a sequence (Creek, 2014, Flood, 1997, Lloyd, 1988). This sequence is also revealed in case studies, such as those from Lloyd (1988), which demonstrate the process within the forensic setting. Likewise, Stanton et al's Occupational Performance Process Model (2002 cited in Cronin-Davis, 2006, p.112) is used in conjunction with the process to explain its use in practice.

The term occupational therapy process is not accepted by all in the wider occupational therapy literature. Case management is the term used by Hagedorn (1995) because she sees the occupational therapy process as not one process, but many. Also she notes the process is not unique to occupational therapy as it combines a problem solving analysis used by various health and social care

disciplines (Hagedorn, 1995). The process described by Boniface (2012) is also similar to that noted above however, although she finds the occupational therapy process an inaccurate label, she does not explain why. There is very little discussion about the labelling of the occupational therapy process and how it is reflected in actual practice, an area that will be explored in my research.

The codified literature on the occupational therapy process is a tidy looking approach. It does not however, contain any empirical exploration of how the process takes place in practice. At best the literature represents a description of how various therapists have used the process in practice. At worst it does not reflect actual practice and presents a fantasy of a clean and tidy process of practice in occupational therapy. It is also unclear how using the process in practice relates to the development of practice knowledge. It is therefore important that this is investigated, which my research endeavours to do. The literature includes various forms and uses of theory in practice, illustrated next.
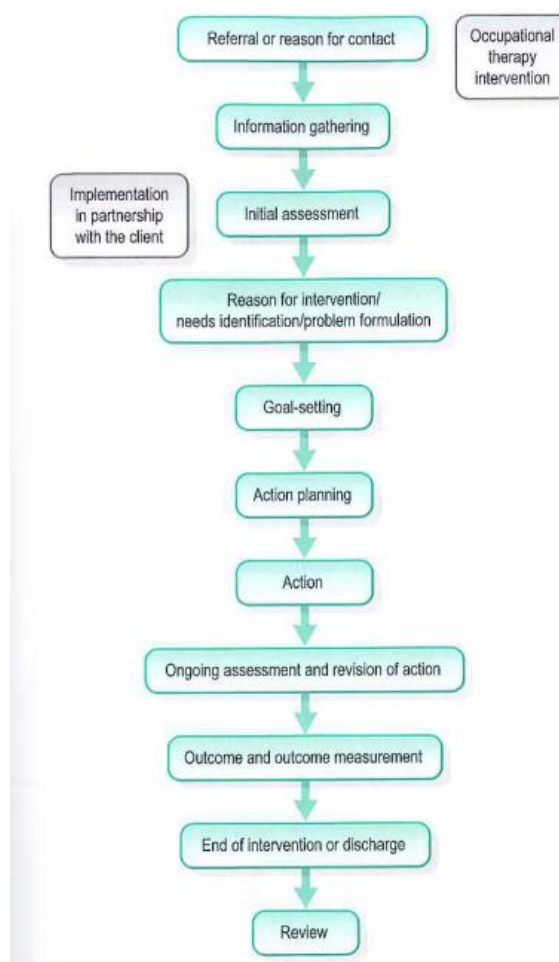
Figure 4. The occupational therapy process (source: Creek, 2014 p, 57.)

1.3.4 Theory and occupational therapy in forensic mental health

Theory development and the use of theory within models to support practice are discussed in the wider occupational therapy literature. Creek (2008) provides a useful framework encapsulating how philosophy, through to theory and the therapist's actions are linked together for occupational therapy practice (see figure 2). I focus here on explanations of theory, models and concepts as these are most prevalent in the forensic literature. First however, I define the theoretical terms.

Concepts are seen as ways to categorise and give meaning to an idea or phenomena, such as to a class of objects; abstractions or social phenomena (Creek, 2010; Scott and Marshall, 2005) or a word or a constituent of thinking (Law, 1999, p. 153) and they may have one or more common characteristics (Cronin Mosey, 1996). The relationship between concepts is more important than the names of those concepts (Boniface, 2012).

Theory can direct, regulate or influence reality so as to achieve a specific purpose (Creek and Feaver, 1993 a and b). Theories offer explanations for what a therapist observes and also make the prediction of intervention outcomes possible (Creek, 2008). Theories therefore have the purpose of describing certain phenomena, explaining how they occur and at what times, as well as clarifying how these facets relate to each other (Creek and Feaver, 1993 a and b). Compatible theories can be combined into frames of reference, approaches and models for use in different areas of practice (Creek, 2008). Theory as described by Creek and Feaver (1993 a and b) is not accepted by all occupational therapists as Boniface (2012) uses the term "theory of occupational therapy" to encapsulate five components of theory including paradigm, philosophy, model, approach and practice.

Creek and Feaver (1993 a and b) found in their review of the occupational therapy literature that there was no one definition for a model for practice. They did note, however, that models help to structure the complex and dynamic phenomena they describe (Creek and Feaver, 1993a). A definition for a model for practice was provided:

> […] a set of theories applicable in a particular field of practice that provides an explanation of clinical phenomena and suggests the type of intervention the therapist should make. It is

the link between theory and practice, a guide in translating philosophy and theory into action. (Creek and Feaver, 1993a, p. 5)

Using the previous definitions of concepts, theory and models of practice it is possible to identify these in the occupational therapy forensic literature. Lloyd (1995) summarised why theory was important for occupational therapy practice in general, but did not link this to occupational therapy in forensic settings. Lloyd (1995) indicates how theory can be applied to, but not derived from practice. Thus, according to Lloyd (1995), ideas and explanations in occupational therapy practice are generated using models, where frames of reference provide the underlying assumptions and concepts used in the models.
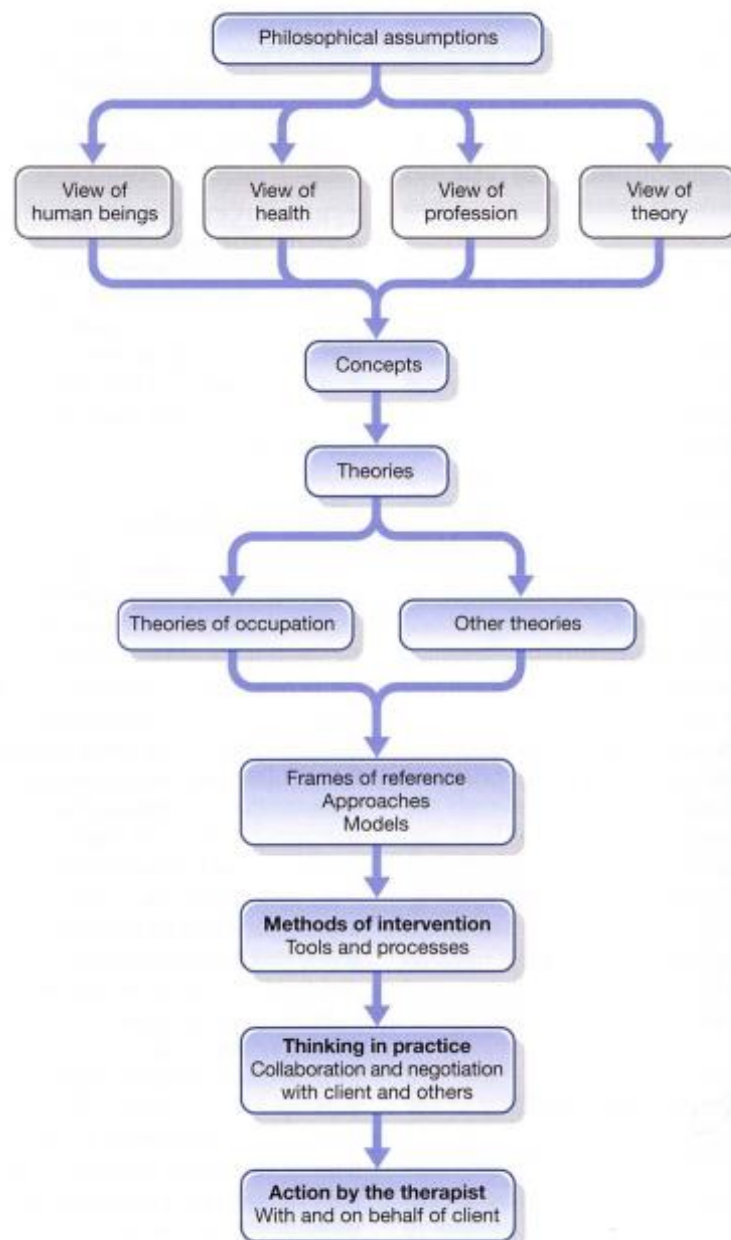
Figure 5. Theoretical framework for occupational therapy theory (source: Creek, 2008, p. 50)

Models can be a generic guide to practice (Creek, 2008), such as Adaptation through Occupation (Reed and Sanderson, 1999), or they can provide more guidance, a structured procedure and tools for intervention (Creek, 2008). For example, the Model of Human Occupation (Kielhofner, 2008) provides various concepts for understanding occupational participation and, to measure these, a large range of standardised assessments. In comparison, there is less literature about interventions using the model, they include group-work (Parkinson, 2014; Kaplan, 1988) and for improving motivation for occupational engagement (De las Heras, Llerena, and Kielhofner, 2003). The Model of Human Occupation has been used extensively in occupational therapy in the forensic setting (COT, 2012).

Lloyd's (1995a) view that the occupational therapists' underlying assumptions and concepts can be found in frames of reference are evident in how moral beliefs about how individuals should behave in society are discussed in the literature. For example, service users should learn to function in society using acceptable behaviours (Freeman, 1982; Lloyd and Guerra, 1988) and should develop their social responsibilities (Lloyd, 1985). Lloyd (1987b) echoes these comments in relation to female offenders. Working with prisoners Farnworth, Morgan and Fernando (1987) suggested that the community would benefit, as well as the prisoner when returning with independent living skills. Freeman (1982) stated that the service user needed to develop an awareness of, and a caring for others within their community. Lloyd (1985) commented similarly, using one part of the definition of performance by Fidler (cited in Lloyd, 1985, p.139), from general psychiatry, which includes the client's ability to contribute to the needs and welfare of others. On the basis of these moral beliefs therapists have the potential to plan interventions to develop skills for socially acceptable occupational participation.

Concepts from other disciplines have been discussed such as deviance, but this has not been defined clearly or explained further by Lloyd (1987 a & c). Lloyd (1987a) links moral beliefs with deviance, suggesting the service user may have limited understanding of moral values, which could be seen as deviant. Lloyd (1987c) also refers back to deviance by identifying seeing the occupational therapist's role with sex offenders as "maximising the potential of the individual to cope with non-deviant life experiences" (p.67). The control theory of deviance (Hirschi,1969, cited in Jones and McColl,1991, p.81) is referred to but without any details provided, it is unclear from where this work stems.

Summary

The case examples of practice experiences (McQue, 2003 and Chacksfield, 2003) were used as supporting information. From the examples shown, theory in practice beyond models of practice is sparse. Certainly some moral beliefs and assumptions in the literature seem to indicate how they may form part of a frame of reference about how service users should be treated and therefore underlie practice. The concept of deviance has also been considered, but this too is not coherently formed into a theory that links with occupation and occupational therapy in forensic practice. Thus the theoretical elements of practice are underdeveloped.

The occupational therapy forensic literature discussed above does not include consideration of the intricacy of occupational therapists' practice experience. There were no descriptions or explanations of the place of practice experiences in knowledge creation. Knowledge can be created from practice to be used in practice and placed in the public domain, but is apparently not valued and as such remains unexplored in the current literature; therefore I seek to examine this aspect. My research sought to use the theoretical framework of Cook and Wagenaar's (2012) epistemology of practice, which conceptualises practice as primary and distinct, but relational with knowledge and context. I applied this framework to a professional group other than public administration.

Any notion of practice, best or otherwise, needs to take into account the characteristics of professional practice as part of the relationship between practices, evidence based practice and a practice epistemology. In order to do this, and to demonstrate how professional practice is characterised, I first consider various practitioners' views on their practice. I then move away from the forensic literature to the sociological and practice epistemology literature.

1.3.5 Characteristics of professional practice: what different practitioners say about practice.

Practice in health-care is understood in a limited way. Such limitations can be created through an emphasis on evidence for effective interventions, through an evidence based approach and its associated pathways and guidelines. So there

are various aspects of practice which are marginalised, with a focus on evidence based interventions and also within forensic settings, risk minimisation.

There are a few voices indicating a different perspective. Physiotherapists and educators, Higgs, Titchen and Neville (2001) see practice in health-care as a blend of artistry, science, craftsmanship and compassion. This blend can help to manage complex and unforeseen challenges filled with uncertainty, suggested by Eraut (1994), an educator of teachers; and described as the "swampy lowlands" by Schön (1991, p. 42), a professor of urban studies and education. Fish (1998), a former secondary school teacher and lecturer in education, sees practice as needing a holistic approach and an acknowledgement of the contextual influences, such as uncertainty (Schön, 1991). Cook and Wagenaar (2012), a philosopher and a policy scholar respectively, suggest another feature of context in practice is that it is swift, fleeting and to varying degrees can be difficult to modify. It is suggested by Beeston and Higgs (2001), both academics and physiotherapists, that the processes of change, which are dynamic and develop over time should be acknowledged. There is an unplanned, improvisational quality to practice (Cook and Wagenaar, 2012), which by its very nature cannot be pre-planned or fully prepared for. Practice therefore is characterised by an indefinable quality that is invisible and mysterious and which has an intuitive and a tacit dimension (Fish, 1998; Fish and Coles, 1998).

The components of practice are formed from what Fish and Coles (1998) call the iceberg metaphor of professional practice (see figure 6). This metaphor is taken further by Fish (1998) where she highlights that it is by understanding the hidden expertise below the water line and developing what lies beneath, that practice is given stability; otherwise this could lead to the iceberg capsizing because the buoyancy is affected by too much doing in professional practice (Fish, 1998). The assumption is that one can bring what is hidden into plain view in order to do something with it. The hidden aspects of professional practice have been called tacit knowing (Polanyi 1966), discussed later. In order to improve practice the clinician needs to look at what they do and identify and increase their understanding of the tacit knowledge at play, by using reflection (Fish and Coles, 1998). In this process practitioners become researchers of their own clinical practice, which is the understanding of practical know-how, of knowing as doing and skilful performance, called the artistry of practice (Fish, 1998), discussed later.

What has been implicit within this discussion so far is that practice is not seen as only being informed by knowledge, with knowledge being applied to practice, as in evidence based practice. The authors whose work I have cited question the primary position of knowledge over practice characteristic of Cartesian views of knowledge. Indeed, Cook and Wagenaar (2012) develop this argument, as they see knowledge as evoked within and explained in terms of the context in which knowledge is situated and as the sum of all practice experiences. This means the accumulation of all jobs performed with the various tasks, roles, skills, decisions and their consequences (Stolcis 2004 cited in Cook and Wagenaar, 2012, p4). Practice therefore includes the histories, futures and aspects that afford and constrain action.

The theoretical arguments about characteristics of professional practice, noted above, illustrated how practice cannot be informed by knowledge alone and how health-care practice needs a holistic approach which includes the wider socio-cultural, political and economic circumstances (Nicolini, 2012, Green, 2009), that can combine science, artistry, craftsmanship and compassion (Higgs, Titchen and Neville, 2001). My research sought to explore what it is that constitutes knowledge from practice, making an original contribution to the field in that no one has investigated this specific area within occupational therapy in the forensic setting and it has not been widely discussed within the profession as a whole (Boniface and Seymour, 2012; Turpin and Iwama, 2011).

Occupational therapy in forensic mental health is a discipline that works with service users who have convoluted health and social needs, within a multifaceted environment, as indicated by the two vignettes of John and Bob. Such intricacy is reflected in the variety of types of knowledge that are a part of practice. What knowledge is used, how it is used, how it influences and is influenced by practice is unclear.

Doing: The things that can be seen and heard in what we say and do in professional daily life.

Experience: On the water surface is the awareness of, and just below the surface is the lack of awareness of one's ways doing and saying.
Knowledge: Just below the surface lies one's know-how. This is made of personal theory and some formal theory.
Feelings

Expectations & Assumptions: bedded onto the three following aspects:

Attitudes
Beliefs
Values

Figure 6. Iceberg of professional practice (source: Fish and Coles, 1998, p. 306)

My research seeks to identify the knowledge used and created in the practice of occupational therapy in forensic settings and to consider how this understanding can improve practice. Ultimately therefore, at the core of this research lies the question:

What does a practice epistemology contribute to our understanding of occupational therapists' practice in forensic mental health?

To address this question I went beyond the world of occupational therapy and included a review of knowledge in professions from sociology. I then provided a discussion of a theoretical framework of a practice epistemology, considering how I can apply my experience to this and to develop a research design to explore other occupational therapists' practice in forensic mental health. My research design included the methods of the critical incident technique, the critical decision method, grounded theory and situational analysis, which are briefly outlined next.

In order to answer the research question. I have used the critical decision method (Crandall, Klein and Hoffman, 2006; Hoffman, Crandall and Shadbolt, 1998; O'Hare et al, 1998; Klein, Calderwood, and MacGregor, 1989), using a range of critical incidents (Flanagan, 1954) linked to each practitioners' practice of the occupational therapy process with one service user for up to 12 months. I examined the critical incidents by using the critical decision method probes of the practitioners' decisions and actions made over the 12 months. My research design is longitudinal and includes multiple critical incidents to reflect the range of practices over the trajectory of occupational therapy provision in forensic settings. The data generation and analysis approach was impacted by three issues. Firstly, data analysis was underdeveloped and limited in the critical decision method. Secondly, data generation by interviews was longitudinal and thirdly, I needed to capture the multifaceted nature of the setting and the occupational therapists' practice. Consequently I chose grounded theory (Corbin and Strauss 2008) for data generation and analysis which was further informed by situational analysis (Clarke, 2005). My design was inspired by the theoretical framework of practice epistemology, set within a context of the sociological literature.

2. DOING OCCUPATIONAL THERAPY IN FORENSIC MENTAL HEALTH: A DIALOGUE WITH PRACTICE EPISTEMOLOGY

In this section I briefly summarise the sociological views of the development of professions and specifically the place of knowledge in professions. Following on from this I discuss various practice epistemology theories and I choose one to which I apply my experience in the forensic mental health setting.

2.1 Sociological perspectives on knowledge in professions

Since the Enlightenment an assumption developed in the western world that empirical evidence was objective knowledge, developed from a scientific-theoretical understanding and was purported to be the best form of knowledge (Whiteford, 2005). This view was shaped by Descartes who also influenced ideas that knowledge precedes practice, which stems from the duality of knowledge and practice that are seen as separate entities and where knowledge is reified over practice (Cook and Wagenaar, 2012; Hager, Lee and Reich, 2012). For instance, training is based on this approach where one learns something and is expected to apply it to the work place (Cook and Wagenaar, 2012; Schön, 1991). A Cartesian view of practice and evidence based practice would see practice as a result of the application of knowledge to a particular health problem. Positivist epistemology stems from the Cartesian perspective (Schön, 1991), and as has been noted before, this does not fit well with the artistry of practice of Schön (1991) and Cook and Wagenaar's (2012) practice epistemology.

From the Enlightenment onwards, empiricism and the scientific method developed (Porter, 2000). There was a move from value laden, tribal and group based knowledge, to supposedly formalised and value-free knowledge (Porter, 2000; Macdonald, 1995). Individuals could engage in learning, build their expertise and develop stores of knowledge (Macdonald, 1995). From the 1850s to the present day there "has been a continuous increase of specialisation in the pursuit and application of complex, formal knowledge and technique" (Freidson, 2001, p.21). There was a move from the 'gentleman scholars', such as Charles Darwin, who were financially self-supporting, to a new world in which the middle-classes were able to explore opportunities for full-time paid occupations (Freidson, 2001). Splits

occurred from the status professions, the original intellectual occupations from medieval universities that included doctors, the clergy, lawyers and university lecturers (Elliott, 1972, cited in Freidson, 2001, p.21). These splits led to the notary public emerging from the legal profession, psychology and social work extended from the clergy (Goode, 1969), and also 'bone-setters' developed from the field of medicine (Freidson, 2001). Consequently, these developments had an impact upon the development of professions and the specific knowledge base for professions.

As with practitioners (discussed earlier), so too have sociologists characterised professional practice. Practice includes autonomous and self-directed work, with discretion applied to the selection of clients and the service to be provided, which is based on the level of competence of the professional (Freidson, 1986). Collaboration with others in professional practice is also an important characteristic (Freidson, 1986). A professional has the capacity to deal with non-routine aspects of problems with living that fall into their domain of knowledge (Goode, 1969; Freidson, 2001). A profession can be characterised as a specialisation in a field where there are multifarious issues to be dealt with. These may have some mechanical aspects, but overall they are such that they cannot be standardised or rationalised; and therefore can innovate and create (Freidson, 2001). This implies the need for the use of professional judgement if tasks are to be performed successfully. These problems may have an indeterminate outcome (Jamous and Pellaille, 1970 and Boreham, 1983, cited in Freidson, 2001, p23) which requires attention to the variation found in individual cases (Freidson, 2001).

In sociological terms, claims to an abstract knowledge base are also one way of determining a group's status as a profession (Goode, 1969). An abstract knowledge base includes a body of principles which would have empirical and social value, as well as including an appropriate level of quality and quantity of knowledge for that profession (Goode, 1969). Abbott (1988) notes that abstract professional knowledge, incorporates a complete set of principles established in a logical, consistent and rational classification system, (one of two, inference being the other). Freidson (1986) considered professional knowledge to be specialised, as well as developed and sustained in higher education by teacher/ researchers. Therefore, professions are a group that must create, organise, transmit and be an arbiter of their knowledge base (Goode, 1969), which is a system of substantive

statements composed of ideas and theories about human activities (Freidson, 1986). Occupational therapy considers itself to be a developing profession in these terms (Hooper, 2006).

For Abbott (1988), academic knowledge is primarily abstract and has the purpose of being applied within the practice of a profession, so exclusive groups apply abstract knowledge to particular cases. Abstract knowledge is accessible in textbooks of a given profession (Abbott, 1988). Freidson (1986) however, proposed that once professionals apply their knowledge in practice, it is changed for a number of reasons. These changes include novice professionals putting theory into practice within contextual features such as the situation, the client, the service provided and financial transactions. Also formal knowledge becomes altered and adapted into lay language to meet the needs of both the client and the limits of the professional's knowledge and expertise at that point (Freidson, 1986). It is because of these alterations that one cannot analyse the documents of formal knowledge in a profession to understand the knowledge used in professional practice (Freidson, 1986).

Both Abbott's and Freidson's work on knowledge in professions was based on the assumption that abstract knowledge underpins and leads to practice. Freidson proposed that such abstract knowledge is changed when applied to practice. This suggested that knowledge for practice has a different quality to the abstract knowledge used to teach professionals. Neither Abbott, nor Freidson consider practice as a creator of knowledge or a form of knowledge in itself. This leads to a discussion on developing theories of practice and how it relates to knowledge, otherwise labelled as epistemology.

2.2 Forms of practice epistemology

There have been discussions in the literature about having practice epistemology for professions in general (Schön 1991); for health-care professions (Richardson, Higgs and Dahlgren, 2004); for occupational therapy specifically (Mitchell 2013); and for public administrators (Cook and Wagenaar 2012). The various conceptualisations of a practice epistemology from the foregoing authors are discussed next.

Schön's (1991) work on reflection and its implications for professional thinking has been encompassed within occupational therapy in relation to professional development (Kinsella, 2001), clinical reasoning (Hooper, 1997; Mattingly and Fleming, 1994) and occupational therapy student education (Collins et al, 2011). Schön (1991) developed a view of a practice epistemology that incorporated two facets. Firstly the positivistic perspective that Schön labelled technical rational, where scientific theory and techniques that had grown from an increasingly industrialised and technological society were applied to the problems of practice; and where there was no place for artistry and craft in rigorous practice knowledge. Schön (1991) saw curricula for the education of professionals that stressed the application of universal rules and theories to practice as too dominant. The second aspect was Schön's re-conceptualisation of a practice epistemology that incorporated "artistic, intuitive processes" (1991, p49). These processes could be brought to situations in practice that included a conflict of values, or that were uncertain, unstable or unique (Schön, 1991). Therefore Schön's management of complex practice situations required the use of creativity and feelings about ways to practice. Schön researched various professions including the profession of psychotherapy, but he did not research other health-care disciplines.

Physiotherapists and lecturers, Richardson, Higgs and Dahlgren (2004), included Schön's work in a practice epistemology for a health care context within disciplines such as nursing, physiotherapy and occupational therapy. Their definition includes "the nature of knowledge and the processes of generation of knowledge which underlie practice" (Richardson, Higgs and Dahlgren, 2004, p. 5). There is a suggestion here that knowledge informs practice, however Richardson, Higgs and Dahlgren (2004) also include a range of sources of knowledge whose development is interdependent with the development of practice. This conceptualisation has an inclusive approach that recognises different forms of knowledge, which can be incorporated into a practice epistemology. There is a sense of a process of knowledge creation that cannot be separated from the dynamics of practice. A more recent definition of practice epistemology incorporates and develops these characteristics (Mitchell, 2013).

An American occupational therapist, Anita Witt Mitchell (2013), has explored what she has called an occupational therapy practice epistemology. Particular

knowledge types are included in this epistemology which "is based on contextual relativism and flexibility, and yet some aspects of knowledge used by occupational therapists tend to be more certain and absolute, like anatomy and biomechanics" (Mitchell, 2013, p.14). This is helpful in elaborating some of the knowledge forms that can be located in a practice epistemology, and as its title signifies, the community for which this epistemology is directed. There is however, limited explication of how knowledge is created from practice in Mitchell's definition. Also Mitchell (2013) locates knowledge and practice within the individual and she does not acknowledge the social and collective nature of knowledge generation. This may stem from some of her sources being from educational psychology and cognitive aspects of epistemology and her particular study of positions taken by students over their educational life. Also occupational therapy is essentially concerned with practice, not theory, so the profession is eclectic in drawing on other sources to use in practice. This is reflected in my interest in Cook and Wagenaar's (2012) work in which their definition also addresses social aspects in knowledge.

Cook and Wagenaar (2012) theorise how practice creates knowledge and context, rather than knowledge being the creator of practice. A practice epistemology here is a detailed definition

> as both the study of knowledge and…the systematically related bits of knowledge of a given community and the patterned activities that give rise to them (i.e. knowledge) and imbue them with the particular sense or meaning that enables us to recognize them as relevant, usable knowledge in a given context (p. 16).

The above definition will therefore be dealt with in sections. Firstly, it is seen "as both the study of knowledge and […] the systematically related bits of knowledge of a given community" (p. 16). This statement acknowledges that a range of knowledge is required in practice. Here social and collective relationships bring different and related knowledge to a practitioner community. A community can be intra-disciplinary as in occupational therapists and inter-disciplinary as in a multi-disciplinary team. These forms of community and how their knowledge combine systematically are discussed in Cook and Wagenaar's (2012) abstract, but it is not

explained how this occurs. This feature therefore requires further theoretical development and empirical exploration.

The next part of Cook and Wagenaar's (2012) definition is that "the patterned activities that give rise to them (i.e. knowledge) and imbue them with the particular sense or meaning that enables us to recognize them as relevant, usable knowledge in a given context" (p. 16). This indicates that practice can lead to the creation of knowledge, and practice can represent knowledge that is significant to that context and can be used within it. If some knowledge is found to be irrelevant to that context it is not used in practice at that time and situation. A key point in this definition is that knowledge, context and practice are seen as inseparable. This view of a practice epistemology sees practice as a primary source of knowledge in itself and the creator of knowledge and context from practice. Thus practice is no longer relegated to a secondary or lowly position in relation to technical rational epistemology.

It is important to note how the practice perspectives discussed so far did not differentiate between theory and practice and knowing and doing. It is therefore ironic that a theoretical stance is required for the practice of my research. I therefore see the theoretical work as inspiration which is used in my research practice, but is not a base or foundation for my research. Having considered a range of definitions of a practice epistemology, I use Cook and Wagenaar's (2012) work for my research. Cook and Wagenaar's explanations were based around public administration and so the work of Richardson, Higgs and Dahlgren (2004) was more relevant in the context as it took into consideration the field of health-care. Mitchell's (2013) work was specific to occupational therapy, the profession being studied here, which was of some use.

Practice epistemology requires greater in depth analysis and explanation; as such practice epistemology can be applied to various professional groups in order to establish its use for practice. In this thesis, the methodology used to achieve this will be an examination of health care within the context of forensic mental health particularly through an exploration of one profession in that field, occupational therapy. Before considering the practice framework and occupational therapy in forensic mental health, concepts in common within practice epistemology are discussed.

2.3 A comparison of concepts in practice epistemology

There are various commonalities between the concepts and forms of knowledge incorporated within an epistemology of practice. I discuss conceptualisations of knowledge and their broad relationships with each other, as well as the developments of related concepts of professional artistry and professional craft knowledge (see figure 8). Definitions of what are concepts and theory have been noted earlier in the section on theory and the occupational therapy literature and I therefore move on to consider forms of knowledge in practice epistemology.

Forms of knowledge common to practice epistemology

The conceptualisations of practice epistemology noted above have some forms of knowledge in common. Tacit knowing (Polanyi, 1966) and *knowing how* and *knowing that* (Ryle 1949) (plus some additional ones) were built into a model of practice knowledge (Higgs et al, 2004; Higgs et al, 2001) and a practice epistemology (Cook and Wagenaar, 2012). The preceding authors, along with their relevance to my research, are discussed following a review of the various forms of knowledge (see Figure 8).

Knowing how and tacit knowing are associated with professional artistry and professional craft knowledge. Artistry of professions was conceptualised by Schön (1991) and has been incorporated into and developed further through Titchen's (2000) and Titchen and Ersser's (2001 a and b) concept of professional craft knowledge. Professional craft knowledge is a metaphor developed from educational research (Brown, McIntyre and McAlpine, 1988) which subsequently was developed with nursing and other educational research, social science and philosophical concepts applied to it. Professional craft knowledge includes tacit knowing that is embedded in practice, through experience, and is specific knowledge that is particular to a client and situation. It is seen as ordinary, is often taken for granted and is not considered worthy of mentioning, but it is also not directly accessible because it is tacit; so it is unarticulated and intuitive knowledge (Titchen, 2000).
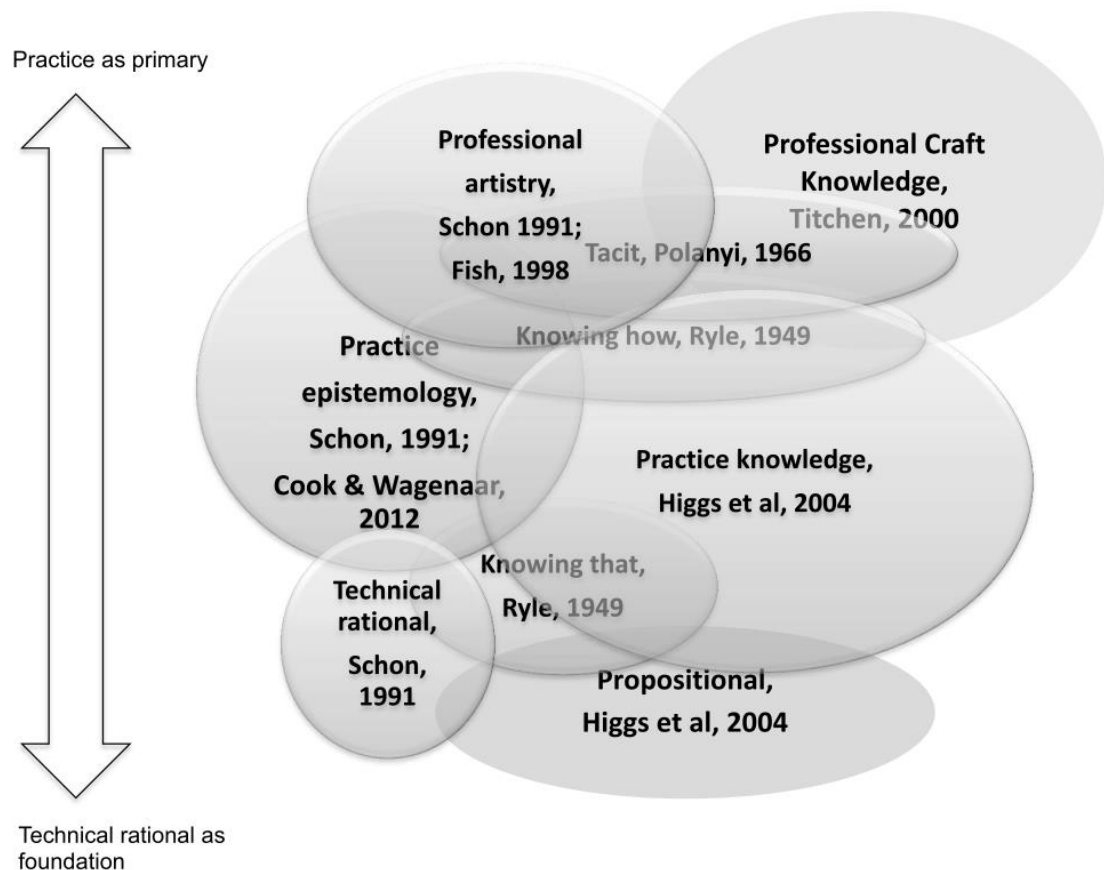
Figure 7. Connections between forms of knowledge within practice epistemology (source: Cordingley, 2015)

Knowing that is about things expressed in propositions that can be known immediately and can be tested as a truth or be falsified (Cook and Wagenaar, 2012). The previous authors as well as Higgs, Andresen and Fish (2004) use the term propositional knowledge which describes and predicts phenomena using scientific and technical knowledge. This is broadly similar to Schön's (1991) technical rational knowledge. An example from the forensic setting is knowledge that a service user may not have leave beyond the secure unit because the required permission from the Ministry of Justice had not been granted.

Tacit knowing is that which is rarely brought to conscious thought, but includes fast decisions that seem almost instantaneous, knowledge that is associated with what appear to be automatic actions and knowing more than we can say (Polanyi 1966). Authors that utilise tacit knowledge in their conceptualisation of a practice epistemology include Schön (1991) and Cook and Wagenaar (2012). Tacit knowing is incorporated in the concept of professional craft knowledge (Titchen,

2000), which in turn is incorporated into a model of practice knowledge (Higgs, Andresen and Fish, 2004), both of which are discussed later. Ryle's (1949) work is also influential, considered next.

The separate concepts of *knowing how* and *knowing that*, established by Ryle (1949) are common to the literature on practice epistemology including Schön (1991), Cook and Wagenaar (2012), Higgs, Andresen and Fish (2004) and Titchen (2000). There is a distinction between knowledge that is acquired through experience and practice and knowledge derived through research and scholarship (Parry, 2001). *Knowing how* enables action and therefore practice and is not expressed or tested in the same terms as knowing that. *Knowing how* and *knowing that* are often associated with, but are distinct from tacit and explicit knowledge respectively (Cook and Wagenaar, 2012). An example of *knowing that* from the forensic setting would be someone who has worked for a few years in a forensic service and who would have internalised the various security measures required. This would include the use of keys and placing keys on a secure belt before entering a secure service user area, a practice which would be contained in organisational policies and procedures. An example of learning through experience and knowing how is checking there are no service users following the member of staff as they go to open the ward door to leave. Waiting by the door to check the magnetic locking system has locked and checking the door before moving away. Both eventually become second nature in a secure environment.

Many of the forms of knowledge depicted in figure 7 above are incorporated into Higgs, Andresen and Fish (2004) model of practice knowledge, illustrated next.

A model of practice knowledge

A model of practice knowledge includes a variety of forms of knowledge and methods by which the knowledge is generated and applied in practice (Higgs, Andresen and Fish (2004). The model attempts to capture the complexity of practice and the practice environment and the unpredictability of it (Eraut, 1994). The value of such a model is to enable experiential knowledge developed from clinical practice to be put through a process of critical analysis. This analysis can then be used to re-organise, generate and implement clinical experiences as

practice knowledge to use as evidence in clinical practice (Richardson, Higgs and Dahlgren, 2004).

Knowledge in this model has been categorised into three broad areas of propositional, procedural and emancipatory knowledge (see figure 8) (Higgs, Andresen and Fish, 2004) and each is now described. Propositional knowledge has been described above. Procedural knowledge enables action and is comprised of experiential and professional craft knowledge. Personal experiential knowledge consists of the knowledge gained through individual life experiences, and also includes the knowledge of the community and culture in which the person lives. It incorporates both experiences and crises from the personal and professional life that are accompanied by reflection (Higgs et al, 2004). This knowing requires the whole engagement of the whole person and their thinking, sensing and perceptions (Higgs et al, 2004). These three types of knowledge combine to create and form part of theoretical and deductive knowledge which explains and interprets practice experiences (Higgs et al, 2004). The different forms of knowledge overlap, inform each other, transform or extend one to the other (Higgs et al, 2004). Informing knowledge and driving practice are non-observable aspects of the practitioner including: their thinking, assumptions, values, emotions, beliefs and theories (Fish and Coles, 1998) as in the iceberg of professional practice (Fish, 1998).

Clarifying that there are various forms of knowledge that operate within practice that go beyond propositional and technical rational knowledge is valuable for the practitioner as it encompasses a broader view of what can potentially be applied as evidence for practice as suggested by Dawes et al (2005). The focus of Higgs et al (2004) model is to provide a way to incorporate a range of knowledge and evidence to be employed critically for a modified version of evidence based practice in health-care professions. Higgs et al (2004) clearly and rightly see it as important to have evidence to use in health-care. The focus on making use of various forms of knowledge purely for evidence based practice misses out on a more fluid, dynamic and practice focussed approach, which is captured in Cook and Wagenaar's (2012) practice epistemology discussed next.
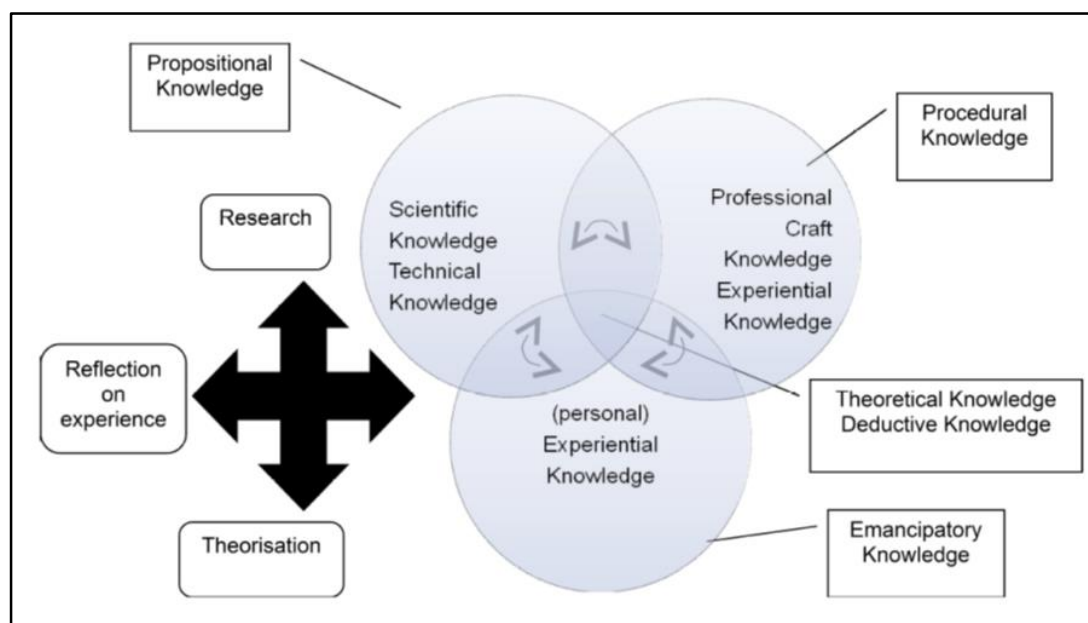
Figure 8. Model of practice knowledge (source: Higgs, Andresen and Fish, 2004, p. 63)

2.4 Practice epistemology applied to occupational therapy in the forensic setting

The practice context applied to explore Cook and Wagenaar's (2012) theory of a practice epistemology is that of public administrators in the form of detectives in a police force and the development of a criminal case. In order to demonstrate whether Cook and Wagenaar's conceptualisations are a useful fit for occupational therapy I apply them to my practice experience as a former occupational therapist in forensic mental health, based on an overview of usual aspects of my practice. As previously stated, my experience indicated the limitations of rational, evidence based approaches and the need for a more inclusive definition of knowledge as evidence.

Cook and Wagenaar's (2012) work is combined with, amongst others, the American pragmatist philosophy of Dewey and Peirce and two Japanese philosophers' work (Nishida, 1911/1990 and Watsuji, 1935/1961 cited in Cook and Wagenaar, 2012, p. 23) and also by Zen philosophy. Borrowed from Japanese philosophy is the belief that knowledge is non-dualist, with relationships in philosophy seen as fluid and dynamic. These are used to reframe the position of knowledge and practice as seen in the Cartesian and Received Views, thus

conceptualising an epistemology of practice (see figures 9 and 10) (Cook and Wagenaar, 2012). Professional knowledge is increasingly being seen as created in situ, through practise (Cook and Wagenaar, 2012). Thus two key views of Cook and Wagenaar (2012) are presented. Firstly that knowledge is inclusive in that it incorporates forms of knowledge such as embodied, engaged and contextualised agency. Secondly that their view of an epistemology of practice includes inquiry that incorporates these knowledge forms, and acknowledges the constraints and possibilities in or of practice (Cook and Wagenaar, 2012).
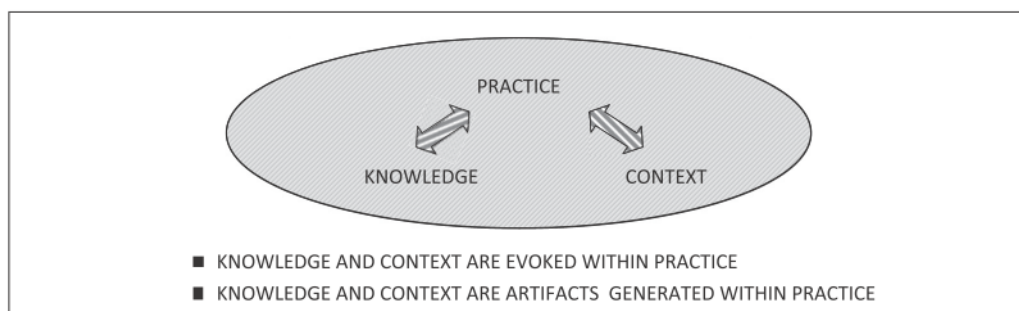
Figure 9. An epistemology of practice (source: Cook and Wagenaar, 2012, p. 18)

There are three interrelated concepts that represent practice: 'actionable understanding', 'eternally unfolding present', and 'on-going business' (Cook and Wagenaar, 2012). Practice is about actionable understanding that is informed by a constantly renewed past, and is directed at what is always a partially decipherable future. This is situated in a present that is eternally unfolding and acted upon within the on-going business of action. In the following section, I will flesh out each of these concepts and apply each one in turn to my practice experience in occupational therapy in forensic mental health.
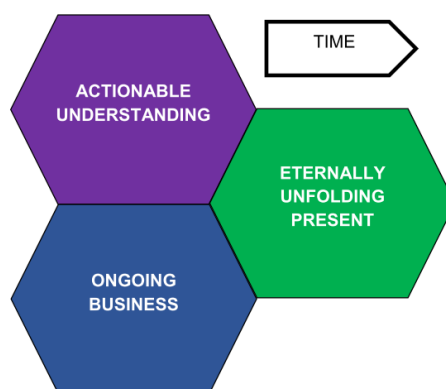
Figure 10. An epistemology of practice (source: Cordingley, after Cook and Wagenaar, 2012)

Actionable understanding accounts for what practitioners do and is explained in terms of the practitioner. The practitioner understands what is known or needs to be known, but knowledge in itself does not direct what is done. Actionable understanding involves the process of mutual understanding of a case, which is constructed by practitioners, and along with the joint achievements of practitioners, enables taking acceptable actions. The case, in the forensic setting, may represent a service user, or given the large amount of group-work involved in occupational therapy, the case may also represent a group of service users. Actionable understanding can be facilitated and constrained by the various rights, responsibilities and expectations of the practitioners both within the practitioner's working world and also in the wider outside world.

Underlying this process is that a form of practice is generated where existing knowledge may be deployed. Within this sphere, a new knowledge may also be created, but it is not primarily a matter of applying knowledge to practice. Practice is seen as primary and knowledge is a tool of and has utility within practice.
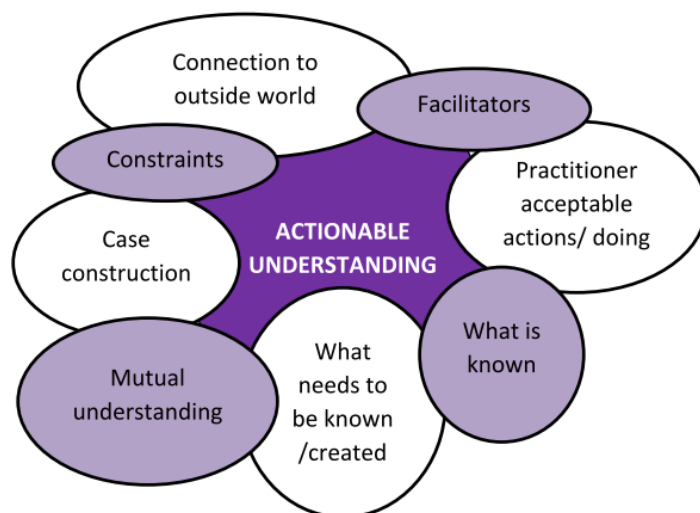
Figure 11. Actionable understanding (source: Cordingley, after Cook and Wagenaar, 2012)

Actionable understanding is explored next in relation to my practice experience in occupational therapy within the forensic mental health field and through the mutual understandings between team members and me.

Actionable understanding **and my practice experience of occupational therapy in forensic mental health**

I had a number of actions to complete that represented work to be done with most service users, also an element of on-going business, discussed later. The wider organisational and team expectations meant that I worked with a blanket referral approach where all service users were seen by me. My professional code of conduct also required me to use the occupational therapy process to structure my practice (COT, 2015). This guides practice and includes: referral, assessment, intervention planning, intervention, evaluation and discharge (Lloyd, 1985; 1987 a, b, c and d). One thing I did was to remain alert until I could act at a specific point. For instance, I would listen for potential referrals to the ward and team, as they were briefly highlighted in each multi-disciplinary team meeting. Then I would wait to hear about any new admission plans. A service user's admission would trigger me to attend a review of the service user's history presented in the first multi-disciplinary team meeting following their admission I would start to complete an admission summary sheet (see appendix 1) also review and organise preliminary information such as previous psychiatric reports, index offence details; police interview transcripts of both service user and witness statements and on occasion, photographs of the crime scene. I reviewed this information for the details relevant to occupational therapy in that setting. I sourced previous admission details and occupational therapy notes and reports from other services. *Actionable understanding* here meant that my actions were to read, review, collate and organise information relevant to my practice from a wide range of sources.

An example of *actionable understanding,* where I developed ways of doing things from the experience of that practice setting, were concerned with my plans for the potential direction that the occupational therapy process might take. I did not always follow this process as stated in the literature. I found I needed to consider the point at which to make contact with the service user and what form that contact would take, which sometimes came before I had even reviewed or discussed the service user's history (as in Bob's vignette). I usually reviewed other professionals' work first, and considered the service users' mental state and their stated wishes (if known) before deciding on an initial plan of action. Often the service user had come from prison, was acutely unwell, had not had much contact with friends or family and had difficulties sorting out financial and social needs related to their

home circumstances. It was better for me to wait until these issues were dealt with and the service user was less concerned by such matters. My *actionable understanding* would therefore be informed by whether I thought the service user required more input from nurses, psychiatrists and/or social workers before I made formal contact. I would thus remain alert to the service user's improvements, but also utilise the practice context and service user's behaviour to initiate less formal contact because I would see service users on the ward before I carried out any formal work.

Making first contact could be influenced by whether I was familiar with the service user from a previous admission, and what their mental state was as reported by other disciplines. Indeed, I was based in an office on the ward and to gain access I had to walk through it, and there were many occasions when I 'bumped' into a new service user on the ward and introduced myself before I had any detailed knowledge of their current situation, for example in Bob's vignette. This could be due to an emergency admission occurring before the team could be informed in a ward round.

I started to build a picture of the service user, identifying my working hypotheses of what were the potential occupational participation needs and skills and possible reasons why these had developed in that way.

Actionable understanding in occupational therapy therefore signifies that multi-disciplinary team members would have a broad understanding of each other's process. Indeed, the first vignette of John's case history is an example of mutual understanding where that information is needed by all members to varying degrees to inform their practice. Mutual understanding also manifests where the team will have some knowledge of a specific aspect of others' work from discussions in clinical team meetings, joint assessments, and joint working on particular pieces of therapeutic work. Team members, of course, have varying degrees of depth of understanding of each other's discipline, but it is through the team's work with the service user that the practice of each discipline becomes increasingly apparent. It is within this context, where team members have various degrees of experience, that the specifics of each new service user, with their unique characteristics, demand the development of innovative and different ways of working, thus creating a new knowledge from practice.

One example of this mutual understanding that also became part of my new knowledge and of the different ways of working was from a discussion between the team that ultimately progressed to me and the consultant psychiatrist. The team were challenged about a service user called Charlie whom we could not engage in basic self-care tasks. He had developed substantial body odour and this was becoming a wider problem because his room was also becoming malodorous to the extent that it seeped into the surrounding ward corridor. Other service users were complaining, and some were verbally and physically targeting Charlie. He therefore became a target for harm by other service users, plus he had possible hygiene problems. The nurses usually took a lead in self-care with the service users. They had great difficulty educating and encouraging Charlie to understand the issues that were arising due to this form of self-neglect. Neither could they motivate Charlie to keep clean. The psychiatrist had knowledge of occupational therapists working within neurology and people who had experienced head injuries and strokes. Charlie had a head injury some years prior to his admission to the unit, and his routines on the unit were mainly to make tea, smoke in the allocated lounge and to spend much of his day in his bedroom. It was therefore difficult to establish his performance skills of problem solving and managing activities. He had been observed performing basic tasks of making a hot drink, rolling cigarettes and basic money management. The psychiatrist suggested I look into cognitive problems of executive dysfunction possibly affecting his ability to recognise his behaviours and the impact they were having on others. This was new knowledge to me and prior to my experience with the CASP project mentioned in my preface. Consequently, I spoke to an occupational therapist working in neurology. She explained executive dysfunction in head injury, how it manifested in occupational participation and how I could assess for related participation problems. On the basis of this new knowledge I set about making a plan with Charlie's primary nurse to explore the situation with Charlie.

Here was a situation where the psychiatrist's knowledge and experience of occupational therapy in neurology that was not connected to the mental health setting, was used to develop my knowledge. This was also facilitated by the psychiatrist's existing knowledge of my role. My knowledge of occupational therapy was enough to facilitate my further understanding when combined with knowledge from the therapist working in an unrelated practice area of neurology. Without such

mutual understanding between practitioners, prompted by Charlie and his complex neurological and mental health problems, this *actionable understanding* would not have arisen.

The next concept is the *eternally unfolding present* which is an acknowledgement of the temporal elements where practice is seen as necessarily occurring in the present (Cook and Wagenaar, 2012). Discussion about a case between disciplines takes place in the present and this dialogue is seen as a component of practice occurring in the present (Cook and Wagenaar, 2012). Cook and Wagenaar (2012) were concerned that identifying practice as contemporaneous may be seen as trivial and may have been taken for granted. This is because to state talking occurs in the present appears obvious, and also because discussion may be perceived as a superficial aspect of practice that does not deal with deeper issues. In the *eternally unfolding present*, knowledge and context take their form and meaning from practice and so are artefacts of practice. So Cook and Wagenaar's (2012) approach has a fundamental epistemological position that means knowledge does not underlie and enable practice.
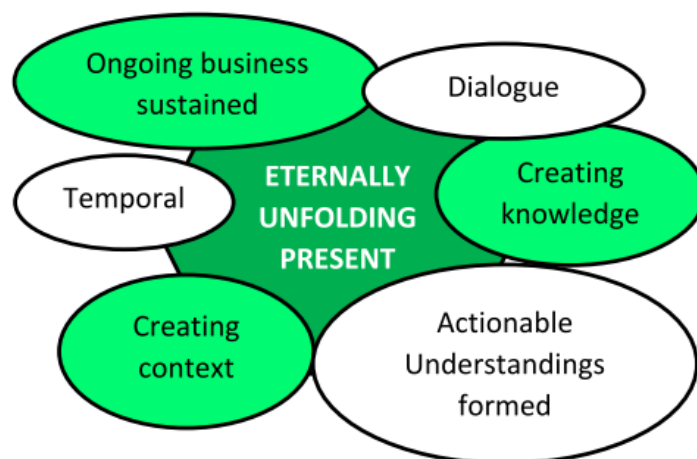
Figure 12. Eternally unfolding present (source: Cordingley, after Cook and Wagenaar, 2012)

Occupational therapy in forensic practice occurring in the *eternally unfolding present* becomes apparent at the admission to the ward of a service user that leads to the start of the occupational therapy process (Lloyd, 1985; 1987 a, b, c and d). A specific part of this process is worked on at any one time, so the impression of a linear or cyclical process is misleading because the focus might be on collecting

further information later in the service user's admission, which would be out of kilter 'with the information gathering process at the beginning of the cycle. One of my early experiences on a ward demonstrates this and also provides examples about *actionable understanding* and *on-going business.*

Vignette 3. Ben and an example of the eternally unfolding present

A service user Ben, had been low in mood, was very quiet and had been mostly staying in his room which I knew from the morning handover of nurses' information. At this point I had not had direct contact with Ben, which was not unusual with this presentation in the early days of a new admission. From Ben's admission details given in the team meeting I knew that he had worked as a cook prior to his admission. At this time I had no direct observations of Ben's current occupational participation skills and constraints. That morning I was doing a breakfast cookery session with two other service users in the ward kitchen. The ward policy was to have open access to the kitchen for all service users to make hot drinks and snacks. I was concentrating on two service users cooking fried breakfasts on the cooker hob. Ben entered the kitchen to make some breakfast. Ben made a hot drink and put some bread in the toaster. Given my focus on the other two service users, who required support, I had no opportunity to observe Ben's skills in this basic kitchen task. I made the assumption this would be fine because he was a cook and therefore had some culinary skills. I also assumed that as the kitchen was open access and the nursing staff had no specific concerns about Ben using the kitchen, it was fine for him to go ahead. He was using a different part of the large kitchen and the facilities he needed were not being used by the other service users. During this time another service user, Tony, entered the kitchen in a rush. He was followed swiftly by a nurse who tried to get Tony to stop until there was a bit more space in the kitchen. Tony ignored the nurse and went directly to the drink ingredients and started to make a hot drink. I was therefore suddenly distracted by Tony who appeared to be in a highly elated mood, and who was not paying attention to others' requests. It was not until I smelt burning, turned around to see smoke coming from the toaster and then hearing the ward fire alarm went off that I realised I had been distracted from trying to monitor Ben from a distance.

Ben's most basic cooking skills were therefore not intact at that time. My assessment of Ben's impaired participation and Tony's elation stems from the

nursing handover that indicated both were acutely unwell. There was no indication from the nurses' observations of Ben and Tony that they were presenting with behaviour that might indicate that they were more unwell than they were. It seemed to me too far-fetched that Tony and Ben had planned to cause the chaos in the kitchen, because Tony and Ben were consistently acutely unwell. Also, given Ben had been successfully employed as a cook, it indicated that his abilities may have been impacted by his acute mental health problems. This was an indication to me that I needed to further assess Ben's skills, especially if he was likely to continue to be a risk to accidentally causing a fire on the ward.

The scenario with Ben and Tony provides an example of my practice in the *eternally unfolding present* where my expectations were not met, and what I thought were reasonable assumptions about a service user, the situation I was in, and what the service users and I were doing. As a concept, the eternally unfolding present is apparent here for two reasons. Firstly I could not predict the situation occurring. I was not to know that the combination of people with their individual characteristics, that were not fully apparent to me, combined with my lack of practice knowledge of that context, at that time, in that particular kitchen environment, were a potential danger. My practice experience and resulting knowledge were contextualised through the specific combination of the people, what we were doing, the events and the environment. Secondly, this practice experience is so specific it could not have been available to me in a codified way through practice guidelines, textbooks and journal articles. In an abstract form, aspects that I was aware of included some of my core skills as an occupational therapist: activity and environmental analysis and adaptation. I considered the analyses prior to the breakfast cookery, and I found I would not be required to adapt the environment and activity at that time when working with the two service users. Tony's elated mood and presence brought much of this into question, especially with the unexpected and unpredictable dimensions that can be part of the *eternally unfolding present*.

What can be gained from applying the *eternally unfolding present* to my practice experience is that it produced a new knowledge for me, created from my practice at that point. It indicates that I wanted to maintain the ward policy to keep the kitchen and service users' access as restriction free as possible. This relates to my belief, as an occupational therapist, that I want to maintain service users' daily living

skills as far as possible. Restricting access to the kitchen environment would have impeded this belief and my approach.

What turned out to be a new experience became a new knowledge and I consequently decided that in future cooking sessions I would lock the kitchen door to prevent access by un-well service users. If service users wanted to make breakfast, I asked them to wait until others in the kitchen were finished and I could then provide access in a controlled environment as well as have the opportunity to observe the un-well service user's skills, and provide support as required. At the same time I adapted the physical environment and provided access for all service users to hot and cold drink facilities through a large opening in the wall between the kitchen and day area.

Characteristics of *on-going business* include a stable state where professional practice is about business as usual, as well as an emergent nature of practice. Therefore *on-going business* is made up of the shared experience of practitioners, their predictable behaviours along with shared memories, meanings and expectations. This is simultaneously tied to practitioners' experiences and activities, but can also be independent of the presence of one or other practitioner, but cannot exist completely outside of the practitioner group. This collective aspect of on-going business is part of the body of experience of each practitioner as they are socialised into the work area. This makes practitioners into a community which gives a meaning and purpose to the activities that constitute the practice of that community. There is also a part of the environment that includes the physical manifestation, objects and artefacts, which here include not only tools, but work procedures, policy, administrative and legal rules that offer a structure, but which is not fixed or static (Cook and Wagenaar, 2012).

Figure 13. Ongoing business (source: Cordingley, after Cook and Wagenaar, 2012)

On-going business has a dynamic nature and the practitioner's continual interaction between the world and their prior experiences means the practitioner and their practice is informed and influenced and responsive. Essentially *on-going business* has a stability linked to the habits of practitioners such as expectations of the occupational therapist to act via the blanket referral approach, to attend multi-disciplinary team meetings, or the team as a whole to produce Care Programme Approach reports. Such habits and stability help practitioners to navigate practice, including times when a perceived or actual threat or some unpredictable event occurs such as the developing trajectory of a case. When *on-going business* is disrupted there may be a response from the team that requires a reflection on the on-going business, an adaptation of practice and/ or to maintain the essential integrity of the team and remove some aspect (Cook and Wagenaar, 2012).

I would structure my work through the occupational therapy process (Lloyd, 1985; 1987 a, b, c and d), so providing a framework for the various duties as well as using the Model of Human Occupation to think about the service user as *on-going business*. This process would be generally understood by other members of that profession. Other members of the multi-disciplinary team however, would have similar processes when working with a service user. There would be a sense that there are similar procedures of assessment going on for all members of the team and the information would be shared in a clinical team meeting, for example in the

case of risk assessments. It may be that some members, such as the psychiatrist and nurse would have already assessed the service user before admission to the ward as would other team members including the occupational therapist. There is a sense that each member's information, at whatever stage of the respective disciplines' process of working with the service user, provides professional specific information to inform the overall care provided for the service users' hospital admission and trajectory.

I have given examples of how practice can be unpredictable and subsequently adapted after an event has occurred, as with Ben and Tony. Also, I have shown how practice can be adapted in the moment, for example when it seemed to me that it was safe to offer Bob scissors in the printing group. The collective aspect of practice was also apparent in the discussions of Bob's access to cookery sessions, and how I then had to review and modify my approach in light of communicating ineffectively with Bob. Practitioner habits of the nurses were disrupted with Charlie's self-care problem. Consequently my work habits were altered due to being introduced to work usually carried out by the nurses, and as such my knowledge grew and developed. Ben, Tony and Bob's situations are replete with references to the environment, including objects within it, and to work procedures in *on-going business.*

Summary

Overall, Cook and Wagenaar's (2012) approach to practice epistemology fits well with explaining some of my practice experiences and how knowledge was created from them. What my practice experience examples applied to Cook and Wagenaar's (2012) work have shown is that there is room for further exploration of occupational therapists' practice in the forensic setting, using Cook and Wagenaar's (2012) approach as a framework for this research. Thus, my research explored the ways a practice epistemology can contribute to occupational therapy practice in forensic mental health, through the following research aims.

2.5 Research aims

Theoretical aims:

1. To critically analyse and explain in what ways, and how, a practice epistemology can inform the practice of occupational therapy in forensic mental health;
2. To identify in what ways the occupational therapy forensic literature can contribute to a practice epistemology.

Research aims specific to the advancement of work on practice epistemology:

1. To explore what occupational therapy-related and other theory are used in forensic settings;

2. To analyse how theory is used in practice and its relationship with knowledge;

3. To investigate in what ways occupational therapists' practice in forensic mental health creates a knowledge

4. To investigate how therapists develop and adapt their practice to create knowledge;

5. To explore what forms knowledge takes in different forensic clinical specialties;

6. To investigate the conditions that create knowledge.

3. THE CASE

3.1 Methodology

In this section I will provide a summary of the research design for this thesis. This will include methods of data generation and analysis, the tools used and a justification for this design. The underlying philosophical and theoretical positions that inform this research are also reviewed. The advantages and disadvantages of each methodology are discussed and I will consider in detail how each is applied in my research.

Previously, I referred to my philosophical position when describing how I came to be interested in particular epistemological approaches to this study. I began by questioning the idea that one form of knowledge can be privileged over another, for example the body of knowledge used in evidence based approaches over knowledge stemming from practical and embodied experience. I therefore sought a theoretical perspective that could take account of the partiality of such knowledge generation and practices. Non-foundational theory is the framework that seems to fulfil this criterion and that I consequently adopt for this study. Foundational beliefs are basic truths (Macey, 2000, p. 136) and the fundamental source of a belief system (Grayling, 1999, p. 332). They cannot be or, do not have to be questioned (Macey, 2000, p. 136). Therefore they need to be self-justifying and self-evident in some way and in themselves do not require justification (Grayling, 1999, p. 332). I take account, however, of Silverman's argument that "methodologies cannot be true or false, only more or less useful" (2010, p. 110).

My research is guided by philosophical pragmatism. American pragmatists, Mead and Dewey conceptualise knowledge as that which is created through action and interaction: meaning that what people do and the structure of their social communication make a fundamental contribution to knowledge construction (Corbin and Strauss 2008). Furthermore, pragmatist philosophy is useful for my study in that it informs the grounded theory approach of Corbin and Strauss (2008), practice epistemology (Cook and Wagenaar 2012), situational analysis (Clarke 2005); all of which I explain further at a later point.

The occupational therapy profession also has links with pragmatist philosophy (Ikiugu and Schultz, 2006; Hooper and Wood, 2002; Breines, 1986). These links have been in the form of friendships and the use of some pragmatist philosophy in the early development of occupational therapy interventions. Some of the early proponents of occupational therapy in the USA had connections with John Dewey. This included Adolf Meyer, a Swiss psychiatrist who had immigrated to the USA. Meyer and Dewey also knew Jane Addams and Julia Lathrop who ran invalid occupations classes at the Chicago School of Civics and Philanthropy that were attended by a social worker Eleanor Clarke Slagle (Quiroga, 1995; Breines, 1986). Habits are one of many areas of Dewey's (1922) work and Meyer was influenced by this (Christiansen, 2007). Both Meyer and Slagle worked together developing a habit training programme for service users in a psychiatric institution (Slagle, 1934; Slagle, 1936). Later work has suggested that pragmatism could provide a philosophical foundation for occupational therapy practice (Ikiugu and Schultz, 2006; Breines, 1986). Furthermore, Ikiugu (2007) has created a model that combines pragmatist philosophy, cognitive behavioural therapy, chaos/complexity theory and other occupational therapy theory.

Philosophical pragmatists take the view that the world is complex and there are no simple explanations for events within it. For them, events are comprised of multiple factors that come together to interact in complex and unanticipated ways (Corbin and Strauss, 2008). As such, the pragmatist view on place of truth claims of knowledge are along the lines of; 'for the time being this is what we know' (Corbin and Strauss 2008) and therefore, by extension, the underlying assumption must be that knowledge is transitory and dynamic. Accordingly, when conducting research, analytic schemes must pay attention to and be located within larger events and not be isolated from social, political, cultural, racial, gendered, informational and technological frameworks within the wider world (Corbin and Strauss, 2008). Herein lies a connection with Clarke's (2005) work, considered next.

Clarke's (2005) methodological stance of situational analysis is from a postmodern perspective, primarily incorporating American pragmatist and social interactionist thinking. Clarke (2005) sees the social world and knowledge as deeply situated individually, collectively, organisationally, institutionally, temporally, historically, materially, geographically, discursively, culturally, symbolically and visually within social life. The aim is to move beyond framing human action over time as a 'basic

social process' in the situation of concern, which is Strauss's traditional grounded theory (Clarke, 2003b). Furthermore, Clarke suggested advancing grounded theory through the postmodern turn by building and moving on from Corbin and Strauss's (1998) conditional matrices used to analyse contexts and action.

Clarke (2003b and 2005) sees a need for greater exploration of complexity and difference of social life, making that the full situation of inquiry that was unaccounted for in previous grounded theory. To this end Clarke (2003b and 2005) looked to postmodern thinking that emphasised "localities, partialities, positionalities, complications, tenuousness, instabilities, irregularities, contradictions, heterogeneities, situatedness and fragmentation – complexities." (p. 555) of social life. Furthermore, Clarke (2005) seeks to identify silences in data, or put another way to make absences of data visible, to see places where data are not, but could be, and that enables us to see what we do not see (Wulff, 2013). Clarke (2003b and 2005) builds on Strauss's social process/ action with a social worlds/ arenas/ negotiations map that allows both social organisational/ institutional and individual level analyses, along with two other maps called situational and positional maps.

As such, Clarke's (2005) situational analysis (detailed below) with its situational maps were useful to examine the practitioner's knowledge and relationship with context and practice. My justification for using this methodology for my research is that I needed a way to explore a world of practice with various intricacies. For example, service users' various health and social needs, as well as their criminal history, who often needed prolonged admission times in forensic mental health settings, which incorporated a range of regulations and other disciplines. I therefore decided that a longitudinal approach for data generation by interviews and/ or emails was required. As such, practitioners were interviewed once a month, over the course of 6 months to a year. This time frame mirrored, to a degree, the length of time of a service user's admission to a secure mental health unit. Corbin and Strauss' (2008) grounded theory (discussed later) was useful when applying this time frame, given the multiple interviews that can occur over a prolonged period of time in order to reach a point of theoretical saturation (discussed later), as well as providing a way to manage and explore the data through theoretical sampling. The focus on each practitioner's work with one client also allowed a range of practice experiences and their intricacy to be explored. This is because there was a history

of practice events to explore, as well as practice that would occur over the time period of the research.

Interviewing practitioners about their practice experiences requires reflection. Schön's (1991) emphasis on the value of reflection is therefore implicit in my research design and therefore research practitioners were required to think about their practice actions and decisions for the interviews. This involved reflecting on their existing practice prior to participating in the research. It also reached a point however, where the research linked directly to their current practice and resulted in a scenario in which practitioners were engaged in an in-depth, detailed reflection and analysis of their practice in a way that is not usually possible in practice due to time and workload constraints.

3.2 Research Design

A qualitative research approach enables an exploration of an aspect of the social world in a specific context. This approach was useful in my research project in that it considers the experiences of a particular social group and how their individual beliefs and actions intersect with the culture (Fontana and Frey, 2008, Finlay, 2006). In terms of my research, the exploration in question takes place within the social world of a forensic mental health setting where the social group are the service users along with other health and social care team members. This world operated within an organisational culture of secure facilities with their associated policies and procedures. The research practitioners were from the social group of occupational therapists, whose reported beliefs and actions in relation to their professional practice were explored. Qualitative research "allows researchers to get at the inner experience of practitioners […] and to discover rather than test variables" (Corbin and Strauss, 2008 p12). The inner experiences in the current research refer to the occupational therapists' cognitions, values, beliefs, emotions and feelings associated with their experience of their professional context of practice with service users in a forensic mental setting. To this end the following research design was created.

The research design combines four approaches (see Figure 14):

1. Grounded theory as described by Corbin and Strauss (2008) and situational analysis, Clarke's (2005) development of grounded theory were used for data generation and analysis.

2. I used the critical incident technique (CIT) (Flanagan 1954) to explore actions associated with specific situations or activities in order to establish the details of the situations. This enabled the practitioners to recall their practice decisions and actions using the occupational therapy process as a framework used to structure data generation through a series of semi structured interviews over 7-12 months.

3. I also used the critical decision method (CDM) (Klein, Calderwood and MacGregor, 1989; O'Hare et al, 1998) as the CIT alone did not provide a deep enough exploration of the practitioners' knowledge. Each practitioner had a timeline created to map the decisions and actions made by each practitioner when they worked with the service user (Klein et al 1989). The CDM was used to probe the decisions made, which enabled identification of the knowledge used in the decisions (Klein et al 1989; O'Hare et al, 1998).

4. Practitioners were asked periodically to reflect about any impact upon their current clinical work due to their participation in the study.
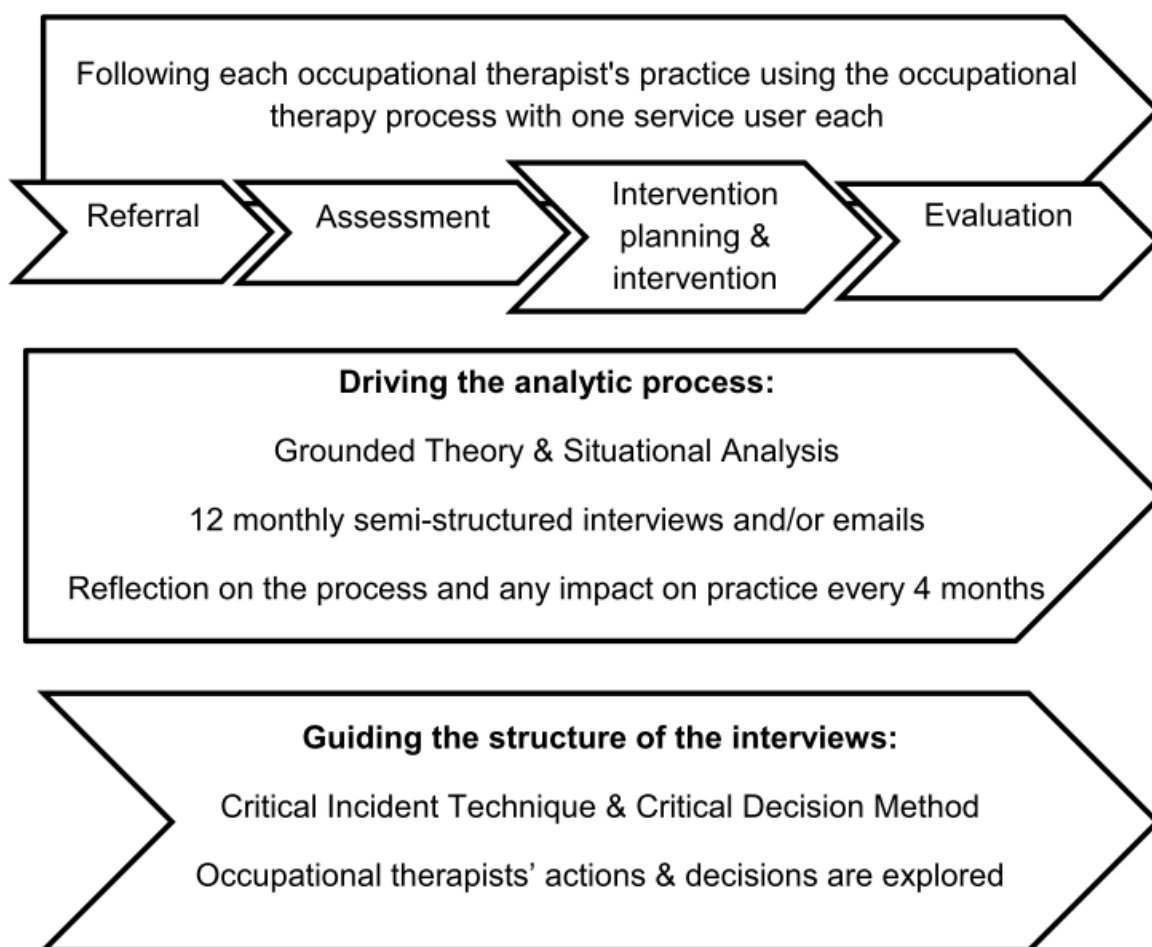
Figure 14. Research design and process (source: Cordingley, 2015)

In the early stages of developing my research design I considered semi-structured interview questions of my own design. I practised these with one of my PhD supervisors questioning me, as I had been an occupational therapist in a forensic setting. The information gathered was partially useful, but there was something missing. My supervisor suggested using the critical incident technique (Flanagan 1954), which I reviewed. This approach was potentially useful, but also did not seem to fully capture the practitioners' knowledge. I searched further and discovered the critical decision method (CDM) (Klein, et al, 1989; O'Hare et al, 1998) related to the critical incident technique that could be used to provide a framework for exploring practitioners' decisions and actions using semi-structured interviews. I present the following to illustrate how the critical decision method (Klein, Calderwood and MacGregor, 1989) and situational analysis (Clarke, 2005) can help to explore and analyse occupational therapy practice.

The critical decision method (Klein, Calderwood and MacGregor, 1989) is a semi-structured interview method using probes (appendix 7) to investigate what was used to make the decisions and direct actions made in practice by the practitioners. The purpose of the probes in the interviews was twofold: firstly, to capture what existing knowledge the practitioners currently utilised in their practice; and secondly to capture any new knowledge created and learnt during their practice. Furthermore, it can be argued that the discussion between me and the practitioners was potentially a part of that knowledge created in practice. Therefore, through the application of a critical decision method, a range of knowledge in practice could be identified, including the technical rational (Schön, 1991), as in the evidence base used by the practitioners and knowledge created from practitioners' practice experiences. The critical decision method alone, however, could not fully capture all of the influences upon the practitioners' knowledge in practice.

Practice as explained in Cook and Wagenaar's (2012) approach to practice epistemology is a complex framework and so requires additional methods to explore the intricacies of the forensic practice setting. Indeed, they are interested in the knowledge and context that occurs as a result of practice (Cook and Wagenaar's, 2012). Situational analysis explores the situation and context (Clarke, 2005), this therefore can be used to research the forensic setting and practice associated with it.

Situational analysis (Clarke, 2005) is a method of understanding action within a specific situation and all that is part of that situation. For this reason, I use situational analysis in my research in order to identify and analyse knowledge within a practice context and practice as a creator of context (Cook and Wagenaar, 2012). The analysis process uses three maps, in combination and individually, that are designed to question and elucidate areas of practice and context. Liz's messy situational map (appendix 8) is an example of the situational analysis elements (discussed in detail later) in the situation of action. The elements are used to inform the generation and analysis of the interview data. A further example of specific elements are included from Ben's and Bob's vignettes (see table 3).

Table 2. Selected elements of a situational analysis from Bob and Ben's vignettes.

Elements	Bob and Ben's situations
Sociocultural	Service users' & staffs' ethnicity, ward and occupational therapy practice traditions
Human	Ben, Bob, other service users, occupational therapist, nurse
Political	Ministry of justice rules
Organisational Institutional	Secure environment, risk assessment, Mental Health Act Section, Care Programme Approach
Nonhuman	Physical architecture and environment, objects within it
Spatial and temporal	Positions of people in specific environments in relation to objects used

On the surface, these elements of Bob and Ben's situations may seem obvious. It is not, however, until these elements and hidden aspects within them are explored in one or all of the situational maps that practice in a particular context becomes more apparent. The analysis of the practice situation and multifaceted elements of practice or elements affecting practice are then identified and explained.

Flexibility in the data generation process was essential as my respondents were busy clinical staff. Therefore, a combination of data generation approaches was devised, providing a choice for practitioners. The data generation methods consisted of all forms of the semi-structured interview as designed in the CDM,

however, it was the means by which the interviews were carried out that provided the flexibility. As such, face to face interviews, email discussions, or a combination of the two were used between me and each practitioner individually. The two approaches chosen by practitioners included:

1. Interview: one hour (approximately) per month for the duration of about one year.

2. A combination of interviews and emails carried out alternate months.

Interviews were digitally recorded and field notes were written at the time of each interview.

I now move onto details about the practitioners and how I recruited them for my research.

3.2.1 Population and sample

In this research there was a population of the social group of occupational therapists (hereafter called the practitioners) working in a particular context of one NHS trust providing secure mental health services. In order to explore each practitioner's beliefs and actions in relation to the secure context, their practice knowledge in making decisions and actions in practice was explored.

The sample of practitioners required was primarily linked to two pragmatic aspects. The first was how many therapists volunteered to participate and the second was how much time was available for me, as the researcher, to transcribe and code the data. The methodological aspect in grounded theory, where saturation in the data generation and analysis is reached and no new insights are gained from the interviews, was also pertinent (Corbin and Strauss, 2008). The aim of this approach was to enable a comparison within and between the different occupational therapy bands and practice areas for the practitioners' knowledge. The sample was therefore purposive as the practitioners had specific professional experience and knowledge that was required for inclusion into this study.

Inclusion criteria

1. Qualified occupational therapists working in forensic mental health;

2. The practitioners must be actively working with the patient discussed in the critical incident technique at the start of the research;

3. With a World Federation of Occupational Therapists approved occupational therapy qualification;

4. Currently working under supervision and line management within the trust Exclusion criteria;

5. Unqualified occupational therapy staff;

6. Employees working less than 4 days a week. This was established due to not wishing to make a further reduction on an existing part-time service provision.

7. Currently under investigation by the then Health Professions Council or other body for breaches of code of professional conduct;

8. Qualified occupational therapists who are not working as an occupational therapist within the organisation, for example generic roles.

The sample consisted of three occupational therapists, Liz, Gladys and Tess (pseudonyms used for confidentiality). This was also a cross-sectional and heterogeneous sample, as practitioners practiced in a variety of security levels: medium & low secure, and in different practice areas of adolescent, women, and mixed gender slow stream rehabilitation wards. The demographic details are in table 3.

Table 3. Practitioners' demographic details

Practitioner's name	Gladys	Tess	Liz
Gender	Female	Female	Female
Band	6	7	7
Time worked in forensic (at start of interviews)	11 months	13 years	13 years
Practice area	women & slow stream rehabilitation*	male adolescents	women
Level of security	low	medium	enhanced medium
Interviews completed	8	7	12
Emails completed	0	6 (collated together over each month)	0

*Gladys moved practice areas shortly after two interviews were completed. All the data from Gladys have been used in this research as well as the subsequent new service user she chose to discuss.

3.3 Ethics and access to practitioners

The research was first approved by the School of Social Sciences ethics committee. An Integrated Research Application System (IRAS) application was made to the Research Ethics Committee and local research and development committee. Permission was granted for the research (see appendices 2a & 2b for copies of the permission letters). In my capacity of researcher, I attended various occupational therapy meetings to describe the study and what would be required of practitioners and to provide an information sheet, invitation letter (appendices 3 & 4). I also provided additional information once a potential practitioner expressed an interest and wanted to know more before they made a final decision to be a practitioner in my research (appendix 5). There were opportunities for potential practitioners to ask questions and they were given a specific time period of two weeks following discussion with me, in which to make their decision. Practitioners were required to sign a consent form to participate (appendix 6). There were a set of inclusion and exclusion criteria (see above) which the potential practitioners were informed of so that they could self-select according to this. The occupational therapists approached to participate in this research were not required to justify their reasons for not volunteering to participate.

3.3.1 Recruitment

I met with all practitioners in person at least once during the recruitment phase, which is a starting point for building a rapport. Fontana and Frey (2008) also noted that gender, age, ethnicity and class can affect the perceptions and potentially the discussion of both the researcher and practitioner in interviews. As a former occupational therapist I had worked at the NHS trust proposed for the research site. This may be relevant during data generation and analysis, where there are data credibility and ethical implications for this, discussed later.

I now consider the purpose of using the approaches, methods and procedures that I decided to use, in order to build a relationship between how practice epistemology is conceptualised, the philosophical assumptions that are incorporated in it, as well as their relationship with grounded theory, situational analysis, the critical decision

method and the occupational therapy profession. I start with the data collection methods.

3.4 Methods driving data collection

3.4.1 The critical incident technique and the critical decision method

I used a self-report technique called the critical decision method (CDM) (Crandall et al 2006) in order to capture the unobservable aspects of skilled performance. This has been used to identify what forms of information and knowledge are sought and used to make decisions in naturalistic settings (Klein, et al, 1989; Hoffman, Crandall and Shadbolt, 1998; O'Hare et al 1998; Crandall et al 2006). The CDM generally involves stages of discussing and exploring a critical incident (Flanagan, 1954).

A time-line is created to map the decisions made, followed by probing questions about those decisions (Klein et al 1989; O'Hare et al 1998, Hoffman et al, 1998; Crandall et al 2006). There are a number of models and other data collection methods that have informed the development of the critical decision method. The most relevant to this research is the Critical Incident Technique (CIT) (Flanagan 1954).

The CIT developed out of work by Flanagan (1954) who researched the performance of USA air force fighter pilots. The method explores behaviours associated with specific situations or activities in order to establish the facts of the situation. It does not consider opinions, emotions and feelings in relation to the event. The retrospective nature of the CIT refers to the recall of a situation or event (Klein et al 1989) that was challenging, non-routine and went beyond procedural knowledge (Crandall et al 2006). The CDM is therefore designed to elicit a retrospective account of a particular situation of this nature (Crandall et al 2006).

The CDM was developed by psychologists who researched cognitive aspects underlying task performance. A number of occupational groups have been studied. For example, urban and wild land fire-fighters, design engineers, pilots, paramedics and tank commanders (Klein, Calderwood and MacGregor, 1989)

white water rafters and emergency control services (O'Hare, et al, 1998). The nature of expertise and the knowledge use in these occupational groups include three forms: factual, if/ then and analytical procedures, tacit and perceptual knowledge (Klein, Calderwood and MacGregor, 1989). Practice epistemology also consists of these forms of knowledge and the CDM therefore is an appropriate tool for use in my research.

An important feature of Klein Calderwood and MacGregor, (1989) conceptualisation of knowledge in expertise is that the tacit knowledge (based on Polanyi's work), forms the context and background that enables articulation of the factual, if/ then and analytical knowledge. Tacit knowledge is important for recognising particular situations and using experience drawn from those situations to make judgements of typicality and to enable analogical inferences to be made explicit. Even if tacit knowledge cannot be elicited, the CDM must help to describe the function of tacit knowledge in expert decision-making (Klein Calderwood and MacGregor, 1989). Each incident used in this research project is case-based and therefore the data derived from it is specific due to it being real life and non-routine. This also highlights the richest data and potentially the tacit knowledge that has not been formalised or that appears in routine decision-making (Klein Calderwood and MacGregor, 1989).

In summary the critical decision method explores a non-routine event or incident in great depth. A timeline of decision points throughout the event is made and probes are then used to elicit the details of what happened, and the thoughts and knowledge used in the decisions that were made by the practitioners.

3.4.5 The procedure of the critical decision method

There are specific stages called sweeps that have to be completed in the CDM. Hoffman, Crandall and Shadbolt (1998) and Crandall, Klein and Hoffman (2006) described four sweeps. The sweeps are incident identification, creating a time line, and deepening. There is a final, fourth sweep called 'what if' probes, which is not discussed because they are concerned with novice expert decisions, which are not part of my research. I now describe the sweeps used for data collection.

Preparation

Planning the critical decision method and preparing practitioners for data generation are important stages. It was suggested that practitioners choose an incident where their decisions had an impact upon the outcome (Crandall, Klein and Hoffman, 2006) and to avoid memorable experiences that were tangential (e.g. death during the incident), or where the practitioner had no involvement in decision-making (Hoffman et al 1998).

The use of up to four sweeps is not intended to imply that four meetings must be used. My research included monthly meetings with two therapists and alternate email and face to face interviews with one therapist. The researcher can transcribe audio recordings and field notes, and prepare for subsequent sweeps (Crandall, Klein and Hoffman, 2006) and analyse the data according to grounded theory and situational analysis methods. The aims of each sweep, the procedure followed and other practical considerations are presented next.

Sweep 1. Incident

The incident sweep to build the practitioner's memory of the event and co-operation between them and the researcher (Klein et al 1989). The practitioner is asked to provide an example of the particular event or situation that is being investigated and to give a verbal description of the entire incident (Crandall, Klein and Hoffman, 2006). The researcher asks few, if any questions, allowing the practitioner to structure the description themselves (Hoffman et al 1998). The researcher's role develops in the next sweep.

The incident used in this research was decided upon by the practitioner in discussion with the researcher. In this forensic mental health context there were too few incidents of the same variety, unlike other research using the CDM which seeks many of the same situations from different practitioners for data generation. The incident chosen was one that captured a 'stand-out' aspect for the practitioner from their experience of actively working with a patient over the previous 6 months. The aim of this research is to capture each practitioner's knowledge about working with that client throughout the duration of their treatment. Here the discussion differed from that suggested by Crandall, Klein and Hoffman, (2006) and Hoffman

et al (1998). The knowledge elicited was not just about the stand-out moment, but also incorporated all knowledge in relation to the service user's occupational therapy. That knowledge was therefore elicited over a longer period of time. Consequently there were a variety of points at which the first sweep was completed. These were structured around the occupational therapy process as described by the practitioners in relation to their service user.

There was the potential for the practitioners' perceptions of the events to be distorted because events were recalled from memory (Guba & Lincoln 1981 cited in Schluter et al 2008 p.109). This was ameliorated by the following approaches. Firstly, using a situation that was atypical or extreme (Flanagan 1954), hence this research used a rewarding real-life clinical and contextualised example from each practitioner's current practice. As the practitioners were asked to choose a service user with whom they were currently working they would have access to clinical notes that they could review to remind them of their decisions, which could be discussed further in the sweeps. Secondly, as the study is longitudinal and both the practitioner and I had access to the timeline, this allowed us to follow-up with a discussion regarding aspects not remembered, or not fully explored at previous meetings. It was anticipated that there would be a point where the practitioner's work with the patient was almost contemporaneous with the interviews. This would then require recall of information over a shorter period of time.

There were particular circumstances in the context of this study that practitioners may have needed to adjust information. These may have occurred in order to preserve the confidentiality in terms of identity or other characteristics of the practice with the service user they chose to use in the study. This may have had some impact upon the data discussed.

Sweep 2. Time-line

I developed a shared awareness between the practitioner and myself using a time-line (see appendix 9-11a and b) (Klein et al 1989). Also I used it to refine, clarify and verify key events, segments and the structure of the practitioner's story and furthermore, allowed me to check for missing elements and inconsistencies in the story (Crandall et al 2006). On the one hand, the timeline captured objectively verifiable events that occurred, whilst on the other, the practitioner provided the

"facts of the case": thoughts and perceptions of the story from their perspective (Klein et al 1989). The time-line also provides the framework for subsequent sweeps (Crandall et al 2006). For the practitioner this is designed to help them engage further with the process, connecting with the story to stimulate memories about the situation and its sequence. I repeated the practitioner's description, using their words, which in turn helps to build rapport and trust and also helps gain the practitioner's full attention (Crandall et al 2006).

I created a figure of the decision points using sticky notes that are placed at the relevant time point. Both the practitioner and I completed the figure. Decision points are the points at which shifts in events occurred due to the practitioner's change in understanding or the points at which they took action. Indications that decision points have occurred were that other choices may have been available to the practitioner aside from the one made. Also the point at which a different decision could have been made is highlighted on the timeline for probing (Klein et al 1989). The timing of events might be approximate or specific, timing may indicate duration, sequence and synchronicity of events and decision points (Crandall et al 2006).

The timeline was created as a useful visual device for email and interview discussions. I produced the timeline with a page set-up on a Microsoft document and emailed it to the respective practitioners (see appendices 9-11a and b). I altered the sticky notes in the interviews with the practitioners' agreement. I then altered the Microsoft document of the timeline and a copy was emailed to each practitioner.

Sweep 3. Deepening: Probes

The aim of the deepening sweep was to "get to the story behind the story" (Crandall et al 2006 p.78). My role as researcher is to work though the layers of information to get deep below the surface story. Each story is contextualised by guiding the practitioner to describe in greater detail the decision points and what occurs at those times. So I questioned what, where, how and the actions at each point to explore further using cognitive probes (Crandall et al 2006).

Cognitive probes have been developed by Klein et al (1989), Hoffman, et al (1998) O'Hare et al (1998) and Crandall et al (2006). I apply the most recent probes and questions in this research, which are from Crandall et al (2006), (appendix 7, where they are listed in the interview procedure). Probes are not limited to what must be objective and verified, as the findings can generate hypotheses and test models (Klein et al 1989). Indeed, there was also the potential to adapt the CDM and create other probes if the existing ones did not cover the areas required in the research (Crandall et al 2006, Hoffman et al 1998).

The focus of the CDM was to obtain knowledge used in decision making and as such, did not allow for the impact of the practitioners' feelings on the use of and development of knowledge. Although O'Hare et al (1998) made improvements by expanding existing probes and developing new ones, they may be altered to capture whether prior emotional experiences or current responses form part of the knowledge used by the practitioners. For example: situation awareness, influence of uncertainty and decision blocking – stress (O'Hare et al, 1998). I was particularly interested about those because they could indicate feelings that were not considered in the CDM that may be linked to making certain decisions and actions. For example: highly emotional situations such as an immediate risk arising or the practitioner's feelings about a patient and their criminal behaviours that consequently may influence their decisions and actions.

In some ways this approach is an art as well as a science, because Crandall et al (2006) note that the researcher directs the interview with the overall goals of the study in mind, and they use their curiosity to indicate when questions and probes should be presented. Not all of the probes have to be used at each point, but Crandall et al (2006) provide guidance for the points at which certain probes may be more appropriate with suggestions for points when the probes should be used when certain comments from practitioners are made. For example: "we just knew", "my gut told me" and "it was obvious that". The final sweep is the fourth, explained next.

Sweep 4. "What ifs?"

This sweep aimed at identifying novice and expert decision making and the nature of expertise, skill and knowledge underpinning this (Crandall et al, 2006). Ultimately

these probes were not used in the research due to not being appropriate or relevant to the topics discussed. I now turn to grounded theory.

3.4.3 Grounded theory

Grounded theory has been evolving, not without controversy, since the 1960s. The history of these developments however, is not a matter that will be discussed/ explored here because the current works I use represent the latest developments in grounded theory and also explore the use of situational analyse too. The more current works include Corbin and Strauss (2008) and Charmaz (2006) and Birks and Mills (2011). The basic procedures of grounded theory are now presented.

In relation to this current research project, as a former occupational therapist practising in forensic services I am familiar with published occupational therapy forensic literature. This provides a unique insight that informs the questioning and analysis of the practitioners. As the researcher, this required me to develop sensitivity to the topic under investigation (Corbin and Strauss, 2008), which could also be done with a preliminary, but limited review of the literature (Birks and Mills, 2011). My practice experiences are therefore useful in providing a point of comparison with the practitioners and knowledge of the salient problems in the context (Corbin and Strauss, 2008) in a way that familiarity with the literature alone would not provide. This aspect of the research is later considered in relation to reflexivity and trustworthiness.

The grounded theory methods of coding, constant comparison, theoretical sampling and using figures are both a way of data generation and analysis (which are illustrated in detail later) (Birks and Mills, 2011; Corbin and Strauss, 2008; Charmaz, 2006) and have subsequently been used with all of the interviews. The focus of these methods tends to be on what the practitioners are seeing and doing, which are then contrasted with each other to highlight data for further generation and analysis (Corbin and Strauss, 2008). Data is generated from people, places and situations (Corbin and Strauss, 2008; Charmaz, 2006). The methods provide a systematic, flexible set of guidelines that include general principles and heuristic devices for exploring practices (Charmaz, 2006). Through the use of these methods, concepts with particular properties and dimensions are created from the data, which is used to construct a theory (Birks and Mills, 2011), that is grounded

in the qualitative data (Charmaz, 2006). Next I briefly consider the nature of data collection and generation for my research.

3.4.2 Data collection and generation

I choose to use the term data generation as the CDM is a framework for initial exploration into the research topic. Grounded theory however, is an approach that provides a substantial part of the ongoing data generation and analysis along with situational analysis.

I need to differentiate between data collection and generation for both the CDM and grounded theory. Generally speaking, when collecting data using CDM, the researcher has little influence over its source (Birks and Mills, 2011). Ergo, in this study, it is the case that I had little/ no influence over actions and decisions that the practitioners chose to share. There is an expectation in the CDM that the researcher can collect data in the form of descriptions made by the practitioner about a particular incident. The two key components of data collection in the CDM are that the interviewer needs to both get the information required and also to manage the procedural and interpersonal aspects (Crandall, Klein and Hoffman, 2006). However, despite this, there is no acknowledgement of the influence of the interaction between the researcher and practitioner.

Data generation however, is an approach whereby the researcher is directly involved with the source of data (Birks and Mills, 2011) and therefore does have an influence on the ways and what data is generated; in my research this incorporates the relationship before and during the research and how this influences the discussion in the interviews between me and the practitioners. The relationship between me, Tess and Liz had already been established some years prior, due to my having worked previously in the same trust as them. Gladys was informed about me and my research through her supervisor, from this she knew I had experience in the forensic setting. She also knew of me from cohort lectures I did at the university, but we had not been in smaller seminar group work together. The impact of this on the data generation is discussed in more detail in the reflexivity section. I completed a pilot of the CDM and CIT in order to establish whether it would be effective to meet my research aims, considered next.

3.4.3 Pilot

To establish the value of the CDM as one of the methods for my research design I used two approaches to pilot it before I made a final decision to use it. The pilot also helped me to see if the structure I had proposed for the first stages of my research design were going to be effective in gathering the required data. The pilot assisted me to develop familiarity with the CDM and with the interviewing skills required for using the probes.

I completed one interview each with two occupational therapist with practice experience in forensic mental health to test the usefulness of the CDM for gathering data about practice knowledge. I was able to try out the first two sweeps of exploring working with a service user in a forensic setting through discussion about the occupational therapy process. Creating the time-line and part of the third sweep of deepening using the probes. The results of this were that I had asked them both to choose a rewarding incident of when working with a service user, but we did not get to the point of discussing the rewarding incident. This was in part due to only having one interview with each therapist and not being able to get to explore the time-line beyond the early stages of the occupational therapy process. On the basis of this experience I decided to ask the practitioners in the research proper to choose a service user with whom they had experienced a range of critical incidents, good and bad, that we could explore, as this seemed a more realistic aspect of practice.

Through this approach, I gained a detailed time-line, but still found areas that I had not explored in depth. These included the index offence and presentation of the service user with one pilot and some occupational therapy specific elements missing from the second; this was because, in this case, her work was concerned more with the service user's anxiety. I therefore altered my research design slightly by asking the practitioners to provide a brief description of the index offence and presentation for context before exploring the occupational therapy process in the first interview. I was also more explicit in requesting that the work be about occupational therapy.

The feedback from both the interviewees provided helpful suggestions that I incorporated into both the research design and future interviews with the practitioners. Both interviewees liked the time-line and how that and the interview questions allowed them to challenge assumptions and that which is taken for granted, and additionally, to identify tacit knowledge. They stated that it could be a suitable tool for reflecting on practice with one practitioner stating that a reflection on the use of the CDM itself could be useful to incorporate into the interviews. She felt that band five occupational therapists might find the exploration of their knowledge too challenging. One final consideration she gave was whether changes in practice could be captured as a result of participating in the interviews, and indeed whether it is important to capture these changes. In any event I incorporated regular reflection points about the research experience and any changes in the practitioners' practice that they could identify from being involved in the research.

The data generated from these two pilots was not used in my subsequent data analysis for three reasons. First, the pilot participants were asked to choose a critical incident from practice that they found rewarding. I realised that my directive focused too much on the positive practice experiences, when it is more likely in a challenging practice in a forensic setting they are more likely to experience a range of positive, negative practice experiences with service users. The second reason was that I had the opportunity to gain a detailed time-line from each pilot participant, but we only achieved a partial achievement of the third sweep of deepening. Therefore the data to analyse was limited the earliest stages of their process. The third reason is that one of the pilot participants realised she needed to have chosen an example that was more focussed on occupational therapy practice rather than on the specific anxiety management with the service user.

I did a further pilot once I had finalised the research design. I asked a learning disability nurse who is currently in practice to pilot the methods and practise my interview technique over three interviews. I did this to get a sense of, and prepare for what it would be like to perform more than one interview and develop my use of the CDM probes. Following these pilots, I started the interviews with the practitioners once I had ethical approval.

3.4.5 Advantages and disadvantages of email and interviews for data generation

Using interviews and email interviews for data generation has advantages and disadvantages. I use transcript as the generic term to refer to both email and interview transcripts. Practitioners would have experienced some form of interview but they may not have been email interviewed. Meho (2006) suggested conducting pre-tests to determine practitioners' preferences in relation to this, however, I offered practitioners the opportunity to use one or both methods according to their requirements at the time. They could change if required, which enabled them to make an informed choice when choosing their preferred data generation method.

From the practitioners' point of view, the advantages of email interviews are that those who might feel uncomfortable in a face to face interview can participate at a geographical distance (Bampton and Cowton 2002). Additionally, some practitioners may prefer to use a written form of communication (Bampton and Cowton 2002). The emails can be sent asynchronously so there is no need for the researcher and practitioner to communicate at the same time (Bampton and Cowton 2002). The practitioner also has time to reflect on the question being asked and therefore can send a more considered reply (Bampton and Cowton 2002).

A disadvantage of using email means the researcher cannot directly observe the practitioner's emotional response to a topic (Seymour 2001). On the one hand, these responses can be useful to indicate aspects such as the question being unclear, a sensitive topic arising, or a different questioning style being required. On the other hand however, emoticons (Seymour 2001; McCoyd 2006) and emotional descriptions in parentheses have found to be used effectively by practitioners (McCoyd 2006). Building an online rapport (Seymour 2001) may be slightly easier due to having met face to face, but the researcher must continue to build an ongoing trusting, sincere, confident and committed relationship.

It has been suggested that the richness of the data collected may be limited through the use of email (Bampton and Cowton 2002). McCoyd et al (2006) however, compared the data collected by email with face to face and telephone interviews and found that overall, emails were 3-8 pages longer than face to face interview

transcripts and six to twelve pages longer than telephone transcripts. Email interviews in this example clearly provided more data for the researchers to analyse.

In the CDM the primary means of data gathering is through face to face interviews with practitioners who have experienced one or more of a range of significant events (critical incidents). Using verbal reports and difficulties with retrospective data generation based on memory of events have been used to question the validity of the CDM (Hoffman et al 1998). The CDM has been argued as valid as it is a case study method which has theoretical support. Grounded theory also has a well-established range of data generation and analysis methods, including interviews that can be highly structured or unstructured (Birks and Mills, 2011, Corbin and Strauss, 2008; Charmaz, 2006). Interviews provide a method for in-depth data generation which is particularly useful for interpretive research where practitioners' experiences on a particular topic can be explored (Charmaz, 2006). The style of interview shapes the study context and content, so framing it (Charmaz, 2006). Using interviews in my research is familiar to the practitioners as they use them in their practice. The CDM and significant events may be less familiar, but structuring their discussion around the occupational therapy process and asking them to talk about one service user, would be a familiar procedure, given the expectation that they frequently explain and discuss their practice in various team meetings, to students and in supervision where they can reflect on their practice.

The use of interviews in a grounded theory approach allows for a variety of ways to generate data. The method allows data to emerge in a flexible way, through what is asked and the way questions are structured (Birks and Mills, 2011; Charmaz, 2006), and the data generated varies within and between interviews (Birks and Mills, 2011). The interviews are actively co-ordinated by the interviewer to create the data to be used to generate theory (Corbin and Strauss, 2008). It is through a combination of interviewing and other methods (discussed later) that a strategy is provided for creating a grounded theory. In my interview with Tess there emerged some early gaps in the timeline that it was necessary to explore further. Therefore, in her second interview, I asked for further details of what I perceived as missing from her timeline. When I interviewed Liz and Gladys, I used, as a basis, that which I had explored with Tess. Throughout the process however, I remained

cognisant of the different practice settings they operated within, I therefore ensured that I asked questions about the same aspects of practice in order to get a sense of the gaps and similarities in the early stages of the practitioners' practice with their service users. Accordingly, I used a semi-structured interview from the CDM, but also created other questions to ask Tess, which I also used for each practitioner in their first interview. My practice experience also played a part in being able to identify these gaps, a matter discussed in more detail later.

There are aspects of an interview that are unplanned and need accounting for; these are recorded in field notes taken following the interview (Birks and Mills, 2011). The researcher may need to capture aspects of the environment that impact upon the interview, for example, the practitioner's non-verbal communication and the researcher's immediate responses to the interactions (Birks and Mills, 2011). I kept a book of notes that I made during the interviews, which initially was almost a full transcript of the interview. As time went on and my familiarity with the interviewees' communication style grew and my ability to use semi-structured questions derived from theoretical sampling developed, the process shifted to simply making brief notes. These were often about interruptions, non-verbal communication, pauses, silences etc. and what they might indicate. The environments in which I met each practitioner were sourced by the practitioners and rarely changed. If the location of the room was changed however, it did remain in an area that was familiar to the interviewee. These field notes may form part of data collection and can be used in the later analysis of the data.

3.5 Approaches driving the analytic process: data analysis

The grounded theory approach incorporates data analysis methods (Corbin and Strauss, 2008) and situational analysis (Clarke, 2005). The aim of data analysis is to create an explanatory theory grounded in the interview data about a particular topic (Birks and Mills, 2011). The data analysis methods of grounded theory are also used given the limited explication of data analysis methods in the CDM.

3.5.1 Software for qualitative data analysis

A software programme provides a range of options for data analysis. I use NVivo9 (QSR International, 2010) and its later update NVivo10 (QSR International, 2012) (from now on I refer only to NVivo10). The value of using NVivo10 is its capacity to manage data and ideas as well as to query, visualise and report from the data (Bazeley and Jackson, 2013). The transcripts are uploaded to NVivo10, which I use mainly to store them in order to assist with my analysis of the data, create codes, memos, journals and figures. The preparation of the documents for analysis and the logistics of managing them are summarised in appendix (20) below. As I discuss the methods used for data analysis and generation below I also note the features of NVivo10 that I used so they remain contextualised and relevant to the development of my grounded theory.

3.5.2 Memos

I used four methods to capture a range of data in the form of memos that are used to record my thoughts, feelings, insights, intuitions, instincts and ideas that emerge in relation to the research, as well as processes and outcomes (Birks and Mills, 2011; Charmaz, 2006). I had memos in the form of a contact summary form, a transcribing record sheet, memos of all the interviews with each practitioner and a memo combining the analysis developed from the previous three memos, which are explained next.

I started the analysis following the very first interview (Strauss and Corbin, 2008; Charmaz, 2006) using a contact summary form (appendix 12) adapted from Miles and Huberman (1994). I captured my immediate reactions following each interview and importantly, I had a catalyst to develop my thinking (Strauss and Corbin, 2008) to create potential questions for the next interview, which is part of theoretical sampling (discussed later). I had another layer of memos and early analysis by keeping a transcribing record sheet (appendix 13) where I captured my reactions to the audio recording of the interviews as I transcribed them. Also I used the record sheet when I made subsequent reviews of the audio files and transcripts. Thus I had a broad structure for memoing, but I was not concerned about the form the various memos took (Strauss and Corbin, 2008) as I treated them as partial,

provisional and preliminary (Charmaz, 2006). I therefore started my memos before coding the transcripts along with the early concrete stage of analysis (Birks and Mills, 2011; Charmaz, 2006) while remaining close to the data (Corbin and Strauss, 2008).

Memos serve analytic requirements in grounded theory. I have knowledge of the topic and therefore it was important for me to try and remain open to new areas for exploration as I start the analysis. For example, I took notice when the practitioners' discussion was similar to my own experience, but equally I listened for examples that were dissimilar to mine. Another feature I tried to be aware of was how the practitioners talked about similar and different aspects of their practice between each other. I therefore started to identify and develop categories about what the practitioners did and what was happening, a purpose of memos (Charmaz, 2006). I was able to remain open to questioning the data to seek the implicit and unstated aspects in the analysis (Charmaz, 2006) and to make comparisons (discussed in more detail later). For example, my early analysis of Tess's timeline from the CDM and the first of all the interviews indicated that I did not know how she received the referral of the service user Zach. I asked her to explain this to me in our next interview and then made sure I asked Liz and Gladys the same question in their interviews. I was then able to develop further questions about the way they dealt with the referral approach.

Memos are a way of keeping track of complex and a cumulative analysis (Corbin and Strauss, 2008). I use annotations in NVivo10 in each transcript and note the annotation in the memo of the respective practitioner to remind me to review them as my analysis develops. Annotations enable me to record my immediate responses and capture further questions to possibly follow-up in questioning the data or for theoretical sampling (Bazeley and Jackson, 2013). I continue with memo writing in two forms, using one memo per practitioner as I code each of their interviews, which facilitates building on earlier analysis of each practitioner's data (Birks and Mills, 2011), that I compare. The memos are compared with early to late and other time points in between, making grounded theory a particularly useful fit for the longitudinal data generation of my research design (Charmaz, 2006). The second memo was compared with the contact summary form and transcribing record sheet to develop strategies for theoretical sampling. The practitioners' combined memo was helpful to indicate differences, similarities, gaps and

ambiguities (Charmaz, 2006) in practice in different forensic settings. The second memo drew all practitioners' data together to develop tentative concepts with their properties and dimensions.

3.5.3 Coding

There are phases of coding that have been described differently over grounded theories' history, so I look to a recent review and summary of these from Birks and Mills (2011). They start with initial coding, moving to intermediate and culminating in advanced coding, where the movement between them is directed by theoretical sampling (Birks and Mills, 2011). I now review the coding phases in relation to my analysis of the data.

In the initial phase of analysis I use line by line coding of each transcript, to fracture the data (Birks and Mills, 2011; Charmaz, 2006) to create separate pieces of the text (Bazeley and Jackson, 2013), in order to see it critically (Charmaz, 2006). Coding data as gerunds, noun forms of verbs, using words that end in 'ing' can help to prevent making conceptual leaps, but also develop concepts and an abstract level of analysis, moving away from purely descriptive codes (Birks and Mills, 2011; Corbin and Strauss, 2008; Charmaz, 2006). For example I used either single words or short phrases in my coding of the transcripts. So, in the case of Tess I used codes such as developing, challenging behaviours, learning, moving, conflicting reports. For Liz I used developing practice, team thinking and sourcing information. Gladys' codes included engaging with occupational therapist, rapport building and collaborating. Each line that I coded using NVivo10 was linked to its original transcript and could be traced back to the transcript at any point.

I sometimes used in vivo codes derived from the practitioners' words from the interviews to represent a code or category (Charmaz, 2006) where I could not easily think of a gerund or could not capture the detail easily and where the practitioners' words were clearer. For example: "almost being suckered into feeling" (Tess IV4) and "occupational therapy is not fluffy" (Liz IV6). This coding moves my analysis to the next phase, explained next.

Intermediate coding is about sorting, organising and synthesising the codes already created (Birks and Mills, 2011; Charmaz, 2006). NVivo10 allowed me to look at line by line codes of interest in relation to the longer passages to which they belonged (Saldana, 2009), which provided me with more context about what I had coded. I organised my codes by initially keeping one folder of codes per one transcript per practitioner. I then combined all the nodes from all the transcripts for each practitioner into one folder. Once all transcripts had been coded all practitioners' codes were combined in one folder. This method of storing the codes allowed me to analyse the data within any one transcript, across the codes of two or more transcripts per practitioner and between one or more transcripts across all practitioners.

There is however, a problem with using multiple folders. For example I have one folder for Liz's interview three that I coded and then added to a folder of all of Liz's codes from all twelve interviews. I would finish with all of Liz's codes, from all of her interviews being placed in a folder along with all of Tess and Gladys's codes. The codes are repeatedly copied into each new folder and this can give a false impression of what and how much data is coded and available for analysis (Bazeley and Jackson, 2013). Ultimately I did not use the analysis tools, such as modelling for visualising the data to make connections and identify relationships (Bazeley and Jackson, 2013). The small number of practitioners and the ease with which the codes and folders can be organised, with regular memos, meant that I was able to manually develop concepts and categories along with figures created in Microsoft Word (see appendices 9-11a and b). This matter is discussed next.

I develop concepts and categories from the codes. "Concepts are words that stand for ideas contained in the data" (Corbin and Strauss, 2008, p 159) also they are interpretations and the results of analysis (Corbin and Strauss, 2008). I collated the related concepts with each of the developing categories, in order to refine them and to facilitate further analysis to establish how they were related. Concepts are composed of both properties and dimensions. The former are the "characteristics that define and describe concepts" (Corbin and Strauss, 2008, p 159) and the latter are "variations within properties that give specificity and range to concepts" (Corbin and Strauss, 2008, p 159). I initially used the NVivo10 sets tool to create categories that contain and hold the concepts and codes supporting them, for example some

early categories were core skills, environment, risk, challenging behaviour, client-centred practice.

There were three practitioners with between seven and twelve interviews per practitioner, and sets can help manage this amount of data (Bazeley and Jackson, 2013). Sets provide shortcuts to any code and can document and hold the items together without merging their content, thus data may also belong to more than one set (Bazeley and Jackson, 2013). As I create each concept with its properties and dimensions and each category, I make a memo to summarise each one (appendix 14) that helped to reduce the concepts and combine them into an emerging abstract theory (Charmaz, 2006). I wanted to see all the codes from all practitioners combined, having completed the sets and related memos about each category. I therefore went back to the combined codes folder and created a code that represented each category and then moved the codes for the associated concepts to their respective category code. This enabled me to see all categories and related concepts, based on the coded data in one place.

I organised the codes into concepts and then into categories according to shared characteristics and patterns in the data (Saldana, 2009). I included a range from Saldana (2009) that included similarity, frequency, causation and correspondence, considered next. Similarity was where things happened in the same way, and emerged in codes about how the practitioners performed their assessments and in the difficulties surrounding their use of the required standardised assessment. Differences are concerned with how actions can happen in predictably different ways. I found the practitioners' variation in sequences and certain orders of actions and decisions were revealed on the timeline. I subsequently found that the occupational therapy process was not followed in a linear fashion. I considered the frequency of how often or seldom actions occurred and my analysis indicated that the practitioners tried to use a specific assessment to measure the service users' occupational participation. Not only that, but the time when assessments were done and how they were enacted showed how seldom the practitioner's used the assessment. As a result of the limitations of the assessment, the practitioners used their observation skills in order to assess the service users. I also found Saldana's (2009) characteristic of causation was apparent from when the practitioners used the standardised tool and their experience of the limitations of it appeared to cause other actions such as finding an alternative, so they used observation. I reviewed

how each practitioner practised in their respective settings such as when using core skills and risk assessment and management. Consequently I found they indicated Saldana's (2009) characteristic of correspondence with other activities or events.

The advanced level is the grounded theory at its most abstract and generalizable (Charmaz, 2006). My concepts are initially formed using terms associated with occupational therapists' practice of such as assessment, risk management and intervention. Thus I tried to make the specific dimensions and properties of the concepts within categories increasingly explicit (Birks and Mills, 2011). As the analysis develops I make figures (discussed later) that include the terms mentioned looking for relationships between sub-categories and categories (Charmaz, 2006). I develop more abstract categories, including frameworks, processes, personal and professional (see appendices 16-17) for conceptual depth and breadth, in order to give a more theoretical view of the data (Birks and Mills, 2011). I develop the final categories to be more abstract and they are presented in the findings. In order to develop and refine categories the data generation has to become increasingly focused, which is achieved using theoretical sampling, discussed next.

3.5.4 Theoretical sampling

Theoretical sampling is a "process for identifying and pursuing clues that arise during analysis" (Birks and Mills, 2011, p.69). Theoretical sampling emerged in the data from the first interview (Birks and Mills, 2011) and an early one from my data was about the referral approach, which I then pursued with all practitioners. I found that all practitioners had the same referral approach regardless of their different practice settings, it became apparent that how the practitioners dealt with the referral approach and that knowledge that codified referral was missing. Grounded theory was therefore a useful approach for charting unexplored areas (Corbin and Strauss, 2008).

I engaged in the cumulative process of theoretical sampling by asking each practitioner similar questions on the same topic and refined the topics as my analysis progressed (Corbin and Strauss, 2008). I "followed the analytic trail" (Corbin and Strauss, 2008, p. 146) in the sense that my memos forced me to

think about and to question the data that then informed and gave direction to the theoretical sampling. By being responsive to the data and not deriving the categories beforehand, this allowed me to keep my sampling open and flexible. I also refined the topics by comparing the data with other data generated in the research, which is illustrated next.

3.5.5 Constant comparison

The overall aim of constant comparison is to create high level, conceptually abstract categories where codes are compared between both the initial coding and later codes and then collapsed into categories (Birks and Mills, 2011). Theoretical sampling and constant comparison are performed concurrently as the researcher thinks through the data by making comparisons with the data and that generates and is generated through theoretical sampling (Birks and Mills, 2011; Corbin and Strauss, 2008; Charmaz, 2006).

I focus on various topics including, but not exclusively (and in no particular order): client centred-practice, the recovery approach, rapport, trusting and empathy, emotions, risk and other assessments. I engage in abductive reasoning to arrive at a plausible interpretation of the data as I examine and scrutinise the data for all possible explanations to be confirmed or not (Birks and Mills, 2011; Charmaz, 2006). I do not make theoretical conjectures for the grounded theory (Charmaz, 2006) at this stage because my concepts are still categories of actual occupational therapy practice. I create various figures (considered below) that represent the categories I refine the figure following discussion with my supervisors and further inductive thinking, to form categories that I collapse and form into the emergent theory (Birks and Mills, 2011).

Incidents in the data are compared with similar incidents (Birks and Mills, 2011; Charmaz, 2006). I use the same or similar critical incidents for analysis, for example all the practitioners discuss their use of the standardised assessment, risk assessment and client-centred practice. These are not however, exactly the same critical incidents. For example the time-line from the CDM is a useful visual prompt and I use it for constant comparison. This reveals the similarities and differences

in how the practitioners use the occupational therapy process. A method of using figures is also incorporated into grounded theory, considered next.

3.5.6 Figures

I created figures as the analysis deepened to aid the analysis, (see appendix 15-17) which relate to the fourth purpose of Corbin and Strauss' (2008) memo writing designed to develop relationships between actions/interactions, conditions and consequences. I found gaps in my developing theory using the figures (Birks and Mills, 2011). For example my initial attempts to see the service user at the centre of practice did not work effectively (see appendix 15-17). I repositioned the service user as a necessary part of practice, but not the only or central part, when thinking purely in practice knowledge terms. I could then identify the properties and dimensions between concepts and categories (Birks and Mills, 2011) more effectively. Using maps is a form of figure, a core feature of situational analysis discussed later. All of these methods ultimately require a process that allows me to judge when the categories require no new information to populate the dimensions and properties, this is called theoretical saturation, considered next.

3.5.7 Theoretical saturation

Theoretical saturation is required for the full integration of the final grounded theory (Birks and Mills, 2011). Concurrent analysis of data and its generation continue cyclically until categories are fully developed to the point of saturation where no further data is required to expand them, (Birks and Mills, 2011, p70). Technically, theoretical sampling would continue until saturation is achieved, however in my research there is a time limited period over which I can interview the practitioners and so not all topics are saturated. Indeed, I see my theory as a preliminary exploration into the practice knowledge of occupational therapists working in forensic mental health. The categories can be explored in more detail and with other areas of practice in occupational therapy, areas for future research. The final aspect of the analysis is how and what maps I use to aid data analysis, illustrated next.

3.6 Situational Analysis

3.6.1 Tools of situational analysis

The purpose of situational analysis is to identify and specify all the salient elements in a particular situation and their relations. They are re-presented in the form of a map from which the data is re-examined, along with the context and elements within it (Clarke 2005). Three types of maps can be used to analyse the data, which are: situational, positional and social worlds/ arenas maps. They provide a tool by which analyses of the situation being researched can be made. The following figure (8) indicates these elements as a matrix.
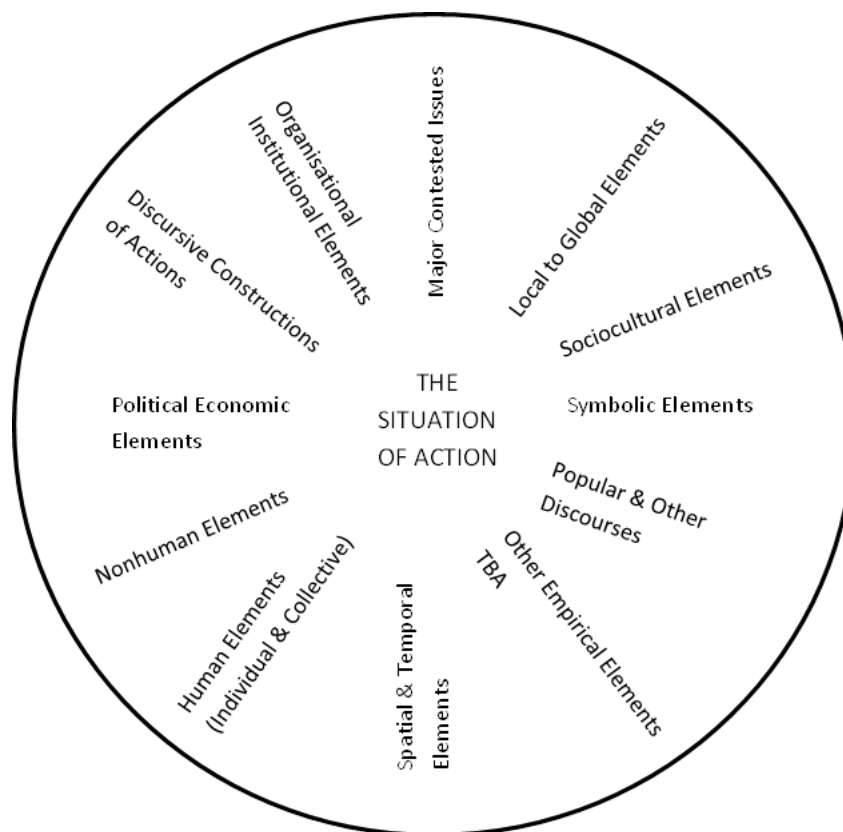
Figure 15. The situational analysis matrix (source: Clarke, 2005, p. 73)

The maps facilitate questioning of the data as it is gathered and analysed during the grounded theory approach. Situation analysis of the matrix elements in the situation occurs and are identified and explored, prompting further questioning of the situation (Clarke, 2005), this process assists with theoretical sampling (Bazeley, 2013; Clarke, 2005).

3.6.2 The process of using maps

The maps are now described in more detail. I used the messy situational map (see an example of Liz's in appendix 8) to examine human and non-human discursive elements, exploring who and what matters and the elements making a difference in the situation (Clarke and Friese, 2007). These elements included historical, symbolic, cultural and political elements (Clarke, 2005) produced by individuals, groups and institutions (Perez and Cannella, 2013). The maps articulated the situational elements and examined relationships amongst them. The messy and complex aspects linked to dense relations & permutations were explored in order to work against simplifications (Clarke, 2005). By keeping the map messy the data were accessible for manipulation. Additionally, as much data as possible could be included, with new versions of the maps kept and dated as they are created (Clarke, 2005). I used the situational map in my analysis, with all of the practitioners, more than any other as it captured a great deal of their data. From this I was able to create a map for each of them, one that was more detailed than the CDM time-line, and which was the starting point for my analysis.

A relational analysis is made of the situational map as it helps to identify relations between elements within the situation (Clarke, 2005. The analysis is achieved by taking photocopies of the latest version of the situational map and each element is considered in relation to each other element, by drawing lines between them, one element at a time per photocopy (see appendix 18) (Clarke, 2005). The relational analysis of the messy situational map identified the relationships with all the practitioners' data about risk which highlighted that risk management had not been explored in any detail, empirically or from the literature about occupational therapy. This then led me to explore the codes further for other details about risk management that I had not previously considered. From this, I found ways in which the practitioners thought about risk in relation to their assessment of it and how they dealt with risk in their interventions and how they created this knowledge from practice. There is one last map created from the messy situational map explained next.

The ordered situational map helps to create new, different and/ or modified categories created from the data in the messy map (Clarke, 2005). I completed an

ordered situational map for risk (see appendix 19) that combined all the practitioners' data. From this, a discussion with my supervisors highlighted other areas that had not been explored through theoretical sampling or through the literature on the topic, which included: risk terminology in everyday life, the history of risk assessment in forensic setting, risk behaviours as predictable and preventable, the public safety/fears and occupational therapy experience in risk assessment. This directed me to source relevant literature that would be useful to explore those areas further.

I returned to the map at a later point, as each map was to be seen as unfixed and constantly changing (Perez and Cannella, 2013). Clarke (2005) includes two elements, the discursive constructions of actions and the individual and/ or collective human actors (see figure 15). Those two elements were elaborated by Perez & Cannella (2013) in their research about post-Katrina New Orleans and the impact of pushing children's public education further into privatisation. Thus oppression of those children using public education was exacerbated and in order to explore that Perez and Cannella (2013) developed Clarke's (2005) two elements. They analysed their data for intersecting oppressive elements that are either explicitly part of dominant discourses or marginalised discourses that systematically represent people. This also included discourses of what/ who were included as dominant and by being excluded, not dominant (Perez & Cannella, 2013). I used those developments to help me to identify the following: the place of the risk assessment and management practices as control of service users and possibly of the practitioners. To see whether service users and their occupational therapy became marginalised because of risk management. Allied to that was whether risk taking was used as an approach to help service users move forward, improving in their occupational participation. Also what became apparent was the marginalised and hidden discourse about how the practitioners placed themselves at potential risk by trying out risk management plans through interventions with service users, in order to help service users. These additional elements were pursued in the development of each concept for risk and therapeutic stages.

The social worlds/ arenas map considers collective aspects of the situation (Clarke, 2005). This includes the actors, their commitments (including on-going discourses and negotiations) and relations within a site of action. The meso-level is analysed which includes the interpretations of a situation and the three social organisational,

institutional and discursive dimensions. This analysis is mindful of the characteristics of social worlds/ arenas which are that negotiations are fluid and there may be coercion, bargaining, constructing & destabilising, all basic social processes (Clarke, 2005). The boundaries are open and porous, discourses are multiple and contradictory and the analyst cannot assume directionalities of influence (Clarke, 2005). The practitioners discussed their work with other disciplines both in the wider team discussions and as specific work, but this map was not used in my analysis. Gladys's interviews indicated some specific work was done between her and psychologists, but this was not so for Tess and Liz. Theoretical sampling based on Gladys's experience alone would not allow for deeper exploration across all practitioners and was to me, a move away from the core exploration of practice knowledge. That is not to say team working has no place in practice knowledge development, but it would have been a specific aspect of practice knowledge and could be a research topic in its own right. Indeed, there were examples of team discussion with the practitioners about occupational therapy risk assessment and management which were analysed using the relational and ordered situational maps noted above.

Positional maps help to identify and plot major discursive positions in the situation and not individual or group voices or experiences (Clarke, 2005). These positions include viewpoints that are conflicted or hidden (Perez and Cannella, 2013) and thus maybe articulated or not, so the map needs to show positions taken and not taken (Clarke, 2005). Also axes must show the variations, differences, focus and controversy in discourses. The aim is to capture heterogeneous and complex aspects, to work against looking for similarities and binaries, therefore identifying multiple and contradictory aspects on particular issues (Clarke, 2005). I did not use this map because elements that were hidden and/ or marginalised had already been identified in the relational and ordered maps in relation to risk and therapeutic stages. Furthermore, there were many instances of similarity in the discourses such as assessment problems, risk and the occupational therapy process to name a few. Variations and nuances in the discourses therefore became apparent in the data, which would be expected when analysing data from different settings.

The value of situational analysis and how and why I used the maps have been explained. The use of these methods needs also to include how they provide rigour and quality in the data generation and analysis, illustrated next.

3.7 Rigour and quality of data collection and analysis

This section explains the various approaches taken to deal with rigour in the data generation and analysis for my research.

Research has been conducted into the reliability of the CDM. Even though the CDM is a qualitative tool for data collection, the concepts of reliability and validity from quantitative methodologies are used (Klein et al 1989; O'Hare et al 1998, Hoffman et al, 1998; Crandall et al 2006), rather than concepts suited to rigour in qualitative methodology, such as credibility, and trustworthiness (Krefting 1991; Lincoln and Guba 1985). It is unclear why this is so, but to remain consistent with the qualitative methodology in my research I consider concepts that can be related to discerning the quality of grounded theory in relation to my research.

Four categories for establishing the quality of grounded theory come from Charmaz (2008) and are: credibility, originality, resonance and usefulness. These also bear some relationship to criteria for quality in grounded theory by Corbin and Strauss (2008). The criteria to consider for credibility of the research can be summarised as aspects about the data: how far it covers the topic, the researcher's depth of familiarity with the topic and how logical and strong are the links between the data and the researcher's argument and analysis (Charmaz, 2008). In this research topic familiarity is managed through my prior practice experience as an occupational therapist in forensic mental health services and my familiarity with the literature in the discipline. Peer debriefing and consensual validation was a way to check my findings for gaps, bias and to clarify interpretations (Bazeley, 2013). I provided a copy of the findings and grounded theory to an occupational therapist based in a secure forensic mental health setting, as well as to the three practitioners. Unfortunately they were unable to check these for me.

Originality can be summarised as how far does the work extend existing theory, provide new ideas and insights (Charmaz, 2008). My research was a new exploration of the practice knowledge of occupational therapists working in forensic mental health. From this perspective, there is a range of new ideas presented in

the findings and discussion are ways to identify the significance of the findings to occupational therapy practice.

Member checking is a method by which the research findings can be verified by checking them with the practitioners themselves who provide their own views on the findings, either as they develop or at the conclusion of analysis (Bazeley, 2013). There have been some criticisms about using member checks. For example, an over reliance by practitioners for member checking may not incorporate contextual changes that might happen daily, and so is inherently unreliable (Sandelowski, 1993; 2002 in Birks and Mills, 2011, p. 99). There could be 'Adulatory validity' (Thorne and Darbyshire, 2005) in which practitioners agree with the researcher's findings simply because they deem the researcher to be smarter or cleverer than they perceive themselves to be. Or they agree with the findings simply because they put themselves, the researched, in a favourable light. Another criticism is that the concurrent data generation and analysis of grounded theory research makes member checks unnecessary (Charmaz, 2006).

The philosophical orientation of my study acknowledges such change, and thus placed the work in the context of; 'for the moment this is what we know' (Dewey, 1922). The social constructivist approach to grounded theory identifies knowledge as socially constructed and subject to change. From those perspectives a member check can be seen as a potential route for adding new insights to the final research analysis, thus building and developing the grounded theory further. I therefore provided a copy of my findings to each practitioner to read and check. One practitioner was able to provide some brief comments about contextual details about her service, not previously discussed, but not about the findings themselves.

Resonance relates to the depth to which the findings relate to other people in similar circumstances, as well as to collectives and institutions related to the study topic (Charmaz, 2006). Resonance also takes into account whether assumptions and traditions have been explored and whether the findings extend their understanding of their worlds (Charmaz, 2006), which is similar to Corbin and Strauss's (2013) criterion of *fit*. Reflexivity can be useful here (discussed later) so too is member checking (Bazeley, 2013). I sent my participants a copy of the transcripts of each of the interviews to read and comment at each subsequent interview. Ultimately none of the practitioners raised any issues and in fact they

often commented how they did not have time to read them. On that basis, in order to ensure my participants understood the basis of my later questions I prefaced my questions with the context based on the interviewees' previous interview discussion, as I led into the new questioning following theoretical sampling and data analysis. In this way I found a way to make links for the participants with previous discussions, to develop the analysis further. The final category is usefulness, where the analysis provides some use to people in their everyday worlds, with further contributions to knowledge and improvements to the world (Charmaz, 2006). Generic processes also need to be identified along with their tacit implications (Charmaz, 2006). As well as member checking, peer de-brief is a useful method for establishing resonance; this is where the researcher works together with impartial colleagues to establish valid information from the research (Bazeley, 2013). I used a twitter discussion with occupational therapists from various practice backgrounds, including forensic settings, to explore one new finding about connection (discussed later). This proved fruitful in developing my analysis and discussion of the topic.

Some other criteria for developing quality in grounded theory research from Corbin and Strauss (2008) are also relevant to my research. Important to credibility is remaining consistent with the grounded theory procedures of constant comparison, developing concepts, theoretical sampling, all of which I did. I was less successful however, in reaching theoretical saturation, another requirement (Corbin and Strauss, 2008). The limited theoretical saturation was because my research was a new exploration in the topic of practice knowledge and occupational therapy in the forensic setting. Therefore it was in many ways exploratory and I took the theoretical sampling to the limits I felt possible at the time, and that further detailed exploration could be made about the categories and concepts developed from the findings.

My research has used two related methods, grounded theory and situational analysis which are methodologically consistent. My use of the critical incidents and the CDM are not explicitly linked to grounded theory. Through my research I found that the use of these latter two methods rapidly became less relevant and the grounded theory methods took precedence. Furthermore, the lack of an explicit qualitative approach to the data analysis of the CDM meant there was an opportunity to try a robust approach by using grounded theory and situational

analysis for data analysis. This is discussed in more detail in the critique of the research.

Self-awareness is crucial for identifying the biases and assumptions of the researcher (Corbin and Strauss, 2008). I partly established self-awareness through the process of reflexivity which is discussed in the next section. However, a related criterion for developing self-awareness is sensitivity for the topic and the ability of the researcher to "step into the shoes of practitioners" (Corbin and Strauss, 2008, p 304). I was in the advantageous position of being able to do this through my previous practice experience. This was further enhanced through discussions with my supervisors who helped me to explore my tacit knowledge from my practice experiences in order to compare this with the practitioners' knowledge. Reflexivity is also useful as a methodology in this regard and is explored in more detail next

3.7.1 Reflexivity

For the researcher to develop a self-awareness of their potential impact on the research process reflexivity is another useful methodological tool. This means their understanding of the influence of their social position, unconscious processes and emotional expression in relation to the research practitioner in the research interview. Reflexivity is the development of a "self-consciously critical, systematic and analytical approach towards capturing more subjective and inter-subjective dimensions" (Finlay, 1998, p 453). Finlay (2002) highlights the reciprocal influence of both the interviewer and interviewee in data collection, and the co-construction of knowledge in the research interview context. This may promote rich insights by examining the personal responses of the practitioners and me, as well as the interpersonal dynamics between us. Those involved may be empowered and have a more radical consciousness opened. The final value of reflexivity can be to evaluate the research process, methods and outcomes and allow public scrutiny of the research integrity through a methodological log of research decisions (Corbin and Strauss, 2008).

There has been much debate on the feasibility of reflexivity, for example Cutliffe (2003, cited in Corbin and Strauss, 2008 p31) questions whether the researcher can completely account for them-self when deeper levels of consciousness are

involved. On the other hand however, Chesney (2001, cited in Corbin and Strauss, 2008 p31) acknowledged that reflexivity may aid the transparency of the research process by providing a nurturing bed in which to place the research findings, which in turn, helps to retain the integrity of the work as well as to develop insight and self-awareness of the influences on the researcher's interpretations of the findings. Reflexivity in grounded theory was a useful tool in this research project as it provided a process whereby I could critically review the history, context and culture of my previous work as an occupational therapist in a forensic setting. A crucial part of my PhD supervision meetings was to explore my practice experiences and to compare and contrast them with the practitioners' data, looking for differences and similarities. My supervisors' questions helped to highlight my tacit knowing of my practice experiences.

In order to assist with reflexivity three approaches were used to record my thoughts, feelings, ideas, possible assumptions and biases. The first occurred after the interview/ email when I would complete a contact summary form. The second was used during the transcribing process and I used a transcribing record sheet to note what arose for me during the transcribing and checking of the transcript for mistakes. The third was the use of memos, which partly became a journal, as it was easier to record my responses along with the data to which they linked in the same place.

There was an implicit acknowledgement that I knew the practice area and would understand the language and topics the practitioners discussed, but this also meant that I must have been aware of the disciplinary ideas and perspectives and potential assumptions made as a result of our shared knowledge (Charmaz, 2006). I therefore had to actively check myself for any assumptions I might make. I was particularly aware of this in relation to the occupational therapy process. Furthermore I became aware of how, despite my knowledge and previous research on risk assessment, there were still some nuances that were missed. It became apparent that risk management in occupational therapy had been a neglected area. Being reflexive and checking my assumptions helped me to remain responsive to the data so categories were not derived beforehand, in order to keep theoretical sampling open and flexible (Corbin and Strauss, 2008).

The relationship between myself and the practitioners in this research is slightly unusual. Our common history naturally created the potential of shared knowledge. However, it can also be argued that, as a male, my experience of power imbalances and gendered relationships might be a very different one to the perspective of the practitioners who were all female (Charmaz, 2006). I did however, become acutely aware of how all three practitioners worked in a different practice area to mine and that I had only very briefly worked with some of the service users and come across only some of the occupational participation problems they discussed. My practice experiences then were not nuanced enough in relation to the specific practice experiences of the practitioners. I had a mental hook with which to hold my practice experiences, but in the case of my research this hook was required for the practitioners' practice experiences and, as becomes apparent later, their personal life experiences, which are all considered now in the findings.

4. FINDINGS

This chapter discusses the findings from my work with my three practitioners, Liz, Gladys and Tess, who discussed at least one service user each, but who also discussed various practice experiences to provide other examples. Liz worked with Claire in the Women's Enhanced Medium Secure Service (WEMSS). Tess worked with Zach in an Adolescent Medium Secure Service and Gladys worked initially with Leila in a low secure service, but shortly after starting the research she moved to a Slow Stream Rehabilitation Service, so she then discussed her work with Andy.

The findings demonstrate how occupational therapy practice in the forensic mental health setting required the practitioner to enact various expectations in the form of steps and rules with their service users. Practitioners also had to be creative in their practice. This was demonstrated in that they could reflect on and change practice for the future and they could act to change practice in the moment. In order to do that, the practitioners used both their professional and personal knowledge and were thus blending these in practice. Thus the practitioners could go beyond those expectations to meet the service users' needs as required in a given situation.

The overall structure of this chapter includes a summary of the emergent categories and concepts generated from the data analysis. The concepts within each of the three categories are all presented with a title and number of their own. Quotations from the three practitioners are used to provide the properties and dimensions of the concepts that in turn form the categories. The presentation of the quotations are indicated in a table in appendix 21. Next I indicate the categories that emerged from the data and my analysis.

I found that the practitioners' practice could be categorised in three main ways (see figure 16), which I briefly describe and justify. The practitioners enacted their practice by using the occupational therapy process as a structure to gather knowledge and develop their knowledge about a service user. The structure was not used in a static or linear way and neither was it a hierarchy. The structure was therefore used in a dynamic, flexible way, according to the presentation of the service user. I therefore created the first category 'steps of practice' to indicate that

steps of practice could be taken in various directions. Steps could even be taken backwards, when a service user had to have their therapy halted because they were secluded or they could not progress further. The steps are related to what had to be done in practice, outlined next.

The second category captures that the practitioners had to meet some specific requirements in their practice. There are time frames for certain practices and there is an expectation to use evidence in practice. Also there are expectations for the practitioners to have regular dialogue with colleagues about the service user's care. I chose a category label of 'rules for practice' because there were some practice requirements. There were however, professional and organisational cultural conventions and traditions of practice that gave the impression of practice expectations. The rules for practice could not always be implemented as expected by the NHS trust and other external organisations, therefore the practitioners had to be flexible and act in the moment in their practice, in order to modify the rules to enable practice in ambiguous situations.

The third and final category emerged from how and in what ways the practitioners worked with a service user. The practitioners had human emotional responses towards the service user's actions that could be difficult for practitioners. Consequently, practitioners actively reflected on their personal values and beliefs, some of which created the need for a nuanced knowledge about service users. Thus through dialogue between them they created narratives that in turn facilitated the practitioners' empathy. The practitioners use their values, beliefs and emotional responses and communication skills developed in their personal life in order to build a therapeutic relationship. The practitioners' combination of the foregoing skills suggested the category label 'blending of personal and professional'.

The occupational therapy process

Blanket referral

Knowledge sources and gathering

Assessment

Intervention and planning

Evaluation: seeing change

Creating knowledge from practice

1. Steps taken in practice

3. Blending the personal & professional

2. Rules for practice

Medical model

A model for practice

Client-centred, Recovery & Strengths based approaches

Risk taking

Sources for evidence use in practice

Therapists' personal values and beliefs

Practice experiences

Narrative building

Connection

Trust

Rapport

Empathy

Occupational therapists' emotions in practice

Occupational therapy is not fluffy: identity of occupational therapists working in forensic mental health

Reflection

Figure 16. Grounded theory with categories and associated concepts of occupational therapists' practice knowledge in forensic mental health (source: Cordingley, 2015)

The figure above is now expanded with a fuller introduction to each category of steps of practice, rules for practice and blending of personal and professional, before presenting the completed analysis and findings. Category one, steps of practice, was concerned with how the practitioners enacted their practice. This was called the occupational therapy process and for the practitioners in the forensic settings explored here, this included a range of aspects that facilitated the understanding of the service user. The process provided a broad structure to enable the practitioners to ascertain knowledge to guide how they decided to work with a service user; it indicated what they observed, their decisions on what knowledge was relevant and then used that knowledge to produce an intervention plan. There were subtleties and complex ways in which the practitioners used the occupational therapy process. These impacted how the service user could be engaged in an effective and meaningful way with the process.

Rules for occupational therapy practice was the second category and represented what the practitioners were expected to do in their practice. The practitioners were required by the organisation to use a particular model; the Model of Human Occupation. Also, the practitioners must use various sources of evidence too. Incorporating other models and approaches were required of the practitioners and included the medical model and the client-centred, and recovery approaches. There was some autonomy in the use of other models, frames of reference and approaches.

Category three, blending of personal and professional aspects of practice, was about building a therapeutic relationship between the practitioners and service users. The practitioners had to make a connection with service users before they could develop a rapport and trust required between them. The practitioners elicited the service users' narrative from discussions and knowledge gathering, which enabled the practitioners to develop a nuanced understanding of the service users. Service users' narratives were compared with and framed within the practitioners' emotional responses to the current service user and particular situations from previous practice, as well as from personal life experiences that all formed the therapists' own narrative. This can happen in the moment of a particular practice situation. The narratives help therapists to develop empathy and compassion towards their service users and their challenging actions. The practitioners' identities, as occupational therapists, are challenged in the forensic setting and

impact upon their practice. Accordingly, the practitioners used reflection to understand their actions and responses to the service users. This became less available in formal supervision as the practitioners increased in seniority and so reflection needed to occur at other times.

Each of the different service areas for each practitioner had a different effect on occupational therapy practice. Gladys and Tess explicitly stated that they spend most of their day on the ward. A feature of the forensic setting was the length of time that service users were admitted to each ward. There was Liz's experience of working daily with her service user Claire, but potentially this could be over a long period of time. Gladys had an expectation of working for a long time with service user Andy, and Leila already had a long admission to forensic services and was in a low secure ward at the early dates of interviewing. Tess could work with her service user, Zach, up until he became 19 years old, due to him being sentenced for his offence. This was unusual for Tess who often worked with service users for much shorter periods of time. This demonstrates how the local working context for the practice of the practitioners was influenced despite all of them working in forensic services. There were commonalities too, which are discussed in the first category of the steps taken in occupational therapy practice.

4.2 STEPS TAKEN IN OCCUPATIONAL THERAPY PRACTICE

The first category of steps taken in occupational therapy practice includes the processes, and knowledge sourced and used by the practitioners for the service users' occupational therapy. Steps encompass the ways in which the practitioners enacted their practice, although these did not necessarily follow a linear pattern. Table 4 includes the concepts that comprise the category.

The practitioners worked in a world where steps were taken to direct the practitioners' practice, such as with the occupational therapy process ('the process' from hereon). The practitioners however, also used their discretion in what needed to be done. There were varying degrees of success in following a combination of the steps and in practitioners' use of knowledge from codified occupational therapy sources, and in category three (discussed later).

Table 4. Category one steps in occupational therapy practice and concepts (source: Cordingley, 2015)

Category: Steps in practice	Concepts:
	Occupational therapy process: subtleties of therapeutic practice
	Blanket referral: accessing occupational therapy
	Information sources and gathering; information gaps
	Assessment; observing service users, standardised assessments; interviews; risk assessment; contextualising risk; team collaboration and risk assessment
	Interventions; risk and interventions; risk and occupational participation grading and adaptation
	Seeing change: evaluation; praise, achievement and recognition

An early part of the process was an analysis of what knowledge about service users was gathered and observed – a step that required methods and tools to achieve. Those early stages provided examples of how the occupational therapy process had complex and subtle characteristics within each of its phases. These characteristics were apparent in specific parts of the process of blanket referral system and pre-assessment, informal and formal assessment of the service users. The findings indicate the times when practice could not be informed by codified aspects of the profession and as such, practitioners found that knowledge created from their practice was the way that their practice could evolve and move forward. In order to create this knowledge the practitioners collaborated with service users, other mental health services and members of the multi-disciplinary team, and they also accessed whatever clinical data existed in the clinical notes.

In broad terms the practitioners used various forms of knowledge in their practice. There were examples from all practitioners where there were various gaps in the practitioners' knowledge that had to be filled, for example, about the service users' history, gaps left by assessment limitations and other gaps, discussed later. These gaps illustrate two aspects. The first was of gaining enough knowledge about the service users at any given moment, to work with them. The second was about the subtleties of practice in specific parts of the process that practitioners needed to understand and negotiate.

4.2.1 Occupational therapy process: subtleties and cycles of therapeutic practice

The process provided cycles of therapeutic practice that were used for specific purposes and could be completed concurrently in some situations. The process and its use by the practitioners are now explored in more detail. By way of an indication of how the process was used by Tess with Zach their timeline is provided in figure 17.
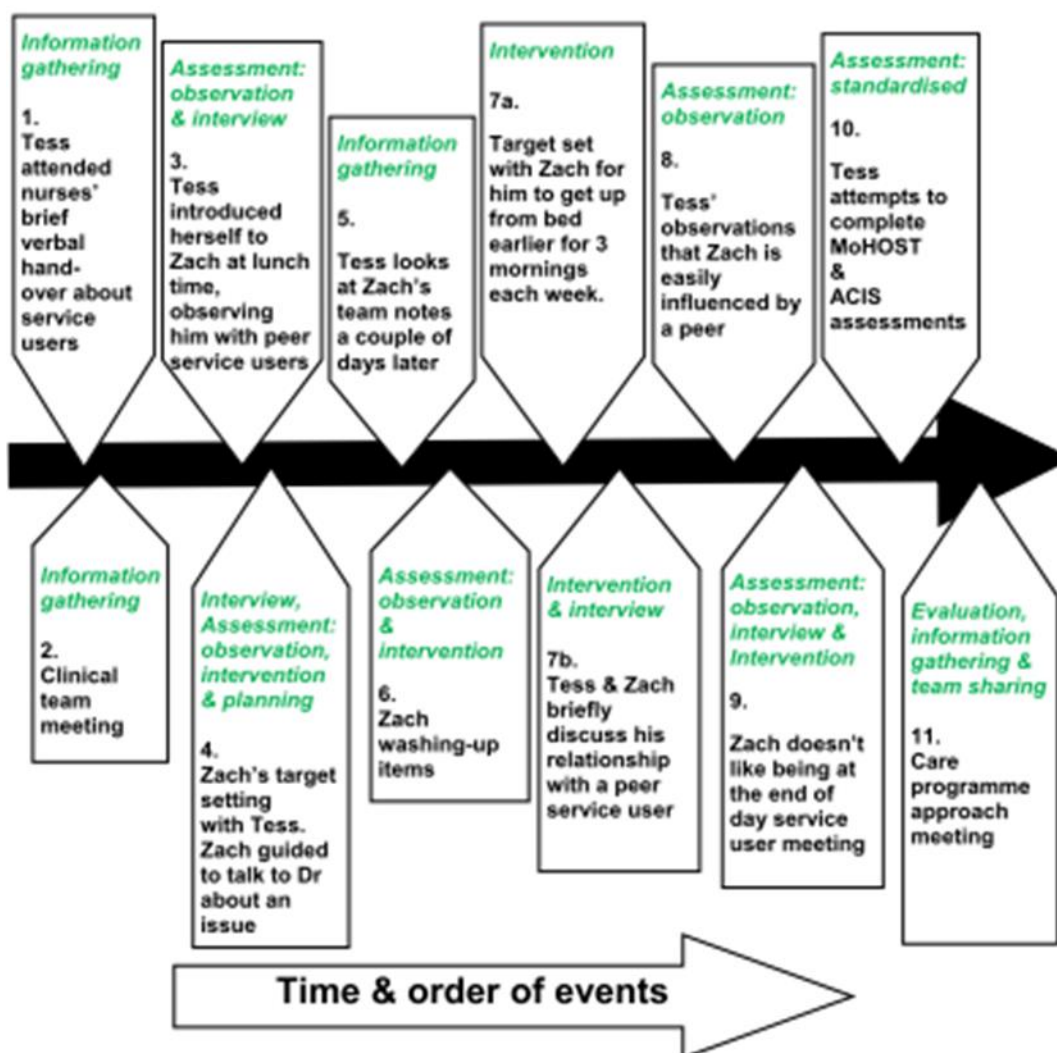
Figure 17. Tess and Zach's early occupational therapy process leading to the first care programme approach meeting (source: Cordingley, 2015)

The timelines are a figure that describes what was enacted in the various aspects of the practitioners' practice with each service user. An example of how the process was used in Tess's work with Zach shows what she did in broad terms, with each arrow representing one or more points of the process. The text in black indicates what was done by the practitioner. The text in green is my categorisation of what each arrow represents in the occupational therapy process. In a sense the timeline represents practice as continuous and each part builds on previous work. The process however, is a more messy experience in practice, with the practitioners moving between the various parts as required and not through a linear, sequential movement, as demonstrated in figure 17 of Tess and Zach.

4.2.2 Blanket referral: accessing occupational therapy

All the practitioners worked with an approach that included the use of blanket referrals of service users to occupational therapy. There were however, slightly different ways of dealing with referrals in relation to each of the service users; Claire, Leila, Andy and Zach. For example, Liz in WEMSS, prior to service users' admissions, had the opportunity be part of a pre-assessment meeting between multi-disciplinary team members to discuss the referral and assessments of each service user. Liz could attend this meeting for Claire, but she did not in that instance. In the case of Gladys; her work with Leila started through a combination of blanket referral, psychology referral and Gladys's identification of Leila's specific physical health care need (see figure 18). In terms of slow stream rehabilitation Gladys was new to the ward and as such, there had been some previous occupational therapy from a locum. There was a list of referrals from the consultant psychiatrist and the team that were provided to Gladys via discussions in the ward round. In the case of Tess, who worked in adolescent services, she had been away on extended leave and was unfamiliar with new service user admissions, but was required to start knowledge gathering about the new referrals.

The blanket referral approach meant seeing every service user admitted to the ward without any verbal or written referral being provided. Blanket referral was defined by all practitioners in slightly different ways, depending on the working procedures in the service:

> *Everyone is seen by OT, irrespective of their level of need at the time*
> *(Gladys 1, 233)*

Gladys's view suggested that the practitioner had no opportunity to decide when occupational therapy would be relevant and valuable to the service users. Liz defined blanket referral as:

> […] a catch all term that's been useful for services to say that everyone is seen
> (Liz 6, 443-444)

Both Liz's and Gladys's views were similar about seeing everyone. There were however, service variations to how blanket referral worked. Leila and Gladys's timeline below (figure 18) shows a different approach to Liz's service area. The women referred to WEMSS needed to meet a criterion for admission to the unit that required the team to see how far the service user's functional, psychiatric and
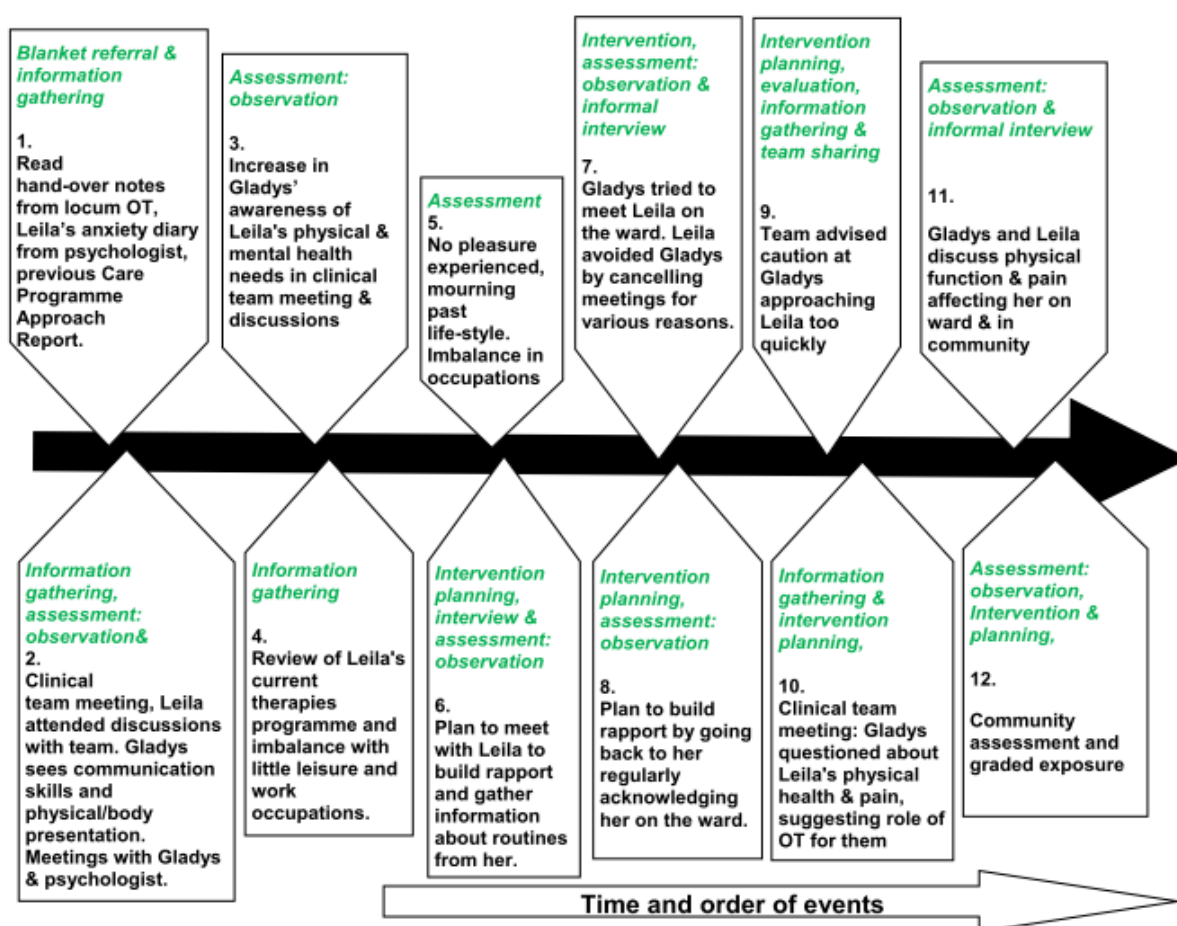
Figure 18. Gladys & Leila blanket referral and early occupational therapy process timeline (source: Cordingley, 2015)

psychological needs could be met. Liz could be a part of these meetings which suggests that this is a form of blanket referral. If the team declined the referral Liz's input would stop. Once the service user met the criteria, a pre-assessment meeting

was held in WEMSS and focussed on risk. Liz linked the pre-assessment and blanket referral processes together and highlighted their importance for her practice:

> *Pre-assessment period is absolutely essential but I think it's supported by supervision and I think its supported by crucial multi-disciplinary team thinking and…it's got to have obviously, the occupational therapist's perspective on it, but I think it has to be shored up by those two things because it's impossible and dangerous to manage a blanket referral system because ultimately the onus is on you; who, and when and how to engage…so it's actually vital*
> *(Liz 6, 432-438)*

Tess had a slightly different approach to acting on her blanket referral due to being on extended leave:

> *On a Monday morning we have the ward round so… and obviously I didn't know him and a couple of other boys so I was listening to what was being said […]*
> *(Tess 1, 249-250)*

Tess was acting immediately on the blanket referral by starting to access information, doing so in an expedient manner for that time. Following the referral Liz decided when and in what ways she spoke to the newly admitted service user:

> *I would introduce myself I would go and make sure before the CTM [clinical team meeting]…I would have introduced myself, and I would have had a discussion then or begun discussions about the atrium risk assessment*
> *(Liz 2, 153-156)*

Liz therefore had a routine for starting her work with each service user. Another example of a routine was where Tess had to prioritise the blanket referrals for who would be seen first:

> *There was particular boy who was admitted virtually at the same time, who had come from another adolescent unit who was only going to be six weeks…and there was much more work to do with him and was in much more of a place that you could work with*
> *(Tess 9, 378-382)*

Tess also needed to consider the discharge plans within her prioritising:

> *I try and focus on the people who are going to be discharged because they are the*

ones who are going to need taking on leave, assessing in the community, assessing
their living skills, budgeting, how they are managing, etc., etc. The ones who have just
been admitted especially if they are really unwell they are the ones I don't ignore, but
I am really not going to focus
(Tess 9, 389-393)

The blanket referral approach required that each service user was seen by the occupational therapist in their respective service with the aim of assessing their occupational participation. Only Tess discussed prioritising her service users and this indicated her particular working context as both Liz and Gladys could be working with their service users for a longer period of time. The referral was an early part of the process for all practitioners, but their practice deviated from the assumption that there was one blanket referral approach. For example, the time practitioners were first informed about a new service users, the local constraints of time frames for admission and discharge and Gladys read Leila's clinical notes when she started on the ward, but she received a specific referral about Andy. In order to act on the referral and to initiate the various therapeutic cycles the practitioners required various knowledge sources.

4.2.3 Knowledge sources and gathering

Knowledge gathering was about the practitioners' disciplinary knowledge and specifically about each service user. It was often completed in the early stages of the process however, this did not stop at one point when the knowledge was gathered. I use the term knowledge gathering rather than information gathering used by the practitioners, as can be seen in Tess and Zach's timeline (figure 17). I do this because the practitioners already knew what they needed to gather. This comes from their practice experiences about the process. Indeed, Liz identified practice experiences from when she was an unqualified worker that she used in her current practice. The practitioners discussed how their knowledge and ideas developed over time and how at points, when they did not know about a particular topic, they would source additional knowledge. So, from this it can be deduced that there is a need for specific types of knowledge, which can be gained from specific sources. Gathering occurs at a variety of times depending on why knowledge is needed and is also often based on how and in what ways the service user presents to the practitioners. For example, to get the most recent details about Zach, Tess attended the nursing handover meeting and the clinical team meeting. She had not

had the opportunity to read more details due to being on recent leave, so she met Zach prior to having a full knowledge of his history. She described how she usually read medical notes and admission assessments for details about where they have come from and reason for their admission and their index offence. In the early stages of the service user's admission Liz had a similar approach to knowledge gathering:

> *[…] two ice-trays are for one woman to swallow and suck on and the other ice-tray is for a woman to crunch it into her hand to get the sensation of cold running down her hand…now both of those are information I have got from a previous environment so that I knew how to say hello, this is what we are going to have and this is what we are going to do…it is just getting that point of connection*
> *(Liz 2, 161-176)*

Feedback from previous environments was useful for direct work with service users in the context of helping service users have access to objects that helped them with sensory modulation and as a way to start therapy (discussed further in category three). Gladys described how sources of the historical knowledge were important to understand about the service users' attachments, their childhood habituation, family and social background and what they are currently doing. This was within a context of how their illness manifested and what could re-traumatise them currently. She recognised however, the limitations of what information was available from locums and the most recent CPA reports. Gladys's choice of what knowledge to gather indicated how she was influenced by her previous experience of working in a women's forensic ward:

> *To be mindful really of how some situations could be potentially be triggers for people or could potentially be quite distressing based on the sort of information gathered through history and risk assessment…and information gathered through the team as well*
> *(Gladys 8, 217-220)*

The knowledge sources were important to Gladys in order to prevent upsetting service users when in discussion with them. Over time, beyond the early stages of the process, it became apparent that other knowledge sources were required by Liz:

> *[…] observational material [and] quite a lot of subjective material which she had never been able to tolerate a formal assessment process.*

(Liz 6, 10-12)

Liz therefore found that she needed to use her observations and find other ways to assess Claire. Liz described sourcing sensory modulation knowledge through web-sites:

> *I basically Googled and had a wander around all of the different sites of and thoughts around it. Now this woman…has had a query learning difficulty…an indication that cognitively she may struggle. So I wanted to try something and also looking at it from a recovery perspective I wanted to share my hypothesis with her. So I looked for something and so I took off the internet a sample of the sensory profile and attempted to do this with her*
> *(Liz 5, 378-383)*

Once Liz understood that she needed to develop her knowledge further, she used a combination of knowledge of experienced colleagues, her practice experience and published work:

> *I had been thinking all of this kind of sensory input when I am not sure of the chronology of this, several things happened…I started to look at some of the web sites on sensory modulation, there were a number of articles published in the British Journal of Occupational Therapy on sensory modulation, an Australian OT got in touch with me who was setting up a women's forensic unit…that would use sensory integration as their primary model of care…and I heard people talking about weighted blankets and I had a memory of working with a man in a forensic centre who would spend long periods of time in seclusion*
> *(Liz 1, 113-121)*

Knowing what and why knowledge might be useful in the early stages of the process was a part of the practitioners' knowledge developed from practice experiences. Over time, as further knowledge was gained from ongoing practice, the need for different knowledge became apparent and was thus sourced. Indeed, this deviated from practice expectations that standardised assessments could gather knowledge about service users. Practitioners however, often had gaps in their knowledge, illustrated next.

4.2.3.1 Knowledge gaps

The practitioners described times when they did not have all the knowledge they thought they needed for their practice. There was an acknowledgement that new

knowledge may come to light at later points. The practitioners continued to gather what knowledge they could for their practice at whatever point they were at with their service users. From their discussion, it was clear that the practitioners expected that some essential knowledge would not be available. Their practice therefore would change later due to new knowledge becoming available. In a sense the practitioners had to continue forward in their practice and find ways to circumnavigate the challenges presented by the lack of knowledge about service users, continuing to observe, assess and plan suitable interventions with the knowledge available. Knowledge gaps became apparent with limited knowledge gathered due to a limited range of observations in different environments being available. Tess described reports about Zach's educational history and fighting at school that conflicted with her observations of him. Tess and her team had a lack of knowledge about Zach at the early stages of work with him. For example they were unsure of his mental health needs and possible learning disability needs. In particular for Tess, she was unsure of what impacted Zach's occupational participation causing him constraints:

> *[…] we also were all struggling to think about him and where he is going, so setting our own aims and objectives in terms of a plan for him is very difficult as we are all completely unsure where he is going and what is best for him - it is still being argued whether he can go to an LD [learning disability] service, back to prison or to a MH [mental health] adult service, there are pros and cons to each of these.*
> *(Tess EM6, 185-190)*

The lack of the required knowledge meant the team had to find ways the knowledge gaps could be filled. The team's difficulty understanding Zach suggested that they needed more time for their knowledge of him to develop. A key point here is that the team could not predict that there would be such a difficulty in knowledge gathering about Zach with the result that they would be unable to effectively evaluate the advantages and disadvantages to each discharge plan option for him. This suggested that there was no one certain answer to meet Zach's needs at that time.

Gladys developed her knowledge about Andy's behaviour and perceptions of the world around him that could not be predicted:

> *What has come up is his sense of danger and that for example on one day the ward could be the most dangerous place…and on another day, for reasons beyond our*

*understanding, the smoking area could be the most dangerous place, or the garden
could be the most dangerous place*
(Gladys 4, 501-504)

Also Gladys and the team found it difficult to interpret why Andy perceived the world
as dangerous. In the early days of working on a women's ward Gladys found the
team discussion provided her with a sense of the team's therapeutic relationship
with Leila from their dialogue. She also recognised how there were knowledge gaps
about Leila if she relied only upon written notes:

*[…] also I can see how she is in a group situation as well [in the ward round]…the tone
of these conversations in medical notes because it is often very factual we said this it
was this, but you miss the tone of this and you miss the conversations that aren't
documented like…I don't think this would be a great idea for her at the moment she's
a bit wobbly this week perhaps we should wait till next week, but whereas what would
be in the notes would be decided to leave to next week as mental state and you don't
get quite the level of detail and…it's interesting to see how other people interacted with
them as well…and the sort of relationship she had with the team and how she viewed
the team as a whole*
(Gladys 1, 354-378)

The team discussion was therefore crucial as a knowledge source for who of the
team members could best engage with Leila and what work might be best achieved
with her that week. Filling knowledge gaps by using medical notes, hearing details
of the team's work with Leila and observing how Leila interacted in team meetings
indicated that Gladys knew of a range of ways and means to find information.
Dealing with the amount of knowledge and judging what was enough for effective
practice was Gladys' experience with Andy:

*I just wasn't sure how to translate that activity that brief activity that was based around
an addiction and into looking at how he would perform functionally in other areas…I
thought I would be really scraping the bottom of the barrel…in order to see what he
could achieve…*
(Gladys 4, 259-262)

Gladys has questioned two moral aspects of her practice about using cigarette
rolling, an addiction, and how fair it was to base her assessment of Andy on one
small form of occupational participation. Knowledge gaps about Andy sometimes
came from other team members:

[…], I would ask a question about say eye contact and she'd be like 'well you know,

we talk a bit but he tends to go back to his room' and I wouldn't get yes, he maintains
eye contact or no, he doesn't maintain eye contact…direct answer…most of the
information is that he does not interact with other people in the group apart
occasionally from her…
(Gladys 4, 200-207)

Gladys was trying to gain knowledge about Andy who did not engage in occupational participation or interact with staff and other service users regularly. Therefore the knowledge that can be gathered is impacted by what has and can be observed about a service user.

4.2.4 Assessment

Assessment within the process was part of the everyday practice of the practitioners. The assessments consisted of standardised and un-standardised tools that incorporated observations of, and discussions with service users. Following the early stages of admission, subsequent assessments for exploration of specific needs were identified and carried out as required. The assessment tool that all of the practitioners were first expected to complete as an organisational policy was the Model of Human Occupation Screening Tool (MOHOST). At different times practitioners used other theories and assessments. The period of time leading to the first care programme approach included ongoing assessments and intervention/s as well as weekly team meetings that provided updates about the service users and from which the practitioners obtained further knowledge from the team members.

4.2.4.1 Observing service users

Observation in practice concerned the ways in which the practitioners watched the service users, in order to establish their occupational participation abilities and constraints. Observing service users was focussed and purposeful for two reasons. The practitioners looked for what composed service users' occupational participation and the practitioners engaged in observation at any time they had contact with their service users. In this sense observations were ongoing cycles within the steps taken in practice. Observations were carried out at various times, in different environments, including social situations, with a variety of forms of

occupational participation. Tess observed Zach's presentation early in his admission to the ward:

> *It's still quite early in the sense of observation, watching trying to work out what he is*
> *capable of in learning and what is illness and emerging illness…*
> *(Tess 1, 191-193)*

Tess's approach suggested that her early observations of Zach were filtered in relation to his possible illness and learning capacity. Another example of such filtering is how Gladys used the theoretical concepts from a standardised assessment MOHOST, to guide her observations of Andy's occupational participation constraints. Tess developed a way of working with Zach that changed as she compared earlier with later observations of his reactions to other people on the ward.

> *[…] as the few conversations I initiated with Zach did not get a response or had a very*
> *slow response I felt I should just go slowly. In the first couple of weeks I observed that*
> *Zach was like this in most situations, with both male and female staff and peers alike,*
> *so became less concerned re interactions with females…*
> *(Tess EM3, 122-125)*

Tess's observations of Zach's actions on the ward built her knowledge about him which informed the ways in which she tried to work with him early in his admission. Observations could take place anywhere, such as Tess's first introduction to Zach in an informal place:

> *[…] OTs are ward based now…we are on the ward a lot...the first time I even met Zach*
> *it was over lunch and…I'll spend time...sitting, chatting, or just observing.*
> *(Tess 9, 202-204)*

Tess observed service users' daily living activities and social interactions. She could also develop a dialogue with them in a much less formal way. Tess made early observations of Zach's responses, including to his peer group:

> *[…] he started to come into the kitchen but more he'd watch things. If the boy [the peer*
> *at the top of the service user hierarchy] told him to stir or do something he might do it,*
> *but he wasn't very spontaneous and he didn't suggest things…*
> *(Tess 11, 44-48)???*

Tess developed her knowledge about Zach's occupational participation including communication skills in group cookery with his peers and with Tess facilitating. This

provided her with knowledge that was similar but also different to that gained from the dialogue between her and Zach alone. Liz watched Claire's actions in a more formal social setting of a team meeting:

> *[…] she was shouting, she was crying…as she chewed, sucked on the Mars Bar she calmed down, her whole affect calmed down. She was able to hear the team. she was able to reflect on what the team were saying and literally you felt the effect in the room and that…because everyone else was like 'oh she is much better when she has got some sweets' and I was thinking 'no actually what we are seeing is a sensory modulation' we're seeing her… we're seeing sensory input which allows her then to regulate and function.*
> *(Liz 4, 29-34)*

Liz made an interpretation about Claire's actions based on combining her observations of Claire with her previous experiences of seeing children and adults acting in similar ways. The practitioners observed service users' social interactions as a part of their occupational participation in various environments. Gladys had various reasons for comparing Andy's interactions in the ward and smoking area:

> *[…] whether there would be any difference in his presentation on or off the ward and especially around any increased level of anxiety. I was interested to see where he chose to sit or stand, or if he chose to sit or stand, if he would communicate with me while we were out there or would choose not to and would choose to be at a bit of a distance to me.*
> *(Gladys 4, 281-285)*

Not only did those observations indicate attempts to understand Andy's abilities, but also his emotional responses to his occupational participation experiences. Tess observed interactions between Zach and other service users on the ward and discussed her interpretation of how they manifested in her work with him:

> *What we are trying to do is to let Zach identify his own interests as his peers often influence him and put pressure on him, which means that he does not express his own views. E.g. last week when discussing what to cook Zach stated he would like to prepare stir fry noodles, his peers suggested other things, and when asked if he would like to prepare noodles, he stated I don't mind and relented to prepare what his peers suggested.*
> *(Tess EM2, 126-132)*

Tess took a moral approach by trying to work for Zach's benefit when he was being victimised by his peers. She also tried to send a message to both Zach and the

other adolescents that they all could have the opportunity to make their own choices about what they did in the group. What was not clear was the impact of the approach on the service users' social dynamic and hierarchy outside of the cookery group. The absence of interactions informs Gladys about Andy too:

> *He doesn't really engage with other service users on the ward and rarely engages with members of staff.*
> *(Gladys 3, 143-144)*

Such limited social interaction may only impede occupational participation if they are required. Gladys identified how Andy had skills in other forms of participation such as art and writing journals and he showed her some of his work. Gladys was however limited in what she could directly observe and this was a key part of the practitioners' practice. Service users were observed in occupational participation by the practitioners, which was mapped against their knowledge, which would include how they themselves participated in the same occupation, about what is required to perform activities, known as activity analysis. The analysis forms the basis of observations and assessment of the service user's abilities and constraints when participating in occupations in a given environment, which too is analysed for the service user's variations and idiosyncrasies of participation. Liz did a self-care activity analysis that she had presented at a conference, into the complexities of managing a daily task within a forensic context,

> *[…] in order to get up and shower this morning in this physical environment you will have to get up… [and] go and get someone to unlock the laundry for you to find the towel. Then you will have to go and get the security nurse to get your key for the red locker and in your red locker there will be the number of toiletries you are allowed to have in your room.*
> *(Liz 5, 231-235)*

Liz has observed that service users cannot get independent access to specific objects used for showering. Service users therefore need to learn the ways in which they can participate in this occupation in a forensic setting. Other tasks that are often particular to women's self-care require further supervision due to the potential to use objects to harm themselves or others:

> *[…] if you want to shave your legs today as well as washing your hair and washing your body you will also need to find out if there is a security nurse of the right gender*

to observe you while you are doing this.
(Liz 5, 235-237)

The implication here is that if a nurse is not available then the service user would have to wait for one to become available. For risk reasons the forensic setting requires what is a regular habit of occupational participation for some women, to become a monitored, controlled and as Liz noted, multifaceted matter. Associated self-care tasks of dressing cannot be fulfilled until security items are returned to the locker and if the service user wants to use a hair dryer they will need to obtain this from the security nurse too. The observations that the practitioners make therefore have to also consider the context of which occupational participation is part and its influences. The context is not always so present, as with Gladys's observations of Andy going for a cigarette:

> *[…] I wasn't sure if going for a cigarette was enough for me to a functional assessment on…given as much as because I am seeing him doing something so incredibly routine…that's over a very short period of time that requires a lesser number of skills…I don't really see him do something that challenges him, we are only out there for a very short time…for the majority of time well be sitting down and can I do an activity analysis on how he gets to the bench, picks, lights his cigarette, smokes?...*
> *(Gladys 4, 245-250)*

Part of this observation was compared to Gladys's activity analysis and involved identifying the limitations of how much Gladys could assess Andy and whether her practice experience was having an impact in such a way that it was not possible to make a fair assessment of him. Gladys could make some observations, but struggled with the limitations of the occupation and a moral concern about making an assessment based on one occupation:

> *[…] he smoked roll-ups, but found it very, very, very difficult to roll cigarettes, but how do I then…really look at that small area of life although in his life a very large area and then translate it to other areas…how to translate that activity, that brief activity that was based around an addiction and into looking at how he would perform functionally in other areas…*
> *(Gladys 4, 255-261)*

Tess observed Zach and found gaps in his occupational participation:

> *[…] even with choosing ingredients to add to something…he can't choose, he can't think of what he wants to do or get involved in.*
> *(Tess 11, 155-157)*

Using a familiar occupation of Andy's facilitated Gladys's observations within a given context. This too provided an opportunity for dialogue between them that developed therapeutic interactions and Gladys's knowledge of his interests and future plans as this example indicates:

> *[…] he told me he loved smoking and it gets him out of his room and he likes to do it*
> *for that reason and he said that it was nice, nice being outside and it was nice being*
> *in the fresh air…*
> *(Gladys 4, 320-336)*

This combination was an example a context created from practice. Andy liked being in a different environment to the ward and participating in a valued activity. These along with the social dyad with Gladys provided a different therapeutic environment from which she developed her knowledge about Andy and was employed in her practice as their dialogue continued:

> *[…] he would like to go in the community and his aim was to be able to get to [location*
> *stated] I asked was there anything you want to go to? And he laughed and said he*
> *really wanted to go to the KFC [Kentucky Fried Chicken] there and was really pleased*
> *about telling me how much he enjoyed fried chicken…*
> *Gladys 4, 321-325)*

Gladys was able to build on her new knowledge about what Andy anticipated doing for his future plans. She asked different questions and new knowledge was created about his preferences. Gladys compared this new knowledge with her knowledge of his history:

> *[…] he's never expressed any kind of food preference or anything like that on the ward.*
> *I don't think he even contributes to the community meal in saying what he would like…*
> *(Gladys 4, 325-327)*

This indicated how what might appear a small, inconsequential even, moment in Gladys's practice with Andy creates new knowledge from and for practice. Indeed, during this assessment their dialogue continued about a female service user who had verbally abused him outside the ward and Gladys continued using her observations:

> *[…] how relaxed he was in the situation being outside, even talking about this other*
> *service user I said are you worried about her at this point? And at that point if I*
> *remember correctly, he said that he wasn't at that stage.*
> *(Gladys 4, 327-329)*

Gladys's and the previous quotes are an example of how practice is a multifaceted combination of various practitioner actions. These included making observations and linking them with previous practice experiences, dialogue and narrative building (the latter three are discussed later). These were used to create a knowledge from practice experiences about service users.   Other parts of knowledge creation about service users are using standardised measurement tools to assess service users, illustrated next.

4.2.4.2 Standardised assessment tools

Standardised assessment tools are a form of assessment using specific concepts that represent particular observations that can be made. They form a part of the occupational therapy process and are completed within a time frame. Each measurement tool has a time frame over which it can be used to gather observations, for example the Model of Human Occupation Screening Tool (MOHOST) used by the practitioners has up to a week for service users with challenging behaviours, depending on the amount of contact between them and the practitioner (Parkinson et al, 2006). Gladys stated she allowed two weeks of observations when she used a MOHOST. Gladys also stated another point in time was at the six months CPA (care programme approach) meeting. The MOHOST was then completed again and compared with the previous results of the tool:

> *[…] over the last few months… he's much more spontaneous about having a shower, he still needs prompting but he's not coming out absolutely stinking any more. He's not putting his hands down his trousers so much you know what teenage boys do. ..he is more interactive and more willing to come up and vaguely initiate conversation, ask how you are.*
> *(Tess 11, 26-36)*

Liz stated the measurement tools she used were helpful to observe and understand the nuances of the service user's functioning that on the surface appears to be effective:

> *[…] it is only when you do the kind of activity analysis that the MOHOST or AMPS assessment allow you to do, you pull out certain key factors around impulsivity, around…sometimes very subtle task organisation…and the classic is generating activity.*
> *(Liz 3, 397-400)*

Liz was discussing how there were specific concepts in the Assessment of Motor and Process Skills (AMPS) (Fisher, 2001) that helped to delineate fine degrees of occupational participation. Tess stated how the MOHOST could be a guide for those not familiar with what to look for and noted how she used it:

> *I think of it almost as a checklist…you need to be thinking of environment, you need to be thinking of the impact, because that is the whole point of it the dynamic open system, different things coming in, reacting in a different way…*
> *(Tess 9, 276-281)*

Tess briefly described the concepts of MOHO on which MOHOST is based. Both she and Gladys used the tool to structure their observations and thinking. The practitioners therefore found the tools useful as a structure for their observations according the concepts of the tools. The tools however, do have a specific way of viewing occupational participation and this may not be effective for various reasons, illustrated next.

Limitations using standardised assessments

All practitioners reported that the assessments they had used did not always help produce knowledge about their respective service users. Gladys described how she had to use un-standardised observations with Andy due to his very minimal occupational participation:

> *I felt I needed to take a step back and do some quite unstructured assessment because I wasn't really sure how I was going to get this gentleman to agree to a very structured assessment...*
> *(Gladys 3, 136-138)*

The tool therefore may be limited with service users with multiple needs. Indeed, Liz's use of MOHOST with Claire did not work either:

> *[…] it's the first time the MOHOST didn't fit…for this woman, and what has fitted is to construct the narrative of a relationship which has been very much, very much circular.*
> *(Liz 6, 44-45)*

Liz found a more effective way to assess Claire by gaining knowledge of her narrative through the stories Claire told her and the team. Tess found she could not use the

MOHOST to assess Zach's perception of his abilities:

> *[…] the first time I did the MOHOST…I wasn't really able to make [out] what his*
> *perception of his skills were the second time was again difficult…*
> *(Tess 11, 26-27)*

Tess's experience suggested the MOHOST could not be used with Zach to identify a characteristic in the key concept of motivation/ volition for occupation (Kielhofner, 2008; Parkinson et al, 2006). Tess had experienced the same limitations when trying to observe other characteristics of Zach's volition:

> *[…] I…still haven't got a full sense of and I think he hasn't got a sense of what drives*
> *him…What motivates you in what you are doing every day?*
> *(Tess 11, 120-124)*

This difficulty impacted on whether Tess could use another standardised assessment such as the volitional questionnaire:

> *[You] watch them choosing things, that's what I'm saying he gets - even with choosing*
> *ingredients to add to something…he can't choose, he can't think of what he wants to*
> *do or get involved in.*
> *(Tess 11, 154-157)*

A tool especially developed to look into detail at the characteristics that make up the volitional concept would be expected to be used to identify Zach's occupational participation problems but Tess could not use it. The practitioners were required to use MOHOST to structure their reports, but Liz could not do this because she only had a basic MOHOST:

> *[…] the CPA [Care Programme Approach] report I'd written…focusses on self-care,*
> *productivity and leisure, but the bulk of the report talks about sensory integration*
> *interventions and how they fed into those three areas.*
> *(Liz 6, 40-55)*

Liz changed her report structure in order to fit with what she was observing of Claire at that time. This suggested that Liz had to modify her use of theory in order for Claire's occupational therapy to be framed in ways that it could be better understood. Liz therefore had to 'break' the organisational requirement that reports followed the accepted format. . Liz's change to the report format came from a situation about changes she had to make about Claire's assessment because Liz could not get a full MOHOST assessment. Liz had observed Claire's sensory

functioning and so wanted to pursue that further. Claire however, refused to do another assessment with Liz:

> *When I've attempted a formalised sensory assessment…she just looked at me and just said this is bonkers, this is mad.*
> *(Liz 6, 22-23)*

In response to Claire's refusal Liz went back to her observations of Claire:

> *[…] in terms of how she used the environment, how she managed her day to day activities, and just purely observe…So which environment stimulated? Which environments calmed?*
> *(Liz 1, 284-285)*

By making these observations about her, Liz knew she had to develop her knowledge in a different way to the MOHOST about Claire. Indeed, this led to their creation of:

> *[…] a formula for the body scan and it's almost like a daily assessment of where her body is.*
> *(Liz 6, 13-19)*

Liz was responding to a need to create a way of observing and assessing that Claire was happy with and that allowed Liz to develop the knowledge that she required in order to fulfil her practice. If Liz had not taken this approach her work with Claire could possibly have been stymied. Tess also needed to create an assessment of occupational participation in the community for the nurses to use when they took a service user on leave. That clarified the finer degree of observations that were required when assessing the skills required for community functioning. Tess spoke of the differences between her assessment and those of a less experienced occupational therapist using another measurement tool:

> *[…] I'd scored them really low…she said yes but he's always polite and always greets [and Tess replied] But they don't expand on that any further.*
> *(Tess 9, 287-293)*

In summary, the practitioners' use of observations and assessments was impacted because the tools and the service users did not coalesce in a way that was useful, or fit a requirement of a standardised tool. Thus impeding the knowledge gathering necessary for occupational therapy to occur. This formed part of the therapeutic

context particular to that practice situation and people associated with it. The practitioners made observations during every contact they had with their service users. This provided knowledge about them at that time and was used at a later point for comparison of changes. The dialogue that ensued between the practitioners and service users was a key way to assess and observe, and provided a way for the practitioners to compromise with service users about what assessments could be used. Interviews with service users were part of that dialogue and another form of assessment illustrated next.

4.2.4.3 Interviews

Knowledge gathering by interview is a flexible method. The interviewer can take into account the context and how this can be altered by the people and events at any one time. Thus interviewing is a dynamic method to explore the service users' perspective. Interviews can be semi-structured standardised interviews, occupational therapist created un-standardised interviews, or informal, impromptu discussions. They involve at least a dyad between the practitioner and service user and also discussion in a group. Interviews form a part of the assessment in occupational therapy process. It is clear from the following extract that Gladys saw interviews as forming part of the assessment:

> *[…] but informal interview…finding out a bit more of her [Leila's] routine, what the things are that she likes, what she would like, where she would like to, where she would like to actually move forward with her to be involved with the OT programme. (Gladys 1, 69-77)*

Gladys had two reasons for doing informal interviews as she explained they help to build rapport between her and the service user and also for information gathering. Gladys spoke of how she would use a particular communication style in discussion with Andy:

> *I ask a lot more probing questions with this gentleman because otherwise often the answers I get are very much 'fine, well, good'…and you don't really get too much of a sense of really is it fine? Is this what you want to be achieving? Is this enough actually for now? And you don't really want to be pursuing that longer-term goal? (Gladys 6, 99-102)*

Gladys took this approach from what she knew of Andy from how he responded in previous

discussions. The dynamic and contextual nature of interviewing became apparent in the next example from Andy and Gladys:

> *[…] I found him disclosing information to me that he definitely didn't feel comfortable with before but it's not strictly related to what I'm asking…for example he had never spoken to me really or only very briefly about anything to do with his symptoms around hallucinatory symptoms rather than anxiety...After I started to ask him a lot more probing questions it started to drift slightly to questions about his family, to conversations about his family, conversations about how he felt the move from the ward was going to go…*
> *(Gladys 6, 115-121)*

This quote suggested that over time and through Gladys's practice Andy became more comfortable to spontaneously share some of his history. This led to him volunteering his current fears about a female patient who had verbally attacked him:

> *[…] he then started to talk to me quite descriptively a particular female patient …This was weeks after we first started to engage with him and it felt like quite a large disclosure at the time. I mean I brought it up with the MDT at the time they were also quite 'oh that's amazing he can talk to you about it' because he's so incredibly guarded about those sorts of things normally.*
> *(Gladys 6, 121-128)*

The unintended consequences of Gladys's approach were that Andy discussed a greater variety of personal topics not discussed with other team members. This dialogue cannot be planned, hence it emerges dynamically out of the current practice, creating a particular therapeutic context. Interviews are expected in practice, but in what ways and the extent to which they are used, and when and where they are used is flexible. Another form of assessment that the practitioners did was for risk presented next.

4.2.4.4 Risk assessment

Risk assessments were seen as a way to identify, evaluate and to monitor the risks. For the practitioners a large part of their practice was devoted to risk assessment and how they incorporated risk into their practice. There were unpleasant implications for public safety, service users and staff if something went wrong with the risks that were taken. At best, this might result in an internal review, at worst a

national enquiry with the possibility of varying degrees of unhelpful media coverage likely. This situation therefore required a clear assessment procedure, with which the practitioners had to engage. Figure 19 showed how Liz worked with Claire to incorporate risk assessment. Risk assessment was about what practitioners saw as risks, where the risks may occur and under what circumstances, as well as who held responsibility for objects that could be used in risk actions. The expectation for risk assessment is indicated here:

> *[…] it's almost as if we have the weight of the information behind us, we have to be seen to be acting in a way that takes notice of all of this, otherwise the Ministry of Justice are going to be going 'hello you knew'…*
> *(Liz 2, 201-205)*

Risk assessment is therefore key in forensic services. Tess identified what she saw as a limitation of risk assessment in that it could only be based on history and the service users' behaviour. Tess's view is provided within her experience of training in using standardised risk assessments including the Historical, Clinical, Risk Management-20 (HCR-20), the Violent Risk Scale and The Violent Risk Scale Sex Offender version and the full Hare Psychopathy Checklist – Revised (PCL-R) that she has completed. Only WEMSS had an occupational therapist created risk assessment, but that this was not a standardised tool. Thus, the participants were using a combination of discipline specific existing knowledge with their observations and discussions with the team and service user to create a risk assessment.
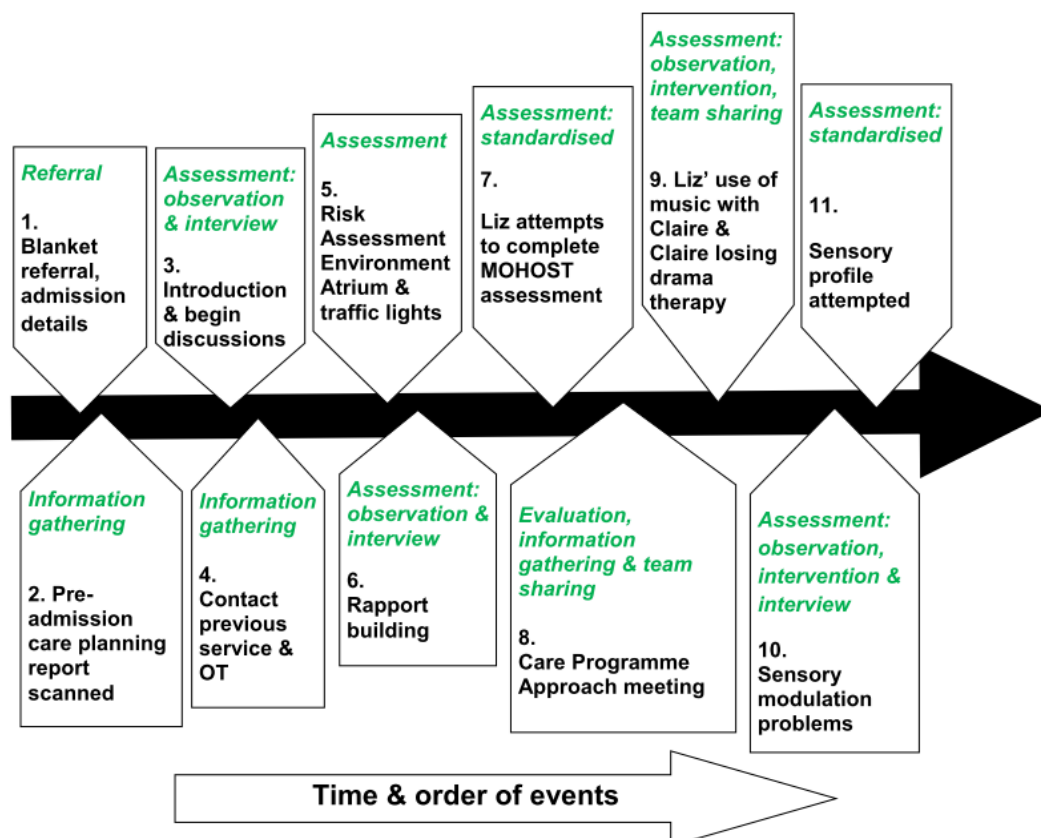
Figure 19. Liz and Claire early stages of the occupational therapy process incorporating risk assessment and management cycles (source: Cordingley, 2015)

Liz highlighted her occupational therapy knowledge about environments such as the community and hospital grounds, which service users accessed and needed risk assessment of those areas in relation to the service user's specific risks. In the ward area, cookery was used by the practitioners and Tess spoke of how focussed risk can get on the use of everyday objects that may not be relevant:

> *I think that people get a bit fixed on the knife and...it's to me more about risk assessment is [for example if someone] has committed...a violent sexual offence, so I want to know if he is saying inappropriate things to female staff …if he has been staring at female staff, touching female staff or male staff...if he has been saying anything, what his conversation is with the other boys. Those are the things I want to know for risk assessment*
> *(Tess 4, 243-249)*

Tess therefore looks at the socially related risks given the potential for harm to others. Similarly, Gladys indicated specific risk concerns for Andy and his relationships with women:

He doesn't really engage with other service users on the ward and rarely engages with members of staff and will sometimes with particular female members of staff become fixated and paranoid...there was that worry as well as a new person I might not be accepted at all.
(Gladys 3, 143-146)

Gladys was thus aware of how she might be at particular risk from Andy. This could impact on starting to build a therapeutic relationship with him, but so too could Gladys's emotional reactions (discussed further in category three). Tess also wanted to know about seemingly inconsequential remarks made by service users as there can be ignored by the team. Hidden risks are a possibility. Tess described one of hiding a knife for harming oneself or another at a later time. Hidden risks require time and events to occur before staff understand the full implications of the risk:

We have noted that...he will hold a grudge so, three weeks after...somebody has pushed him or something, that he'll suddenly wallop them on the head...three weeks later or something.
(Tess 4, 359-362)

This highlighted the subtleties in risk assessment and that some knowledge would not become apparent until a service user had committed harmful acts on the ward. These may not be related to their index offence and risk history, but were a part of the ward context that was dynamic due to its mix of people. The importance of assessing the context of harmful actions is considered next.

4.2.4.5 Contextualising risk

The practitioners discussed how they contextualised risks in relation to the service user's index offence. This involved how the therapeutic relationship between the service user and therapist had developed and how it might be impacted by risk. Practitioners tried to understand how far they could offer opportunities for occupational participation and take account of risks too. Tess did this by considering whether she could use knives with Zach by comparing this to his index offence which did not include the use of weapons neither did his criminal history. Tess had further justification for using knives with Zach:

[…] you don't have access to his thoughts but you also know about him in the sense
of he's not violent without encouragement.
(Tess 11, p.216-218)

Thus Tess took into account her knowledge gaps. She knew Zach might not tell her about his thoughts to harm her, if he had them. She could however, use knowledge about when he was likely to be violent. This suggested she had to make a trade-off between her partial knowledge and making a prediction of what might occur. Tess might not have been prepared to work with knives if she perceived the trade-off as too indeterminate. Tess described how she would approach the context of using knives with service users:

[…] If I then don't think somebody can be responsible…for making those decisions I
will discuss them with the team. I generally do that anyway but, I won't necessarily say
I am going to give you a knife do you feel safe with that?...If they've had no particular
issues or they've come in when they've been really unwell…or if I just don't feel if I've
got that relationship…
(Tess 14, 33-37)

In order to establish the context of any risk taking with a service user Tess needed to combine a range of factors. These included the extent of her therapeutic relationship with an adolescent, and how far they could make informed decisions and take responsibility for their actions, along with the team's view of their capacity. Gladys also felt that Andy's current goal did not have any associated historical and contextual risks as revealed in this quote:

[…]I do have to look at the risks surrounding it but I just didn't feel that they were
current…any significant risk was quite a few years ago…I didn't feel like they related
to the goal in a way that I would need to be particularly…worried about it…
(Gladys 6, 377-380)

Gladys compared her existing knowledge about Andy and his risks and when he last committed his index offence with his current presentation. The time that had lapsed since his index offence also formed part of her assessment. She identified Andy's occupational participation plans and environment contextualising her risk assessment:

[…] community access is low [risk] in terms of the level of supervision he would
require…and the activity that he wants to get involved in are low risk, buying food
activities…and so the forensic side hasn't necessarily come into as much. But even,
even in terms of geographical area he really doesn't want to go too far. …so it's less
of a concern really.

(Gladys 6, 444-450)

Gladys had to make a judgement using her existing knowledge and she had to make a prediction of Andy's future risks on that basis. Gladys therefore made an individualised risk assessment, of which prediction is implicit, but there is no certainty this would be the case. Gladys also took into account time, future plans and risk combined with her existing knowledge:

> *[…] unless something changes dramatically…it will be such a very long time until he does anything outside of this ward…apart from going to a very, very, local shop unescorted, that the risk he poses to other people are minimal…*
> *(Gladys 6, 435-438)*

In effect Gladys proposed what could be new knowledge created from that particular practice situation. Whether her predictions occur and thus new knowledge would be created in the future, could only be established at that future event. Risk knowledge is gathered and shared with decisions made between the team; however, this can lead to social tensions within the team, an issue that is illustrated next.

4.2.4.6 Team collaboration and risk assessment

There were ways in which the practitioners had to negotiate national expectations, organisational policies and procedures, legal constraints and statutory obligations and disciplinary ethics and code of practice, the service user and their recovery (considered later) and the team members. This included decisions about when to take risks, how to go about taking them and with whom:

> *[…] for me it's checking with no-one else has any objections...if I am prepared to take that risk that is fine...but I don't want anyone else to say why did you do, but he did this...so it's about making sure the MDT agree.*
> *(Tess 4, 235-238)*

These local decisions are part of the everyday practice in forensic settings. Tess sometimes had to make decisions about risks to be taken when the legal decisions over-rode clinical decisions:

Where somebody is being released and...they are suddenly saying do some cooking sessions because he's gonna be living on his own next week and I'm thinking well I hardly even know this person...I would just be literally like right okay and what I might do sometimes is ask for another member of staff just to be with me...just out of I'm not a hundred percent sure...
(Tess 14, 57-64)

That example was particular to Tess's working context. In this type of situation Tess had no detailed knowledge about the service user. This suggested that she would have knowledge gaps and yet would be required to take some risks in order to provide occupational therapy. A situation that could impact all the practitioners' was in the event that collaborating and sharing risk information between services and staff failed. Liz felt this left both the service user and staff vulnerable:

Information can get lost in the transition [between services] and...that makes us vulnerable to the relational security failures...as well as the physical [and] procedural security failure…it also makes other services vulnerable if we don't hand that information on...
(Liz 1, 406-408)

Sharing knowledge and collaborating between team members was also problematic. Tensions in the team arose when concerns about a service user's risk of creating a ligature from underwear elastic to harm herself and the proposed leave were not thought through:

… her behaviour had been...so prolonged...there had been a culture embedded: this woman does not have underwear...So in terms of my question as an occupational therapist I am really sorry but functionally if we are saying that she can manage the challenges of unescorted ground leave...and we are saying she can't manage her own underwear...
(Liz 2, 214-221)

A team culture had developed in dealing with risk and the service user. Liz's perspective was from her occupational therapy specific knowledge, combined with risk assessment and management knowledge (considered later). She needed to share her perspective in order to make the team aware of the potential for sending an incoherent message to the service user. This situation also suggested an oppressive practice could have been enacted without Liz's comments. Another tension was between Liz's supervisee and an experienced nurse arose:

I've supervised an occupational therapist who was relatively new to this service who came to me in floods of anxiety and panic when a ward manager turned around and said well you've got a kitchen assessment [with] this woman I'm scared she's going to stab someone otherwise.
(Liz 6, 410-413)

This indicated the expectations of another team member, of an occupational therapists' role in risk assessment. This suggested the manager assumed that one kitchen assessment would provide a definitive answer and prediction of whether a service user would harm others in the future. It ignored however, any contextually relevant knowledge about the risks. It also brought into question any therapist's lack of knowledge and experience about risk assessment in occupational therapy and how this is developed. Indeed, the amount of collaboration about risk assessment between the team and Liz showed how risk assessment was flexible and dynamic:

There is actually a great deal of assessment that takes place almost on a half hour basis about what tools [Claire] can access, what environment she can access, and from there which tasks she can then access.
(Liz 6, 78-80)

Liz framed this in occupational participation terms with the emphasis on place, person, objects and tasks. This is one specific way of looking at risk and other team members would have their particular disciplinary lens by which to assess.

In summary, the practitioners' developed their knowledge about the service users by means of observations, assessments, and dialogue that was created through interviews and discussions, that together amounted to their practice experiences. Thus the practitioners' practice differed from the expectations that a standardised assessment would capture the knowledge required to move onto the other cycles of the process. Their practice was to combine their tools of practice from which they created new knowledge about their service users. Furthermore, the practitioners' risk assessment deviated from the expectation that there were standardised assessments that could assess, because the practitioners had no such tool and so their practice experiences created the knowledge for their risk assessment. This practice led to intervention planning followed by intervention, considered next.

4.2.5 Interventions

The main focus of the interventions concept was based on the ways the occupations were used and how the practitioners created, modified and adapted them for a service user's individual needs. In order to provide occupational therapy however, they needed to construct new knowledge in the form of an intervention plan and interventions that were particular to each service user. These aspects of practice are illustrated below. Claire's familial relationships were a key area for Liz to build into the intervention plan. In the following quote she explains why:

> *Ninety percent of the women have very, very, problematic relational matrices and it's really about steering a path, as coherently as possible, which says our primary responsibility and place for rehabilitation is with the woman. But we have to honour their choices around relationships. So it's really ensuring that, for instance, this woman has access to anything she needs to maintain those roles with her daughter and with her mother, and actually the one very functional relationship she has with her grandmother.*
> *(Liz 3, 113-118)*

Liz provided opportunities for occupational participation in order to create items that could be sent to Claire's family. The practitioners used interventions that were occupations for service users' occupational therapy. Some of these were the regular, every-day occupational participation that on the surface might appear uneventful:

> *Most of the individual work I do anyway is either sensory stuff, or taking them on leave…and doing individual cooking sessions.*
> *(Tess 9, 415-416)*

The practitioners used their knowledge of a variety of therapeutic techniques to facilitate occupational participation. The techniques used were the occupational therapists' core skills which included analysing activities and the environment and grading an occupation, and adapting the physical and social environment to enable occupational participation. Liz required a highly structured, risk limited form of intervention that incorporated Claire's difficulties with concentration and focus on an activity, but when graded, facilitated occupational participation:

> *It was a project we could work on consistently so…shorter sessions more frequently so every 2 or 3 days there were repetitive tasks that she could get she could have*

mastery over, but also be really clear about what we could set up [as] a rhythm to a session which she gave feedback of being very positive. So we engaged with this and…she chose a project a paper mache heart for her daughter and we worked on this project for a number of weeks..."
(Liz 2, 135-141)

Liz's way of working demonstrated her aim to provide Claire with mastery and achievement in occupational participation. Liz showed her core skills of analysing an activity for what occupational participation was required in order to perform an activity to compare to the service user's capacities at that time. Also she considered how an activity and environment can be graded from easier to more challenging levels. The plan covered a range of aims of providing an ultimate challenge of creating an end product for her daughter that was meaningful to Claire. In this example Liz graded the activity over a time period over days, weeks and by session that the activity was performed. The activity also provided opportunities to build Claire's skills through repetition. Liz also slowly graded access to the various atrium environments that required an increasingly complex range of occupational participation skills. Indeed, Liz drew attention to how the service user could be encouraged to use the atrium to focus on their own well-being, as she explained in this quote:

[…] we try and get them engaged in the atrium process either through leisure or vocation…because then they can start meeting a greater number of their needs for them-selves whether that's sanitary towels, soap powder, you know if they can literally come downstairs and shop…
(Liz 2, 72-76)

Liz had used her knowledge of how to analyse the activities of laundry care and women's self-care in order to know what items were required. In tandem she analysed the environment of the atrium for the facilities that provided access to those items in the shop. A graded plan of intervention to access the required items in the required environment was thus created and formed the specific context of occupational therapy for women admitted to WEMSS. Grading interventions was integral to planning with the service user and was client-centred (considered later in the findings) in this example from Gladys:

[…] I've been able to grade it so the idea has been okay fine that's what you would like to do. In the meantime how can we break it… down into much more manageable chunks…

(Gladys 6, 79-81)

Indeed, without Gladys's knowledge about Andy's history, she would not have been in a position to grade the intervention as he:

> *[…] has in the past put a lot of pressure on himself to achieve very, very high standards…which haven't worked out for him…*
> *(Gladys 6, 81-82)*

In her example, Gladys provided a justification for grading the activity based on how high Andy had previously set his goals. This provided the basis for regular dialogue about current interventions:

> *There's been a few conversations about taking things one step at a time, because it makes things easier to manage, because it links with his anxiety; but not changing the goal, the goal still remains.*
> *(Gladys 6, 82-85)*

Gladys's knowledge had developed to incorporate new observations about Andy as well as their dialogue. This facilitated a new knowledge that enabled them to modify the intervention plan as required. By using sensory interventions in a highly controlled environment, Liz combined her existing knowledge of Claire's response to sensory approaches with her core skills of activity grading and environmental adaptation. This was a creative process that was part of practice that formed a new knowledge. Liz explained this process:

> *[…] we would make…a weighted blanket by using up to ten blankets from the laundry and putting them on top of her. In the way that you would use the treatment protocol observed in multi-sensory environments so I would introduce one piece of sensory stimulation at a time. So…there was a very structured approach to the session, I would come in, I put the theme tune to the Titanic on the cd and it's on a repeat…(Liz 1, 151-156)*

Liz used blankets from bed linen to create a weighted blanket. This gave her and Claire control over the weight produced, which was important as Claire had some physical injuries that could be impacted by too much weight being laid upon her. Liz therefore used everyday objects to produce a weighted blanket system that are manufactured and can be purchased. Claire saw the intervention as meaningful and valuable to her needs as she also purchased her own furry blankets that provided a touch sensation, along with fur and silk pillows. Temperature and smell were also included by using ice and scented cold wipes for her face. The intervention structure also included who was going to do what, during the

intervention:

> *We lay the blankets on I then work out with her where I'm going to be in the room and*
> *[where] her hands are going to be whether inside or outside depending on whether*
> *she is using ice or a wipe…*
> *(Liz 1, 150-185)??*

The choices were made on the basis of how Claire wanted the intervention to proceed at any given time. This suggested that Liz used her existing knowledge of the plan they had established, but had to be prepared for a change to it. The intervention also included a:

> *[…] structured debrief, which includes a body scan she will tell me it's a good day it's*
> *a bad day and go through a narrative of her day…We do this for half an hour so…*
> *(Liz 1, 167-178)*

The quote above indicated that sometimes tools and methods of interventions needed to be created and questions developed for specific service users. Liz discussed how she and Claire created the body scan that they used:

> *[…] she basically processes her feelings she then does a body scan my head feels,*
> *my neck feels, chest feels, my stomach feels…and then there is a statement about*
> *where she is now and we do exactly the same process but in reverse about removing*
> *the stimulation piece by piece blanket by blanket the music turns softly off...*
> *(Liz 1, 179-183)*

Liz indicated how, in an unusual environment for an occupational therapist, they were 'using the seclusion as a form of sensory modulation' (Liz 1, 232) for Claire:

> *I asked the team to consider when she was secluded to allow me to go into the*
> *seclusion room review and to give her wine gums to suck on and …then have a*
> *conversation with them and also have a blanket around her as well.*
> *(Liz 4, 44-47)*

This was also an example of an adaptation of the purpose of such a restricted environment to help Claire to focus on her sensory functioning in order to help her to become calmer. On a related point Liz could not always facilitate an occupation for Claire, but she provided access to other objects such as teddy bears and lavender oil in order to help reduce Claire's sensory over stimulation. Not all of Liz's work with Claire involved the use of objects for sensory interventions. Enabling participation in occupations also required access to objects:

> *There has got to be a tool. There has got to be you and me and we are talking over a*
> *table, well then…[picking up items on the table – cup, pen, digital recorder, paper] this*
> *is the tool and this is the tool and this is the tool…when the table is the tool…these are*
> *tools, this is the environment, what goes in, what goes out, but it denies or*
> *supports…the occupational activity…*
> *(Liz 2, 311-315)*

The practitioners therefore facilitated the service users' access to objects in order to participate in occupations. Through their practice the participants tried to prevent occupational injustices, which were the denial of, restriction from, or reduction of service users' access to occupational participation. The challenge for the service users was that they may not be able to participate in these everyday activities for various reasons. Examples included the ways security restrictions impacted self-care discussed by Liz and limitations to access the ward kitchen to cook meals discussed by Tess. Gladys discussed how Andy's plan to travel to the community for a meal was restricted mostly due to his social anxieties, but he also had restrictions placed on him due to his index offence. There were many restrictions to occupational participation due to Claire's prolific and fast cycling harm to self and others. Liz therefore had to be creative to find interventions to help Claire maintain important roles that were outside the forensic setting:

> *She only has letter box contact with her daughter…it is absolutely vital though that she*
> *is able to think about her role as a parent in a dynamic way…So when she has been*
> *able to use other environments it has always been about thinking about how she stores*
> *her daughter's photos, making memory boxes to send to her daughter…via the*
> *adoption service.*
> *(Liz 3, 82-86)??*

Liz recognised that Claire's role as a mother was highly restricted. Liz looked for ways she could use occupational therapy to maintain contact in these circumstances:

> *[…] holding in mind her daughter without being directly in contact with her and what*
> *does that mean? What does that look like? She may celebrate her daughter's birthday*
> *without being in contact with her…making that role meaningful for her because it's her*
> *major role, identity…*
> *(Liz 3, 86-89)*

Liz needed to develop a new knowledge about how a mother role could be facilitated and maintained in WEMSS. This was an example of a complicated

situation and how Liz created a new practice that was part of a new context that included Claire's current situation and her meaningful occupational participation choices. There were other examples of less complicated occupational forms and Tess indicated how the staff provided opportunities for the adolescents:

> We set targets with the boys that they can they want to achieve and work on over the week and all the boys come into that and…we have got a sheet of paper with different things like attending therapies, ADL, personal care, health, diet, education, just to you know a guideline for what kind of targets.
> (Tess 1, 117-121)

The examples Tess provided could be achieved in the forensic setting with little need to have contact with others outside of the setting. The interventions provided by the practitioners did not have associated protocols for treatment related with an evidence base. Indeed, this diverged from current expectations, however, the service users all presented with such varied and specific intervention needs, associated with particular contexts. The practitioners' practice therefore was the only route by which they could create knowledge in order to make intervention plans and carry them out. Whatever occupations were used, the participants needed to plan for the risks associated with interventions, considered next.

4.2.5.1 Risk-taking and interventions: grading and adaptations

Risks were generally managed through planning interventions; how risk management and the appropriate interventions were handled and carried out were combined in practice within the forensic setting. The practitioners completed risk management plans in order to provide opportunities for service users' occupational participation. For example Liz found paper mache was a low risk to Claire if she ingested that material. The wider socio-cultural context and risk concerns of the public in the UK impacted upon the therapeutic work that could be done with service users:

> The real difficulty is that around positive risk taking...we've moved into a much more litigious and ambulance...chasing...blame culture, so before you could probably sit down and have those conversations about somebody going out either onto the grounds or into the community and look at...one of the potential risks...are we comfortable with this area of positive risk taking? Can we widen the margins for it? We are now more likely to shrink them.

(Liz 12, 306-312)

Such a context therefore affects the risk assessment and management of the practitioners and team. Both the service users and Liz had to be prepared for potential problems with interventions and risks:

> *You may at some point slip, if you do, what do we do?*
> *(Liz 12, 315)*

Part of planning for the risks implied planning for what could go wrong and how that would be managed. As such they related to the earlier findings on risk assessment and how there could be no certainty until the situation arose, if at all. Indeed, the topic remains an area for exploration as it was not discussed further. Practitioners needed to recognise when different ways of risk management were required:

> *It's much more about relational security I suppose…you know rather than focussing on a tool.*
> *(Tess 4, 249-263)*

Tess recognised that there needed to be a discussion with service users about potential risks as perceived by both them and the workers. Implied was that the practitioner and service user trusted each other enough to have that discussion in order that the practice could move to the stage where the intervention could be considered. Also the need to acknowledge the anxiety that workers had when incorporating taking risks in service users' interventions:

> *You have multi-disciplinary support for whether you call it positive risk taking or therapeutic risk taking because it's about everybody signing up to holding the anxiety about supporting someone to move forward…whether that's moving into the kitchen, going out of the unit, going out on leave, whatever it is.*
> *(Liz 12, 329-333)*

Liz's comment indicated the team responsibility in making decisions about risk-taking. Moreover, Liz indicated why risks had to be taken:

> *[…] almost like we leap in…but the reason we leap in someone will end up sitting there with nothing.*
> *(Liz 2, 278-279)*

This suggested an occupational therapy view where the practitioners wanted to

provide opportunities for occupational participation in order to develop service users' skills but also to prevent occupational injustices. Other ways practitioners incorporated risk management plans and grading interventions were when Tess gave responsibility to the adolescents and:

> *[…] after two or three times we gone out on unescorted leave I will give them the money and go through the ingredients and they have to go off and get their ingredients and come back with the receipts...being given that responsibility and sometimes I'll be a bit wary and I'll be like oh could you just get this?...I will...give that person £5 and ask them to go and get some pasta…and get that for me with the receipt so just one item and then maybe two or three… so again grading it. They love that responsibility because - I always say this is a big responsibility I'm giving you money, you know I don't want you to get me into trouble, I don't want to get you into trouble you know and so far I haven't been let down.*
> (Tess 14, 135-148)

This suggested that risk-taking is a combination of offering the service user the responsibility to do a task, along with being trusted to do it, and is allied to a level of uncertainty as to whether the service user will act on the risk. Indeed, risk-taking in this context is as much a part of unquantifiable matters such as trust and responsibility, aspects of the therapeutic relationship (illustrated in the category of blending of personal and professional) and dialogue between practitioner and service user. Liz described a process for WEMSS where access to various environments was graded by a traffic light system. The practitioners and nursing staff engaged with this process indicating that different environments presented different opportunities for risks and risk-taking. The focus of this was about access to physical and social environments in the unit:

> *[…] grading around…do they need one-one support? Do they not need to be in an area with tools? Do they not need to be in a stimulated area? And do they need to come down to the shop when it is very quiet?*
> (Liz 2, 84-87)

The grading here involved the people required, the physical places and objects and how stimulating the environment could be. In the early stages of an admission Liz said the risk management was centred on the ward area. Liz's practice involved helping Claire develop her occupational participation by slowly moving and grading into other environments in the atrium, incorporating her risks. Liz describedthe ways in which access to writing materials were offered to Claire, in order to

maintain her familial role:

> *[…] whether she would be allowed to use a felt tip, a pencil, a paint pot … How are we*
> *going to manage?...Was she going to dictate to people? Were we going to get some*
> *voice recognition involved? Yes but she had also swallowed batteries as well...*
> *(Liz 2, 226-238)*

Liz demonstrated how she had to question about what materials could be used and the risks they posed. Liz ultimately needed to make Claire's occupational participation possible:

> *So these conversations go back and forth and become quite complex...but you need*
> *to get to a place of drawing all this together and this is where we are going to step*
> *in…you have to…make it possible for this woman in this environment, with this risk*
> *information, make it possible for them to…use these materials.*
> *(Liz 2, 235-241)*

The decisions made could be about making a plan with the least possible risks, but that still had some risk. Tess indicated how she might grade risks in a cookery intervention:

> *I might use like no tools, or you know just make a cake and use stirring things,*
> *measuring things out…rather than using knives.*
> *(Tess 4, 231-233)*

Tess therefore chose recipes that did not require sharp implements, or adapted existing recipes to avoid using them. Liz explained how she created a new therapeutic environment, by adapting Claire's bedroom:

> *[…]I thought what is wrong with her using dough or cookie dough in her*
> *room…Can I create a hygienic space so that she can bake in her room without*
> *tools? And the answer is yes…she has an en-suite bathroom so without*
> *tools…with just hands, bowls and ingredients…*
> *(Liz 7, 69-72)*

Liz used parts of the existing environment combined with an adaptation of the environment to facilitate Claire's cookie making. Also Liz adapted the way the ingredients were mixed by using no tools other than Claire's hands:

> *[…] it did make an awful lot of mess and we need to use plastic sheeting, but we*
> *made the whole thing and she scooped them out and we used flour and she*

scooped them out on the baking tray and away we go and she really enjoyed that
and she really enjoyed the sensation on her hands as well.
(Liz 7, 69-76).

Claire was restricted from using the ward kitchen and security items. Liz combined her knowledge of Claire's sensory modulation needs, Claire's risks and the environment of her bedroom with Liz's core skills of adaptation of the environment and activity. From this came a new knowledge of a range of interventions for a specific therapeutic context. The participants needed to combine their core skills with risk management in order provide occupational therapy in the forensic setting. Liz's practice combined risk management with an intervention for Claire:

> *[…] robust conversations about engagement and challenges that service users will*
> *face in environments given the forensic histories that they've got...So if I walk into a*
> *room with this woman … the first thing I will say to her is Am I safe to here? Am I safe*
> *to be at the doorway? Am I safe to be half-way to be in the room closer to you? Am I*
> *safe to bring tools?*

Liz therefore created a combination of questioning about Claire's risk assessment and risk management for each intervention of that type as it was used. Liz demonstrated what I call the mini phase occupational therapy process within the intervention step of the occupational process. Based on Claire's responses, Liz assessed, made a plan, carried out the plan and evaluated Claire's actions. Liz describes this further:

> *That is the dynamic conversation and yesterday she said to me 'Liz I need you to step*
> *back and I need you to step back now. I need you stand at the doorway today'. I want*
> *to do this. I don't want to do that and I need you to be away from me. That's fine. The*
> *question is, can you keep yourself safe and can you keep other people safe?*
> *(Liz 6, 342-350)*

Liz therefore used the associated phases of occupational therapy process to work through risk assessment and management at the intervention cycle. A number of ways to approximate the safest testing of the potential risks came from Tess:

> *I'm not saying you shouldn't be counting in your knives I think that's really important*
> *but as in …I'll either use knives and equipment...or I won't...Rather than I'll only use a*
> *knife this size or I've used a knife that's blunt…to me that's pointless. I've seen the*
> *benefits of assessing somebody in the kitchen without tools...just making a*
> *cake…what I don't see is almost graded tool assessment...because I think I'm sorry a*

knife that size and a knife that size [indicated size] can both damage you...and if they
are going to do it, or secrete it, or something they are going to do it.
(Tess 11, 229-236)

The practitioners had to work with service users to try taking risks in a controlled environment. This was in order to test their capacity to refrain from engaging in risks should they be motivated to do so, and find new ways of limiting their risk actions. The context of the forensic setting could rarely match the index offence, so this would be an approximation. There was a combination of practitioner and service user dialogue and observations in relation risk assessment, allied with risk management and interventions that incorporated core skills in occupational therapy. These demonstrate a nuanced and multifaceted practice for which there was no protocol or evidence base. Such a practice requires ways to see changes in occupational participation, these changes are considered next.

4.2.6 Seeing change: evaluation

The practitioners had ways that marked changes, indicated improvements or drew attention to backward steps or plateaus that the service user had made in their occupational participation.   These also provided a point for evaluation of the occupational therapy received in order to see change in the practitioners' goals and targets set with their service users. When these were achieved they were celebrated, which served a range of purposes. Seeing changes occurred at different times, such as in the moment of each intervention or contact and at the time of a team review each week, or at the CPA meeting. They were a time to review service users' occupational participation. Claire had on occasions been unable to remain in her CPA meeting until Liz helped her manage the sensory stimulation by providing a wine gum for Claire to suck on. The practitioners helped service users to develop a direction to aim for in their therapy as Tess described in the following quote concerning Zach:

[…] one of the things he is really bad about is getting up early in the morning so … we
set a target for getting up by nine o'clock three mornings a week and he would go
straight to education and we set a target of getting up by ten o'clock and then attending
the second half of education…
(Tess 1, 142-148)

Zach's target was part of the context of the adolescent service. It suggested that

this was enough of a measure of progress without the need for outcome measures, if indeed one so specific was available. Tess observed Zach's occupational participation, comparing this week by week:

> *One of the first things he did with me was washing up, and he was …very thorough*
> *and you couldn't interrupt him, but just really, really slow. And methodically working his*
> *way through things but wouldn't notice, like you'd have the sink here, you'd have the*
> *pile of plates and maybe a couple of pots and pans or some other plates next to that,*
> *he would wash up the plates and then he would say I've finished now and you would*
> *say you haven't done this bit and he'd look at it as if he'd not seen it at all…*
> *(Tess 11, 43-49)*

Tess could see from this observation where Zach was capable, his style of doing tasks and what he saw and what he missed in the immediate environment around him. Tess compared her observations of Zach doing the same task at a later time:

> *He got to be slightly more spontaneous with the washing up but the other day he did*
> *the washing up he was still slow and methodical and I did a couple of times have to*
> *say I think that one's washed enough now, almost as if he got a bit lost in it. But he*
> *was much quicker … and also more responsive too. … this time when I said 'oh I think*
> *you've, it's finished' he sort of looked at it 'oh yes I have' and moved on…*
> *(Tess 11, 49-55)*

Tess used a direct comparison of the same task done at different times that indicated changes. Zach's speed of performance of the task, his capacity to notice more of the environment around him following Tess's prompts and cues, and improved communication were observed. A finer degree of Tess's observation is apparent next:

> *[…] we were making two chicken dishes and two fish dishes and he was like this fish*
> *isn't cooking quick enough I don't know why …what he couldn't do was realise that the*
> *pan wasn't on the hob properly… he was just much more spontaneous about*
> *suggesting how things were moving on in the cooking.*
> *(Tess 11, 43-67)*

Tess observed that Zach was seeing problems with the speed of cooking of the fish. She also gained further knowledge about the finer degree of his lack of awareness of the objects and their position on the hob and their impact upon cooking the fish. Thus, his awareness was still lacking, along with his ability to consider the possible reasons for what occurred. From what Tess said of the

changes she observed, she started to build her knowledge of Zach's occupational participation, comparing it from earlier to later observations, seeing finer degrees of change. Fine degrees of observation and evaluation were required for service users who had fewer occupational participation skills such as Zach. Alternatively Gladys acknowledged with Andy, what would appear to be inconsequential to someone without similar social anxieties:

> *[…] you are coming out far more frequently on your own because he was going out to walk for a while and now he's going out two or three times a week and he was like yeah, yeah I am.*
> (Gladys 8, 139-141)

Liz could see how Claire's access to objects for occupational participation had increased, but could very quickly be reduced again:

> *Two weeks ago we were having a much better week she had tasks, she had books, she had pens, she was writing goals with me, she was thinking about baking the last two weeks I have, lost some perspective and I'm right back in the, right back in the very restricted environment with her. If I think about it, 3 weeks ago we had reduced our daily sessions to meeting every 3, three times a week to actually set goals and do a relaxation session and to bake. So actually her occupational perspective had widened, quite radically.*
> (Liz 6, 97-102)

Liz also used the reduction of daily occupational therapy as an indication of how Claire was able to participate more independently. Liz also found increased access to various environments was a measure of Claire's improvement:

> *[…] at a time when she became much, much, better she was accessing the atrium, the hairdressers in the atrium the gym, the shop, the boutique, she accessed ground leave.*
> (Liz 2, 139 -140)

The practitioners provided examples of their previous practice experiences that formed a new knowledge. They used their experiences to generate new knowledge about the service user's particular context and their individual needs. Specific therapeutic contexts were created through the combination of those aspects that comprised practice, from which different knowledge was derived. In that way, the practitioners differed from the expectation that technical rational knowledge was the driver of practice.

In summary, this category was about the steps that the practitioners took in order to engage their service users in their occupational therapy. The practitioners used the occupational therapy process, but this was a complex collection of practices that included dealing with the blanket referral approach, knowledge gathering and prioritising their caseload, assessment, discussion, observation, interventions and evaluation. These were phases of work that were often practised simultaneously and not necessarily in the order just indicated. Indeed, assessment included risk assessment and intervention included risk management in combination with the core skills of occupational therapists.

The practitioners had to alter the cycles of the occupational therapy process by creating new knowledge from practice of different ways of working as unexpected situations occurred. Examples were meeting service users before the practitioners gathered knowledge about them, blocks in developing their occupational participation and backward steps and plateaus in the service users' progression with their occupational therapy.

The one step that was not explored was the discharge of service users from occupational therapy, but this was likely to be due to their having not reached that point with their service users and so it was not relevant for discussion. It is possible that practitioners and service users could discharge, that is stop, a particular piece of work, aim or target when they evaluated the progress made and the relevance of continuing with planned interventions; but this requires further research.

The cycles of the occupational therapy process provided a structure that was used in practice, but the process was not a foundation on which practice was based. The process was used flexibly as the practice situation demanded. Indeed, practitioners used smaller phases of the process (assessment, intervention, evaluation) at any given particular point such as when the focus was on assessment or intervention.

The practitioners' knowledge of using the steps of practice came from the enactment of those steps, combined with the service user and their presentation at any given time that created a new or slightly different knowledge from practice, along with a variation or new knowledge in the therapeutic practice context. Another knowledge used for practice, included specific frames of reference and models of practice along with requirements for some aspects of practice, all

presented in the next category.

4.3 RULES FOR OCCUPATIONAL THERAPY PRACTICE

The second category of rules for occupational therapy practice was about how the practitioners were expected to follow rules that came from national expectations, organisational policies and procedures, legal constraints and statutory obligations and disciplinary ethics and codes of practice in order to provide occupational therapy. The rules for practice came from three directions, national and local directives and disciplinary guidelines. Some of these rules were set by the organisation and others by the professional organisation. I therefore labelled the category as rules for practice because there were explicit directions in the form of organisational procedures for some of what the practitioners needed to do in their practice. Thus the first expectation to be met was to use a particular model of practice and meet a time frame by which assessments were completed and reviewed.

The practitioners were expected by the organisation to use the Model of Human Occupation (MOHO), to guide the practitioners' in their practice and also had to use its associated screening tool for the baseline assessment. There was a time frame required for assessment when a service user was first admitted to their respective ward. There was an expectation in the wider discipline that practitioners would incorporate a client-centred approach with which the practitioners were familiar. Also expected was using evidence for practice.

The organisation incorporated the recovery approach to varying degrees in the services. Thus, the organisation incorporated new approaches and so the rules for practice could be changed. Practice could be driven by the organisation or by national policy, as in the need to do Care Programme Approach meetings that incorporated risk assessments. All workers were surrounded by risk procedures that the organisation expected to be completed. Thus risk assessment and management was dominant in forensic settings and influenced all practice. Risk aspects were directed nationally through the Ministry of Justice and Mental Health Act (2007) which filtered down locally within the organisation to be enacted by the workers.

Despite practitioners being expected by the organisation to engage in certain practices, there were times that they needed to change what they did. The practitioners had to decide and justify when changes were required. Reasons included when service users presented in ways that prevented practitioners using the model or assessment. On occasion, MOHO had to be replaced by other theory (as described earlier in my literature review seen in its broadest terms as theory for practice), that could more effectively facilitate service users' occupational therapy.

The rules for occupational therapy practice category is in its broadest sense what has to be done, but can be modified as the practice context, service users and workers change. The concepts in the category are summarised in table five.

Table 5. Category two rules for occupational therapy practice category and concepts (source: Cordingley, 2015)

Category: Rules for occupational therapy practice	Concepts:
	Medical model
	A model for practice
	Motivation
	Environment
	Strengths-based approach
	Recovery approach
	Client-centred approach
	Risk taking, recovery and client-centred approaches
	The multi-disciplinary team
	Sources for evidence use in practice

4.3.1 Medical model

The practitioners needed to be aware of psychiatric terminology of what constituted the various diagnoses and their associated behaviours, signs and symptoms, called the medical model. The practitioners all had different ways of using that knowledge, influenced by both the team approach and individual practitioner experience and requirements. There were examples where psychiatric terminology was less of an influence. For example, Tess and her team worked without a diagnosis for the adolescents:

They do not wish to diagnose any child under 18. I am used to working without a diagnosis and think it is better…It is the symptoms that we focus on and each person is individual. I suppose [there is] more of…the personality disorder aspect which cannot be defined as more than emerging personality disorder or conduct disorder.
(Tess EM5, 25-28)

Tess preferred seeing the adolescents as individuals, therefore the focus on symptoms rather than a diagnosis suited her. Liz clarified the way in which the team understood the mental health needs of the women:

It's probably been the least diagnostically focussed place I have ever worked…it's very much on the observed behaviour and what are we doing...
(Liz 3, 344-349)

Liz's experience of the limited use of psychiatric diagnosis was therefore similar to Tess's. Gladys indicated what she wanted to know about service users' mental health:

What was their mental state, how stable were they in terms of mental state…what are they doing now and where are the holes?
(Gladys 3, 384-385)

Gladys said it was important to know about diagnoses and associated symptoms. They helped her develop her knowledge about the service user:

I found that they gave windows into how someone was really feeling and how they were going to be, how they would present, how they might receive information and react to an activity or an assessment…and also to know what's normal for him, so in as much as I've noted that and I rarely get eye contact from now I know that's normal for him and now I really pick up on it if I get quite a lot of eye contact.
(Gladys 4, 442-446)

Gladys combined the psychiatric knowledge with the knowledge she gained from the occupational therapy process. Gladys questioned the meaning for Andy of the knowledge she gained:

I feel that perhaps that I wouldn't want to discard that bit of information but I would possibly like to think about what it means for that person. Is it just they're having a good day? Is…feeling a bit more comfortable or a bit more confident…or maybe possibly even a bit aggressive…
(Gladys 4, 446-449)

Gladys therefore created her knowledge so that the psychiatric and occupational

therapy knowledge was turned into details that were less about pathology and more about the service user's emotions and experience of their current situation. Gladys used that knowledge to inform her decisions and interpretations about her use of assessments:

> *[…] and if I was going to be carrying out some formalised assessment in the future, which at the moment is unlikely but if I was I would want to know what was normal presentation for him and what normal fluctuations for him…in his mental state so that I could be aware of them and I wouldn't be thrown…*
> *(Gladys 4, 449-464)*

Gladys therefore developed a nuanced knowledge about Andy and used this as part of the occupational therapy process with him. The psychiatric terminology was a core feature of the forensic setting, but the practitioners' experience deviated from this as a diagnosis was a less prominent lens to view the service users. Indeed, it was the signs and symptoms related to occupational participation that provided more use for the practitioners, as did the service user's experience of them. The practitioners used another lens to view service users that was a model of practice, illustrated next.

4.3.2 A model for practice

The NHS trust required the practitioners to use MOHO with all of the service users admitted to their ward. Up to the point the practitioners worked with the service users discussed in my research they used MOHO to structure their thinking and capture complex human experience:

> *MOHO is used and guides our thinking, particularly as it has an expectation that we complete a MOHOST within a month of admission. I find this often does not give answers but gives areas which highlights [what] need[s] further attention.*
> *(Tess EM5, 52-55)*

Tess clearly saw MOHO as a way to guide her thinking about service users. Using theory in this way reinforced the split between thinking and acting. Tess also noted the organisational requirement for assessing the service user within a time frame. The best that the assessment could do was to be used to identify areas for further assessment. Liz believed MOHO captured service users' complexity:

> *[…] human experience is complex…and I don't think apart from MOHO [Model of Human Occupation] we have a model of occupational functioning which reflects that*

complexity…I think we are still in danger of being reductionist rather than complex.
(Liz 4, 366-368)

Liz did not elaborate on how and what concepts of MOHO did not help her develop her knowledge about Claire's complex presentation. She did however, summarise what did work for Claire's familial roles:

[…] thinking about volition, thinking about her habituation. How do you support a mothers' role when she only has letter box contact with a child?...What you do is you think about the volition, you think about the wish to be in contact, you think about the wish to mark anniversaries, you create memory boxes…you validate that wish to be in touch and…that behaviour can be validated…
(Liz 4, 383-386)

Liz explored Claire's meaningful roles by using a concept of habituation in MOHO. Liz could not however, use her MOHO knowledge further, so she had to use previous knowledge combined with the new practice context about Claire's sensory functioning, discussed earlier, to create new knowledge. Liz had a strong belief in MOHO:

Ethically and philosophically MOHO works for me…therefore it's the lens I will look through someone with...I will use MOHO as an underlying principle…I believe in MOHO and I believe it explains, so I will use it…so in terms of limitations it is difficult to identify…
(Liz 5, 314-318)

Liz found the use of a model explained what she was seeing with service users' occupational participation, even though it did not do so for all aspects of Claire's participation. MOHO's concept of role however, provided a doorway to find interventions for role maintenance:

[…] you negotiate with the adoption services about that letter box and social work is used to the hilt to manage that non-contact…and you are validating that woman's role. It's also essential that the women are not infantilised because again that invalidates those roles as mothers, carers, daughters…and MOHO speaks to all of that.
(Liz 4, 388-388)

Liz had an unshakeable belief that MOHO explained a service user's occupational participation. As a result, she acknowledged it was difficult for her to see the limitations of MOHO. To some degree Liz's view may have reflected the organisation's adherence to MOHO. Tess highlighted the impact of using one model and associated assessments upon practice:

[…] when you are sort of expected to do certain MOHO assessments…you know we've
had training…it's kind of difficult to vary it from that really.
(Tess 4, 212-215)

The organisational requirement to use MOHO and its assessments had the potential to limit the practitioners' creativity and knowledge development and to not meet the service users' occupational participation constraints. An additional problem might arise where newly qualified occupational therapists only use MOHO and so don't develop their knowledge about other ways of seeing the service users' participation capacities and constraints.

The practitioners' development of knowledge about their service users however, was not always fully supported by MOHO. In these instances Tess and Liz used sensory approaches with either the service user or with other examples discussed earlier. The practitioners therefore, could modify the rules for using MOHO in order to meet the service users' needs when it did not provide the 'right' set of rules. The practitioners attempted to use MOHO with Claire, Andy and Zach, but each explained how it was not as effective for them as it had been with other service users on their caseload. Gladys had difficulty using MOHO to conceptualise Andy's occupational participation in the early cycles:

I have been working quite hard on building rapport and almost put to one side thinking
about too much to do with the MOHO yet. And also because things change with him
so readily, it's very difficult to say so. I haven't really…
(Gladys 4, 515-517)

The practitioners incorporated other concepts and theories, some specific to forensic settings, into their practice. In this way the rules for practice diverged from the expected use of MOHO and were modified by combining other theory into the existing concepts of MOHO, when possible. The practitioners did this to varying degrees to help them to conceptualise what was happening in the forensic environment and what impacted their service users. Some concepts were related to MOHO and could therefore be incorporated within that model, for example the concept of environment.

4.3.3 Environment

The practitioners' had knowledge of the concept of the environment from MOHO, They used this in their practice by combining the forensic area in which they practiced and where the service users lived, as well as where they engaged in therapeutic work. Their knowledge about the forensic environments was in part informed by pre-registration education about them and their previous practice experiences. Arguably the practitioners had an implicit knowledge about the impact of environment on humans from their own life experience, aside from disciplinary conceptualisations. Gladys however, explained that she had limited knowledge of the forensic environment before she started working in the women's service. All the practitioners however, had existing knowledge that forensic environments consisted of physical, social and organisational aspects. The practitioners therefore had to develop new knowledge about the particular environmental impacts upon occupational participation. They included their knowledge in their assessment and intervention plans, discussed in category one. A therapeutic environment was also created where therapeutic relationships could be developed between the practitioners and their service users, discussed later in category three. Social groups of service users could be observed:

> *[…] looking at how women use the smoking shelter, how they interact there…*
> *(Liz 3, 366)*

Liz used a specific kind of social environment for particular observations linked to a place that offered a particular occupational form. Andy had considerable fears about social situations, and there was a situation about how he perceived others as a possible threat to him, as Gladys reported what Andy said:

> *"The person that owns that motorbike there you know yesterday they were staring at*
> *me in a menacing kind of manner and I was just trying to kind of smoke and they just*
> *kept staring and staring and it really wasn't very nice."*
> *(Gladys 8, 141-143)*

Gladys was able to explore Andy's perception of the situation, developing new knowledge about his current anxiety. She was then able to use her knowledge within the existing intervention of going into the hospital grounds, to create with Andy, other ways that he could perceive the situation in order to assuage his fears. Liz observed Claire in a social environment of a large team of professionals:

> *[…] she came to clinical team meetings which she can find very, very, stimulating.*

(Liz 1, 64-65).

Liz made other observations about that type of social situation where Claire became less stimulated due to changing Claire's access to the object of a chocolate bar in that environment, explored in category one. Indeed, Tess spoke about the social environment and the potential impact of service users upon each other:

> *[…] the environment and not thinking about somebody as an individual…and actually getting frustrated at times that people weren't considering the dynamics on the ward more than they were…but it's not really thought about very deeply…but if somebody is being manipulated and somebody else is manipulating…they are going to continue.*
> *(Tess 9, 250-255)*

That was also part of the therapeutic context of the service user and team of workers, including the practitioners. Tess's concern however, was for staff to look more at the interactions between the services users and how their social communication could create new knowledge about them. Other examples included where Liz developed her knowledge about the WEMSS environment analysing a range of the atrium places such as the café, library, shop, gym and hairdresser. Liz developed her knowledge of how these environments could be used with her core skill of environmental analysis:

> *The physical environment lends itself to that because you look at the ward, then you look at the atrium and then you look at the garden and the unit…*
> *(Liz 3, 361-362)*

Some of those places could also be used to observe social communication linked to work roles that the women could have in those places. Liz developed her existing knowledge about the physical environment of the WEMSS unit and the atrium within it. She analysed the human-made architecture and different objects available for different occupational forms in the various places, as well as natural areas such as gardens. The practitioners' knowledge included expectations that there would be different actions and reactions from service users in different locations, as revealed by Gladys in the following quote about Andy:

> *I have only ever really seen him in two maybe three environments for such brief periods of time and it's not as though he's had a uniform response to each he doesn't always react the same way in each environment.*
> *(Gladys 4, 518-521)*

Gladys asserted her knowledge of how her analysis of different environments and occupational participation were combined and used as a comparison in order to develop her knowledge about Andy's occupational participation. Gladys had a moral dilemma as she was unsure of how to use her new knowledge about Andy as it had gaps in it and whether she had enough knowledge to produce a fair and rounded assessment of Andy. Another area that the practitioners developed their knowledge about the way a forensic setting could impact patterns of occupational participation was when addressing needs and choices for washing within the forensic setting:

> *[…] you can't have a china mug you can only have a plastic one...no you can't have a toothbrush, we'll give you a mouth one that you can chew on. No...we'll give you toothpaste every day in a cup...*
> *(Liz 2, 257-259)*

Liz developed her knowledge about how the forensic setting impacted a fundamental activity of self-care. In order to meet security requirements such activities had to be modified by the nursing staff in order to allow service users to perform them. There were also limitations in what clothing service users could have to dress themselves:

> *[…] no you can't you've got a pyjama cord...and you'll say a dressing gown and I'll say no you've got a dressing cord and you'll say a belt for jeans and I'll say no you can't have that either...my jeans have got studs on well you can't bring those in either.*
> *(Liz 2, 253-256)*

Such limitations also impacted a service user's identity and how they expressed themselves through their attire, this was not however, explicitly discussed by the practitioners. It did relate to providing opportunities to participate in looking after oneself:

> *[…] although it is complex it, what we're talking about is everyday occupational activity...and it is how we manage a welter of risk information and don't completely deprive the women of occupational functioning*
> *(Liz 2, 260-262)*

That indicated the changes that needed to be made from how service users would ordinarily carry out their activities of daily living in an environment of their choice. It emphasises the control the workers have over such activities, impacting upon service users' agency in their occupational participation of meeting their own

needs. Liz had knowledge of the wider environment from which the service users came and how they influenced their occupational choices:

> *[…] occupations…don't exist in some kind of void…life choices, criminogenic occupations, meaningful occupations…exist in a life and it can be a life that's challenged by poverty, education challenges, economic challenges, social challenges, psychiatric challenges.*
> *(Liz 12, 251-255)*

Liz's knowledge therefore included a context about service users' access to and choices made about occupations prior to their admission to a forensic service. Liz used her knowledge of the wider context when developing new knowledge about the particular service user's narrative (discussed more in category three). Liz also used her knowledge in relation to how she saw the potential impact of forensic settings. The forensic environment could cause restrictions with extreme consequences:

> *What we're talking about is everyday occupational activity...and it is how we manage a welter of risk information and don't completely deprive the women of occupational functioning. So almost has to be thought about...because otherwise you will end up with a completely sterile environment...which don't end up much different from seclusion to be honest.*
> *(Liz 2, 260-264)*

The environment that was in part about rehabilitation, could have the effect of preventing occupational therapy. Liz had knowledge about the potential for reduced opportunities for occupational participation that occurred due to Claire's risk management plan:

> *A very senior clinical who went 'when this woman comes out of seclusion she's going to be in a completely stripped room' and I went 'what are you going to do with her?' She said 'engage her'. I said 'how?' 'Because she is in protective clothing, no bra, no knickers or socks [in] a shift…She's got no books, no letters, no television, she's got a radio embedded in the wall. She's got no food, she's got no drinks, she's got…nothing. How are you going to engage her, what are you going to engage her with? She doesn't even have toilet roll, you are issuing it sheet by sheet'...*
> *(Liz 2, 262-268)*

Liz's colleague seemed unaware of how that restricted environment impacted occupational therapy. Those restrictions and environmental limitations were challenged by Liz. She had knowledge of the relationship between environment

and occupational participation in forensic settings and shared this with the team:

> *That dynamic says that I will bring this to you and we will engage in it together…unless*
> *you are going to do a talk therapy session you are going to need a focus for your*
> *engagement, which was when they said okay some letters from her daughter, a*
> *blanket that she likes, a cushion that she likes. It gives people material…to engage*
> *with.*
> *(Liz 2, 262-278)*

Liz helped to create the team's knowledge that the practitioners enabled service users to participate in meaningful activities as far as the secure environment allowed. Liz was explicit in her view that risk management led to environmental limitations that had consequences for future occupational choices and participation:

> *Forensic environments are disabling, dis-empowering, dis-occupying...so we need to*
> *be really attuned to looking at the environments to see how it impacts on someone's*
> *function past, present and for what the future occupational narrative can be.*
> *(Liz 2, 452-455)*

Liz's quote highlighted how she had used her existing knowledge of her core skills to analyse the forensic environments she had worked in. She had created the term "dis-occupying", which was an example of her knowledge used to create a term in the context of other oppressive characteristics of the forensic environment. Liz's new knowledge was not dissimilar to occupational injustice discussed in category one. Liz tried to engage Claire despite the environmental restrictions wherever she could:

> *Even in the most restrictive of environments you can have someone who can engage*
> *occupationally... they've played mindfulness games through the observation hatch or*
> *we've had conversations through the intercom whether that is singing, or poetry…*
> *(Liz 3, 306-308)*

Liz developed a new knowledge about how she could use her practice with Claire in seclusion, the most restricting of environments. If Liz had not attempted to work with Claire in that way she would not have created a knowledge about what occupational participation was possible in such an environment. Liz spoke of her developing knowledge about Claire's sensory experiences created on the basis of her existing knowledge. Liz had knowledge from reading an autobiography of a vet diagnosed with Asperger's Syndrome who used a cow-press that provided her with

a particular sensory experience:

> *[…] again if you think about this woman in the cow press…you handle this woman's*
> *needs for seclusion if you think about restraint it's a very you are absolutely boundaried*
> *and externally reinforced and you are held.*
> (Liz 6, 202-204)

Liz also gained knowledge from her previous practice experiences of service users who had been held by staff using physical restraint techniques:

> *So there is the emotional component of being held, but there is also the physical*
> *component of that sensory input the proprioception…that you are getting back. You*
> *are safe, you are held… another woman told me that she evokes situations around*
> *this, but I do wonder about that and this woman [Claire].*
> (Liz 6, 204-210)

Such action of the service user to meet their sensory needs in the environment can be considered extreme. Gaining knowledge about what such actions meant to, and did for service users was a particular form of knowledge grounded in a particular practice context. Liz therefore created a new knowledge that might also be relevant for use with Claire.

4.3.4 Motivation

The Model of Human Occupation incorporated the concepts of motivation and volition. Liz also used the term motivation to describe how and in what ways service users may participate in occupations. Liz's knowledge of motivation included the way different people were motivated to make different choices. Liz found in the forensic context that it was important to discuss with the service user's their choices, and how positive those were. This led then to how far practitioners could support them or not along a particular choice of pathway. The particular issue being choices around criminal acts. Workers also had a different perspective about whether service users were motivated:

> *[…] [he] was described as unmotivated, this man wore white jeans that he'd laundered*
> *and took care of himself and blinded you, they were dazzling to behold and I was being*
> *told this man was unmotivated.*
> (Liz 12, 98-100)

That example showed different perceptions about what was a motivator for a

functional activity of daily living. Gladys gave an example of the volitional characteristics of service users on the slow stream rehabilitation ward:

> *[…] the self-confidence level of people on the ward is really low, really, really low actually, very poor self-confidence, really poor self-efficacy…there's like one or two people here who can be a bit grandiose at times and everybody else has real difficulty believing in their ability.*
> *(Gladys 8, 271-284)*

Gladys demonstrated her use of theoretical concepts separate from, and related to volition in her practice. Liz explained a service user's motivation influenced by a wider social context, for the potential to engage in harmful acts:

> *[…] social, cultural, economic values. The guy that I was working with when I was working in the East End of London who turned round and said to me Liz I am never going to sit in Starbucks drinking gingerbread latte when I am discharged from hospital. What am I going to do? How am I going to manage pubs, weddings, christenings, what am I going to do when I am faced with very…highly alcoholic situations and I need to be doing something…*
> *(Liz 12, 126-133)*

The wider socio-cultural situation for this service user was to be with his family, but their values were to celebrate and do leisure activities that were strongly linked to drinking alcohol, which for him was part of his index offence. Implicit within this example was the impact of using alcohol to the extent it would impact upon his physical health and well-being. Such values that act as motivators for occupational participation needed to be explored by the practitioners. Liz explained that the impact of a highly structured and secure institutional life of the forensic setting was to externalise the locus of control service users' with personality problems, so they functioned extremely well. There were many problems when that structure was removed:

> *[…] the transition then down to lower levels of security particularly relational security, the step down is too much of a challenge the attempt is sabotaged through fear…and you see it time and time again in forensic services and this service is very good at trying to manage transitions the best way it can but it is still very, very, tricky coming down from 24 hour observed care…to even a lower level of security….*
> *(Liz 3, 327-331)*

The structure provided by the relational support from therapeutic relationships with workers was crucial. Along with a place to stay, regular access to food, a small amount of financial benefits and a structured timetable of activities:

> *[…] 'so you will do this or you won't get that or you don't do this and you won't get your leave' etc., etc., you are just, I believe on a hiding to nothing…*
> *(Liz 3, 334-335)*

Liz found externalising locus of control to be counterproductive. Liz believed occupational therapy was useful for developing an internal locus of control:

> *[…] you have to find occupational goals for people to work towards that they then internalise and become meaningful to them which then they can plot their pathway through secure services…I believe it is the only meaningful way…for a robust pathway and discharge.*
> *(Liz 3, 335-338)*

Liz described the challenge to service users who had extremely high needs of emotional security and relational support needed to be part of the therapeutic work. She also highlighted how service users needed to be engaged in exploring and using their own agency in meeting their needs, for which occupational therapy could offer. Liz did not make a connection between locus of control and volition that may have indicated a move away from using just one model as a rule for practice. A core aspect of the therapeutic work was therefore helping service users' to find healthy, well-being enhancing motivations for occupational participation in order to build their capacities to function effectively in the community. Choice was one characteristic of the volition concept in MOHO, and impacted their participation in their occupational therapy, considered next.

Choice

A fundamental part of practice was that service users needed to choose to take part in occupational therapy. Without this expressed choice, the practitioners could not take their practice with a service user any further. They did however, find ways to engage service users who declined to engage with them, which is considered in the third category. Part of client-centeredness was trying to identify choices for occupational participation within the wards and the wider secure setting of each practitioner and Zach's choices were facilitated as:

[…] each boy chooses …a role whoever does the washing up gets the first choice of
what to do the next week and so he took, has taken up the washing up role.
(Tess 1, 123-125)

Tess highlighted how not every occupational choice could be provided, but there were some available within a restricted range in group cookery. The practitioners were challenged to find choices of occupational forms that service users found meaningful.

Liz discussed having objects associated with meaningful occupations was:

Even if her bedroom is completely stripped because she has inserted, or tied a ligature
or even if she is in the great depths of despair, there will be photos she can access.
And she has never hurt herself with any of the photos…so she has tried to asphyxiate
herself with toilet paper for instance but never used any of the photos in any way to
harm herself.
(Liz 3, 97-100)

Liz's knowledge of how Claire used her photographs was important to help Claire hold onto her meaningful roles and the occupations that she could use to maintain them whilst in WEMSS. Choice was also part of a client centred approach which MOHO incorporated, but could also be used separately from MOHO, illustrated next.

4.3.5 Client-centred approach

Tess noted other features of client-centred practice were to be optimistic about what could be achieved and be creative in achieving them. Tess believed that the choices available to her were limited:

[…] you can't do everything that they want to do…
(Tess 14, 532)

She did not go into why this was the case. Exploring service users' expectations, their capacities and constraints was a part of the client-centred approach and helped the practitioners to see what potential service users had to meet their occupational participation interests within a given environment. The practitioners discussed with me mostly about the recovery approach that had some similarities with client-centeredness, in particular hope, illustrated next later.

4.3.6 Recovery approach

Liz identified the form that the recovery approach took in the forensic setting. The service user had to acknowledge what they did and how that related to how they wanted their hospital admission to progress. Liz also noted service users needed to develop their plan at the earliest point the service user could. Liz talked of hope as an important feature of recovery:

> *There is something about hope…which is integral to this process and I know it doesn't sound like a very scientific concept but hope for change is absolutely vital in this environment with these women and if that is felt to be lost then we are losing the treatment battle.*
> *(Liz 2, 38-41)*

Indeed the notion of hope was a necessary requirement for therapeutic change. Tess highlighted the need for hope with such long stays that were part of life for many service users in forensic settings. Tess included the service user's recovery with their future potential:

> *[…] the recovery journey it's just about your story about thinking forward, not thinking this person's gonna to be in an institution for the rest of their life.*
> *(Tess 14, 489-491)*

Tess therefore included the service user's possible future narrative in her intervention planning. She also spoke of how she saw the relationship between recovery and occupational therapy:

> *[…] that's what occupational therapists have been trying to do for years.*
> *(Tess 14, 491-492)*

Tess was not the only practitioner to express her views of the connection. Gladys saw common features between client-centred practice and the recovery approach:

> *Client-centred practice and the recovery approach are again very overlapping principles and so I suppose the most important thing is to keep asking what he wants…and how he thinks that things are going.*
> *(Gladys 6, 96-99)*

Gladys asked Andy questions in order to enact the principles from client-centred and recovery in her practice. From this she would create new knowledge using both of those approaches. Tess's use of recovery also manifested in her practice:

> *[…] my target setting each week is recovery…is, maybe that should be called a*
> *recovery journey, a recovery setting…because it's about thinking what are you going*
> *to do this week to get, for you to get better?*
> *(Tess 14, 512-515)*

Tess made a link with recovery as getting better, however this could be seen in terms of recovery from an illness, which was not the focus of a recovery approach. Liz highlighted other ways recovery manifested in her practice:

> *[…] there is no documentation that the women cannot see or apply to*
> *see...consequently…my thinking is informed, your whole way of expressing*
> *has…certainly for me has changed radically.*
> *(Liz 3, 190-193)*

The way Liz recorded her knowledge in her documentation had therefore changed according to organisational requirements. Tess could see the benefits of the recovery approach in the wider organisation:

> *[…] there are patients on panels for…interviews, that there are patients in meetings*
> *giving their views…sometimes it can be a bit tick boxy but I still think it's the principle*
> *is great…and actually paying patients to do these things, you know to be on a panel*
> *or to attend certain meetings I think that's really important.*
> *(Tess 14, 544-548)*

The organisation had an increased recognition of the need for service users' perspective and representation on mental health service provision. Tess felt this was only done in a limited way:

> *On the other hand I haven't seen any great improvements to anything else,*
> *particularly…because of recovery…Maybe it's given people a bit more hope we did*
> *have a recovery conference and we had a guy come and talk who was very interesting*
> *and he … described his journey through mental illness…*
> *(Tess 14, 549-553)*

Tess identified other ways in which the message about the recovery approach was being given by the organisation and implied a change of perspective from the organisation with increased hope being more apparent. Liz, however, noted how

Claire's complex, regularly cycling emotion and actions got to a point where she harmed even those workers with whom she had a very good therapeutic relationship. The impact was to make necessary changes in the way they worked with Claire:

> *[…] people are prepared to work with her but feel massively ambivalent about her progress. People were prepared to work with her sympathetically, empathetically, but not necessarily pro-actively, and that's had a big impact on I think on my own…because I feel as if I am dragging the team behind me now. It's not that they're obstructive…to anything I do…what we are doing at the moment is containing…we are not working dynamically…*
> *(Liz 4, 195-200)*

The team were therefore struggling to work in a way that promoted Claire's recovery. The practice context had shifted considerably and the team's knowledge for working with Claire developed into containing her:

> *[…] you know she is cycling from seclusion, to room, to de-escalation, to room…with occasional forays out and then usually a period of self-harm event or an attack event…and that's that pattern now there's no other changes to the narrative it seems to me and I think that's pretty much about a loss of hope…and I think the team are burnt out.*
> *(Liz 4, 209-212)*

Liz and the team therefore had difficulty holding the hope for Claire. Their practice became a pattern of responding rather than seeking to practice in a new or different way. Liz highlighted how taking a recovery approach may have been detrimental to Claire:

> *We recognised what we had probably done was psychologically abandoned her and left her hanging, because she knew [unit named] were making up their mind. We couldn't [do] anything, the uncertainty was too great too much, way, way, way, way too much feeling unwanted by us and not convinced that she was wanted by [unit named].*
> *(Liz 5, 278-281)*

Liz and the team had not seen Claire's difficulty containing her anxiety over the uncertainty of her future. There was an incompatibility between using recovery approach principles and Claire's emotional needs:

> *[…] the recovery model would say you will obviously inform service users of any decisions about their care we did her an enormous dis-service…and you marry the*

fact that by actually, from a recovery perspective, supporting the service user's…right to know about their treatment actually de-stabilising her because she was psychologically not robust enough to hold that uncertainty whose rights are you really holding in mind?...in discharging our responsibility.
(Liz 5, 283-288)

The implications here were for how far principles for practice could be upheld when seen in the context of individual service users' capacities and constraints. Gladys described how difficult it was to understand Andy's sense of hope:

[…] will often say a little bit of what he thinks you want to hear and downplay how difficult things actually are for him to achieve and so you weren't really sure how much of what he was saying he actually held hope for…and it's still a little bit unclear…
(Gladys 6, p. 45-48)

Gladys was therefore working with a partial knowledge about how a recovery principle could be used with Andy. She looked for signs that hope for Andy's goal was possible:

[…] because I knew that he had been able to achieve this getting into the community at least once in the last couple of years then I didn't feel like that it wasn't impossible…That there could still be this hope…
(Gladys 6, p. 48-51)

Gladys however, could not predict whether he could reach his goal. Furthermore, there were more aspects that could affect his goal:

[…] to help him get there in the end, even though perhaps the time scale in which he felt that it was going to take, or the effort that it might require, or the support that it might require, could possibly be more [than expected].
(Gladys 6, p. 53-55)

The only way to gain the knowledge of whether these aspects would have an impact would be when Andy engaged in his therapy when Gladys would have the opportunity to observe the changes. Gladys felt it was important for her to feel hope for service users to:

[…] if I'm not able to feel hopeful about someone achieving their goals in any way you wonder why you are doing that piece of work… it seems like it's destined to fail in that case
(Gladys 6, p. 58-61)

Gladys's belief could be related to the need for her to hold hope at times when the

service user might lose hope, or waver in their attempts to achieve their goal. She also highlighted a client-centred approach:

> *[…] it would be unusual to collaboratively come to a goal with your client that you have*
> *no belief in the part of collaboration it seems an injustice to them almost…'*
> *(Gladys 6, p. 64-66)*

Gladys noted the need to be genuinely interested and willing to be a part of the service user's goal. Gladys spoke of a level of interest and willingness that turned into advocating on behalf of a female service user. She was, according to Gladys an amazing singer and her goals and recovery plan incorporated that, but the team had a different perspective:

> *[…] and a lot of members of the team were like it's completely unrealistic…but had*
> *never heard her sing, or you know weren't aware that she'd wrote quite a fair bit of*
> *music and I didn't see why it was unrealistic.*
> *(Gladys 6, p. 398-400)*

Gladys was alone in her support of the service user's goal. Gladys therefore sourced ways in which the service user could engage in her interest and develop her skill:

> *I said why? You know there's music courses. If she wants to do some voice lessons*
> *she could do that…there are ways that mean perhaps she could get on track to doing*
> *something like that, and we thought that through and that was we decided actually that*
> *she could pursue it… (Gladys 6, p. 401-432)*

Gladys's belief in the service user and willingness to try something that was an unusual practice situation meant she was creating a new knowledge. Gladys incorporated the service user's changing mental state into her developing knowledge as the practice context changed:

> *[she] had a tendency of becoming a little bit [mental illness symptom] and so it then*
> *became I'm going to win X factor…From that point on, and there were some members*
> *of the team that felt that it wouldn't be fair to have her believe that she could one day*
> *win X factor,*
> *(Gladys 6, p. 401-432)*

The team saw popular culture becoming incorporated into the service user's mental state. Gladys's view was about how entrants might feel:

> *[…] I saw it through slightly different eyes. Well lots of people going on there, who do*

think they are going to win…
(Gladys 6, p. 401-432)

Gladys thus tried to limit the service users' experience being turned into a pathology. Gladys further explored the service user's context and risks associated with the experience of being an entrant:

> *You could be at risk from the public …that sort of thing could potentially de-stabilise,*
> *look at SuBo [Susan Boyle]…the pressure is massive, you could actually be at risk of*
> *being exploited by other people who make these sort of programmes and would you*
> *be prepared to have your forensic history plastered across the nation in that way?*
> *There would be very little escape from it in that case and how do you think that would*
> *affect you?*
> *(Gladys 6, p. 411-417)*

Gladys had to make sure she and the service user understood the risks. Gladys used a client-centred approach to explore the service user's interest and to help her to make an informed decision about pursuing her goal. Gladys did not completely discount the service user's mental state as it deteriorated, but she did not fully accept the service user's experience as fully grounded in a symptom of a mental health problem. Gladys therefore had to balance the mental health and forensic issues with ways to support the service user's occupational participation plans. Liz gave the impression that workers who tried to enforce a recovery approach upon any service user did not understand its principles:

> *Where there are tensions for me is between the lens that is put on patients or service*
> *users that says your recovery will look like this because I think that's better for*
> *you…That's where the tension lies…and that's not just in secure service that's in any*
> *service.*
> *(Liz 12, p. 108-111)*

Liz's example demonstrated an oppressive practice, the antithesis of a recovery approach. Gladys highlighted links between recovery and occupational therapy:

> *[…] what do people really want, rather than what do we think they should have. And*
> *how difficult it is to…see that happening when you're quite unwell…and how to get to*
> *that end stage and…as the OT helping to be some kind of vehicle for that…The*
> *language of it is very recovery but…it is the recovery approach it's also very much kind*
> *of what a lot of OTs do. (Gladys 6, p. 21-28)*

Gladys provided questions to ask that would create knowledge linked to recovery and occupational therapy approaches. Tess also had similar views about recovery:

[…] to me it's occupational therapy. ..it's client-centred-ness it's…putting the client at the centre of their journey, it's the thinking about their future, thinking about their potential.
(Tess 14, p. 476-479)

Tess's view also implied a narrative approach to her practice and trying to see how far a service user could progress. The rules for practice up to this point had to incorporate a model and two approaches that were seen as a requirement for the practitioners' practice. The practitioners had to go further by combining those with risk management, another requirement, into their knowledge, illustrated next.

4.3.7 Risk taking, recovery and client-centred approaches

The recovery approach, at the time of the research interviews, was not formally incorporated into WEMSS, but Liz tried to include it into her risk assessment and interventions and legal system requirements with Claire. Liz combined those requirements with a client-centred approach in a dialogue with Claire:

[…] in order for everyone to feel confident about you leaving this environment, or for instance taking on that challenge, we need to know that you are safe and we are safe. In order for that to happen we're going to be more confident if you can do this this and this, but you need to make a decision about what you feel happy and prepared to do… what's being asked of her, what she feels safe and competent to do and the optimum level of challenge.
(Liz 12, p. 62-71)

Liz therefore considered the service user's criminal activities and how they could move away from them by finding other forms of occupational participation. Liz integrated recovery with client-centred practice and positive risk taking:

It's the two interlocking circles so we have the ministry of justice…which represents…security…physical, procedural, relational security and that whole environment of restriction and you have health, so promotion of recovery, engagement of client centred practice and those two circles overlap and in that middle bit certainly I think forensic occupational therapy sits and certainly that's where positive risk taking sits…being grounded in considerations of what has brought someone into a secure service but also being grounded in kind of how that process of recovery is owned…
(Liz 12, p. 16-24)

This quote was about combining a range of approaches that could be seen as

conflicting with each other however, it was the practitioner's job to blend them in the best way possible, creating a new knowledge that enabled service users' occupational participation. There were no guidelines informing the practitioners how to combine those aspects, they had to develop their knowledge from their practice. Gladys referred to knowledge about a strengths based approach that she had gained from a different practice setting of working with older people and their physical and mental health needs.

4.3.8 Strengths-based approach

Gladys's explained the strengths based approach was a way of seeing the service user's abilities, what they could do in occupational participation and building upon that. She clarified that she had to frame her use of language and how she perceived service users. She therefore looked for ways that service users had succeeded to a given point and also taking service user's actions and rather than framing them in a negative way, turn that around into a positive. Gladys did this because she felt more comfortable using that approach. Also it was important ultimately to make things easier or better for the service user and a strengths based approach offered that possibility. She also found that her relationship with service users improved and that they believed in her and themselves a bit more, so they achieved more. Gladys had also described how a strengths based approach could be combined with the recovery approach in the forensic setting:

> *It links to recovery…and holding the hope for people…or presenting you with skills that they feel that they've lost, doesn't mean…they can't still work with a strengths based approach. I acknowledge how they feel…and…that's all acknowledged and validated however, from that point we'll be looking at…how do we turn this into a strength for you.*
> *(Gladys 8, p. 58-65)*

Gladys made connections between the established client-centred and newer recovery approach principles that were used in occupational therapy practice. Gladys's comparison of principles indicated her reflection and critique of the compatibility of approaches for practice. The teams were beginning to work with recovery as a potential core approach and were therefore an important feature of practice, considered next.

4.3.9 The multi-disciplinary team: the social working environment

The practitioners discussed the working relationships developed through their daily practice, by particular pieces of discipline specific and joint work, and specific referral to occupational therapy. Team working was a core feature of the practitioners' practice. The types of communication and how the teams worked together and functioned along with how the teams provided support for their members were all discussed.

On her move to the slow stream rehabilitation service, Gladys received specific referrals from the team and found that they were well informed about the service users. The team's examination was supportive and gentle for a sensory interventions with Claire to calm her mood. Indeed, Liz had a discussion with the consultant psychiatrist about other women with potential sensory modulation problems. Overall Liz felt supported by the team and she found the team worked most successfully with Claire when they had all agreed on the plan for her. Tess recognised the specific roles of team members and also said she felt able to question the team.

Gladys highlighted how she had to negotiate with the team, aspects of Leila's physical health and pain experience that she found were not being addressed, but to which the team were not fully responding:

> *It was brushed over very quickly and because I had come from an area where I was working with older people previously and physical health problems are much more frequent…I felt that it was somewhat in my role to take the realistic viewpoint that actually these things may be impacting on her ability to do other things for her day to day life*
> *(Gladys 1, 418-421)*

Gladys was clear in her role as the team member who focussed on what impacted Leila's occupational participation. Working with the wider team members was important for Gladys to check her plans were in line with the teams. This included specific collaborations with psychology and work with Andy and Leila. Another example was Tess's needed to create an assessment for other disciplines to use

when taking a service user into the community. Other sources of knowledge for use in practice are considered next.

4.3.10 Sources for evidence use in practice

There were some other examples of how the practitioners used what they considered various sources for evidence for use in practice. Liz discussed a government report:

> *[…]in terms of forensic services for women being more successful it needs a higher degree of relational rather than procedural or…physical security…the Corston report flagged it up.*
> *(Liz 4, 531-534)*

Liz incorporated those suggestions into her work with Claire. The research for sensory work on weighted blankets and how Liz sought this was explained:

> *The New Zealand summary paper, which talked about the use of weighted blankets and the reduction in violent activity [had] some statistical worth…*
> *(Liz 4, 118-119)*

Liz spoke briefly of the quantitative evidence used in the sensory work. Searching for research for evidence was prompted in different ways:

> *There were several articles published in the British Journal of Occupational Therapy looking at sensory input into adults in mental health environments and kind of questioning if there was something we hadn't captured before.*
> *(Liz 5, 41-44)*

Liz found the articles prompted further questioning about Claire's sensory functioning. Tess described a situation with a change in a boy's actions on her ward that prompted her to source sensory literature:

> *[…] I was able to look up and about why people wear back-packs and it is actually… comforting and you know the feeling that something's around you…it's almost like somebody giving you a permanent hug…so it was quite good …the sensory side of it and I was able to… put much more of an argument so they [the team] were less freaked out about it…why he'd started wearing a back-pack…*
> *(Tess 14, 433-441)*

Tess's evidence helped the team understand the boy's actions and in turn created

a new knowledge for them all. Gladys described how she had no guidelines, evidence based or otherwise, for her new role in slow stream rehabilitation and how she responded:

> *[…] it was building up from scratch, using more relevant bits of experience previously…no real guidelines…so it was sort of piecing bits together.*
> (Gladys 8, 265-265)

Gladys therefore had to use her practice experiences, which formed a new knowledge, in order to create new ways to work in the slow stream rehabilitation setting.

In summary, the rules for occupational therapy practice category highlighted the various lenses the practitioners used at different times and concurrently to view the service users. The practitioners' lenses were what they knew and were forms of technical rational knowledge. They were expected to use theory such as the medical model, MOHO, recovery and client-centred approaches. The use of concepts from the MOHO, such as volition, motivation and environment and roles were very much part of the practitioners' framing of their understanding of their service users. Liz found locus of control a particularly useful concept in her work. Other theories were used based on the practitioner's belief in their value and observation of service users' positive responses, as with Gladys's use of a strengths based approach. There were also examples where Liz and Tess were thinking about sensory functioning, which was not covered by MOHO and so required another theory to help them understand this aspect of their service users' occupational participation. The practitioners, in essence, deviated from the expected use of one model and other approaches. Practice required different lenses and the practitioners each modified their use of theory and they did not use it prescriptively. When Liz and her team did follow principles without considering the individual service user's context, their practice was not successful.   The practitioners therefore used various forms of knowledge for practice and not as a base for practice. The place of professional values and beliefs were hinted at in the foregoing section but how they relate to the personal and emotional experiences of the practitioners are presented next in the third and final category.

4.4 BLENDING THE PERSONAL AND PROFESSIONAL

The practitioners' practice included a combination of aspects that went beyond a codified and technical rational knowledge gained from pre-registration education. Previous practice experiences from their working history were a key source of knowledge used when working with service users. The practitioners used the service users' current actions and their history to develop a nuanced understanding of their narratives and how they related to previous, current and potential future occupational participation. The practitioners used each service user's narrative to start connecting with them to build a therapeutic relationship. This was achieved in subtle and small ways that existing standardised tools and organisational procedures could not guide or direct. Gladys's work with Leila incorporated such an approach and is presented in figure 20.
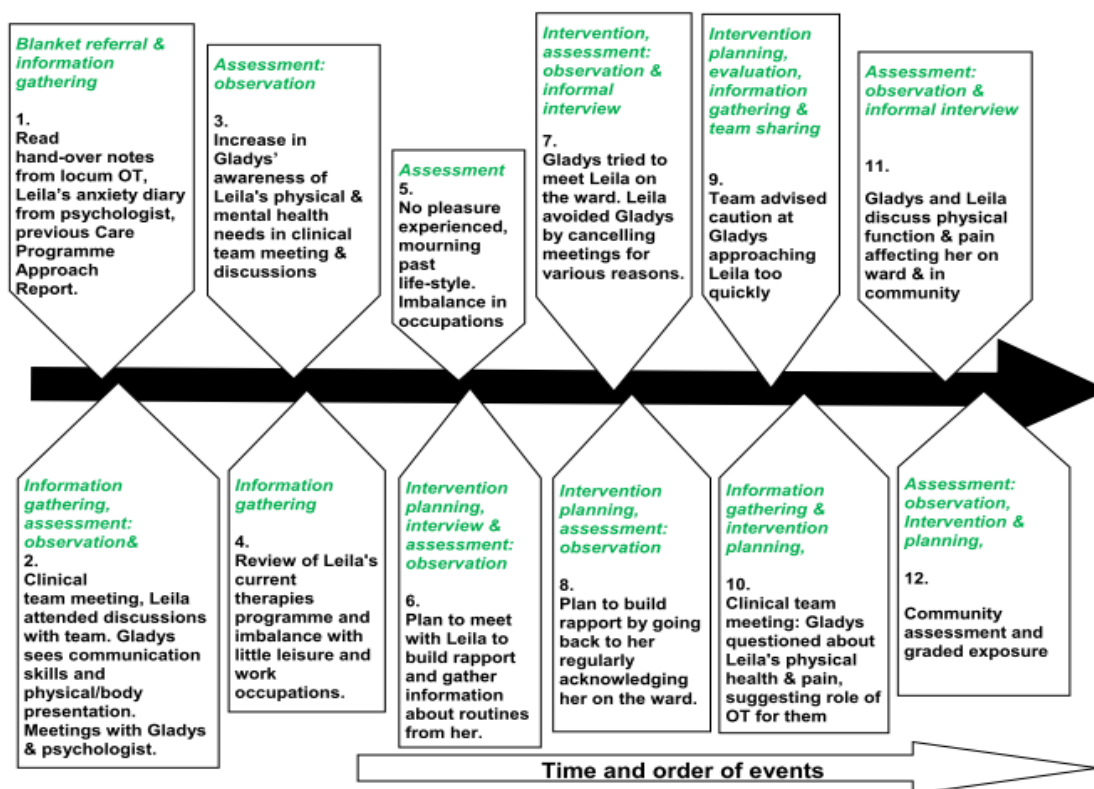
Figure 20. Gladys and Leila's timeline of the early stages of the occupational therapy process (source: Cordingley, 2015)

The practitioners used their personal values and any emotional responses to practice events involving service users, monitoring and incorporating them into their practice where relevant. The findings suggested that the practitioners'

emotions were a human response to practice events. Such responses were influenced by two aspects. One was the life context of the practitioners, including their values and beliefs and the other was their immediate perception of the service users' actions. The practitioners' moderated and evaluated their human emotional responses within a professional context of trying to be non-judgemental and empathetic, whilst aiming to provide effective occupational therapy. The blending of both personal and professional experiences was achieved through reflecting on any given practice situation. In particular, those that required a renewed look at the service users' needs, a revision of their existing occupational therapy plan and at unusual situations where the experience of practice did not relate to the current situation.

Table 6. Category four blending the personal and professional category and concepts (source: Cordingley, 2015).

Category: Confluence of the personal and professional	Concepts:
	Therapists' personal values and beliefs
	Practice experiences
	Narrative building
	Connection
	Trust
	Rapport
	Empathy
	Occupational therapists' emotions in practice
	Occupational therapy is not fluffy: The identity of occupational therapists working in forensic mental health
	Reflection

Before moving on to illustrate the concepts that constitute the 'blending of personal and professional' category, the cycles of the therapeutic relationship are presented.

Therapeutic cycles

Therapeutic cycles were developed through the relationship between the practitioners and the service users as they engaged or disengaged with the

occupational therapy process. This referred to the building of rapport, trust, respect and responsibility, empathy and emotional elements of the work. There were ways of building both the therapeutic relationship and improving the service users' confidence, by evaluating the service users' achievements. Maintaining the therapeutic relationship through the difficulties, set-backs and contextual limitations was an important part of this process too. The knowledge gathered by the practitioners was used in practice to move the relationship forward and develop ways to respond to the service user in a given moment. This practice was part of the joint narrative of the service user and practitioner, not unlike a journey undertaken together. There were various points where the journey was temporarily halted. At other points the journey was facilitated and moved forward. There could be points where they travelled back or stopped, reached a plateau or temporarily halted the journey for a period of time. Those junctures were opportunities for review and reflection of practice experiences. The practitioner's values and beliefs could be part of practice choices, illustrated next.

4.4.1 Therapists' personal values and beliefs

The practitioners described their values and beliefs and how they influenced their choice of practice area, which formed part of the way they viewed the service users. Personal life experiences and roles were also part of the drive to work in secure settings. The interaction between the practitioners as occupational therapists and their personal life experiences, as well as how the personal affects the practitioners was highlighted. Liz talked of the 'lens' with which one views the world and having that when entering forensic mental health practice. So she spoke of bringing her own context with her that included a long standing interest in women and gender issues. In her under-graduate education she completed a dissertation about women, drama, performance and incarceration in various institutions including Broadmoor hospital and Holloway prison. Her interests have included what people do when incarcerated and the traumatic histories behind that.

Gladys spoke of her personal approach in life about her tendency to make things perfect and how it impacted her work. She found she questioned whether she did the right thing for Andy and by getting the correct information to feedback to the team. Gladys however, questioned:

> *[…] is that really what it's about?...It's made me realise that even though we have to have outcome measures and, not realised, but reinforced, it's very much about the process, or it feels that way to me. Rather than the end game, even though the end game is often pushed by the team.*
> *(Gladys 4, 579-582)*

Gladys felt a tension between her personal style, job role, others' expectations and a new knowledge. Gladys found attachment theory was very helpful to understand the service users and develop an empathy, but she found that the work resonated too much on a personal level:

> *[…] it's an empathy, because it helps you to understand why someone is the way that they are in the first place really and what horrific childhood experiences have led them to this, or good childhood experiences, or unusual ones, or whatever have led them to their ways and patterns of thinking.*
> *(Gladys 3, 349-353)*

The personal impact on Gladys, along with technical rational theoretical knowledge and her experience of working with the women, formed her new practice knowledge. Tess's responses were linked to being a mother:

> *When you've got teenage children it's difficult…not to think of it from their perspective…I think oh my god you know, how would my…if that had happened to my child how would I feel?...so that side of it is horrible. And I don't think that would ever go…*
> *(Tess IV14, 698-702)*

Tess had a human response linked to her personal context when reading about a service user's index offence. Tess also highlighted the influence of her mother:

> *My mum was incredibly accepting of absolutely anybody…I wasn't brought up with a prejudice like that…*
> *(Tess IV7, 398-401)*

Trying to resist prejudices was a valuable approach for the practitioners. The practitioners did however, sometimes deviate from the expectations of being objective in their practice because they were human with values and emotional responses to practice events. For instance they had to consider the service users' challenging actions and risks in relation to occupational participation and their practice experiences, discussed next.

4.4.2 Practice experiences

The participants' practice experiences came from different forensic services and other experiences from unrelated practice settings. Gladys used her previous practice experience working with older adults in the early stages of dementia, in the forensic setting:

> *[…] I was encouraged to…frame things in terms of what people can do. There would be notice [taken] of what was difficult now, but what could they do and how could we use those strengths to keep them as independent as possible…that approach has followed me a little bit.*
> *(Gladys 8, 108-119)*

Gladys used her previous practice experience of a strengths-based approach and knowledge created from that, in a new practice area. She explained such an approach was easy to use and she was surprised that it wasn't already a part of the forensic setting, as it could be used in tandem with most other approaches. Gladys explained how she preferred to use a lens that showed service users' strengths. Gladys also used knowledge about re-traumatising the service users gained when working in the low secure women's service:

> *[…] you would have all this projection from someone and you'd be quite unsure why and a couple of weeks down the line find out a bit more about their past where like 'oh well right okay if I'd have known that I wouldn't have come up behind them quietly and completely spun them out'. You can't always avoid things like that. I wanted to be able to know that where those possibilities were.*
> *(Gladys 3, 298-302)*

Gladys's experience was linked to a knowledge gap about how her actions could have a powerful impact on the service users. She incorporated this into her knowledge and used it in her new work setting of slow stream rehabilitation. There were, however, aspects of her role that were new to her:

> *[…] what am I supposed to do? What's the approach here? Oh no-one knows, oh right okay…it's treatment resistant schizophrenia, it's gonna be difficult to engage with people and build rapport was almost...what I got in terms of when I moved here so it was building up from scratch using more relevant bits of experience previously…*
> *(Gladys 8, 259-263)*

Gladys was working in conditions of uncertainty due to her limited knowledge. Her

practice had to be improvisational when there were practice situations of which she had no prior experience or technical rational knowledge. She acclimatised to a new working context, as she discovered how to practice there:

> *[…] the subtleties of people's successes on this ward…compared to on other wards where it's like 'ah wonderful you now have 4 hours of unescorted leave', here it would be the first time after two years, you did the washing up… having to look quite carefully at…really breaking down…what people are able to do*
> *(Gladys 8, 271-277)*

Gladys had to modify her previous knowledge about how to observe and identify service users' successful changes, thus creating new knowledge. She had to learn how to respond when achievements occurred:

> *[…] and celebrating…what might seem in perhaps other wards to not really be significant…celebrating little victories as very significant, and you know feeding back to the person how significant it is.*
> *(Gladys 8, 278-280)*

The experience of celebrating very small successes with service users created a new knowledge about that context. Over time she developed a clearer understanding of the ward following her experiences over a few months:

> *I think I understand the pace of the ward a bit better and the pace of the way that um our service users work and the sort of approaches that work a bit better.*
> *(Gladys 8, 310-311)*

My longitudinal research design helped to create the conditions that allowed the slow creation of new knowledge to become apparent in Gladys's working context. Gladys used her previous knowledge created from her experience of working with Leila to her work with Andy. She had used similar graded exposure interventions with Leila in collaboration with a psychologist and felt comfortable doing similar work with Andy. Gladys clarified the occupational focus of the work:

> *[…] that could be a good starting point for him especially as he had no real interests…no leisure occupations or anything like that, really he didn't get involved in helping out on the ward or anything.*
> *(Gladys 3, 272-274)*

Gladys needed a starting point for Andy's occupational therapy and going to the community for a meal as a leisure pursuit. Liz learnt of a way of categorising

occupations into self-care, leisure and work from her previous experience working as an occupational therapy assistant in an older people's mental health setting. Liz's sensory work with Claire prompted her to reflect on a practice placement:

> *[…] with a number of very young children as a part of my training at a school in outer urban London and I was involved in particular types of sensory integration work and this had a similar feel to it when I worked alongside [Claire], how she described how she would calm herself.*
> *(Liz 1, 69-75)*

Liz therefore gained knowledge created from her practice placement education that she linked with a later post-registration practice experience in a secure setting:

> *In my previous environment which was a male forensic unit…working with someone with query Korsakoff's dementia [alcohol related illness]…He would become less aroused if he had blankets to wrap himself up in and a darkened room, so if stimulation was removed he was able to regulate and function.*
> *(Liz 5, 37-41)*

Liz combined the two experiences into her current practice context, creating a new knowledge in tandem with her practice with Claire. Liz spoke of gaining knowledge from learning from others' knowledge. She had spoken to a therapist practising in high security with service users with extreme risks, in a highly restricted seclusion environment for many days. There were still occupational participation possibilities:

> *[…] how you then access an occupational life if you are reduced to simply being - the only thing you can do perhaps is fold paper, but you know if someone can fold paper they can be involved in origami…and you start from there.*
> *(Liz 3, 302-304)*

The value of practice experience was that 'it's only experience that makes you the practitioner you are … plus imagination' (Liz 2, 428-429). Indeed, that links to the knowledge that can be created from practice experience. Liz indicated her knowledge developed from practice experiences of Claire's communication style:

> *[…] so and so didn't go downstairs and get me a drink, so and so didn't go and get my locker key, so and so didn't speak to me last night, it's her way of saying I feel anxious and upset at the moment. I can't feel you caring for me…*
> *(Liz 5, 412-414)*

Liz's practice experiences and reflections about Claire provided Liz with a new

knowledge of how to understand what emotions Claire was communicating.

> *[…] and I have learnt that that is a much more effective way of tracking how she can be … this morning she was sitting crying and I came in and she said I've scratched my arms last night…she said the staff wouldn't put me on observations last night they just offered me seclusion. So I said to her do you feel cared for at the moment – 'No'. Okay. 'I feel all upset inside, I don't feel cared for'. Those are the type of conversations which we can have.*
>
> *(Liz 5, 412-426)*

Liz therefore had learnt over time from her practice experiences which gave her a nuanced knowledge about Claire. Using a range of practice experiences as a form of knowledge was different from the requirement to use evidence such as the 'gold standard', but it provided one of various forms of knowledge for use in practice. Indeed practice experience particular to each service user was created through a dialogue with the practitioner about the service users' narrative, discussed next.

4.4.3 Narrative building

The practitioners tried to develop a nuanced view of the service users' occupational participation in relation to their history, to obtain a holistic picture of them. Liz explained how she gained knowledge about narrative from a key text about occupational therapy and narrative:

> *I trained when [the] Mattingly articles came out…So the whole idea of an occupational narrative really seized on me and works for me. What stories people tell themselves about their occupational values and their environments. It's always been for me the way to think about an occupational life and…I am a big MOHO person…so those type of narratives work with that.*
>
> *(Liz 3, 44-48)*

Liz found her pre-registration education provided the impetus for using narrative. Liz provided questions about how she learnt about service users' narratives:

> *So I try as much as possible to think about people with a 360 degree which a narrative helps with. So who are they and who are they related to? And where have they come from and what's their story? And who do they like, what do they do and what did they do before?*
>
> *(Liz 3, 48-50)*

Liz therefore started to contextualise the service user and gain a rounded view of

them and their occupations. She elicited service user and forensic specific narrative:

> *[…] what does the narrative tell me about risk? What does it tell me about interests? What does it tell me about education? What does it tell me about generating a meaningful structure? What does it tell me about her ability to organise, to be productive?*
> *(Liz 2, 379-382)*

Liz sought knowledge of the narrative in the context of the service user's life span:

> *So we need to be really attuned to looking at the environments to see how it impacts on someone's function past, present and for what the future occupational narrative can be.*
> *(Liz 2, 450-455)*

Liz combined what she observed about their occupational participation and the environment concept from MOHO. Narrative linked to environments helped Liz to understand service users:

> *There will always be a narrative leading up to this, usually a generational narrative and that as an occupational therapist when we look at our historical narratives and particularly where MOHO is so useful…because you look to see what the environment was that contributed to the function that you are seeing now.*
> *(Liz 2, 445-449)*

Liz used her practice experiences about many of the women's history of different forms of abuse, perpetrated through family members over generations. She combined that with the environment concept from MOHO to create new knowledge particular to each service user. Liz characterised difficulties with emotions with a narrative from a film:

> *Emotional regulation is almost impossible. The analogy I use for students is to think about…the man eating plant in…Little Shop of Horrors – Audrey [two] who needs to be fed, feed me, feed me now!…and Seymour fed Audrey [two] again and again and again and again and again and again, and she was never sated…*
> *(Liz 4, 523-526)*

This was a powerful image from a narrative that indicated the way an analogy can be useful in explaining some of the service user's experiences from their narratives. Liz underscored the emotional challenges:

[…] people will tell me in a very, very emotionally honest way I am really bored I haven't
seen anyone for 15 minutes…the need, the emotional regulation is very, very fragile.
(Liz 4, 527-529)

Liz's example included how that service user could not generate occupational participation for themselves that may well have also been impacted by the restrictions of the setting. Liz's experience of Claire's emotional responses was that:

Part of her presentation is to become weighed down with guilt and shame effectively
becoming intolerable for her, to become over-stimulated by that and sabotage any
progress for herself.
(Liz 1, 318-321)

Claire's actions in response to her emotions became self-defeating, which was her particular narrative that formed part of Liz's knowledge about her. More of Claire's narrative was provided:

[…] we have discovered is that there is no such thing for this woman as a body and
feelings. They are completely fused. How she experiences the world and how she
experiences her relationship to the world is through her body,
(Liz 1, 168-170)

Such a multifaceted narrative required time and repeated practice experiences for Liz's knowledge to develop. Liz provided powerful descriptions of Claire's narrative:

"I shoved the spoon down my throat because my chest felt so empty and lonely and it
was a way of filling it up and it made me feel better. I was so angry with the Dr because
she had half her body out of the office and half her body in the office and I felt she
wasn't really there for me so I lunged at her hair and squeezed it really hard because
I was so angry".
(Liz 1, 173-177)

Those examples were so particular to Claire, that the only meaningful way to create knowledge about her was from her narrative. Tess tried to understand Zach's narrative from early in his admission:

He was also able to identify that his behaviour is more difficult when he is with certain
peers and so we talked briefly, but it was very brief about what he can do about that.
(Tess 1, 148-149)

Tess had very little of Zach's view about his occupational participation because of

his limited capacity to discuss it. Tess therefore had a limited knowledge about his narrative:

> *He really doesn't seem to be able to concentrate on anything else you know so he won't talk while he is doing it…it doesn't seem to be anti-social because he will just say that was a nice meal wasn't it…now there are questions about his ability to learn so it may be that he has some sort of learning difficulty I just find it very striking that to me it is as if he doesn't see it on the left hand side [of the sink]…and how much of this is illness or some kind of learning problem we don't know, probably a bit of a combination.*
> *(Tess 1, 180-188)*

Tess combined her observations of his occupational participation at any given point with any dialogue with him and knowledge gathered from other sources, to create her knowledge about his current narrative. That was however, challenging because it was more about Tess's narrative as a therapist trying to develop her knowledge, rather than of Zach's narrative. Tess observed that when Zach was asked a question he did not respond, or was slow with his reply, or he demonstrated other actions:

> *I might say have you thought what targets would you like to achieve this week and he'll start picking his nose, but if I say last week you did really well on that shall we, so guide him a little bit more with the target, he won't pick his nose so much…I think it's because he gets nervous.*
> *(Tess 14, 369-384)*

Tess used her practice experiences of Zach and made an interpretation of what emotions prompted his actions. Gladys also had a challenge eliciting a narrative from Andy:

> *Trying to get a bit of a narrative from him about anything to do with himself really whatever he was willing to give to me.*
> *(Gladys 4, 288-289)*

Gladys also tried to understand Andy's narrative and the impact of anxiety:

> *His levels of anxiety are very very high and…even though he has community access leave up until just beyond the local community, he doesn't take advantage of it almost at all and it's quite sporadic, it fluctuates. He at one point was able to go out to the main road…*
> *(Gladys 3, 105-108)*

Gladys reviewed Andy's history of having done some occupational therapy in the community and his current actions of going for more frequent cigarette breaks, to contextualise what could be a possible future for him. This narrative however, like Tess, was that of Gladys an occupational therapist. Over time Gladys could directly ask Andy about his experiences and build his narrative from his dialogue with her:

> *[…] and I was saying what about it was…difficult for you? What was it that you were particularly worried about? It sort of teased out that he was worried about being attacked by this gentleman*
> *(Gladys 8, 143-145)*

Gladys was therefore developing her knowledge about Andy's perspective and his narrative, through brief interviews during the intervention. Liz highlighted service users' narratives particularly linked to a forensic setting:

> *[…] the level of social deprivation and to understand the horrific nature of the offending that the majority of men and women that I have worked with have come [from, and] have perpetrated and to understand the victim-perpetrator split doesn't actually exist in most of the men and women we have, you know it's bundled up into the same person…understanding the great damage that's been done by their offending to others and the trans-generational nature of that.*
> *(Liz 12, 491-497)*

Liz highlighted the multifaceted narrative that helped create the required a nuanced knowledge of each service. Liz's knowledge of a service user's narrative was useful for developing empathy towards them. Narrative for Liz included her understanding of particular diagnoses of personality vulnerabilities and the relationship with the patterns of the service user's occupational participation in the past and the implications for their future occupations. Liz gave an example from a discussion of an incoherent team narrative around risk:

> *We are going to give this woman unescorted ground leave this week in this clinical team meeting because we feel that she is safe and we have worked hard enough. Are we going to give her, her, underwear back because she's at risk at tying ligatures? No, no, we're not going to…she has tied many ligatures in the past. We are going to give this woman unescorted ground leave and the challenge of that environment without her knickers…*

Liz highlighted the inconsistency in the team's knowledge to that point. Her knowledge of occupational therapy and risk taking with service users highlighted

the issue:

> *[…] that kind of incoherence drives me [makes a face] because it doesn't have any*
> *occupational coherence whatsoever…So the narrative is you have worked to think*
> *about many, many, challenges in terms of keeping yourself safe. We are now saying*
> *in that environment where there are lots of challenges, we believe you can keep*
> *yourself safe, yet we don't think you are safe with knicker elastic.*
> *(Liz 3, 65-70)*

The service user's narrative of risk was of working hard to keep herself safe. New risk taking was related to the new plan for the service user to access environments outside of the forensic unit. The team's trust in the service user to take that risk was incoherent because they were happy to give her permission to have unescorted leave to go outside of the unit, but they were not willing to take risks by allowing the service user to have access to her underwear. Therefore Liz helped to highlight the team's incoherent knowledge that was created from the narrative. Gladys considered Andy's future possible narrative:

> *I needed to meet up with him more frequently, if possible, and spend a bit more quite*
> *a lot more I figured it would take a while for [Andy] to feel comfortable with me and to*
> *want to engage in our assessment and intervention process and that I may not be able*
> *to look at anything other than him going for a cigarette with regards to his functional*
> *ability…that might be the only way in I actually have.*
> *(Gladys 4, 359-364)*

Andy's narrative was of his slow progression that formed Gladys's contextualised knowledge about the situation at the current time and how that might impact future practice with Andy. The future narrative needed to incorporate the service user's risks as well as wishes about their occupational therapy:

> *In a risk environment I think coherence is really important in terms of care planning*
> *and for me care plans are about the narrative of rehabilitation, what you call that a*
> *recovery plan, whatever you call it. It's about a coherent narrative that says this is*
> *where I am, this is where I want to be and his is how I am going to get there…my*
> *narrative around it should be directly reflective of what they want…where they want to*
> *be…"*
> *(Liz 3, 73-76)*

Liz indicated a degree of trying to predict future events, however, intervention planning and other cycles of the occupational therapy process could be altered through evaluation of how the service user's narrative unfolded over time. Tess

reflected on what she might have predicted for Zach's future abilities and she said:

> *If you'd have said to me a year ago actually no it'll be fine in a year's time, I think I've*
> *had been like no I really don't think it will be. So I think it's about judging people too*
> *quickly and writing people off. You know just staying positive about people.*
> *(Tess 14, 687-689)*

The ability to understand the service users' narrative was required for developing a nuanced understanding of them, one that encouraged an empathetic view of the extreme actions and emotions displayed by service users. Narrative provided the story of past, present and potential future. The practitioners had difficulties with meeting the practice requirements of using a standardised measure to gather knowledge about the service users and found limitations of MOHO in explaining their circumstances. Therefore the practitioners had to use other methods such as narrative building. This is not to suggest the foregoing methods were mutually exclusive, but narrative creation was the more effective for the practitioners' knowledge gathering with the service users discussed here. Despite the value of understanding the service user's narrative, there were challenges in verbally eliciting this and the practitioners had to create a connection in order to find other ways of building their story, as discussed next.

4.4.3 Connection

Making a connection was the starting point between the practitioners and service users and was required to build rapport and trust. Without the connection between them occupational therapy could not occur and was closely linked with choice. If the service user did not make a choice to connect with the practitioner then no occupational therapy could continue. Working with Leila, Gladys explained:

> *When I first started working with her it was a lot of rapport building really. She was*
> *relatively reluctant to engage with OT as she had quite a packed ward programme a*
> *lot of which was quite, quite, heavy, heavy on the therapies and I think she likes it that*
> *way." (Gladys 1, 56-58)*

Gladys also noted that Leila was reluctant because she seemed suspicious of Gladys. For Gladys to find that connection with Leila she wanted to acknowledge her every time she saw her:

> *A lot of saying hello to her on the ward…just touching base, because she was very*
> *reluctant to meet with me it took a while to get to see her…she would cancel me, or*
> *be too unwell that day - whatever, she actively avoided me. I don't know even how you*
> *would term that there was a lot of going back to let her know I was there to try and*
> *build some sort of relationship just through acknowledging her on the ward.*
> *(Gladys 1, 217-222)*

Gladys demonstrated hope that in the face of regular rejection, her persistence and repeated greetings would start a connection. Tess echoed this in her approach in how her working context required a different way to form a connection:

> *My decision to introduce myself during lunch was just that as we are now ward based*
> *I have lunch on the ward with all the boys, I introduced myself to Zach informally then.*
> *The more formal introduction was done during an individual session on a Friday pm.*
> *As there is no OT room at all now, and we are expected to be on the ward all day. I*
> *often have to take brief opportunities available to me.*
> *(Tess EM3, 79-84)*

Tess noted how she greeted service users on the ward:

> *I greet everyone when I come onto the ward ensuring I use their name.*
> *(Tess EM3, 120-121)*

Basic social greetings were Tess's starting point for connection. Tess clarified a fundamental point about making a connection with anyone:

> *As much as he didn't know me I didn't know him.*
> *(Tess 1, 254-255)*

The forensic setting however, required that risks and symptoms of mental health problems such as levels of suspicion and paranoid ideas had to be incorporated into the practitioners' knowledge. A starting point however, had to be made and a focus on a particular action indicated a readiness for connection:

> *He seemed to be relatively comfortable around me, made eye contact a couple of*
> *times.*
> *(Tess 3, 473)*

Tess therefore looked for cues in service users' actions to move her practice forward. To make a connection, the practitioners' reflected on how to present themselves to their respective service users. Gladys explained she wanted to be gentle, not domineering and not to frighten Leila off. Gladys's practice with Leila

initially was to actively greet her on the ward. Later she stopped and waited to see if Leila changed from her current presentation:

> *I could continue to come back but I wasn't sure how that would affect her mental state or my own safety, or whether at this point where she is starting to come out a bit more whether that might become a bit intrusive for her…so I then felt that I would wait a little bit longer and see how things progressed with her.*
> *(Gladys 3, 404-407)*

Gladys used her existing knowledge to reflect on potential problems with her approach to Leila. This indicated that Gladys tried to predict what might occur and on balance she waited before continuing to offer occupational therapy. Gladys's approach was to greet Leila in a casual way whenever she saw her on the ward. Her plan was to build familiarity with Leila, even though she continued to ignore Gladys. The point Gladys aimed for was to have a few minutes where Leila would talk with her. Gladys persisted with trying to initiate a connection whenever she saw Leila as there were no other ways to do this than for Gladys to hope for a change in Leila's choices.

In the early stages of Claire's admission, she told Liz of her index offence:

> *[…] anxiety on her part…in terms of are you going to accept me, reject me, work with me.*
> *(Liz 6, 431-432).*

Liz had to interpret what this could mean for their developing therapeutic relationship. Liz stated how the therapeutic relationship started:

> *The first point of engagement is building rapport and it was with this woman as well and we had a conversation about how…scared she was that as an occupational therapist I was going to think she was a really bad person due to her offence...*
> *(Liz 1, 313-326)*

From the earliest cycle of the process Liz expected to start to build rapport with Claire. Claire's anxiety about how they could work together created a new practice context for Liz who had to reflect on the situation as it started to form new knowledge. Liz created a way of working with Claire using her developing knowledge:

> *[…] it was important that we had a mutual or neutral approach to her, including myself…this is the way forward, so in this environment this is what you want me to do, if you want to go to the*

atrium, these are the assessments…so not matter of fact, but because she was so pre-occupied with this offence just making sure that we were…very grounded and very matter of fact and therapeutic rapport was built up, not without due consideration of the very serious offence but not letting it over shadow the whole process.
(Liz 1, 321-327)

Liz and Claire started to create a relational context where they acknowledged the risks from the earliest point of their connection. These formed the initial parts of Liz's new knowledge about Claire. Leila also presented with a multifaceted history and current experience of high anxiety and neck pain that linked to a clear team experience and history that formed a new knowledge. Gladys believed the team to be inured to Leila's pain, despite requesting and waiting for further health tests. Gladys found the team's knowledge almost a stumbling block to how she could develop her knowledge about Leila. Gladys tried to push past that block:

[…] I didn't not want to take her seriously and that if that was the case, rather than go is that really stopping you going? Okay if that's what you think is stopping you, how do we change it? And go with a much more sort of pro-active approach, which in a way she couldn't kind of get around…
(Gladys IV 1, 471-474)

Gladys therefore wanted to assess Leila's neck pain and if there was a problem. Leila still refused Gladys's offer of help:

[…] 'well no I don't want to get anything to make it any easier'…which possibly was more likely to do with anxiety and fear, than to do with pain…but then we weren't really that sure either how much of the pain was to do with the anxiety, it's sort of chicken and egg.
(Gladys IV 1, 469-478)

Gladys was left with a developing knowledge that had gaps because she still could not engage Leila in the occupational therapy process for either her mental or physical health. Gladys actively searched for a way to connect with Leila that meant informing Leila of ways to help with her neck pain:

[…] perhaps I can look at her room environment and see if there are ways of helping to move things around so that she's not having to do looking up, or another way to do it as it turns out her [condition] to see if there is anything I could do for her physically…
(Gladys 1, 441-444)

Gladys therefore provided Leila with a clear view of what could be done. Gladys identified something that was important to Leila that led to a therapeutic connection:

[…] that was important to her at that point…and because the team were reluctant for me to get involved with regards intense OT work at that point they were quite happy for me to do the physical work with her and I could do that in a bit of a non-threatening manner and it was what she wanted to do and I could get to know her a bit better and find out a bit more.
(Gladys 1, 524-528)

Gladys's example seemed almost serendipitous for her to use as a start for her connection with Leila, but it demonstrated the emerging nature of practice over time. Gladys also used her practice experience from an older people's physical health care setting in a different setting of mental health, thus creating a new knowledge and context for providing occupational therapy for Leila's neck pain and high anxiety. Gladys was also able to use her occupational therapy skills in a way that allowed her to acknowledge the team's existing knowledge, but to create a new team practice context and knowledge about Leila. Gladys could have been in a position where she followed the team's knowledge, but she had skills that she could use to help Leila for one need, but which could also act as a doorway to other work relevant to her mental health needs.

In summary, occupational therapy practice involved working with service users' particular multifaceted needs. The above examples were about the earliest cycles of the occupational therapy process of the practitioners' practice; the purpose of which was to find a connection before any rapport and trust building could take place. Indeed, the expectation was that the practitioners would build rapport and trust with service users to move the occupational therapy process forward. The need of practitioners however, to find a connection first and to be creative in their practice, in the moment, did not fit with an evidence based approach, but was required in order to work with the service users.

Developing the therapeutic relationship

The persistence of the practitioners to make a connection was a way of demonstrating to the service users that they could be trusted. The practitioners' implicit message was that it was worth the service user investing time and trust in a therapeutic relationship with them. Once the therapeutic relationship had developed, Gladys actively sought to maintain the relationship and build rapport,

using this to increase Andy's confidence in his occupational participation. Accordingly she:

> *[..] asked about how he was feeling when he was out there, there was a lot of observational stuff and low level, very informal interviewing really, using quite a lot of empathy and checking in with him very frequently about how he felt about being there and whether he was still okay to be there…to try and build rapport and also a little bit of trust in me. If at the point things became difficult for him it's okay, we don't have to talk about it anymore or it's okay we can go back in if that's what you'd like to do.*
> *(Gladys 4, 292-297)*

This was a compassionate practice, by which Gladys helped Andy to be able to go outside of the ward and become less anxious in doing so. Gladys showed awareness of Andy's feelings, what motivated him, his mental state, and the social environment. She created new knowledge that developed into new intervention plans to facilitate Andy's occupational participation. Liz noted how service users' progress could alter swiftly:

> *The women we work with…the point of engagement can turn on a coin.*
> *(Liz 2, 172-173)*

Such swift changes impacted their relationship. Trust was therefore important between service users and the practitioners in order to withstand such changes, highlighted next.

4.4.4 Trust

The therapeutic relationship built trust and for that to occur a dialogue was required between the practitioners and service users about the occupational therapy process. Indeed, for service users like Andy and Leila that was in combination with Gladys's gently persistent attempt at connection. Tess reinforced the trust by reminding the service users of their working relationship to that point, in order to set boundaries and expectations with the boys when using sharp objects:

> *[…] we are going to use knives in this session and some of them are quite big knives and you are not gonna be threatening me, because I know that I always sort of say something like [that], because you've always been really good with me and I know that you are not really that [way] sometimes you shout...and that's not you.*
> *(Tess 14, 174-179)*

That way of working was created though Tess's practice, forming her knowledge about ways to prepare the adolescents for risk-taking. Developing trust between them was also about respect:

> *One of the words that they all say respect, respect man...they can't bear it if they feel if your patronising or disrespecting them, but respect isn't just about this 'oi respect man'...it's literally about are you gonna treat me like an adult? Are you gonna be open with me? Are you gonna judge me? They all really feel it despite their big images*
> *(Tess 14, 155-159)*

The adolescents used the term respect, which came from that particular age group in that practice context. Tess included it in her knowledge of how to communicate her trust to them. Indeed, Tess tried to show the adolescents they could be trusted:

> *[…] a lot of it is about being told off all their lives and not being given any responsibility and just feeling like they can't rise to any[thing] and I think by doing that you are showing them respect because you are saying I respect you enough, I trust you enough, to go and do this for me, and you are not gonna run away and spend that money.*
> *(Tess 14, 155-164)*

Tess used her knowledge to provide interventions that showed a different way that the adolescents could be given responsibility, and the message that they were respected. Tess took a risk with the therapeutic relationship and the therapeutic challenge when an intervention may not work or may fail. Time was one requirement for developing trust:

> *Staff are given a lot of time to spend with clients to build up rapport and trust and things like getting to know them better because they're a client group that have such low levels of motivation…and self-efficacy.*
> *(Gladys 3, 46-48)*

Gladys's experience was particular to slow stream rehabilitation. Her new knowledge created a practice context with the service users where she required a lot more time to build trust than she had previously experienced. Andy trusted Gladys and subsequently told her more about his fears:

> *[…] he will ask me about things that he's not sure of as to whether or potentially how real they are...or seeking reassurance as to whether or not things could be threatening as things are very threatening for him especially around other people...*
> *(Gladys 8, 134-138)*

The therapeutic relationship between Gladys and Andy had therefore developed to a degree that Andy felt more comfortable. Gladys was able to develop her knowledge through their dialogue during interventions, developing the practice context:

> *[…] what about it was it difficult for you? What was it that you were particularly worried about? I sort of teased out that he was worried about being attacked by this gentleman and then...*
> (Gladys 8, 145-147)

A phase of the occupational therapy process therefore occurred. Gladys evaluated what was happening during Andy's intervention and consequently she used interviewing to further assess and developing the intervention in the moment:

> *[…] challenging those thoughts and thinking about why else the man might have been staring at him and what the other options that in order for it not to sort of spiral too much...into catastrophising...things around his anxiety, he could have been staring at you because he wasn't wearing his glasses, and he was squinting and trying to work out who you were, perhaps he thought he knew you, or perhaps he was just thinking.*
> (Gladys 8, 134-145)

Gladys could continue the intervention in that way because she had gathered knowledge about Andy's fears and how he could perceive other's actions as something to be feared. That was an example of how the practitioners judged the right time to start their feedback and gain the service user's perspective in their joint evaluation about the service user's participation. The practitioner also had to judge when and to what extent they could discuss the service user's difficulties and challenging actions, discussed in more detail later. The service users needed to trust the practitioner that they would be supportive and compassionate, but fair and honest, which was related to the rapport between them, considered next.

4.4.5 Rapport

Making a connection was the beginning of rapport development that built into a meaningful therapeutic relationship. Andy sought reassurance from Gladys after he had been verbally abused by a female service user in the hospital grounds and hadn't spoken to anyone about it for two days:

I came again to go out for a cigarette and…quite surprisingly confided in me what happened which I found quite unusual because I was a new member of the team and he doesn't tend to trust females particularly and up until that point had shown no real desire to want to engage with me and so I took that opportunity because I know this service user very well I used to work with her.
(Gladys 3, 167-172)

The extent of Gladys and Andy's rapport and therapeutic relationship was not apparent until he initiated a dialogue about his experience. The situation was a new practice context that developed during a planned intervention from Gladys's current knowledge. From the unexpected nature of the situation Gladys, used a phase of the process, subsequently creating new knowledge that was used for intervention in the moment:

I offered him some empathy, if you do want to go out you can come with me now if you like, we can go now, I'll be there, I know exactly what she's like and we'll be able to bat her away a little bit…so you can have your cigarette in peace and to reassure him that actually in all the time I have known her here I have never known her to be physically aggressive. Just general reassurance, but truthful reassurance, rather than just don't worry it'll be fine. I know that in reality physically she is not going to threaten that's what he was worried about.
(Gladys 3, 176-182)

Gladys had prior knowledge from working with the female service user and she was able to incorporate that into her intervention with Andy. That kind of practice context could not be predicted or planned for ahead of it happening. She therefore had to practise in the moment. Gladys combined both her prior and new knowledge with a compassionate response to Andy. That provided him with enough trust in Gladys to agree to start the community graded exposure intervention. That example sounded almost serendipitous. It was important however, not to underestimate how Andy's perception of Gladys had developed up to that point. The question here was how and to what extent it had developed, of which Gladys was unsure. What was also apparent was how Gladys communicated with and attempted to be empathetic towards Andy, giving an indication of her personal values, illustrated next.

4.5.6 Empathy

The blend of the personal and professional for the practitioners was a key feature

of their practice and formed part of their empathetic approach to such a challenging practice setting. Empathy was required for the practitioners to see the service users' perspective and was created from their narrative. Empathy was part of creating a compassionate response to service users, which at times could fail, and needed the practitioners' reflection in the moment to monitor and moderate their empathic responses. Liz described empathy:

> *[…] I think we are born to be empathic…we are born to attach to each other...if we think about what empathy is it's kind of the ability to see the other's perspective…you know, see, like, move towards, be gentle about…*
> *(Liz 12, 512-519)*

Liz linked her knowledge of empathy to attachment theory. Gladys echoed Liz's view that if you could not empathise how could you understand service users and what they were experiencing? Gladys had difficulties developing empathy when she first started working in secure settings:

> *[…] if they had been violent toward someone or had committed some gruesome murder…or had been predatory towards other people…It was difficult for me to maybe separate it, or maybe see them as the same person. Initially I really found it hard not to just see…the index offence and history.*
> *(Gladys 7, 18-23)*

The extreme crimes prevented Gladys from seeing the human. Gladys's empathy developed by contextualising Andy's previous life and growing up. Gladys also considered Andy's index offence where he felt very frightened because he thought he was going to be attacked. She found an empathy about his actions in that people could do anything to defend them self. Gladys described how she developed empathy in the women's service:

> *[…] stories are so harrowing about people's backgrounds…I developed empathy…because what had led [to] these women's histories were just so awful. The abuse they'd been through was really awful and you wondered how their lives could've turned out any differently.*
> *(Gladys 7, 25-29)*

Hearing the narrative of abuse and survival helped Gladys to empathise. Liz also linked the service user's narrative to understand their past, with empathy to build a therapeutic relationship. Liz did not think building empathy was a skill, but:

> *[…] understanding it, where it comes from, why it goes and when it fails, I think is a*

skill…
(Liz 12, 511-512)

Liz recognised empathy could fail. She highlighted the inherent uncertainty of practice:

> *There is a pagan saying never name the well that you may have to drink from…it's the idea you don't know where you may need to go for your work, what you may be confronted with and what you may feel about that and what you may have to engage with…so say I will never, this never happens to me - it's just not possible in this work. You don't know where your empathy will fail…or certainly be challenged…So it's important I think.*
> *(Liz 12, 461-470)*

Liz implied practice could occur in the moment when the practitioner was uncertain due to lack of knowledge and an unfamiliar practice context that could unfold at such times. Tess described how her practice with Zach, over time, changed her view about him "I've found myself a year later not judging him quite so harshly." (Tess 14,698). A challenge to empathy was how it was needed for women's sensory experiences of self-harm:

> *I've met women who will speak about cutting and cutting to produce a sensory, produce kind of like a physiological reaction which is soothing, either from the blood flow, or pain, or sight, taste sometimes.*
> *(Liz 6, 196-198)*

Such a challenging experience for workers was not particular to forensic settings, but in Liz's practice setting specifically for women service users, there was the potential for many women to engage in those actions. Those practice experiences could be emotionally challenging, considered in the next section.

4.5.7 The occupational therapists' emotions in practice

The practitioners' emotional responses to what service users experienced was also a knowledge that the practitioners used in their practice. The practitioners' emotional responses to their service users were used as an indicator by the practitioners that they need to review their values and beliefs about both the situation and the service user. Despite the professional context, the practitioners were still human beings and would therefore experience emotional responses to the particular situations in which they found themselves. The following was Tess's

emotional response to Zach when she first met him:

> *I was unsure about him due to nature of the crime, and in addition at times he stared*
> *at staff, people were unsure if this was intentional or poor mental health. I was a little*
> *nervous, not that I would be hit but the fact that no one knew him well and he was*
> *interacting minimally.*
> *(Tess EM3, 94-99)*

There were knowledge gaps in those early knowledge gathering cycles. Liz considered the skill requirements for working with multifaceted service user needs:

> *[…] in this trust with person-centred planning it is a belief that is a basic skill and that*
> *you should just be able to get on with people…I actually think that is wrong I think to*
> *be able to understand some [of] the complex personality structure that come alongside*
> *severe and enduring trauma you need a very good sense of yourself and a very good*
> *sense of the other and what can be elicited within you is very good way of working out*
> *what is going on…*
> *(Liz 2, 417-422)*

Liz's knowledge told her that client-centred work required going beyond everyday communication skills. She highlighted ways to do that:

> *[…] transference is a useful tool for the multi-disciplinary team, whatever discipline, to*
> *try and work what is being communicated…and I think that takes time to develop…and*
> *reflection and process with and training…*
> *(Liz 2, 417-426)*

Communication and client-centred practice therefore required knowledge development from practice experiences and technical rational sources. Tess had an intense response to reading Zach's notes before meeting him:

> *When I first read about this client I was like that's horrific and it's happened to me so*
> *many times…where I've gone Oh my god. In [hospital named] particularly but his is*
> *probably the most serious crime we've got…*
> *(Tess 14, 694-698)*

Tess's immediate response to Zach's index offence was in a context of it being particularly serious. She became less anxious at being attacked and about inappropriate comments being made as her familiarity with Zach increased. He stared at everyone less and was generally polite and all staff felt more able to question him about his actions. Gladys explained the anxiety that could be provoked within both herself and the staff team by Leila:

[…] she projects quite a lot of anxiety onto you so working with her is quite anxiety provoking as well that also came up in reflective practice actually, because we spoke about her so much and there was a lot of talk around how other people felt anxious working with her.
(Gladys 1, 191-194)

Gladys's experience in working with Leila was to become too emotionally enmeshed with her:

I found working with [Leila] incredibly challenging and had quite an impact on me outside of work and actually talking about it as well in the context of these meetings…it was quite hard actually, not hard in like I couldn't deal with it, it was quite emotional and felt tied in. A little bit too enmeshed…in the way I felt with this woman.
(Gladys 4, 102-107)

Gladys's experience highlighted the human qualities she had and how they impacted her professional context and role. Paying attention to how the therapist feels in response to the service user was highlighted by Liz:

Listening and thinking about what you are feeling when you are alongside people because there are clear communications about safety, coherence, about anger, sadness, envy…
(Liz 12, 237-241)

Liz actively used her feelings about service users as a form of communication. Knowledge used for practice was therefore also about how the practitioner felt in response to working with service users:

For me it's not you know in terms of people's criminogenic pasts…I'm kind of more interested about how I feel about them when I'm in the kitchen with them. Do I have a sense of threat, fear, challenge, sadness, disbelief. You know, what's going on?
(Liz 12, 243-246)

Knowledge was not just reading sources and listening about service users' histories and risks, but listening to feelings evoked by them. Emotional responses were not just about the challenging or frightening aspects of service users and their actions. Emotions were also conveyed by the Gladys's surprise in the earlier stages of her work with Andy when she realised his plan to go into the community was a specific interest and not as she had thought, an arbitrary place to go to. Liz explained how she felt at a loss at the start of her work with Claire:

When she came I can remember feeling at a complete loss…this was a woman who swallowed things, tied things, stabbed women, stabbed men, attacked women, attacked men, attacked when she was on observations, attacked when she wasn't on observations
(Liz 2, 98-100)

Liz felt challenged by Claire's history at the earliest cycles of the process. Liz identified Claire's interests and values:

[…] grandmother on the phone, writing to her daughter who she has contact with, looking at photographs, scrapbooking, but equally these tasks and these environments could over-stimulate her and provoke a dis-regulation as well. So the thing that we have got today which would calm me, is the thing that tomorrow would lead me to throw or hit or pull…or punch…
(Liz 2, 108-113)

Liz found that a test of her was how interventions to uphold Claire's interests and values could be a benefit and a liability. The practice context was unpredictable and Liz used a combination of risk management plans and practice occurring in the moment to manage that. Those comments suggested an identity as an occupational therapist that was not separate from being a human, with anxiety and other emotional responses to the service users' criminal offences. Those kinds of issues impacted the practitioners' identity as occupational therapists in the forensic setting, highlighted next.

4.5.8 Occupational therapy is not fluffy: The identity of occupational therapists working in forensic mental health

The practitioners all commented on the ways they explored and had discussions with their service users about their challenging actions. Such discussions included looking at committing crimes, the related risks and what impact that could have on future occupational participation. Occupational therapy therefore focussed not only on occupational participation such as self-care, work and leisure pursuits, but also on anti-social activities. Liz said occupational therapists needed to consider such activities in their practice:

I think criminogenic occupations are something that we are almost scared to talk about,

in the process of not being fluffy. Occupational therapy isn't fluffy. It annoys me…sometimes we are honest and robust and that's not nice sometimes. We are not the good guys, we are the people that will hopefully have robust conversations about engagement and challenges that service users will face in environments given the forensic histories that they've got. (Liz 6, 339-344)

Liz used the term criminogenic occupations to conceptualise how crimes could be seen as occupations. She therefore incorporated a way of seeing crimes in a way that justified that she could explore them further with her service users. Liz gave an example of substance misuse:

[…] if someone is a user someone is a drug or alcohol user to the extent that it impacts on their ability to function, there are very robust, real conversations we need to have with people. If you are not going to use drugs, how do you see yourself being able to generate activity for yourself to fill your time?
(Liz 6, 346-356)

Liz highlighted that if a service user was going to stop engaging in all of what was entailed in obtaining and misusing illegal substances, they needed to explore alternative options of time use. This appears simplistic, but it had to be explored and the practitioners were the people to do so. Liz explained how she explored crimes as a form of occupation:

[…] so that we've got a real sense of what they mean, what criminogenic occupations do for them, and the fact that there is going to be a time they are going to need to resource themselves with...
(Liz 6, 363-383)

Liz focussed on the meaning of engaging in criminal activities for the service user. She also considered how they compared with other occupational forms:

[…] if you are not going to be involved in acquisitive crime, what [do] you choose, what [do] you want? What…if you are also going to be involved in a kind of straightforward world of work?
(Liz 6, 363-383)

Liz therefore questioned the service users' understanding of how and in what ways they were changing their occupation choices. She gave an example of the intricacy of her practice:

I had a conversation with a service user and told me that if he got a job, with a wage, he would be the first member of his family for three generations to pay tax and national

insurance. So there are lots of issues in terms of criminogenic occupations and because there are values tied up in them as well...because this was the same service user who told me his father was a fucking idiot for paying tax and national insurance.
(Liz 6, 363-383)

Liz therefore saw the service users' plans were at odds with his values expressed in his comments about the established family cultural values. Liz's knowledge was created from having a dialogue with service users to explore their experience of engaging in criminal acts and the implications for their future occupations. Tess also challenged Zach when he stared at her:

Having those quite honest conversations, even though he's not very bright, but being able to say why are you looking at my chest?...How's that making me feel? And just getting those responses.
(Tess 14, 628-631)

Tess discussed how she challenged Zach's actions towards her and her response combined with their therapeutic relationship to that point, which also required a response at the time of the event. Service users' plans could require guidance to modify them once they had been given the opportunity to make their suggestions, for example with Gladys and Andy:

We sat down in a private room and made a plan he was...I felt at that stage, a bit unrealistic about the first stage, so for example I would say what do you think would be the first thing? And he would say 'ah perhaps going to the patient bank'. I am very aware that he hasn't been out that far for a number of months or weeks at least.
(Gladys 3, 203-206)

Gladys's view about what Andy could achieve was different to his. She had knowledge of his previous participation and she compared this to his current suggestion. Gladys acted in the moment to suggest a more realistic plan:

So I tried to rein, grade it backwards a little bit and start with 'well let's just sit on the ward together for 15 minutes', so we wrote up a plan of 10 weeks of very gentle graded exposure...
(Gladys 3, 206-208)

Gladys was firm but gentle in her suggestions and she used her core skill of grading the activity. From that point they had an intervention plan to work towards:

[...] the first couple of times I went to go to ask him if he was ready to start he said no. Then I said we are definitely going to be starting next week and so I need you to be

ready and I'll come and warn you the day before and I'll let you know [in] the morning
if those are the things that helps and he said okay.
(Gladys 3, 208-212)

Andy could not carry out the plan, so Gladys again had to modify it to move beyond his anxiety and reluctance. She delayed the plan and built in ways to better prepare him the day before and the following morning leading up to the intervention. She again was firm but compassionate in her approach. Gladys used her knowledge gathered from the team and clinical notes, which was combined with her existing knowledge about Andy. She created new knowledge at each contact with him because he changed the practice context slightly. She used a mixture of trying to remain focussed on the plan, but also be flexible for Andy to add what he felt he needed to help him. Each of Andy's attempts to change the plan added to each new practice context and consequently developed her knowledge of how to work with him. Tess's approach was to be clear about approaching therapeutic situations when using knives:

> *"I think it's okay to...ask, be very direct and say...do you feel safe with? Will you do*
> *this? And can you do? Are you all right with knives?... asking them about whether we*
> *can use a knife in a session or whether they feel safe with me. I think that's just in*
> *general it's something that...I like to do, I like to put the responsibility onto them…"*
> *(Tess 14, 18-26)*

Tess was preparing the service user for occupational participation and the link with that and risk. She was engaging them in thinking about their risks, an approach that she had gained from her practice experience that had become her knowledge, which she used with those interventions.

The practitioners therefore had to combine an approach that explicitly considered the service users' risks and the practitioners' knowledge that included what they knew about maintaining a therapeutic relationship and being empathetic. The practitioners needed to respond swiftly in fast changing therapeutic situations that were inherently uncertain. Therefore, interventions had to be modified in the moment, which would deviate from the way intervention guidelines and protocols would be expected to be used. One of the opportunities for exploring practitioners' experiences was reflection, highlighted next.

4.5.10 Reflection

Reflection in the findings is split into two parts that consist firstly, of how the practitioners used it in their practice and secondly, their reflections on the influences on their practice during the course of the research. Liz valued time to think about her practice:

> *What's happening to the NHS at the moment is the belief that thinking is a waste of money. Thinking is crucial, and so the more time there is to think…*
> *(Liz 12, 640-641)*

Liz believed a wider context had an impact on the value placed in reflection, which indicated how reflection was not seen as a valid form of knowledge creation. Gladys echoed that:

> *You don't often get…necessarily as much thinking time as that…you just find yourself kind of doing, doing and then having moments to think, consolidate your thoughts and then go back to…doing …*
> *(Gladys 8, 450-452)*

Gladys separated her doing from her thinking, but this was about her face to face practice with service users and then needing time to reflect on what she had done. Both were parts of occupational therapy practice. Tess indicated the team reflective meetings and how they reflected that:

> *"It's not just my journey, I think it's the whole teams' journey."*
> *(Tess 14, 636).*

She highlighted the social nature of practice. Liz implied she used Freud's concept of the evenly hovering attention as a form of reflection in the situation:

> *[…] to ourselves in the occupational therapy encounter is essential, it's a kind of checking with yourself and where you are…*
> *(Liz 12, 470-471)*

Liz's comment suggested being reflective and acting in the moment of the therapeutic situation for the impact upon the therapist and the service user.

The findings suggested that there was less time for reflection in general, but there was also a culture of minimal supervision about practice for senior staff from band

six and beyond. Liz noted more experienced occupational therapists did not discuss service users in any depth:

> *The lack of clinical supervision…at this grade…and at this time...the band seven knows what [to] do and off you go then…So my clinical supervision is more about managing…service development, service issues, rather than the case analysis that you would have done perhaps as a basic grade…*
> *(Liz 4, 428-432)*

Gladys identified how the importance of reflection was denuded as the practitioner became more experienced:

> *You get some in-depth supervision at band five level and band six it's oh you're a band six you don't need this anymore. It's really helpful just more sign-posting…at this stage …and also…there's always in any job, the risk of…getting a bit…used to the way that you do things and continuing to do them in that way.*
> *(Gladys 8, 475-480)*

The implications were that practice could become habitual and routine without reflection. The impact would be to not see the service user's individual circumstances and develop or source new knowledge to meet their specific occupational participation constraints. The practitioners valued having time to reflect and review their practice, but there were limitations to that. The research therefore offered them an opportunity to reflect in depth, in a way not done for some time. In the next section they provide their perspectives on the place of the research in their practice with the service users.

Reflection on the research experience and how it influenced the practitioners' practice

Gladys spoke of the way her participation in the research could be used for any therapist:

> *I think this would be really helpful at any level…and it's nice to be, to have someone to ask you questions well why did you?...so that you can then [think], well I don't know, why did I do that? I don't know, is that what I should be doing? And…work it out that way rather than just do it because it's habit of the way that you formulate cases.*
> *(Gladys 8, 477-484)*

The research therefore represented an in-depth form of reflection on Gladys's

practice. Tess echoed that as participating in the research led to reflecting more on Zach than she usually would. Liz also valued the opportunities offered by the research:

> *[…] to have an opportunity to think like this, I think has supported the work, because it's meant that I have been much more mindful about when an intervention's worked, whether it hasn't, what was my reasoning for doing this? Where is the evidence base? Had I thought about it? (Liz 12, 640-646)*

Liz found that she could reflect in depth on how she used evidence, her reasons for practicing in the ways she did and to evaluate the effectiveness of her practice. Indeed she found:

> *That opportunity to kind of analyse…the more I think about the work it makes the work stronger and more robust.*
> *(Liz 12, 646-648)*

All the practitioners experienced the research as a way to reflect deeply on their practice with a service user. Gladys was also reassured about her practice:

> *[…] it's not necessarily based on an approach, it's based on my experience and therapeutic use of self and…that's fine and it's not, not enough….*
> *(Gladys 8, 437-439)*

Gladys found that she did not have to use an existing theory or approach. She used her practice experiences and ways of working as a form of evidence, which implied she saw her practice as a form of knowledge.

In summary, the category of blending the personal and professional combined the human and humane qualities of the practitioner, with the art and science taken from previous practice experiences. A range of knowledge was combined with practice experiences and human qualities, such as empathy and emotional responses. The practitioners indicated the limited opportunities to reflect and think in depth about their practice. They showed however, their need to reflect on their human responses to the service users' index offence and other actions in relation to the professional expectations and context. Each practitioner's identity as an occupational therapist and their internalisation of a stereotype of their role was changed by the forensic mental health setting. They had to explore the implications of service users' occupational participation and how that related to their criminal

activities in the past, present and future. The practitioners therefore listened and explored the service users' narratives to develop knowledge about the service users and their actions. The practitioners were then able to develop a nuanced view that facilitated a humane empathic response towards the service users.

5. DISCUSSION

This chapter is organised in the following way; firstly I provide an overview of the motivation behind my research; secondly I discuss what my findings say about the implications of practice epistemology for occupational therapy; next I consider the limitations of my research and finally a conclusion and review of the research aims with an outline of some possible directions for future research.

Overview of the research topic

There were expectations upon occupational therapists to see research as the evidence based for their practice (COT, 2015). There were expectations upon occupational therapists to be evidence based in their practice (COT, 2015). They were directed to use research as the profession's evidence base (COT, 2015). That however, meant that other forms of knowledge were not included for use in the evidence base and thus for practice. The limited research about occupational therapists' practice knowledge therefore means that there was limited research about practice knowledge for use in practice.

A consequence was that occupational therapists' knowledge derived from practice was not acknowledged as a valid form of knowledge in itself, when compared to the methodologies used for the 'gold standard'. During my reading I became aware of an assumption that there was only one 'gold standard', which implied there was one form of knowledge available for evidence based practice that reified the gold standard over all other research methodologies (Whiteford, 2005). The term 'evidence based' practice implies that practice could only be informed by one source of knowledge, the technical rational, that was external to the therapist, seen as the received view and Cartesian separation between doing and thinking (Cook and Wagenaar, 2012). Evidence therefore was seen as being 'applied to' practice and not generated 'from' practice. This ignored the possibility of other forms of knowledge being generated from and available for practice.

Practice epistemology (knowledge), is concerned with the way in which knowledge was created from practice, what aspects of this knowledge were accepted in occupational therapy and how such knowledge was used (Mitchell, 2013). My

research sought to explore the ways a practice epistemology could describe and explain knowledge created from and used in the practice of occupational therapy in forensic settings.

My research aims that I will address in my discussion include how a practice epistemology can inform the practice of occupational therapy in forensic mental health and what the discipline's literature can contribute to the topic. Also to explore how practitioners use theory and its relationship with knowledge. As well as to consider the conditions and ways by which therapists used practice to create knowledge. Also any variations in a range of forensic clinical specialties is also addressed.

Key findings

Here, I provide an overview of my most pertinent findings that I discuss in more depth in the remainder of the chapter.

Occupational therapy practice in forensic mental health was enacted with additional features of the occupational therapy process including blanket referral management, risk assessment, risk management and risk taking. The occupational therapy process was used as a structure for practice. Each cycle of the process however, was not a base or a foundation for practice because each cycle was performed simultaneously. There were a range of expectations, locally, nationally and disciplinary that had to be met in practice. For example using MOHO and MOHOST, which were seen as part of evidence based practice required in order to carry out cycles of the process. Such expectations gave the impression that practice occurred in stable conditions.

There were however, uncertain practice conditions, where service users did not match the practitioners' expectations and required a different way of working. Also the therapists experienced knowledge gaps for which there was no evidence base, or where there were limitations in the knowledge sources, such as theory, available to them. They needed to engage in a practice that questioned the situation and what they knew and didn't know, in order to bridge the knowledge gaps. Thus a new knowledge was developed from practice if the technical rational knowledge (Schön, 1991), or previous practice experiences could not meet their practice

requirements, or indeed, if such knowledge was not available. Occupational therapists used various sources of knowledge in their practice, including practice experiences and their reflections about those experiences; often the ones with an approach that required action at a particular point not previously planned for. Occupational therapy in forensic mental health was therefore not based on just one research methodology for creating knowledge for evidence.

The other process, meeting expectations, managing uncertain and new practice situations, and reflection on and in practice were combined to create new practice knowledge and a new practice context. Consequently practice was a form of knowledge. Furthermore, practice epistemology provided a language to understand in what ways occupational therapy practice in forensic mental health could create a form of knowledge.

An overview of conceptualisations of practice

Up to this point I have used the term practice without a recap of its meaning. Practice in health-care was a blend of artistry, science, craftsmanship and compassion (Higgs, Titchen and Neville, 2001), which summarised a multifaceted array of related actions. A range of perspectives about practice, its characteristics and dimensions therefore is required. To summarise here, practice is a combination of human agency, collaboration between workers and embodied acts that have a history, (Cook and Wagenaar, 2012), and develop over time (Beeston and Higgs, 2001). Practice is carried out in conditions of uncertainty and complexity (Eraut, 1994), in a context that could be dynamic (Beeston and Higgs, 2001), swift and fleeting, and therefore had an unplanned, improvisational quality (Cook and Wagenaar, 2012). There was an intuitive and tacit dimension too (Fish, 1998; Fish and Coles, 1998). Practice therefore cannot be pre-planned or fully prepared for (Cook and Wagenaar, 2012). This summary suggests that it is clear that practice was not purely a matter of applying knowledge in order for practice to occur, however, how this related to occupational therapists' practice in forensic mental health is to be clarified over this chapter.

I organise the discussion according to four questions:

- The first question considers what did the practitioners actually do in their practice?

- The second question asks what were the practitioners expected to do in their practice?

- The third question looks at how did the practitioners use and create their practice knowledge to bridge the gaps left by limited available evidence and codified knowledge from the discipline's literature for practice?

- The fourth and final question pertains to what new knowledge comes from my findings, particularly what practice epistemology can add to occupational therapy practice?

5.1 WHAT DID THE PRACTITIONERS ACTUALLY DO?

The actual practice of occupational therapy refers to a combination of two components. The practitioners used their previous practice experiences and their creation of new ways of practice when the existing knowledge sources did not meet their current requirements. In these latter situations the practitioners created new knowledge from their practice, however they were not aware that they were doing this. In effect they probably categorised these as practice experiences and did not see the importance of them as a form of knowledge. I now discuss examples of the practitioners' actual practice in relation to the codified sources, the first is blanket referral.

Blanket referral: access to service users

The blanket referral approach is a simple title for a practice and knowledge that the practitioners developed through their enactment of its various facets. The codified work on this type of referral provided very little detail or nuance of occupational therapy practice from physical health practice in HIV (Cusack, 1990), stroke (Fletcher-Smith et al, 2014; Shah, 1998), terminally ill care (Holland, 1984) and older people (Sainty, 1990). Indeed, there were few papers discussing blanket referral from in-patient mental health (Polimeni-Walker, Wilson, Jewers, 1992), with just one about the wider implications of blanket referral (Harrison and Hong, 2002). Indeed there was a lack of explanation about blanket referral practice in the codified disciplinary sources, for example in an international edited mental health text book by Creek (2014) and forensic specific edited publication from Couldrick and Aldred (2003). The practitioners therefore had no option but to develop their knowledge through their practice.

Practice was facilitated by the blanket referral of service users to therapists, upon their admission to the respective service. Blanket referral has been described as the point where all newly admitted service users were assessed by an occupational therapist (Cronin-Davis, 2006; Polimeni-Walker, Wilson, Jewers, 1992). Indeed, historically, an early code of conduct stated that medical clinicians needed to be aware if a blanket referral approach was in operation (British Association of Occupational Therapists (BAOT), 1990). A key finding from my research was that

the blanket referral was not a straightforward application of a referral mechanism that then led to other parts of the occupational therapy process. The blanket referral was one specific aspect of the process that was not explored in any depth in the literature on referral. Indeed the practitioner's work setting and team practices created differences in the how the referral was enacted.

All three practitioners provided examples of where blanket referral was different to each other. Gladys's experience in slow stream rehabilitation was that referrals could also be made specifically by the psychiatric consultant (Freeman, 1982) and the multi-disciplinary team (Lloyd, 1988). In addition to the direct referrals, Gladys considered all the other service users on the ward as blanket referrals in order to be sure of their histories to prevent re-traumatising them through her lack of knowledge about them. Gladys therefore justified using blanket referral at that time, which was reminiscent of direct referral. Lloyd (1995) took the view that the referral source must provide the reason for the referral and state questions to be answered by the occupational therapist's assessment. With blanket referral however, there was no referral source. Gladys expected to work with a blanket referral approach when she worked in the women's low secure service, but this was not explored further.

Liz's blanket referral started from the pre-admission meeting by the fact that a dialogue between team members ensued about each new referral. Tess was informed about new admissions when she attended nursing handovers. She prioritised when she needed to start occupational therapy based on their discharge plans. If available, this included the time frame and place of discharge and Tess prioritised those service users who were soon to be discharged into the community. Her priority list was dynamic, dependent on new service user admissions to the ward and changes in others' needs as time moved on. Therefore Tess monitored service user movement and altered the list as required. She described prioritisation as something that came naturally to her, but we did not discuss this further and the other practitioners did not discuss their use of a waiting list, it is therefore an area that would benefit from further research.

All the practitioners modified the blanket referral approach according to the context for practice. Actual practice using blanket referral was not represented as clearly as it could be, for instance in the form of published context specific case examples.

One paper reviewing the impact of blanket referral on service users' access to occupational therapy groups in a Canadian non-forensic mental health setting, found that they attended a range of groups, but were not provided with an introduction to the purpose of occupational therapy or provided with an individual rationale and goals of their occupational therapy (Polimeni-Walker, Wilson, Jewers, 1992). That example reflected partially how the practitioners could sometimes see service users on their wards and be in a position to chat to them before they had gained much knowledge about them. Indeed, it could be a mechanism for therapists to do some partial filtering of whether the practitioner needed to pursue that service user more actively because they were ready for occupational therapy. The actual practice of such an approach however, was more problematic, a matter that is discussed later.

The practitioners clearly used their autonomy to practice what they judged to be correct within multifaceted circumstances, a notable feature of professions (Freidson, 2001; Goode, 1969), and implicit in blanket referral. Indeed, Harrison and Hong (2002), two occupational therapy academics in the UK, wrote an opinion piece about their concern of occupational therapy becoming diluted if they had no autonomy over the referral approach. That however, could be a double edged sword, as having blanket referral with the autonomy of practice that goes with it meant occupational therapists could become isolated from the team (Harrison and Hong, 2002). The practitioners in my research did not appear to be in that situation, indeed the opposite was apparent. Blanket referral for the practitioners was at the very least the gateway for them to access the service user in order to continue with the rest of the occupational therapy process.

5.1.1 The occupational therapy process

A key finding in my research was that the practitioners did not 'follow' or 'apply' the occupational therapy process. The knowledge gathering and assessment cycle of the process was used firstly to make a risk assessment of the service users in forensic settings. The practitioners therefore modified the early cycles of the process to work for them in the forensic setting. Additional findings indicated that the process provided a structure for practice, but did not form the base or underpinnings of the trajectory of each service user's occupational therapy.

The practitioners' existing knowledge was that risk assessment was key, as risks needed to be identified in the forensic setting due to the potential harm to themselves and other service users and workers (Neeson and Kelly, 2003). The practitioners' focus linked to risk as they often provided access to, and used tools and equipment in any given environment (Cordingley and Ryan, 2009). Moreover, they knew of the opportunities to make tools for harming others (Fairhead, 1997; White, et al, 2012). The practitioners needed to identify the specific risks involved and the situation of the index offence (Lloyd, 1988) during knowledge gathering because it was important to be aware of risks prior to meeting service users (Barton, 2003). The knowledge created from the practitioners' practice concerned how those early stages of the process, as reported in the codified work (Creek, 2014), did not take account of where knowledge gathering about service users' risks and their assessment occurred. The practitioners therefore had to create a new knowledge from their practice by finding ways to incorporate risk into the assessment cycle of the process.

5.1.2 Risk assessment

The practitioners had further nuances in their practise of risk assessment in those early stages of the process. They first gathered knowledge for risk assessment in various ways such as Tess going to a morning nursing handover followed by the team meeting not accessing written notes and reports before introducing herself to Zach at lunchtime. Liz had access to pre-assessment reports about Claire. Liz's usual approach was to gain some initial knowledge before she introduced herself to a service user and then she gained further knowledge from the team meeting. Gladys sourced knowledge from the team clinical notes, but she knew of the limitations of these, so she looked for more current experiences of the team and their interactions with Leila.

This was an example of how the practitioners' technical rational knowledge (Schön, 1991) was too limited for the "messy" realities of their practice. The practitioners therefore had to consider their practice experiences which had formed their practice knowledge (Cook and Wagenaar, 2012). Tess and Gladys's risk assessments were not linked to a specific approach. The practitioners did not use

measures to provide a standardised risk assessment and level of risk score. Actuarial measures quantified and predicted risk (Cronin-Davis, 2010) and were briefly discussed by Liz and Tess who were trained in a range of standardised risk assessments. Tess worked in a context where risk assessments were not standardised for adolescents. However, although Liz did not comment on whether she tried to use measures with service user Claire, she did describe how multi-disciplinary risk assessment might occur every 30 minutes at times when there was the greatest potential of Claire harming herself and/ or others. Furthermore, Liz developed a dialogue with Claire for use every time they engaged in therapy. This was designed to facilitate an open discussion about what risk Claire could present to Liz at any given intervention, the aim being that this would then inform the next point of action. These examples indicated a continuous, dynamic process of risk assessment (Cronin-Davis, 2010, Cordingley and Ryan, 2009), which was so particular to Claire's presentation and context that it would not have been possible to develop a standardised risk assessment to capture that degree of service user specificity and context over such a small time frame in ordinary circumstances. Consequently, a particular practice developed in which the need to assess Claire frequently became common practice (Cook and Wagenaar, 2012). It was from this process that the team's shared practice knowledge about the specific use of risk assessment was created (Cook and Wagenaar, 2014).

Liz did not quantify the WEMSS traffic light system, but the system was a symbolic indication of level of risk, rather than a numerical score. Early discussion in the literature directed therapists to quantify and predict risks which was categorised as a security level for safe management of the service user (Lloyd, 1988), but it was unclear what the author meant by security level. There were broad categories of maximum, medium and low secure services, but no other form of quantifying each risk was noted. Specific to sex offender work and occupational therapy Lloyd (1987c) identified the need to predict risk on the basis of already documented sexual deviance (sic). Lloyd implied that this should be done at the time that knowledge gathering occurred and did implicitly highlight risks. However, in neither of her case studies, either for Raymond or George (Lloyd, 1988), did she address any form of risk assessment that identified specific risks (Lloyd, 1987c). Occupational therapists do not have discipline specific standardised tools for quantifying and predicting risk, they therefore have had to create their own ways of risk assessment from an occupational participation perspective. Some codified

work has already laid some ground-work on the topic (Connell, 2015; Cordingley and Ryan, 2009). It was therefore clear that risk assessment occurred in two ways in the process. The early cycle of knowledge gathering about the service user indicated some risks. This however, had to be combined with a dynamic use of the process in order for the practitioner to continue with the phases of the process that include assessment, evaluation or intervention. Those parts of the process are indicated by the practitioners' new knowledge created at each point of contact with the service user which occur at other parts of the cycle such as at times of interventions and evaluations. The environment however also needed a risk assessment and this is discussed in the next section.

The practitioners were required to do a risk assessment of the environments in which occupational therapy occurred. The expectations of the degree to which checking the environment occurred varied according to security levels of the organisation. Liz and WEMSS focussed on risk assessment of the environment. For example, in a medium security facility, my experience was that tools and equipment were required to be counted in and out whilst shadow boards for tools kept within locked cupboards, also noted by Dressler and Sniveley (2005). Indeed, this also occurred when I worked in non-forensic, acute mental health services, but without the emphasis on harming others, but more for harm to self. Also in a medium secure acute setting, secreting a potential weapon in the soil when gardening was another risk (Dressler and Sniveley, 2005).

Existing practice knowledge may become fixed, the impact being that it becomes difficult to create a new practice knowledge. Tess provided an example that there could be too much focus on one specific risk area, for example the use of knives and their size and sharpness. These issues were apparent in the literature too with Fairhead's (1997) example, found in a maximum security hospital in South Africa, of screwdrivers with a short shafts and scissors with rounded ends and short blades, being used at all times. This example was from a service context not explored in my research interviews however, this was also the case in other secure forensic settings. Given the potential for service users to harm others with objects in the environment, there need to quick and easy ways to prevent objects being used in such a way. Also ways are required to check such objects have been returned by service users and locked away. That form of practitioner habit (Cook and Wagenaar, 2012) makes sense in that context. There does however, need to

be flexibility in meeting individual occupational participation choices that also relates to the individual's risk. A catch all rule does not achieve a contextually congruent client-centred approach (Law, Baptiste and Mills, 1995) to occupational therapy risk taking. I discuss change in relation to risk further.

Therapists' views reported in the literature suggested that practice knowledge about risk has to be changed when the service users' index offence and current situation were combined. For example, Gina a practitioner in Cordingley and Ryan's (2009) research indicated that the context of an offence was not necessarily an indication that the service user would commit the same offence in similar circumstances. Indeed it was hard to see how the exact same circumstances were possible to be recreated and lead to the same offence (Connell, 2015). The possibility of risks changing over time arose for Gladys in her work with Andy and Leila, discussed next.

Gladys's knowledge about what she considered a risk included the time since the index offence was committed and the service users' current presentation. Gladys' view on Andy's and Leila's risks in part were about how long ago their index offence was committed, what remained current risks and what were new risks. She saw the latter as more pertinent to the service users' current presentation (which can't be discussed due to service user confidentiality) and occupational therapy. Gladys knew that the index offences of both Andy and Leila were committed over a decade or more ago and her current knowledge was that they did not present a current and immediate risk. That practice knowledge was created from her work with Andy and Leila (Cook and Wagenaar, 2012). The issue of time that elapsed since the index offence and the implications for knowledge about risks were not discussed in Cordingley and Ryan (2009). Other literature has looked briefly at this issue, considered next.

Cronin-Davis (2010) interviewed two therapists, Harriet and Caroline. They recognised the need for risk assessment and procedures, and knew not to be complacent about them, but were frustrated by them. The organisation required that Harriet followed their security procedures for two of her service users. In her view these procedures should not be required as they had a long admission to secure services, with offences that were context specific, additionally they had never shown any aggression during their admission. The procedures included

routine searching of occupational therapy environments and Harriet completed risk assessments. A process that she saw as a time wasting exercise in the context of her particular service users.   The other therapist, Caroline, found the risk assessment policy of the unit was enforced in situations where service users had to have an assessment. This in turn, prevented her service user from attending an off ward cookery session, despite her risk assessment that the service user was ready to do this (Cronin-Davis, 2010). Certainly therapists incorporated practice knowledge about the service users' past risk actions (Cook and Wagenaar, 2012), but the implications of this for developing new practice knowledge are currently unknown and so requires further research.

The practitioners needed to collaborate and build a dialogue with both service users and team members about risk assessment and management. The practitioners therefore had to incorporate various perspectives and wishes, and so a new practice context and knowledge was created (Cook and Wagenaar, 2012). The service users' views about their risks were not discussed by occupational therapists in Cordingley and Ryan (2009). Connell (2015) however, provided a case study that included the dialogue from an occupational therapist and the service user's perceptions about his risks. Indeed, the Ministry of Justices' expectations about risk were built into discussions between Liz and her service users. She tried to give service users the control and responsibility as much as possible by using client-centred (Sumsion, 2006; Law and Mills, 1998) and recovery approaches (Drennan and Alred, 2012). Tess aimed to have an open discussion with service users about tool use, encouraging them to make decisions about what tools they felt capable of using without risking harm to themselves or others. Cordingley and Ryan (2009) did not research the combination of risk assessment and client-centred approach that they identified as an area for further research. That limitation however, must now include the recovery approach in further research. Risk assessment should be seen as a component of the assessment cycle of the occupational therapy process, however, before a risk assessment was completed, knowledge has to be gathered, a concern that will be considered in the next section.

5.1.3 Knowledge gathering

Gathering knowledge is the term I use for what the practitioners and the literature call information gathering in the occupational therapy process. Pre-assessment in the COT (2002) standards was similar to information gathering and Liz was the only practitioner to discuss how her service had a pre-assessment meeting to discuss referrals to WEMSS. This meeting was for the multi-disciplinary team, not just directed by occupational therapy standards and was only used in WEMSS. This may reflect why Liz was the only practitioner in the interviews to use the term pre-assessment. Data collection was the label used for information gathering and incorporated a review of service users' hospital notes including nursing history and moving beyond this into occupational therapy specific information gathering (Lloyd, 1985). Also Liz included various forms of interviews and procedures by which to interview service users and to test their occupational participation (Lloyd, 1985). The term information gathering is de-contextualised from how the practitioners used existing knowledge and created new knowledge from practice.

I have therefore used the term knowledge gathering. This was because the practitioners had knowledge from their pre-registration education and previous practice experiences about service users in order to tailor occupational therapy. The practitioners therefore already had a context and a justification for gathering knowledge rather than information. My perspective also acknowledged what the practitioners knew and what they needed to know (Cook and Wagenaar, 2012). Using the term information gathering does not give due credit for the multidimensional nature of existing practice knowledge and creation of new practice knowledge (Cook and Wagenaar, 2012).

The practitioners gathered knowledge predominantly at the early stages of the service user's admission. One of the key features of their practice however, was that they could gather knowledge and carry out assessments (that were linked to knowledge gathering) at various cycles of the occupational therapy process. The practitioners' knowledge gathering included the categorisation of knowledge and knowing the parameters of what could be gathered from each source. The practitioners gathered knowledge to understand the service user and their history prior to admission and the circumstances leading to their admission.

Gladys's reasons for knowledge gathering developed out of her practice experience that not all of the knowledge was in the clinical notes. She therefore

observed the team with the service user and had a dialogue with them all to create the new knowledge that she required. Also Gladys tried to build on the service users' previous therapy using the limited written notes from a locum occupational therapist. With this knowledge she took previous intervention plans and successes there might have been and tried to develop the therapy further. Gladys based the occupational therapy on the service user's identified goals. For this she needed to develop new knowledge about the service user in order to use the existing intervention plan and develop additional plans.

The codified work shows what knowledge therapists required in order to practice in the forensic setting. The index offence (Lloyd, 1987c; Cordingley and Ryan, 2009) and categories of criminal history, educational and employment background, leisure, social interaction, personal (care) and home management, personal qualities and future plans were identified (Lloyd, 1987c). Another category specified by Gladys was information about the service user's family history and attachments (from attachment theory) and childhood activities. Gladys had developed her practice knowledge (Cook and Wagenaar, 2102) about re-traumatising service users when working with women service users. Harris (2003) highlighted that the abuse and negative roles associated with women service users' experiences should not be re-enacted. Gladys used that experience by gathering knowledge about her new service users in slow stream rehabilitation. She did not however, indicate how effective it was for her practice knowledge in that new practice context (Cook and Wagenaar, 2012). Duncan (2008) also suggested by understanding historical details therapists can be sensitive to questioning about them. The practitioners organised their knowledge gathering and knowledge gained about each service user with those categories. Other ways of gathering knowledge included various forms of assessments, discussed next.

5.1.4 Assessment

The practitioners were not able to complete the service users' full baseline assessment within the earliest stages of their occupational therapy. Zach, Claire, Andy and Leila could not be fully engaged in the early stages of interview or observational assessment using the MOHOST. There was an assumption in the literature that one comprehensive assessment could and should be completed

(Lloyd, 1985). The practitioners had knowledge of standardised tools and outcome measures as well as interviews that are both structured and semi-structured, with some being standardised (Barton, 2003). These provided a range of possible ways to develop knowledge about the service users (Flood, 1997, Barton, 2003). Despite this array of possible forms of assessment, they could not be used effectively with the service users, a matter that is considered further.

The practitioners experienced contextual issues that impacted such a view of how a baseline assessment using MOHOST could be completed. Gladys was new to a ward and its purpose, and Tess had returned from an extended period of leave. Liz however, said she obtained a basic MOHOST assessment about Claire, but Liz found this did not fully explain Claire's occupational participation strengths and constraints. The practitioners therefore found their existing knowledge about the MOHOST did not facilitate their practise of assessment. The literature emphasised the point that occupational therapists should try to develop and use standardised measures where possible, to support evidence based practice and demonstrate effectiveness of occupational therapy (Barton, 2003; Cross, 2000; Flood, 1997). COT (2002) had a criterion that any assessments used needed to be in keeping with the philosophy of the unit and chosen models of practice. In my research this fitted with the organisation's adoption of MOHO and its associated assessments. Creek (2014) highlighted a need for a screening assessment from which further detailed assessments were identified. This was a similar process to that proposed by MOHO (Kielhofner, 2008) and MOHOST, Creek (2014) however, did not specify a particular model or assessments. The practitioners provided examples about how they completed different assessments, at different times, indicating the ongoing nature of assessment (Duncan, 2008; Barton, 2003; COT, 2002). The assessment of service users therefore required a different assessment approach discussed next.

5.1.5 Core skills in assessment

The practitioners needed to assess service users to gain knowledge about their occupational participation. They had knowledge of the core skills of occupational therapists who used activity as an assessment medium in itself (Barton, 2003), which was referred to as activity analysis:

"Activity analysis is a process of dissecting an activity into its component parts and task sequence in order to identify its inherent properties and the skills required for its performance. Analysis allows the therapist to evaluate the therapeutic potential of an activity and manipulate it to increase that potential." (Creek, 2003, p.37)

This forms one of the core skills of occupational therapists:

"…the core skills of the occupational therapist are built around occupation and activity…using activity as a therapeutic tool…to promote health, well-being and function by analysing, selecting, synthesising, adapting, grading and applying activities for specific therapeutic purposes." (Creek, 2003, p.36).

The practitioners therefore had technical rational knowledge (Schön, 1991) that had to be combined with practice experiences with service users that created practice knowledge (Cook and Wagenaar, 2012) of ways to assess service users without the need to use standardised assessments. In fact they used their knowledge of the observation of service users when performing activities and compared this against how that activity would be carried out by a healthy individual. This still provided an assessment and a baseline of the service users' occupational participation.

Barton (2003) talked of informal assessment during an activity of a game of pool and listening to and observing service users during play. She underplayed the significance of this by calling it informal, as the occupational participation of these activities still provided an assessment using occupational therapists' core skills of activity analysis that was fundamental to their practice. This was related to how occupational therapists' used observation skills, which would be crucial in the example above. The practitioners used their knowledge of the flexibility of assessment to create new knowledge about their service users in a way that formal assessment could not.

5.1.6 Assessing the service users when they were ready

Liz, Gladys and Tess all provided examples of meeting their service users at a level of engagement that they could manage and not as stipulated by a policy or a standardised assessment. The practitioners therefore used a client-centred

approach of allowing the service user to take ownership of, and direct the changes to the process that they wanted and felt capable of doing at any given time (Parker, 2006). The practitioners may not have been explicit about their approach, but it was client-centred none-the–less. All the practitioners found that they had to alter their knowledge of what was possible to assess and therefore altered their expectations of what the service users were capable. Each one needed to be assessed at their level of capacity at that time. The practitioners had to take a step back and meet the service users at a different level of ability to that required by MOHOST and when Liz used a sensory assessment. Such an approach is reminiscent of therapists using a "practiced eye" to see if and see how about the service user and coming to know about them (Mattingly and Fleming, 1994, p321). The findings suggested the practitioners did not expect or anticipate the limitations of MOHOST for their service users. The practitioners therefore used their existing knowledge of other ways to assess their service users, without using MOHOST. Consequently, they used direct observations of service users' occupational participation in whatever way they engaged, at a given time.

5.1.7 Observations rather than standardised assessment

Liz had observed how Claire became highly stimulated, agitated and aroused, with reduced concentration in team meetings. Liz was able to make those observations due to her prior knowledge gained from practice placements in pre-registration education. Liz observed how Claire calmed down when given a sweet (candy) to suck. Liz tried to explore this further with a standardised sensory functioning measure she had found on the internet, but Claire refused. Liz therefore used her practice knowledge (Cook and Wagenaar, 2012) of her earlier observations of Claire since her admission. Consequently Liz created a new knowledge about Claire's sensory responses and functioning in that environment. In turn a new practice context from using sensory approaches with Claire and observing her responses was created (Cook and Wagenaar, 2012).

The practitioners' made careful observations of the service users. The limitations of the standardised tools available for assessment of service users placed an extra emphasis on the need to use observations. Gladys used Andy's smoking routine to try and build a picture of his occupational participation, especially because he

rarely left the ward, did not mix with other service users and rarely attended groups. Gladys also found a way to assess Leila's neck pain by observing how Leila moved and asking her about her experience of moving that subsequently led to other occupational therapy for Leila. Tess observed Zach washing-up items in group cookery where some were on the left side of the sink, which he did not realise he had not completed until Tess told him. All of these observations were too specific and individual to use standardised assessments. They did however, provide a baseline observation of the service users' occupational participation and a starting point for further assessment and intervention for comparison of earlier to later observations.

The practitioners' observations were fundamental to their practice. The service users engaged in occupational participation and their strengths and constraints were observed. Observation in practice was discussed in Fleming and Mattingly (1994) who did a major ethnographic study of clinical reasoning in America over two years. They followed the practice of between four and fourteen therapists' from mostly physical and some mental health practice areas. Occupational therapists used a variety of standardised assessments, experienced therapists however, used observation frequently during the course of completing a therapeutic activity with service users (Mattingly and Fleming, 1994). A more accurate portrayal of therapists' observation in practice was "action-seeing-observing-interpreting-acting" (Mattingly and Fleming, 1994, p321), which reflects the occupational therapy process as set apart from the cycle of evaluation.

Evaluation appears to be counted as interpreting, which from their description included "the mental process of making links between present information and past knowledge" (Mattingly and Fleming, 1994, p. 324). Mattingly and Fleming did not define the act of seeing, or clarify the relationship between that and observing. I suggest that observing included different forms of assessment and interviews (discussed next) and a comparison with an activity analysis of the given activity. The observation also would include the service users' particular style, rituals, habits and routine of performance patterns (American Occupational Therapy Association, 2014; Kielhofner, 2008), that could be influenced by the forensic context. A limitation of Mattingly and Fleming's reasoning process was that it was portrayed as linear and practice was not necessarily so neat and tidy (discussed later in this chapter). Part of the practitioners' assessment also included using interviews.

5.1.8 Interviews

The practitioners used various forms of interviews to obtain knowledge about their service users. These were general discussions when 'bumping' into a service user on the ward and might be the briefest of contacts. Gladys described how she tried to greet and ask a question of Leila whenever she saw her on the ward, to little effect. Gladys asked Andy questions specific to his difficulties with going outside of the ward when they went to the garden for a cigarette. For instance, she would ask him how he was feeling about being there and whether he was okay to continue. Gladys used the term informal interview for this approach which underplays the value of interviews. An initial interview (the first) may be used primarily to build the relationship and a later interview can gather details about a specific area of occupational participation (Barton, 2003). Gladys also didn't seem to be aware of how such interviews could develop new practice knowledge, but she, Liz and Tess had knowledge of other ways that interviews were useful, outlined next.

Interviews were seen as the "mainstay of assessment […to] provide depth and richer understanding to assessment" (Barton (2003, p. 34) and were therefore integral to the assessment (Lloyd, 1988). One purpose of an interview was to decide whether or not further knowledge was necessary and also to indicate whether standardised or other assessments were required, including questionnaires designed to structure an interview (Lloyd, 1988). An initial verbal interview was seen as enough to collect all the self-reported information from the service user about their life as relevant to occupational therapy (Lloyd, 1985). Later literature differs from Lloyd's view in that at least a brief interview was required (Dressler and Sniveley, 2005), and interviews may have varying degrees of structure, and occur at different stages of the assessment (Barton, 2003). An initial interview may be used primarily to build the relationship and a later interview to gather details about a specific area of occupational participation (Barton, 2003). There were no published studies on the use of occupational therapy interviews in the forensic setting. The literature considered above could have been based on practice knowledge, but this was not made explicit. The practitioners' discussion about how they approached interviewing service users provided data that revealed

how the practitioners developed their knowledge and practice about interviewing service users.

5.1.9 Interventions

The practitioners' focus of practice was about facilitating service users' access to occupational participation in the forensic setting. This was a key role and required deft negotiation between the restrictions of the environment, the service users' capacities, choices and risks, as well as the practitioners' capacity as an occupational therapist. Stelter (2007) found service users could miss groups due to intensified supervision required for more distressed service users, thus impacting the staff levels available for escorting and remaining in therapy areas. Liz did not use groups but did individual work with Claire, but Claire became regularly distressed necessitating seclusion impacting her access to occupational therapy. If Claire could not remain calm enough to write letters or go shopping in the atrium for gifts for her family, all of her activities to support familial roles were potentially restricted. Liz therefore created a new practice to maintain Claire's familial roles even in that highly restricted environment. Claire could, for example, dictate letters to Liz for her family. Liz also used sensory approaches to calm Claire down that could help facilitate her earlier move from seclusion to de-escalation thence to her bedroom. Gladys provided an intervention of adapting Leila's bedroom environment. She used previous practice knowledge from occupational therapy with older people and unrelated to forensic practice, in order to facilitate Leila's occupational participation with reduced pain. Gladys therefore found a new context for her practice that required her existing practice knowledge in order to create a new practice knowledge. There was no disciplinary literature on these ways of working and so Liz and Gladys had to create a new practice knowledge in order to facilitate occupational therapy in these unusual practice situations.

Other restrictions to practice and offering occupational participation opportunities to service users were noted by Fairhead (1997) where scissors needed to be attached to the service user's trouser belt loop with string attached to the scissor handle. This may be part of a particular culture of maximum secure settings in South Africa and it was not mentioned by the practitioners. The implications of this approach however, could be to infantilise and patronise service users in an effort

to provide opportunities for occupational participation. This indicated the recurring tension between using tools, equipment and everyday objects in secure settings, with risk management requirements and therapists' attempts to offer meaningful occupational participation for service users. It could be argued that there is a fine line between practises that became oppressive due to security restrictions and objects being necessary for occupational participation. The participants tried to prevent occupational injustices from occurring. For example the deprivation of meaningful occupation, the imbalance between accessible occupations and too many passive occupational pursuits. There seemed to be a deep sense that those available were incompatible for meeting basic needs or wants through pleasurable occupation (Wilcock and Hocking, 2015).

Evaluation

In the occupational therapy process, evaluation was carried out when an intervention was completed (Creek, 2014; Lloyd, 1985). Standardised assessments were seen as ways to measure outcomes of occupational therapy and were available to the practitioners. It was possible to use the screening tool (Parkinson et al, 2006) to measure change at regular intervals, which the practitioners were required to do for each service user's CPA report. The term outcome was associated with evidence based practice as a way to measure the effectiveness of an intervention (Clarke 2003a; Forward et al, 1999, Lloyd 1995). The literature on MOHO summarised by Kramer, Bowyer and Kielhofner (2008) in the latest edition of MOHO, had become increasingly focussed on what happened at the beginning and end of therapy, rather than that which evolved through practice between those points.

The practitioners had a challenge in the practise of evaluation as they were unable to use the screening tool as a baseline measure of their service users. In that situation they therefore needed to use their early observations of the service users' occupational participation to create a baseline from which they could make a later comparison of the service users' participation in the same occupation. The practitioners used their observations in that way which meant a standardised assessment was not required. This therefore illustrated the importance of observation and how it could be used for later evaluation in practice when

standardised measures were not effective or developed. Practitioners could observe changes, but they also needed to gain the service users' perspective of their goals. Tess and Gladys' service users' limited communication made this an additional challenge in their practice.

The process was not the clean and tidy hierarchical representation of the process as provided by Creek (2014) and so was not a manifestation of what happened in practice. The practitioners had on occasion to step aside from the particular cycle of the process to engage in another one, which was in line with Barton's (2003) more flexible view that occupational therapists have to consider the service user's progress and risks to determine assessment opportunities. Unlike Lloyd's (1985) view of the process as being one point of assessment and interview. This is considered further.

There was a relationship between Mattingly and Fleming's (1994) view about how therapists developed their knowledge and Cook and Wagenaar's (2012) practice knowledge creation. Mattingly and Fleming identified that therapists had a knowledge about acceptable ranges and degrees of service users' actions, that is their physical movements. It should be noted those explanations were focussed on physical occupational therapy and appear reductionist. I therefore highlight that therapists observe all aspects that are required for occupational participation, whether that be in physical or mental health practice.

The practitioners combined their existing practice knowledge created from practice experiences and technical rational knowledge (Schön, 1991) from clinical and pre-registration education (Mattingly and Fleming, 1994) and I suggest subsequent education, training and practice experiences. I am not proposing that technical rational knowledge (Schön, 1991) and education precedes or even explains practice, which separates doing and thinking (Cook and Wagenaar, 2012). There is however, a knowledge gained from technical rational (Schön, 1991) sources, such as the occupational therapy process, that the practitioners at the very least used as a point of comparison when they enacted a cycle in their practice. Indeed, the comparison highlighted how technical rational (Schön, 1991) sources did not meet the practitioners' needs. Practice therefore, had to be modified in order to meet the practitioners' requirements of using the process. The practitioners therefore created new knowledge from practice to make the process work with

each service user and their individual presentation. Practitioners observed the ways occupational participation was and was not effective in meeting service users' goals, a process which had to be interpreted, in part, through knowledge of the service user's narrative (Mattingly and Fleming, 1994), discussed in more detail later. That practice suggested practitioners used Mattingly and Fleming's (1994) reasoning process. One other aspect noted by Mattingly and Fleming (1994) was how practitioners used inquiry to develop their knowledge. I suggest that inquiry was enacted though the practitioners' reflection on their practice, as an informal method of research use in practice, which was potentially carried out soon after a practice event. From those aspects a new practice knowledge was created (Cook and Wagenaar, 2012).

In summary, the occupational therapy process must not be rigidly adhered to as it would prevent or limit the creation of nuanced knowledge about service users and impact creating new knowledge from practice. There was no empirical evidence nor theoretical exploration in the forensic literature about the specific ways therapists used the process, how it varied between them and environmental influences on its use. My research findings provided the first exploration into the process in this setting.

The practitioners developed their knowledge about the process and how it could be used to facilitate practice from their pre-registration education, including practice placements and subsequent post-qualifying practice experience. There was a need to have a codified occupational therapy process that explicitly represented those aspects of practice based on practice knowledge of the variation and a non-sequential use of the process.
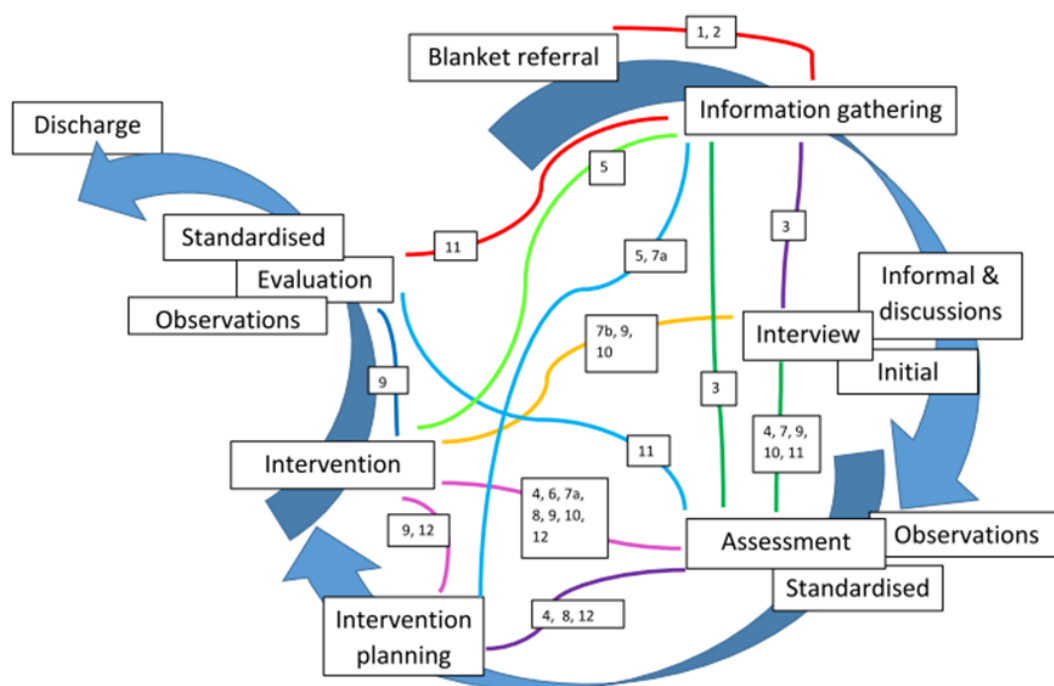
Figure 21. Tess and Zach actual practice of the occupational therapy process as the cycles and phases were practised; based on the timeline below (figure 17) (source: Cordingley, 2015)

The occupational therapy process was not carried out in a uniform and sequential way. Practitioners could not gather interview data and assessments with standardised tools in one time period. They required multiple, opportunistic meetings with service users in order to start the process. There were situations that arose that had not been planned by the practitioners, but were seen as a potential way to start the process or provide a focus for the process that had previously not been apparent. To this end I have created a figure (21, above) of the various ways in which Tess used the process with Zach. The original depiction of the sequential process is laid out around blue arrows. The various numbered coloured lines depict the points of practice that occurred in the cycles of the process and are taken from the numbered arrows on the timeline of Tess and Zach's occupational therapy process (Figure 17 re-produced below for ease of comparison).
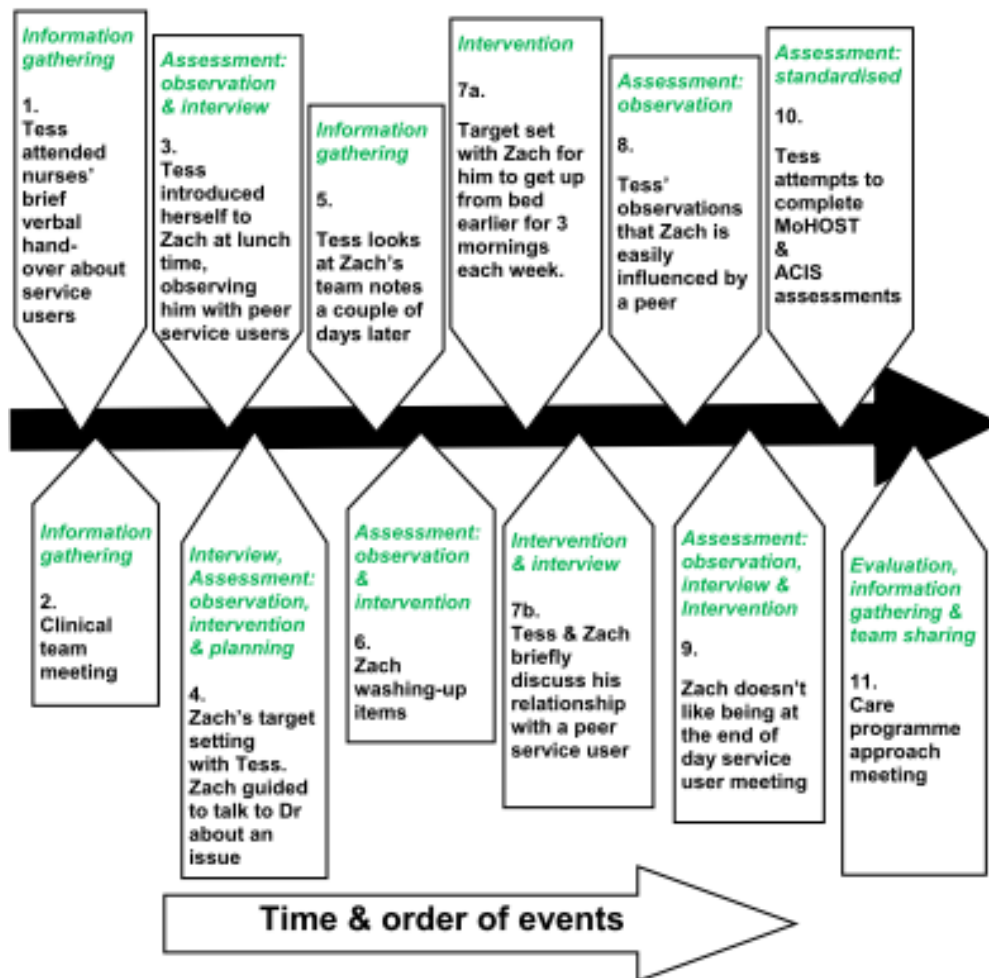
Figure 17. Timeline of Tess and Zach's occupational therapy process as the cycles were actually practised (source: Cordingley, 2015)

In essence the process was only a structure and could not be adhered to in a linear fashion. Practice with the process required movement back and forth between whichever aspect of the process was required, in the knowledge that various parts of the process could be achieved simultaneously. The process could not be used in isolation of a therapeutic relationship, a matter that will be explored in the next section.

5.1.10 Therapeutic relationships: Rapport

The practitioners discussed how they saw the importance of creating a therapeutic relationship with each service user. A therapeutic environment was about the participants creating primarily a social, but also a physical environment that enabled service users to engage in occupational therapy. Establishing a

therapeutic relationship that incorporated rapport building was a key part of occupational therapists' practice in the forensic mental health setting.

A new model in the wider occupational therapy literature was the Intentional Relationship (Taylor, 2008) which concerns the therapeutic use of self and includes rapport building. Building rapport was considered one of the basic criteria for relationship building in occupational therapy that was about "making deliberate efforts to make a client feel comfortable in one's presence and to establish a common ground for communication" (Taylor, 2008, p. 177). Therapeutic use of self and rapport are not areas that have been covered extensively in forensic literature and, as such, could be considered as an area for further research.

The practitioners saw building rapport as the first step in developing a therapeutic relationship with the service user (Mason and Adler, 2011&12; Schindler, 2000; Lloyd, 1988). The assessment cycle of the occupational therapy process was seen as one place to start rapport building (Prentice and Wilson, 2003; Duncan, 2008), linked also to the initial assessment (Lloyd, 1988).

The particular challenges of building therapeutic relationships with service users with a diagnosis of a personality disorder required knowledge for practice. Occupational therapists are guided to develop assertiveness, honesty and to set clear limits and expectations of service users which are focussed on the here-and-now (Dressler and Sniveley, 2005). Also it is suggested that therapists are most effective when all service users have an experience of therapists that are fair and consistent, as highlighted by Fairhead (1997). Dressler and Sniveley (2005) also note that being reliable, within rational limits and showing genuine respect and concern are also crucial factors; as are being fair, firm, consistent and caring (Fairhead, 1997). Regarding the latter point, Fairhead indicates that service users may feel guilty about their crimes and frustrated by the indeterminate length of their admission, so not demonstrating care towards the service user may result in a negative reaction. There were no empirical or practice examples to support those examples from the literature, but on a human level, aside from any professional concerns those suggestions have some merit.

A dialogue between the participants and service users started the process of building rapport for developing a therapeutic relationship. Mason and Adler

(2011&12) note it is important not to underestimate the value of developing a therapeutic rapport with service users. The research participants identified features of therapeutic rapport as an honest, caring and helpful attitude, and a healthy respect for service users along with a sense of humour (Mason and Adler, 2011&12). Fairhead (1997), supported the latter and added that effective authority over service users and gaining their respect would prevent service users from attacking workers whom they respected, trusted and liked.

The ways of and degrees of rapport development between occupational therapists and service users went beyond the use of initial assessment in the early cycles of the occupational therapy process. Indeed, rapport was developed through the practitioners' persistence in trying to engage with the service users who demonstrated their reluctance for some aspect of occupational therapy, such as Leila and Andy. Additionally Zach's slow progress with ongoing interventions and Tess's attempts to identify his interests was another way. Liz and the other practitioners could only use informal methods of assessment including, observations and discussions to work with their service users.

5.1.11 Relational security

A form of security that was called relational has been considered only briefly in the literature by Duncan (2008) and McQueen (2011). Kinsley (1998, cited in Kennedy, 2002, p.434) identified two parts to relational security. Quantitative was the staff to service user ratio and the time period spent in face-to-face contact. Qualitative was the trust between service users and workers, as well as the balance between accessibility (openness) and invasiveness (intrusiveness) (Kinsley (1998, cited in Kennedy, 2002, p.434). Trust between workers and service users as part of relational security was noted in Department of Health sources (DH, 2010; DH, 2007). Kennedy (2002) also noted that three forms of security, procedural, environmental and relational were relevant to all areas of mental health. Liz spoke of relational security breakdowns or reductions in worker support during the transition of women from one service to another leading to the loss of confidence between service users and workers. Tess also noted the relational context in risk management recognising that in the early stages of Zach's admission each were in the mutual position of not knowing each other. McQueen (2011) highlighted

relational security was required in a setting that has to be secure in order to provide a safe environment to enable therapeutic work. Unfortunately the examples provided by the participants were not enough to explore the topic further in relation to practice knowledge (Cook and Wagenaar, 2012) secure settings, occupational therapy provision and therapeutic relationships between therapists and service users; I would suggest therefore that further research in this area would be beneficial.

In summary, the therapeutic relationship between therapists and service user was the least explored area in my research. Furthermore, how relational security and the therapeutic relationship in occupational therapy in the forensic setting are combined is an area that also requires further research.

5.1.12 Trust

Trust and rapport building were often mentioned together in the literature. Liz considered that the notion of trust or distrust of service users was too simplistic. Tess implied Zach trusted her because he engaged in occupational therapy, though this explanation may also be too simple. Gladys however, had more difficulty gaining Leila's and Andy's trust to work with her. The degree of honesty and trust could be affected by the dual role of workers of providing care and also enforcing rules, reporting information and protecting the public (Livingston et al, 2013). Indeed one participant service user highlighted they sometimes had to bite their tongue a bit and guard their emotions for concern at the impact on his progress (Livingston et al, 2013). Freeman (1982) elaborated on the topic by noting the service user may have learnt not to trust anyone, including their parents, from an early age, especially if placed in care by them. Service users could have perceived occupational therapists as workers in authority and thus mistrust them (Schindler, 2005). Indeed, it might be that a long time was required to build trust (Taylor, 2008) and the forensic setting provided a lot of time to work with service users. The implications for practice knowledge and trust in the therapeutic relationship requires further research. Associated with the therapeutic relationship was the need for the therapist to develop empathy for the service user, discussed next.

5.1.13 Empathy

Empathy was seen by the participants as fundamental to understanding the service user's criminal offence, life experience and emotional world. Without empathy the participants could not develop their practice knowledge (Cook and Wagenaar, 2012) about the service user's circumstances. In the forensic setting, however, empathising was also challenging and Gladys had to actively develop her empathy through her practice knowledge when she was new to the forensic practice context. New practice knowledge that helped with empathy was created through knowledge gathering, dialogue with colleagues about service users' extreme actions and practice experiences of harm aimed at workers. Both Gladys and Liz explained how empathy was both important and necessary for a nuanced and compassionate view of their service users. The practitioners did not discuss therapeutic use of self, but the literature on the topic included empathy, discussed next.

5.1.14 Therapeutic use of self

Therapeutic use of self had a relationship with developing practice knowledge (Cook and Wagenaar, 2012). Gladys developed empathy towards the women through her practice. Liz accepted the technical rational knowledge (Schön, 1991) that humans were born to empathise from attachment theory. Her understanding of when and why empathy failed was a skill and so that was developed in practice and thus became a knowledge (Cook and Wagenaar, 2012). Therapeutic use of self included the practitioners' awareness of their ability to use their personal skills in communication, relationship building, boundary setting (for example when Gladys placed limits on Andy's requests to make last minute changes to the intervention plan), encouragement and empathy towards service users (Taylor, 2008, Hagedorn, 2000; Mosey, 1986/1996). The preceding authors provided codified literature on the topic. I suggest however, that there was an everyday knowledge that was informal and rarely acknowledged for its use in a professional context (Freidson, 2001). Therapeutic use of self was honed through practice experience and reflection-in-action and reflection-on-action (Schön, 1991) (discussed later) about those experiences that in turn built new practice knowledge (Cook and Wagenaar, 2012). Also a repertoire of skills for relationship building with service users in the forensic setting was part of practice knowledge (Cook and

Wagenaar, 2012). What was not explored so fully in my research was if a therapist saw a service user on the ward, was it an informal greeting? Did a therapist employ therapeutic use of self at any contact? Was a therapist in a permanent vigilant state to use therapeutic use of self, given the context, when in direct contact with service users? These questions could be explored in further research. An aspect related to therapeutic use of self was the place of the practitioners' emotions in practice, discussed next.

5.1.15 Occupational therapists' emotions in practice

Inherent within the setting was the requirement that occupational therapists consider both the emotional responses of service users and the therapists' emotions in return. The participants therefore required self-awareness of their emotions and responses to challenging situations and information linked to service users (Kromm, 1982; Fairhead, 1997). That was part of the practitioners' own narrative that included the blend of the personal and professional, and how that related to the subsequent cycles of practice. The emotional aspects of occupational therapists were underexplored theoretically and empirically in the discipline from a forensic perspective.

Practitioners' emotional responses first arose from reading about and/ or verbal reports about a service user's index offence and any previous offending history (Chacksfield, 1997). For instance, Tess made a connection between her own children and Zach's history. Their emotional responses to their service users required a reflexive and reflective approach to deal with both their response on a human level related to their personal life experiences and how they impacted their actions in the practice context.

Negotiating boundaries was a part of practitioners' therapeutic use of self (Taylor, 2008). Practitioners monitored their emotional reactions to the service users' actions, history and presentation at any given point of the occupational therapy. Gladys discussed where she had difficulty with maintaining limits in the relationship with Leila and the impact upon her emotional state. Alice a manager, described a problem with a therapist working with service users diagnosed with a personality disorder who identified too much with the service users. Her supervisee could not

see how she was caught in the transference of those service users' diagnosed with personality disorder and how with supervision she was still unable to see her own highly expressed emotion and lack of emotional maturity to work more effectively (Cronin-Davis, 2010). In those situations emotional resilience was required of therapists where they were emotionally robust, 'tough-skinned', had good boundaries and were self-sufficient and confident and in their abilities to deal with the practice environment and was noted by Alice and Lesley, in Cronin-Davis' (2010) research.

Boundaries could become blurred leading to intense relationships between practitioners and service users. Liz experienced times where the opportunities for Claire's occupational participation would become very restricted and Liz could also be drawn into this limited view. The impact was that the occupational opportunities became more restricted as Claire's behaviours became more challenging and she required more secure and restricted environments in which to reside. Liz reflected on the experience and her awareness increased about how she could be influenced by Claire. This became a new practice knowledge for her (Cook and Wagenaar, 2012), and so she was more aware of future similar situations.

Practitioners experienced anxiety with particular service users. Gladys felt anxious about putting too much pressure on Leila to try to engage with her that could lead to Leila trying to harm Gladys. Tess was also nervous about the potential of being attacked during her early work with Zach. The main focus about emotions in the literature had been about therapists' anxieties. Crimes such as sex offences may be particularly challenging (Duncan, 2003) and particular diagnosis such as anti-social personality disorder (Cronin-Davis, 2010). The team was expected to collaborate and take positive risks for the service user's quality of life and recovery plan (DH, 2007). There can however, be anxiety around taking positive risks with service users. Liz noted her team hoped that there would not be an adverse situation arising from risk taking. Indeed, Fairhead (1997) noted a team approach and backing prevents a feeling of worker insecurity, as well as preventing inappropriate decision making and reactions towards service users and situations. The participants experienced emotions and developed their empathy as they elicited the service user's narrative, discussed next.

5.1.16 Constructing a narrative

The procedural nature of practice in the forensic setting initially directed narrative building because knowledge gathering for risk assessment was required. Indeed, all the practitioners built the narrative from a worker centred starting point. The participants initially constructed a narrative to varying degrees with and without the service users. For example, Tess's process of knowledge gathering and knowledge building about Zach, however limited in detail, had already been gathered from the nurses' hand-over. Tess therefore started narrative building in a worker centred way, before any direct contact, to hear how the service user constructed their past narrative (Mattingly and Fleming, 1994). Liz started building the service user's narrative from the team pre-assessment and pre-admission meetings and subsequent reports. Although the early stages of narrative development were worker centred, the narrative generated was still part of the practitioners' creation of their practice knowledge (Cook and Wagenaar, 2012).
Another part of the service user's narrative that was worker centred was in relation to risk assessment. Tess commented on how some workers said they preferred not to read the clinical notes prior to meeting a service user in order to limit their bias about service users. Preventing discrimination however, was already required in the code of conduct (COT, 2015). Moreover, Tess and Barton (2003) stated that a reason to gather knowledge about service users was to ensure that they would know as much about the risks as possible before engaging service users in therapy. The forensic practice context required risk assessment and therefore the service user's narrative included risk in relation to their criminal history. The key issue was that the narrative was constructed rather than told (Mattingly and Fleming, 1994) to provide a nuanced picture of the service user, therefore providing a phenomenological view of them (Mattingly and Fleming, 1994). Both new practice knowledge (Cook and Wagenaar, 2012) and the service user's narrative were therefore connected because both were created and used as a knowledge for practice.

5.2 WHAT WERE THE PRACTITIONERS EXPECTED TO DO?

The practitioners were expected to practice in a range of ways, directed by various sources. The main source of technical rational knowledge (Schön, 1991; Higgs et

al, 2004) such as theory, measurement tools, pre-registration education, post-registration courses, training events and the internet, were used by the practitioners. For instance expectations for practice came from the organisation that had policies and procedures to be followed, government requirements such as the cross party strategy for mental health (DH, 2011) and risk management (DH, 2007). Also service provision reviews such as the Corston Report (2007), and standards and codes for practice (the Health and Care Professions Council (HCPC), 2013; COT, 2015). The literature that codified occupational therapy practice also provided expectations of practitioners. The practitioners therefore had a knowledge from these sources that impacted their practice. Indeed, it is more inclusive to see such sources as 'knowledge used for practice' rather than evidence or knowledge based practice. The practitioners however, had to reflect-in-action and on-action (Schön, 1991) upon the usefulness of that knowledge in relation to each current practice situation; and that in turn influenced the knowledge that was created from practice. The specific areas that I discuss include evidence based practice, the occupational therapy process, risk assessment and management and the use of theory in practice.

5.2.1 Evidence based practice

The practitioners indirectly referred to basing their practice on evidence. There was the large amount of discussion about MOHO and MOHOST and how they found them useful for guiding their thinking. They did not discuss the 'gold standard' in evidence based practice and how their resources did or did not fit with that standard. Indeed, they did not indicate any sense of anxiety that their sources for evidence were in any way deficient as seen in the context of them not being of the 'gold standard'. Liz noted however, that some of the research for using weighted blankets for reducing violent actions had some statistical support. Otherwise they mentioned evidence sources from their pre-registration education, locating material on the internet, such as a standardised sensory assessment, as well as autobiographies and television programmes. The practitioners therefore used evidence, described in the literature (Lloyd, 1985, 1988) and as required by COT (2015), HCPC (2013) and (COT (2002) standards for practice for occupational therapy in forensic residential settings identified a criterion about basing practice on evidence. As the foregoing documents did not specify what accounted for

evidence, the practitioners were still using a wide range of written and other media as evidence in their practice. Their sources also provided a narrative of people's life and experiences. It may be that the practitioners did not need to speak of an evidence base explicitly because one was implicit for practice given the high degree of quantitative research supporting the development of MOHO standardised assessments. Indeed, MOHO was described as an evidence based model of practice based on research of the validity of its concepts (Kielhofner, 2008). It was very difficult to find literature that critiques MOHO and its oeuvre.

There was an increasing use of the term evidence informed practice (Rycroft-Malone et al, 2004). That term suggested practice was not based on evidence, but evidence was a part of the knowledge available to incorporate into practice as relevant to the particular service user. The question of what counts as evidence however, may still mean that there is a hegemony of research methodologies counted as evidence. The practitioners used a variety of sources of knowledge to incorporate into their knowledge about their service users that they used in their practice. Indeed, an opinion piece related to a research project about UK occupational therapists' use of evidence in practice indicated multiple sources could be, and were used for an individual client-centred approach to practice (Reagon, Bellin and Boniface, 2010). The authors suggested a move away from the dominant view of evidence based practice to incorporate multiple sources on which to base evidence (Reagon, Bellin and Boniface, 2010). The limitation in that view was that the authors still used the term evidence and as a base, that is foundation, for practice. I suggest therefore that it is better to say that evidence is constituted of various forms of knowledge, and it is knowledge that is used for practice and not practice based on evidence or even practice based on knowledge. This is because practice knowledge is one among various forms of knowledge and a particular form of knowledge created from practice to be used for practice (Cook and Wagenaar, 2012). There should be a more inclusive view called 'knowledge used for practice'.

5.2.2 The occupational therapy process

The practitioners used the process because of their previous knowledge from pre-registration education including their practice experiences pre and post

registration. Also their knowledge from the codified literature (Creek, 2014) and professional standards (COT, 2015) on the topic provided a powerful message to always incorporate the process in practice. The process has been discussed at length in what the practitioners actually do in their practice, so at this point I highlight a specific discussion about the time frame for assessments.

The practitioners needed to complete their first MOHOST by four weeks following the service users' admission. The timing of when assessments were carried out were indicated by both the procedures of the assessment and the organisational policy. At the early stages of admission the practitioners were required to use the MOHOST that could be completed following observation of the service user over two weeks (Parkinson, 2006). Fitzgerald (2011) described using MOHOST scores for a baseline assessment in his UK based forensic service. It was not clear who in the organisation in my research, established the time frame for the completion of MOHOST. In my experience, a time frame was established by the head occupational therapists across the organisation, in consultation with the occupational therapists in the teams. There may have been justifiable reasons for the organisational policy. Therapeutic reasons could be to make sure that practitioners ensured there was a baseline measurement of occupational participation from which to compare at a later date, for any changes. Procedurally it may have provided an audit trail of practice events to prove the practitioners were doing their job and within the time frames expected. For example additional MOHOSTs were completed for Care Programme Approach reviews at three or six month intervals. Indeed, the literature did not justify why a week was chosen in which to compete a baseline assessment in one service discussed by Hunter and McKay (2008).

Timing for completing assessments in the literature was most often discussed in relation to the early stages of admission (Duncan, 2008; Hunter and McKay, 2008). There was limited indication in the literature of when, how often and what forms of assessment were relevant for service users. Such limitations however, make sense in the context that practitioners had to combine their existing practice knowledge (Cook and Wagenaar, 2012) about forms of assessment, any standardisation requirements and what they knew of the service users at any given point. For example Liz tried a sensory assessment at a later point in Claire's therapy. Gladys made ongoing assessments of Andy's communication and social anxieties and

Tess observed Zach's improvements in washing-up and cooking. Those examples indicated that during any given cycle of the process, the practitioners simultaneously observed, assessed and interpreted service users' actions (Mattingly and Fleming, 1994). A new practice knowledge was created at any given cycle of the process and a particular practice context was created at those cycles (Cook and Wagenaar, 2012). This was because there would be changes to the service user's occupational participation, their wishes, and the wider physical and social environment, including the development of the therapeutic relationship (discussed later), along with any number and type of possible differences compared to previous cycles of the process. For this reason, the practitioners had to consider two other aspects of standardised assessments, objectivity and subjectivity, discussed next.

5.2.3 Objectivity and subjectivity

There was an expectation that assessments such as outcome measures, should be used in practice to provide objective evidence of intervention efficacy, and should be routinely used in order to justify service provision and financial expense on services (COT, 2015; Duncan and Murray, 2012). Objectivity and subjectivity in the practitioners' practice became most apparent when assessing service users.

What was missing for the participants in their practice was their ability to use MOHOST with their service users. Liz could only use the MOHOST to get a broad assessment of Claire. Andy's existing habits and routines of occupational participation were so limited that Gladys did not try and assess him with MOHOST. Not using MOHOST had an impact upon making a baseline assessment and therefore they had to rely on their observation skills. Duncan (2011a) saw the value of standardised assessments was to provide an unbiased picture of the service user's performance. Using observations alone would be seen as not valid and unreliable, and therefore not objective; meaning observations were open to the bias of the individual occupational therapist (Duncan, 2011b).

Occupational therapists however, had to pay attention to the service user's occupational participation from a holistic perspective linked to the environment and humans' social, physical, spiritual and psychological needs (Ikiugu and Pollard,

2015; Hammell and Iwama, 2012). Thus the service user's emotional state and their sense of meaning, purpose and experience of occupational participation were all important when making a judgement about when and why to use a standardised assessment. Those aspects may not all be measured with one standardised tool, some may be unstandardised observations, others may be ascertained through discussion, still others are standardised interview based assessments.

There were a range of issues that needed attention when using standardised assessments. The practitioners needed to observe and ascertain aspects that were not formally part of the assessment. For example: pain, fatigue, anxiety/ fear, concentration/ distraction, motivation & engagement, rapport, environment, side-effects/ drug response and therapist familiarity with the assessment (Laver Fawcett, 2007). They would have a bearing on service user's performance of the assessment and thus the results. There were possibly two problems of adhering to a rigid approach of always using standardised assessments. Firstly, an evidence based approach would expect therapists to have to use a standardised assessment to measure every aspect of a service user's level of occupational participation noted by Laver Fawcett (2007) in order to ascertain whether any other assessment could be used. Secondly, this was clearly untenable, unwieldy, unachievable and not economical as not every aspect of practice can have an assessment created for measurement.

Practice required professional judgement and needed to include the blend of the professional and personal such as the science of standardised measures and the humanist aspects of the therapeutic relationship and therapeutic use of self. Using just standardised measures to assess and protocols and guidelines for interventions was counterintuitive to a client-centred approach where service users needed to be part of the decision about whatever assessment was used in practice (Parker, 2006; Law, Baptiste and Mills, 1995). Risk assessments were also expected in the forensic setting, discussed next.

5.2.4 Risk assessment

Risk assessment in the forensic setting had developed into core business, this is so because the public had needs for safety from harm from service users when

they went on community leave and unescorted ground leave (Cronin-Davis, 2010, Lindstedt et al, 2004). College of Occupational Therapists guidelines (Pearmain, 2010) indicate that risk assessment and management must be embedded as part of safe and effective everyday practice and not seen as an optional extra. Each practitioner apparently accepted risk assessment as integral to the forensic environment (Neeson and Kelly, 2003; Cordingley and Ryan, 2009; Connell, 2015). Given the weight of public protection agenda and professional expectations, occupational therapists must not ignore risks, however, they needed to be aware of the range of ways of seeing risk and the implications for their practice knowledge.

The importance of highlighting the point when risk terminology started to be used reflected the wider societal views about risks that consequently changed terminology and practices. Risk had not always been the term used in forensic mental health, other words such as danger, dangerousness, and violence have been used interchangeably (Cordingley and Ryan, 2009). It was difficult to establish the historical development of the term "risk" from an occupational therapy perspective, but an early record of its use in the literature was from Lloyd (1987c). An email discussion with Jeannie Mee (2014), who worked with Mary Crawford to establish Broadmoor's occupational therapy services, indicated that the term risk became more prevalent following the move of mental health service users from large psychiatric institutions to community care in the early 1990s. The occupational therapy literature was also not clear on the history of when the term "risk" was used instead of "dangerous" and "violent". The practitioners therefore were working at a time when the risk discourse and practices associated with it were firmly embedded in the forensic setting and the team's work, discussed next.

5.2.5 The multidisciplinary team and practice knowledge about risk

The practitioners were expected to share service users' risks assessments with the team. This derived from an official requirement for using the Care Programme Approach (1990) and part of the context of service provision and monitoring in mental health. A disciplinary requirement was to share any plans involving tools and equipment with the multi-disciplinary team. Tess used the clinical team meeting to get the team's view on any new risks or changes to her risk

assessments and how she would manage them, which Duncan (2008) supported. Liz and her team, first started risk assessment in the pre-assessment and followed this in the pre-admission meetings. There was subsequent collaborative risk assessment with nurses once a service user was admitted to a ward, indicating the team communication required (Fairhead, 1997). Practice knowledge was therefore infused with a variety of reasons for having to do risk assessment and included the shared experiences and dialogue between team members who shared that knowledge (Cook and Wagenaar, 2012). Indeed, practitioners were expected to share a range of their knowledge about the service users with team members, considered next.

The practitioners were expected to feed back to the team at regular intervals in formal team meetings, about their knowledge in relation to the service user. The practitioners presented their knowledge at any given point as they used the occupational therapy process. Gladys had encountered an unusual situation with how Leila was coping with her physical pain. The team was an established group and Gladys was new to the team at the time. She asked about the team's knowledge of Leila's physical health and their understanding of how she expressed her pain. The team knowledge was that Leila's pain was in part to do with her anxiety, leading her to exaggerate her pain experience. Gladys joined the team with 'fresh' eyes, and a practice experience of having worked in elderly physical health care. Gladys was able to bring this different knowledge to the forensic setting and used this to raise the team's awareness. The team and Leila agreed to Gladys trying to explore Leila's physical pain and functioning. From current practise a new context developed and Gladys and the team created new team knowledge that gave further clarity to the existing team knowledge (Cook and Wagenaar, 2012).

5.2.6 Risk prediction and control

There were different epistemologies for viewing risk and its assessment, which impacted upon occupational therapists' practice of risk assessment. One view came from a techno-scientific epistemology. Risk was seen as an objective, neutral entity that was independent of humans and their perception of risk (Dennhardt and Laliberte Rudman, 2012). That view was implicit in the recent occupational therapy forensic papers on risk (Connell, 2015; Cordingley and Ryan, 2009). Risks were

therefore identified by assessment and could be predicted and risk could be controlled by its removal, elimination or reduction; otherwise known as risk management (COT, 2006).

Risk could best be identified based on the past, but at its best was an unreliable guide (Garland, 2003). As Tess stated history of a service users' risks was all that the practitioners had to inform their assessment. Even actuarial measures that quantified and statistically analysed risk relied on history (Garland, 2003). It might be more correct to say that the practitioners' previous practice experiences could provide a practice knowledge about a service user's risks in history, but prediction on that basis was not possible.

The techno-scientific view that risks need to be objective and measurable is problematic when immediate actions in a volatile situation are required. Dealing with immediate risks was of most concern to therapists given the service users' occupational participation using equipment and tools and when on community rehabilitation visits (Duncan, 2008). Searching for certainty through risk assessment in an uncertain world and trying to make predictions based on this was fraught with difficulty. Surely the intricacy inherent in the transactions and dynamic inter-play between risks and the person, the physical and social environment and occupation (Cutchin, 2007) suggested not all risks could be assessed, predicted and planned for. Indeed, a way of predicting risk and having a plan to eliminate risk meant that all risks had to be accounted for, which was an idealistic and potentially oppressive practice.

There was an indication that occupational therapists think about risk in other ways, as one of the themes in Cordingley and Ryan (2009) concerned therapists' risk perceptions and interpretations. They included beliefs that risk had a dynamic nature and that they saw context as an important influence on risk, but also future risks may not be reflected in the context of past risks. Other perceptions for example, concerned how one worker may perceive a basketball hoop as an opportunity for occupational participation of basketball, whereas the head of security might perceive the same risk as an opportunity to use the hoop to escape (Cordingley and Ryan, 2009). By acknowledging there could be different ways of seeing risk, there was an implicit leaning towards a cultural/symbolic perspective, where the identification of the risk was socially constructed, and also an

acknowledgement surrounding the values inherent in naming and framing risks (Dennhardt and Laliberte Rudman, 2012). That said, there was still room for further exploration of the epistemological influences on risk conceptualisation in occupational therapy in the forensic setting and other practice areas.

A theoretical occupational therapy perspective on how risks can be assessed is possible. The combination of person, environment, occupation performance and participation model from Baum and Christiansen (2005) was used to organise the literature and focus group data on risk assessment in occupational therapy by Cordingley and Ryan (2009). The practitioners in the current research did not explicitly refer to using any theoretical approach to their risk assessment. Liz spoke of a focus on the environment in WEMSS risk assessment, and this focus was not surprising given the place of environment in MOHO. The practitioners did not however, explain how they used, if at all, other parts of MOHO to conceptualise risk assessment. In the absence of any formal tool for occupational therapy risk assessment, a theoretical approach was a sensible way to construct a view of the service user's risks. I do not suggest taking this approach to differentiate theory and thinking from doing and practice, but to use theory in combination with practice experiences, such as incorporating more of the service user's narrative about risk, to create practice knowledge about individualised risk assessment in occupational therapy. Further research on how MOHO is used in risk assessment is indicated. Theory use in practice is discussed in more detail next.

5.2.7 Using theory in practice

My findings demonstrated how forensic occupational therapists were educated and worked within an organisation, and wider health-care system that assumed and expected knowledge and thinking preceded, was required for, and informed practice, otherwise known as the received view (Cook and Wagenaar, 2012). The practitioners perceived their knowledge was applied to their practice, so the received view about knowledge informing practice was apparently enacted in their therapy.

It had been suggested that practice without a theoretical base was like guesswork (Higgs et al, 2001). Turpin and Iwama (2011) and Hagedorn (2000) noted that

occupational therapists valued propositional and non-propositional knowledge reflected in the concepts of art and science of practice, a 'two-body practice that combined the impact of diseases on occupational participation and the illness experience (Mattingly & Fleming, 1994). Therapists therefore acquired new knowledge through action (Turpin and Iwama, 2011). The powerful positon that MOHO held as the most researched and developed model of practice used in practice is discussed further.

The practitioners were required to know about MOHO (Kielhofner, 2008). That model was not specific to forensic practice but the earliest references to it in the forensic literature were Paulson (1980) and Lloyd (1987a). Subsequently various therapists discussed the use of MOHO in forensic settings in Australia (Lloyd 1987a & b; Lloyd & Hall 1988), the UK (Duncan, Munro and Nicol, 2003; Walsh & Ayres 2003; and Hunter and McKay 2008) and America (Munoz, 2011; White et al, 2014). The practitioners were expected to use MOHO as the filter through which they gained knowledge about all service users admitted to their settings. Using MOHO in this way implied that theory was seen as preceding practice, considered further.

For much of the forensic and occupational therapy literature there was an assumption that knowledge came before practice. The common phrase of 'a knowledge base' for practice (Lindstedt, 2011; Flood, 1993), or a "sound theoretical base for practice" (Hagedorn, 2000, p.vii) and knowledge underpinning practice (Clarke, 2003; Martin, 2003) and to apply a frame of reference (Lloyd, 1988) were used in the occupational therapy literature, so forming part of its discourse about the positions of practice and theory. This was reflected in Tess's statement that MOHO guided the therapists' thinking and in Liz's comment that MOHO was an underlying principle for her. It was suggested that therapists needed to choose the best theories to "drive practice" (Duncan, 2011, p. 339), all of which indicated the received view. Duncan (2011), however, later stated that "theory should grow in and from practice" (Duncan, 2011, p. 413). Indeed Turpin and Iwama (2011, p. 800) stated that theory needed to 'serve' practice and not drive it. This suggested a turnaround from thinking and theory development driving the doing of practice. This type of inconsistency was confusing when trying to understand how theory and practice related and how they were co-constructed. Of course those statements need not be mutually exclusive if the theories that drove practice were indeed created through practice.

A potential problem was when theory became dogma from which practice followed and to which practice was shackled (Fish and Boniface, 2012). Having an organisational mandate to use only one model, as in the organisation in my research, appears dogmatic. The reasons for aligning a number of forensic services to one model may be that it simplified practice theory links with which to consider the complex needs of service users. Rogowski (2002) drew on Creek's (1990) view that an eclectic approach encompassing several models was possible when working with service users. The need to understand the models and critically analyse them for their use in any given practice setting was underlined by Rogowski (2002) and Ashby (2013). These processes meant the therapist would develop an awareness of those aspects of the models that were incompatible and conflicted and that should not be combined for practice with the service user (Martin, 2003).

The practitioners were required to use a model as a vehicle by which to explore and explain each aspect of the service users' occupational participation. Models were understood as a way to generate ideas and explanations about occupational therapy practice (Lloyd, 1995), thereby enabling a frame and a structure for therapists' practice with service users. Martin (2003) suggested that because therapists need to explain and justify their practice, theory could be used as a rationale for practice. Lloyd (1995) stated that the service user's needs should be compatible with any chosen theory however, this depended on how therapists went about choosing that theory. The practitioners in my research were required to use MOHO which meant a theory was selected prior to starting any occupational therapy process. A model provided a conceptual lens by which the practitioners perceived the service users and their needs, which from thereon determined all occupational therapy (Hagedorn, 1995). Theory driven practice was where the theory had to be adopted before intervention was started (Hagedorn, 1995). MOHO (Kielhofner, 2008) was described as important for such practice and was seen as a requirement of the organisation.

The advantages of a theory-driven approach were that it could be time saving as fewer choices needed to be made about other theories and interventions to be used and therapy could be provided faster (Hagedorn, 1995). Additionally, a therapist may become more adept within a limited and defined practice (Hagedorn,

1995). All three practitioners indicated a deep familiarity with the use of MOHO. The disadvantages were that the conceptual lens altered the practitioner's total perception before any work with the service user. Therefore any beneficial information or interventions could be lost through the reductive, narrowing of vision in a theory-driven practice (Hagedorn, 1995). Liz commented that she might not see the limitations of MOHO because she liked it and therefore, being biased in its favour, might not be more critical of it. There were however examples where the practitioners developed their knowledge about the limitations of MOHO through their practice with the service users, which is discussed later under the question of how could the practitioners not practice as expected. Before that point however, a specific characteristic of choice within the concept of volition from MOHO and its relationship to the practitioners' practice is discussed further.

5.2.8 Choice

The practitioners had to work with service users' choices from two perspectives, one was about their engagement with occupational therapy, the other was the ways in which MOHO and other approaches were used to conceptualise choice. A fundamental requirement was that service users had to agree to work with the practitioner in order for them to provide occupational therapy. If service users refused, the work could not be taken any further, however the practitioners developed ways to move beyond such an impasse, a consideration discussed later in my thesis. Part of the client-centred approach however, involved helping the service user to make an informed choice (Sumsion, 2006; Law and Mills, 1998) to participate in occupational therapy. The practitioner therefore still had to find a way to engage with the service user in order to facilitate that practice.

Service users may have not perceived engaging in occupational therapy as a free choice. A refusal to attend therapy would not be a meaningful choice as this could delay discharge (Craik et al, 2010), or further restrict other benefits and pleasures such as community leave. Trying to coerce service users could be counter-productive to therapeutic aims for groups which would influence the effectiveness of group-work (Kelly, 2003). Choice therefore promoted motivation for working on goals, but if not motivated, service users could become resentful and undermine

the event. Research indicated that removing coercion however, led to service users reverting to previous patterns of re-offending (Helbig, 2003).

MOHO provided the concept of personal causation that included making choices. The forensic setting made choice making an intricate matter for service users and practitioners. The practitioners did not refer to the MOHO conceptualisation of choice in relation to volition, but the opportunities for service users' choice were important to their practice. Gladys found on her ward that the service users, including Andy, were very low in self-confidence and self-efficacy. The latter referred to the thoughts and feelings about the perceived effectiveness of meeting one's desired life goals using personal abilities (Kielhofner, 2008). Making choices was linked to whether service users felt they had the capacity to do so (Helbig, 2003). Also the practitioners had to offer opportunities for occupational participation from which choices could be made. An aspect of offering choices was that practitioners had to make sure they were demanding but within the services users' abilities (Helbig, 2003; Martin, 2003). Practitioners know this as 'the just right challenge'.

Gladys used the term 'self-confidence' because, although it was not a MOHO term, it had a resonance with occupational therapists. For example, a qualitative study of twelve (ten men, two women) mental health service users residing in an acute unit, found the experience of baking increased their confidence and in turn their self-esteem (Haley and McKay, 2004). Unfortunately Haley and McKay did not include quotations from the interviewees to support their interpretation, which limits the veracity of their findings. The practitioners had knowledge of MOHO however, other concepts were used, but there was no explanation of the resonance between them. Choice, MOHO and the client-centred approach were theoretically connected. The concepts however, were implicit in the practitioners' expression of them as part of their practice knowledge. How the concepts and MOHO were related to recovery was also not explicit and is considered later in the discussion.

In summary, examples have been provided of how the practitioners' practice knowledge was created in both what they actually did and what they were expected to do. The difficulty of uncertain and new practice contexts required the use of existing knowledge, whether from pre-registration education, further training or reading. A new practice knowledge and context derived from practice indicated the

flexible, creative ways in which the practitioners' and team's knowledge was generated. Practitioners incorporated evidence from a range of sources that was part of their existing knowledge and it became part of a new knowledge created from practice. Seeing evidence purely as a base for practice ignored the ways in which knowledge was created in a much more flexible, creative way as the practice context required.

5.2.9 Occupational therapist's personal and professional values

There was an expectation that the personal and professional should be mutually exclusive in the sense that occupational therapists should be objective about their practice. Indeed, therapists were required to be aware of their values and beliefs and how these might impact upon any discriminatory and unethical practice (Health and Care Professions Council, 2013; COT, 2015). Arguably, it was the practitioners' personal values and beliefs that drew the participants into working and using them in a therapeutic discipline. Denshire (2002), an Australian occupational therapist and academic, discussed how it was an illusion that the personal and professional in practice were separate and how combining the personal and professional was an underground practice (Mattingly and Fleming, 1994). Indeed, Denshire (2002) noted that reflecting on the subjective to make it explicit provided greater depth to practice. My findings suggested however, the practitioners only partially declared their values, beliefs and personal emotional challenges in practice and why they were so.

The practitioners did not explicitly discuss how they used the personal and professional in their practice knowledge. Given that partiality, I took the view that the practitioners engaged in a 'blending of the personal and professional' rather than experienced a 'confluence' (Denshire, 2002). I made that judgement on the basis that it was still too difficult for the practitioners to fully express the personal when it became apparent through challenging practice situations and subsequent reflection. The practitioners were not so explicit about the direct impact of personal life experiences on disciplinary practice to the extent that they experienced an overt 'confluence of personal and professional as Denshire (2002) explained her ideas.

The practitioners did however, give brief indications of their worldview, a philosophical concept explored by Hooper (1997) an American occupational therapy academic. She carried out a case study of an occupational therapist who came from Mumbai, India, and worked there for 15 years prior to going to the USA approximately five years before Hooper's research with her. Hooper (1997) explored the therapist's practice in relation to her sociocultural beliefs and life experiences of the world. Hooper (2007) called such beliefs pretheoretical commitments and from her analysis categorised them as personal beliefs about reality, life and death, human nature and knowledge (Hooper, 1997). Hooper found the therapist's beliefs influenced her reasoning, so they indicated some similarity with how the practitioners used their values and beliefs and therefore had a part to play in practice knowledge. Unsworth (2004) noted that the therapist's worldview needed to be included with pragmatic reasoning that included the personal and practice context of the therapist. Unfortunately she did not provide further empirical work about worldview, except that there was an absence of discussion about the personal component of pragmatic reasoning by her research participants when interviewed. She noted further research was required to provide more robust research into the relationship of worldview and pragmatic reasoning (Unsworth, 2004).

It may be that the practitioners were more overt about the personal in their supervision and did not want to go into that detail in a research project. They all however, spoke of the limited opportunities to discuss service user related matters in supervision, but had group reflections with the team. Indeed, expressing details of personal life experiences in a team group could make practitioners feel too vulnerable (Denshire, 2002), a particular challenge in forensic services. Practitioners may also be accused of not being objective enough in their practice.

Liz explained her interests and work of various forms, not just occupational therapy, with women in forensic services that spanned over 20 years. Indeed, Denshire (2002) chose to work with children and youth at a time when she experienced motherhood, which upon subsequent reflection in her academic studies, indicated a continuity between her personal engagement in occupation and her disciplinary practice about service users' occupational participation. Joe a manager in Cronin-Davis's (2010) research noted that therapists needed to want to work in the forensic setting, and not just to cope with it. Thus personal motivations for wanting to work

in the forensic setting were indicated even in a practitioner's choice of work. There were ways in which the practitioners did not meet the expectations of practice, leaving gaps that required bridging, which are discussed next.

5.3 HOW WERE THE PRACTITIONERS NOT MEETING PRACTICE EXPECTATIONS? BRIDGING THE GAP.

The practitioners experienced various ways in which they could not meet practice expectations. In broad terms they can be seen as knowledge gaps. For example the blanket referral approach was not codified in the literature. Gaps were created when practitioners could not ascertain the knowledge they required from team members and when developing the therapeutic relationship was stymied. Also when standardised assessments were ineffective at certain points and when the organisational policies did not meet the service users' and practitioners' needs. Interventions and risk taking had no detailed codified literature. Also theory sometimes did not explain the service users' needs. There were also gaps in how the codified sources related to actual practice and situations of uncertainty and the unexpected events arising in practice. The discussion now moves on to consider those aspects.

5.3.1 Blanket referral

An assumption could be that one occupational therapist per ward, as in the practitioners in my research, could have worked with every patient on their case load. Tess needed to create an informal waiting list for moving beyond blanket referral though to other cycles of the process. She stated that, in relation to establishing which service users were most likely to be discharged first, she would prioritise them, whereby those with less pressing time frames would be placed lower on the list. That approach had not been explicitly acknowledged as a consequence of the assumption. By not acknowledging such an informal waiting list approach, the organisation kept that aspect of practice implicit and silent, leaving the practitioners holding the responsibility to deal with whatever repercussions arose. Thus stress may arise when trying to juggle a range of service users' occupational participation constraints and the practitioners' inability to work with every service user on the ward concurrently.

5.3.2 Limitations with team members' knowledge

Despite the various team members' sharing of information and knowledge, there were still gaps in knowledge. The nature of the gaps could be uncovered from others' reports of their observations of service users, Gladys's example where she liaised with the activity co-ordinator who ran a group, was a case in point. Gladys' colleague was unable to furnish her with the information she was looking for, because the co-ordinator had not made the observations Gladys was seeking. This left her knowledge about Andy's participation in the one group that he attended, with its potential social links with other service users and staff, as incomplete. Another example from Gladys is where she knew that the medical notes would contain only so much information and that she needed to speak to team members in the various meetings in order to gain a detailed view of the service user.

5.3.3 Problems building a therapeutic relationship

The role of initial interviews for rapport development (Lloyd, 1988) is a broad statement without clarification. None of the participants could do a full initial interview, but they could all do partial interviews and brief discussions with their service users. The only way for Tess to build rapport with Zach at this time is through her unstandardised assessment, observation of him and discussions that provided limited detail from Zach. These examples indicate that rapport occurred in small steps and in ways that the service user determined by the length of time they engaged with the participants. The implication that one initial interview (Lloyd, 1985) is enough to develop rapport places the control of this in the hands of the occupational therapist, and does not acknowledge the part that the service user plays in agreeing to and limiting an initial interview and thus the opportunity to build rapport. The emphasis on client-centred (Sumsion, 2006) and recovery approaches (Drennan and Alred, 2012) to practice bring a different dynamic to the therapeutic relationship.

Building rapport through assessment was a blunt way of describing a process that was rarely straightforward. Tess's assessment of Zach was restricted due to his limited occupational participation at the time. Thus her ability to develop rapport with him was diminished. The process of building rapport, implied in Tess's discussion, in the early stages of her work was slow and was only apparent through Zach's engagement in occupational therapy. Indeed, MOHOST was not easily used to build rapport because it was primarily based on observation of occupational participation. Any discussions that may occur between a therapist and service user can inform the MOHOST, but other interview based assessments were required for that from MOHO (Kielhofner, 2008).

5.3.4 Connection

I refer to the point at which the service user and therapist first agree to start working together a connection. This is based on a comment from Liz about getting a point of connection with the service user where they can start working together. Connection had to be established before any rapport building took place. Without the service user's willingness for connection with the practitioners, occupational therapy could only occur partially or not at all. Connection had to form part of an early phase of practice not captured in the literature. A point of connection with a service user was particular to whether they wished to work with the participants beyond the initial introduction. The times when the service users and participants were first introduced in a meeting or when initiated on the ward, could be seen as the first point of connection, but in fact they were not. The participants had to understand what aspects and in what ways the service users were motivated to engage with them. They sought agreement from the service users to work together on their therapeutic relationship that were key aspects of client-centred practice that incorporated the choices that service users could make (Parker, 2006; Law, Baptiste and Mills, 1995).

The practitioners had similar practice experiences that were their difficulties connecting with their service users, which impeded working together. Each participant had difficulty in those initial stages of connecting with their service users. Gladys and Andy had very limited contact in the early stages of trying to connect. Gladys had to create opportunities to make a connection with Andy due to his very

limited occupational interests of rolling a cigarette and his avoidance of going for a walk to the garden with her to do that. Liz believed Claire was anxious at starting occupational therapy with Liz. Service users could also feel guilty about their crime (Fairhead, 1997) or indeed, embarrassed. Service users' previous experiences might create a situation in which they found it difficult to form and sustain therapeutic relationships with workers. Furthermore, they might have put energy and time into trusting a worker to find that they were going to leave, which in turn raises issues of fear of abandonment and rejection (Taylor, 2008). The service users' may well become reluctant to connect with an occupational therapist as a result.

The way rapport and a model of the intentional relationship (Taylor, 2008) was conceived in the literature however, did not consider the point prior to and from which rapport started. The reasons for the emphasis on making a connection may be linked to the amount of trust a service user was willing to give to the therapist to take that first step to engage in occupational therapy.

Therapeutic moments with service users had to be captured, as jointly planned work was sometimes out of the participants' control. Stelter and Whisner (2005) called those small moments when a service user could be directly engaged as 'therapeutic windows of opportunity' (p. 79), echoed as windows of opportunity by a manager in Cronin-Davis' (2010) research. Indeed, a participatory action research study on intervention planning and the multi-disciplinary team in a forensic service in Canada (Livingston et al, 2013) found service users valued the casual interactions outside of the formal treatment planning conference. For team members also, that was a way of building rapport and for understanding service users in a richer, dynamic way (Livingston et al, 2013). Making a connection between the participants and their respective service users was also an example of the subtle skills of the practitioners in motivating and engaging service users (Alred, 2003).

The participants had to actively locate, enable and take advantage of circumstances for connection with their service users. Gladys in particular had to use various approaches before she connected with Leila and Andy. Gladys persisted with greeting Leila whenever she saw her on the ward, trying to actively engage her in a discussion about occupational therapy, which she always refused.

This was part of how one might go about social pleasantries and greeting someone who was known to the therapist. It was also a much deeper acknowledgement of the service user and their importance in the therapeutic relationship. It said the service user had value in the relationship and should be appreciated as someone who could make choices about their engagement in occupational therapy (Law, Baptiste and Mills, 1995). Gladys was continually rebuffed when she knocked on Leila's bedroom door. Gladys persisted, but remained aware of the possible risk of harm to herself if Leila felt too pressured. What was interesting was what prompted Gladys to persist with Leila when she consistently refused to engage with Gladys. Indeed, a twitter discussion about my findings on connection suggested whether the practitioners' persistence may have helped develop trust and an understanding of the ups and downs of a positive relationship (Morris, 2015), such as Gladys returning to Leila despite her refusals. Thus the service user would have a better sense of whether they wanted to connect or not. One further comment from twitter, suggested that a connection may be part of rapport building, rather than a precursor (Tempest, 2015), as I had suggested. The literature is not sufficiently nuanced to state either way, thus further research was therefore indicated. Service users needed to be enabled to make an informed choice about engaging, or not in occupational therapy, which still required a connection. Making a connection was therefore an aspect of practice knowledge developed through trying to work with service users who were reluctant to engage in occupational therapy. Future research could look at how a connection developed in other areas of occupational therapy and mental health.

5.3.5 Screening tool assessment limitations

There were examples from all of the practitioners where the evidence base did not support their assessment when using a standardised measure. It was assumed that if an assessment has been standardised for a particular service user group in particular circumstances, that the assessment would be reliable and valid and could be used in a standardised way. The MOHOST (Parkinson, Forsyth and Kielhofner, 2002) was developed as a theoretically driven observational measure of individual service users' occupational participation in an acute mental health setting. Indeed, Parkinson's et al view was not dissimilar to others in that a theoretically based approach to practice in general was valued (Turpin and Iwama,

2011). Forsyth et al (2011) highlighted key features of MOHOST that could be used to gather data informally from various sources such as informal conversation, proxy report, team feedback or medical records that allowed practitioners to get to know the service user. A second version of MOHOST was developed (Parkinson et al, 2006) and was used by the practitioners. The practitioners found, however, that even working in rehabilitation (where service users would be more stable in their mental state) and acute environments, the service users were not presenting with enough range of occupational participation to complete this measurement. The service users' mental state, motivation, and general level of engagement also impacted the assessment. The screen could not be completed for three of the service users (Claire, Andy and Zach). This was not the experience of practitioners reported in Forsyth et al (2011) who stated the tool was useful for non-cooperative, non-verbal service users with limited cognitive capacity. The MOHOST, in my research, was not successful for establishing a robust range of scores of service users in three different practice areas, including WEMSS and adolescent, two acute settings. Providing direction for further MOHO assessments could not be achieved, for which MOHOST was originally developed (Parkinson et al, 2002).

5.3.6 Limitations of outcome measures

The practitioners found MOHOST could not be used as a baseline and outcome measure for some of their service users. MOHO was seen as a way for occupational therapists to justify and demonstrate being evidence based in practice (Kielhofner, 2008). Parkinson's (2014) practice knowledge suggested MOHO was more effective in one-to-one assessment and intervention planning. Using MOHO to justify interventions was not noted, indeed, Parkinson's (2014) comments implied a research drive for theory and assessment development of MOHO. MOHOST and other MOHO related standardised assessments and other occupation focussed outcome measures assessed changes in whatever aspect of occupational participation for which they were designed. What was not acknowledged was that outcome measures did not identify how changes came about, and who was responsible for the changes. Often the service user experienced a range of interventions from various team members that could have an impact upon occupational participation. It is likely that work on service users' specific occupational participation constraints by occupational therapists would

improve them, but outcome measures do not provide that knowledge. There were other limitations of using assessments, discussed next.

5.3.7 Environmental impact upon standardised assessment

Service users in the forensic setting are very restricted in their occupational participation. Restricted in the sense that opportunities for occupational participation are limited and highly controlled in the forensic environment (Craik et al, 2010). Also restricted in terms of not being able to participate in occupations according to their interests and patterns, style and habits of participating, because the context for participation is different. The organisational four week rule for completing a baseline assessment did not take into account the context of the occupational participation. MOHOST was also designed to identify areas for further in-depth assessment. Therefore, the multidimensional aspects that could be observed when not using a standardised assessment, could be missed. Standardised assessments by design have to focus on specific aspects to measure, they cannot make assessments for the holistic perspective valued in occupational therapy.

The flexibility offered to the practitioner and service user by using informal assessments may have been confusing to service users if they did not know they were being assessed. Cronin-Davis (2010) interviewed service users with a diagnosis of personality disorder, and in their responses did not identify that their occupational therapists assessed them. There would be an ethical issue if service users were not making an informed decision to engage in occupational therapy however, this was unclear in Cronin-Davis's work. It may be that those service users' therapists were using informal approaches, core skills and observations, along with informal interviews and discussions rather than structured or standardised interviews. If the therapists had gained service users' explicit agreement to participate in occupational therapy then whatever methods they used would be encompassed within this agreement. The discussion on the process thus far, has already identified the intricate ways in which the process cycles and phases occur; indeed, this would be too much information for the service users. A more important time for clearer explanations would be when standardised assessments were used. Cronin-Davis (2010) did not explore those possibilities, highlighting that

therapists should be explicit about the process and purpose of their assessments to service users. She did not however, acknowledge that an overly formal or simplified approach to explaining the cycles of the occupational therapy process to service users could hide the intricacy of occupational therapy practice. Such intricacy is difficult to explain to service users, especially if compromised by acute illness experiences. Furthermore, in a recent twitter discussion between occupational therapists with forensic experience, it was highlighted how standardised assessments could be used to justify occupational therapy to the team and not to service users (Macleod, 2015). That kind of approach was not client-centred.

5.3.8 Interventions and evidence limitations

The practitioners were expected to be evidence based in their practice, but the literature that codified practice about interventions linked to MOHO was limited. Most of the literature about interventions based on MOHO was about the use of theory in the form of a variety of activities linked to the concepts in a model of practice. There was some literature that represented authors' practice knowledge from their experience of combining MOHO and interventions. For example, the remotivation process was linked to the volition concept (de las Heras et al, 2003). Group work interventions focussed around the exploratory stage of change were developed by Kaplan (1988). She concentrated on the early part of therapeutic group interventions in a relatively undemanding and safe environment. By participating in activities in groups service users experienced their capacities, a part of personal causation and their preferences and values; all from the volition concept in MOHO (Kielhofner, 2008). A more recent addition is from Parkinson (2014) who used MOHO to create an intervention package. The practitioners did not discuss whether they knew of any published work on using interventions that related directly to MOHO concepts. The practitioners therefore were unable to meet evidence based expectations in relation to MOHO and interventions in particular. This leads me to consider how the practitioners' practice knowledge was used and created in order to bridge the gaps between expectations of practice and limitations of risk management and providing interventions.

5.3.9 Combining risk management, occupational therapy core skills and interventions

There was very little detail in the literature about how to practice risk management in forensic settings. There were broad exhortations that risk management must be done in practice (COT, 2015). This section therefore discusses how the practitioners enacted their risk management plans. How risk management manifested in practice became more apparent in the analysis of the findings using Situational Analysis (Clarke, 2005), and so up to now was a topic that had not been explored empirically.

My findings provided empirical support that the practitioners included a combination of core skills of practice for risk management and risk-taking, along with components of the occupational therapy process previously discussed; including knowledge gathering, assessment, interventions and risk assessment. I discuss what core skills are and how they were combined with the other aspects noted above, in practice.

Core occupational therapy skills for grading and adapting environments and occupational participation for positive risk taking and management were required (COT, 2012). Also a flexible approach to occupational participation that met the fluctuating security needs of the service user was required (COT, 2002). The COT (2012) view of the entwined nature of risk assessment, management and risk taking, along with core skills was the most recent, they provided no empirical support for their view but it was likely created from those authors' practice knowledge. Indeed, Munoz (2011) did not identify core skills in his description of a knowledge and skill set for forensic mental health practice, which was remiss given their core position in occupational therapists' practice. Core skills were knowledge developed in pre-registration education and were one aspect of practice that cut across all practice areas in physical and mental health. Munoz's (2011) view was also an example of how the relationship of core skills, risk assessment and management have been under explored in the literature.

Others in the forensic literature identified core skills and the therapist's ability use them to meet the service user's occupational participation constraints and capabilities in relation to the environmental influences present (Fairhead, 2005; Chacksfield, 1997; Flood, 1997). Modifications to activities and environments using adaptation and grading were possible in a secure setting (White et al, 2012; Duncan, 2008). Activity adaptation was defined as:

> "[…] the process of changing the demands of an activity for a specific therapeutic purpose. Changes may be made to tools, position of equipment, materials, speed of performance, repetition, specific movements, strength and resistance, sequence of tasks, simplicity or complexity, instructions, context, location, number of practitioners and degree of choice." (Creek, 2003, p38).

Liz described how helping service users to access various environments in the WEMSS atrium might require various adaptations that were specific to the WEMSS physical environment. Dressler and Sniveley (2005) were the closest in identifying how therapists created intervention plans and how they altered in relation to risk taking. They noted the need to have highly controlled and structured intervention planning in the early stages of work with service users, which reduced as they demonstrated more reliability and predictability (Dressler and Sniveley, 2005).

Facilitating occupational participation with core skills made rehabilitation within the forensic environment possible (Freeman, 1982). Liz did a no tools cookie baking session by adapting Claire's bedroom, rather than using a kitchen with its equipment and associated security restrictions. To manage hygiene rules they had access to water for cleaning in an en-suite bathroom and they used plastic sheeting to cover furniture. The cookie making was adapted so that Claire used her hands to mix and stir ingredients in bowls and then placed the mix by hand on baking trays, without the need for cutlery.   This intervention was a creative approach to occupational therapy that was required in the forensic setting (Hunter and MacKay, 2008).

Activity grading meant:

> "[…] manipulating the factors required for the performance of a task or activity in stages so that the activity becomes progressively more difficult or easier to carry out. An activity can be graded to increase or reduce social, emotional, cognitive, perceptual or physical demands. The environment can also be graded, for example to add more stimulation, pressure or stress." (COT, 2009, p38).

Fairhead (2005) suggested therapists carefully select recipes to avoid using knives for cookery in a kitchen. She could have used activity grading more by moving from the recipes she suggested, to recipes that gradually increased the use of different types of utensils and equipment. She would see service user's risks reduce as they would demonstrate their skills development by how the service user participated in cookery and how far the therapist took risks with the interventions. Fairhead did not seem to consider practice creatively as Liz had, which was a less creative use of core skills. Also it was an example of how little codified occupational therapy knowledge there was on detailed and creative strategies of risk management embedded in occupational participation in forensic settings. Liz's approach suggested that she used her existing practice knowledge, combined with the new practice context that developed, and created a new practice knowledge about how she could use her core skills for a cookery intervention not ordinarily completed in a bedroom.

Challenging the existing procedures to facilitate occupational participation maybe required of therapists, as with Liz's example. O'Connell (2010) noted that sometimes the overarching policy of a service, such as no tool use in the prison context, needed to be challenged to have risk management that reflected the individual's risks. One size fits all procedures should not be allowed to dominate therapy (O'Connell, 2010). By not being creative and reflecting on how to use core occupational therapy skills to their fullest potential, the creation of practice knowledge becomes stymied. Using a very limited range of interventions would lead to limited opportunities for service users that would not help develop their occupational participation strengths. Practitioners could potentially increase and

enact habits and traditions of practice because the limitations placed on them by the setting (Cook and Wagenaar, 2012) and their own lack of creativity. The impact on practitioners could be less need for reflective, reflexive and therefore creative practice. Opportunities could then develop for occupational injustice created by occupational therapy practice. These latter aspects require further research. There were other challenges to taking positive risks, discussed next.

5.3.10 Risk taking

Risk taking was required in order for the service user and practitioner to see how effective their occupational participation was in challenging situations. Occupational therapy risk management plans included an expectation of attempting to reduce risks and also the provision of opportunities where positive risks could be taken for service users' therapeutic benefit, a part of client-centred practice (Sumsion, 2006). Chacksfield (1997) and Freeman (1982) noted how occupational therapists provided the opportunity for service users to try out interventions that may impact upon their stress levels and prompt aggressive responses. The therapist would then work in a client-centred way and connect emotionally and intellectually with the service user (Parker, 2006). The results of such approaches become new practice knowledge (Cook and Wagenaar, 2012), in part because there were no codified risk-taking approaches for occupational therapists to use in practice.

Occupational therapists' own fear response could have impeded positive risk taking, but they must be prepared to take positive risks. Cronin-Davis (2010) saw this particularly in the context of working with people with a diagnosis of personality disorder (Cronin-Davis, 2010). Cronin-Davis (2010) does not differentiate which form of personality disorder to which her comment referred, but those service users diagnosed with anti-social and borderline personality disorders are particularly challenging. Indeed Liz said she understood the challenges that would be apparent when she found any of her service users had a personality disorder diagnosis. Tess and Gladys spoke of how they were wary of Zach and Leila's risks in the early stages of trying to work with them.

Research about when risk taking went wrong on the street-level work of police, teachers and vocational counsellors showed an impact of an increase in bureaucratic control (Maynard-Moody and Musheno, 2003), thus the possibility of positive risk taking shrinks. Positive risk taking may be more related to the different thresholds of various workers (Duncan, 2008). Workers may reduce risk taking when they were fearful of doing so, therefore they are less likely to take them. Crawford (2003), an early pioneer of occupational therapy in Broadmoor, a UK maximum secure hospital, in her foreword to Couldrick and Alred's (2003) book, noted risk taking needed to occur for rehabilitation of service users. Therapists must not however, forget the wider public safety and organisational security and safety approaches (Flood, 1993).

Street level work can be dangerous and unpleasant (Maynard-Moody and Musheno, 2003). To deal with those aspects the workers in Maynard-Moody and Musheno's (2003) research acted on their discretion to provide safer and more pleasant conditions for themselves, sometimes leading to a poorer service. Workers' discretion in practice, therefore has an impact upon the longer term prospects for service users to improve and benefit from the service offered. The practitioners in my research, used their discretion in how they made positive risks in the therapy provided. The practitioners did not talk about guidelines or protocols associated with and required for their therapeutic work and risk.

Maynard-Moody and Musheno (2003) stated that the ways that organisations tried to reduce worker discretion was through increased bureaucratic control such as the inclusion of more supervision, increasing its effectiveness and elaborating and enforcing rules and procedures. The practitioners in my research did not give the impression this was happening to them. Apart from existing high levels of physical and relational risk management restricting opportunities for occupational participation. Rani and Mulholland (2014) found service users were unable to meet the 25 hours of structured activity due to higher security measures. Prevention and Management of Violence and Aggression (PMVA), breakaway and de-escalation techniques are key aspects of the physical management of risk (Duncan, 2008, DH, 2010). Occupational therapists can be involved in procedures for controlling service users by physically restraining them (PMVA) or removing themselves from physical harm (breakaway) (Cronin-Davis, 2006, Urquhart, 2003). Liz had received training for PMVA and she believed that having that training possibly resulted in

the teams' agreement to providing occupational therapy with Claire in a seclusion room. Some occupational therapists argue that being involved in PMVA with service users would compromise the therapeutic relationship, however Urquhart (2003) and her team took the view that forensic mental health is by definition engaging in work with people who are detained against their will and so an impediment to therapy may occur anyway.

Indeed, the practitioners were more able to use their existing practice knowledge and create new knowledge by developing new ways to take risks. Dealing with dynamic practice contexts and risk assessment of individual service users (Cordingley and Ryan, 2009) is required. So too is practice knowledge that includes occupational therapy core skills to carry out essential observations of risk taking through interventions.

In summary, the place of risk assessment and management have traditionally been seen as separate from the occupational therapy process. They were however, required as core features of practice in the forensic mental health setting. This combination was not a simple add-on to the process. The practitioners had to assess their service users' risks and it therefore makes sense to establish a place in knowledge gathering and the assessment part of the process and likewise for risk management and risk taking in the intervention part of the process. Risk management and occupational therapists' core skills of activity and environmental analysis, grading and adaptation have not been explored in any depth in the literature. The practitioners demonstrated how occupational therapists have had to create a new knowledge from their practice in order for them to practice. They combined steps, rules, creativity and reflection. In that way they went beyond existing directives to risk assess and manage noted in the literature, to create ways to work with risk that formed their practice knowledge.

5.3.11 Occupational therapy process summary

My study was the first to explore ways in which therapists use a codified/ text book version of the occupational therapy process in forensic mental health practice. I have shown how the practitioners combined their core skills of practice, risk assessment and risk management with the occupational therapy process in the

forensic context. A key finding is how the practitioners had to modify the official codified work on the process in order to achieve their practice with their service users.

There are situations that arise in practice that cannot be dealt with by using process as a rigid framework. Indeed, if the practitioners' did not modify some of the process at particular points, they could not practice in a way that facilitated the service users' occupational therapy. Therefore practitioners used these procedures autonomously and creatively in order to achieve their practice with their service users.

5.3.12 Theory in practice

The practitioners identified when MOHO did not help them understand the service user. For example the concept of volition (what one chooses, anticipates, experiences and interprets about what one does as an actor in one's world and which occur as patterns of thoughts and feelings) was made up of three inter-linked components of interests, values and personal causation (Kielhofner, 2008). Tess could not develop her knowledge of Zach using the volitional concept in MOHO (Kielhofner, 2008), because he could only identify very limited interests related to occupations on offer on the ward and nothing from his life in the community. Andy too could identify his interests, but there were few and the one occupation that Gladys was later able to engage Andy in was his artistic work. The practitioners wanted to know about the service users interests, as this was one of the early points of trying to understand in what occupations they would potentially participate for intervention planning. Interests were identified as enjoyable and satisfying to do (Kielhofner, 2008, p.47). It was difficult to identify why the volition concept did not help the practitioners explain their service users' occupational participation. Indeed, it may be that the practitioners did not expand volition into enough of its various characteristics. The practitioners looked at interests, meaningful occupations and self-efficacy to various degrees, but there were other characteristics that needed to be considered.

Liz found that using all the concepts in MOHO in the early stages of the process did not help her to understand Claire's occupational participation. She found only

the meaningful familial role in habituation was particularly relevant to Claire. Habituation was another key concept in MOHO that Kielhofner (2008) defined as an "internalised readiness to exhibit consistent patterns of behaviour guided by habits and roles and fitted to the characteristics of routine temporal, physical and social environments" (p. 64). Opportunities for developing a worker role were available in the atrium in WEMSS. Also roles that encompassed shopping, hair care and reading were also possible in the atrium. Gladys found in the early cycles of the process with Andy, she could not use MOHO to explain his occupational participation due to his limited time spent in the engagement in anything beyond highly routine and habitual activities. That in itself gave some indication of his habituation, but Gladys did not comment on that.

Literature exists about roles that could be used as a source of knowledge. For example, Freeman (1982) suggested that service users may have a misunderstanding of what was expected by given roles in society due to limited opportunities to develop them, or they may have lost their own societal roles. Also what was seen as an acceptable role in society (Freeman, 1982; Lloyd, 1987b) and how they used roles to meet their needs (Lloyd 1987, Lloyd and Guerra, 1988) have to be considered by therapists. It has been noted that specific roles, such as the role of worker may be a major problem for them (Lloyd and Hall, 1988). Those papers addressing this issue did not use any theoretical or empirical exploration of role, taking it as a given that occupational therapists would understand what was meant by the term role, and its relationship with occupation and occupational therapy. The literature may have represented the authors' practice knowledge, but this was not explicit.

Liz however, focussed on Claire's sensory functioning, which MOHO included in terms of a human's biological preference for sensory modes that influenced volition and in relation to performance capacity, the "ability to do things provided by the status of underlying objective physical and mental components…" (Kielhofner, 2008, p. 21). Indeed, MOHO allowed for other theories that addressed performance capacity (Kielhofner, 2008). Tess used sensory theory with Zach to explain the behaviour of a boy wearing an empty back-pack. Tess combined her technical rational knowledge (Schön, 1991) about sensory experiences with the emerging practice context that was part of her new practice knowledge (Cook and Wagenaar, 2012). Liz combined her records of prior observations of Claire's

responses to various environments, and gained a new practice knowledge with which she later incorporated technical rational knowledge (Schön, 1991) and the sensory frame of reference from Ayres (Walker, 1993) and Brown and Dunn (2002). This gave the practitioners the opportunity to select and use other theory as necessary. Despite the organisational requirement of the practitioners to use MOHO for all of their assessments and framing their thinking about service users, they had to be flexible about the theory that they incorporated into their creation of new practice knowledge for the individual service user's particular occupational participation.

5.3.13 Environment and MOHO

All the practitioners used the concept of environment in their technical rational knowledge (Schön, 1991) from MOHO (Kielhofner, 2008). Environment was defined as the "physical and social, cultural, economic and political features of one's contexts that impact upon the motivation, organisation and performance of occupation" (Kielhofner, 2008, p.86). There was an "environment impact" (p. 88) which provided opportunities and resources for occupation as well as demands and constraints. These all shaped performance, which is defined as doing an occupational form or task (Kielhofner, 2008, p.109). Thus there was an intimate and reciprocal relationship between the environment and humans (Kielhofner, 2008).

Some of the environmental aspects of social, political and economic conditions in MOHO about the influences of poverty, educational and social challenges were only discussed by Liz. This implied some understanding of occupational injustices (Wilcock and Hocking, 2015), previously discussed in interventions in the first discussion question. Liz however, did not comment explicitly on occupational injustices, apart from the suggestion of occupational deprivation (Wilcock and Hocking, 2015), in her comments about forensic environments being disempowering and disabling and dis-occupying. The literature broadly indicated those social inequalities in the discussion of stigma linked to various secure settings (Flood 1997; Platt 1977; Paulson 1980) and restricted access to occupations in the community (McQueen, 2011; Lin, 2009). It was unclear whether Liz was modifying her technical rational knowledge to incorporate a new way of

categorising occupational limitations with her use of the term dys-occupying. She was trying to be explicit about the impact of forensic environments upon service users' occupational participation and so was possibly developing her practice knowledge combined with other forms of knowledge.

The literature indicated many aspects of the forensic environment that could lead to occupational deprivation, but the concept was not explicitly used. High secure environmental restrictions discussed by Helbig (2003) were also relevant to other secure settings. Restrictions to occupational participation included for instance, the fixed and often rigid limitations impacted on service users' opportunities, time, autonomy, goal attainment and developing competence. Another limit to practice in the forensic setting was reduced access to resources such as equipment. Limited community access due to legal restrictions and reduced worker numbers could lead to reduced escorts that many service users required (Flood, 1997). Such limitations could reduce a service user's participation and motivation, along with a reduced perception of control over their life, which Martin (2003) argued was an experience of occupational deprivation. There was indeed, a fine balance between public protection with risk management, and duty of care to service users that incorporated rehabilitation and recovery (Mason and Adler, 2011&12). The practitioners were aware of such problems even though Tess and Gladys did not explicitly state their technical rational knowledge (Schön, 1991) about the foregoing aspects of the forensic environment and occupational injustices, the practitioners all had practice knowledge (Cook and Wagenaar, 2012) about the forensic environment and how they needed to use that knowledge to prevent or limit restrictions to occupational participation.

Developing the service users' occupational participation was a priority for occupational therapists. Service users were expected to develop the skills required for effective functioning for eventual discharge from hospital to the community (Farnworth and Munoz, 2009). Movement through environments was a part of occupational therapy, such as through the atrium described by Liz, in order to develop necessary skills.

It was the practitioner's role to provide access to a therapeutic programme (Flood, 1997) and without an occupational therapist there was no conduit to provide those environments or to provide resources restricted only to service users. Indeed, the

wider disciplinary literature indicated that service users needed an ally (Donskoy, Stevens, Bryant, 2014) who practiced in a client-centred way (Parker, 2006). Occupational therapists in the forensic setting were the conduit for providing access to a variety of environments and security/ contraband objects (items not permitted or under staff control, e.g. alcohol, drugs, knives, mobile phones and the like) required for occupational participation. Gladys's work with the service user who wanted to pursue her musical career was an example of being such an ally. It was not just matter of being able to engage in occupations, indeed access to an occupational therapist was required in order to assess the service users' specific risks in relation to occupational participation interests, strengths and constraints in order to facilitate therapy. Gladys had not experienced such a practice situation before and she therefore had to create a new practice knowledge (Cook and Wagenaar, 2012) in order to work with the service user. A new practice context was created from her developing practice knowledge about the particular occupational participation requirements of the service user and necessary interventions.

The practitioners were not entirely using MOHO in a theory-driven way. They were more flexible in reaching out to the service users' needs when MOHO could not provide a relevant explanation. Liz's practice indicated that she partially used a process driven approach (not to be confused with the occupational therapy process) where the therapist chose the most relevant theory after they had an understanding of the service users' needs and goals (Hagedorn, 1995). Liz tried to use MOHO, but reflected on a situation where Claire calmed down after eating chocolate in a stressful team meeting. Liz found instead that her practice knowledge from her student practice placements and later forensic work experiences, were more useful for developing new practice knowledge about Claire, that in turn prompted Liz to locate other sources of knowledge. Indeed, Gladys could not fully explain Andy's occupational participation of rolling cigarette's through MOHO, so she refrained from using MOHO, especially in the early stages of the process. Indeed, the practitioners did not indicate whether MOHO was more effective once they had a more developed practice knowledge (Cook and Wagenaar, 2012) of their service users and is an area that could be researched further.

Other ways in which the practitioners explicitly combined different concepts from different models was also apparent. Liz's practice experience as an occupational therapy assistant was where she first learnt about the occupational categories she used in the CPA. Indeed, the practitioners needed to use theory with discretion, where appropriate and not apply theory automatically (Fish and Boniface, 2012). Other team member's views of service users' motivation differed from Liz. She provided an example of how a service user was seen as unmotivated by the team, but she saw the effort he made on keeping his white jeans in an excellent state of cleanliness. Another example from Liz was from motivational interviewing training where she learnt that people were not unmotivated, but had different motivations. Liz also referred to how useful the concept of locus of control was to her in drawing together knowledge about service users with personality challenges that related to volition (Kielhofner, 2008). Despite the organisational expectation that the practitioners' should use MOHO, they used it as a broad approach to explain occupational participation, but focussed on key concepts such as environment, volition and habituation as required, but not necessarily together. Furthermore, they had to incorporate more features about the client-centred approach than MOHO provided, as well as the recovery approach.

5.3.14 Practice and a client-centred approach in the forensic setting

From a therapeutic stance client-centred approaches were an important principle in the practice of occupational therapy.

> "Client-centred occupational therapy is a partnership between the client and the therapist that empowers the client to engage in functional performance and fulfil his or her occupational roles in a variety of environments. The client participates actively in negotiating goals which are given priority and are at the centre of assessment, intervention and evaluation. Throughout the process the therapist listens to and respects the client's values, adapts the interventions to meet the client's needs and enables the client to make informed decisions." (Sumsion, 2000, p.308).

There were tensions for the practitioners trying to work in a client-centred way. In one way the practitioners needed to be client-centred as directed by their code of conduct (COT 2015). In another way such practice could be impacted by the security restrictions and risk assessment requirements of the forensic setting.

The practitioners discussed client-centred practice when I asked about it in the interviews. Indeed, what was more often discussed by Liz for instance, was the recovery approach for Claire and how that fitted with client-centred practice and positive risk-taking. Tess spoke mostly of how she found recovery a different way of talking about client-centred practice. This may have been in the context that practitioners would be familiar with client-centred practice as key to their practice, but the wider multi-disciplinary team may not have been familiar with this approach. The recovery approach, however, has been adopted by many mental health trusts for which workers are expected to embed in their practice.

Tess considered client-centred practice and recovery to be similar in being optimistic and creative about practice with the service users. She did not clarify what she meant by creative, however, consideration of the context in which a client lived demanded flexibility in the approach of the therapist in all intervention situations (Dunn, Brown and McGuigan 1994). A challenge to employing flexibility with risk assessment and risk taking in the secure setting was in how far practitioners could work in the moment with risks, which need to be identified through assessment, prior to therapeutic work. Though it needs to be acknowledged that risks could change within a therapeutic encounter given the expectations of change through therapy and the dynamic nature of risk assessment and risk taking (Cordingley and Ryan, 2009). It would be expected that changes in risks may occur over a long time or within one session, but the disciplinary literature has little to say on that matter. There were no examples of how the therapists adjusted their practice in that way, whether managing a risk or other intervention. This would be an area for further study, incorporating the opportunities for observing the therapist in a practice situation with a service user, followed up by an interview to establish what prompted the change in their approach.

It may be that different levels of client-centeredness, depending on the needs of the client and nature of the intervention were required (Law and Mills, 1998, Sumsion 2006). Tess noted a key part of client-centred practice in a secure setting

was that the therapist could not support everything the service user wanted to do, particularly if this was of a criminal nature. In client-centred work however, the therapist could discuss their own values about criminal and non-criminal acts without imposing their view or being authoritarian (Parker, 2006). Part of that discussion would include the socio-cultural, legal and service user's values about crime, as Tess and Liz did with their service users. Such discussions were also part of the service user being assisted to make informed choices (Law, Baptiste and Mills, 1995, Sumsion 2006).

In summary, the practitioners used MOHO for their practice, but they did not always explain how they used the detail of the key concepts. Furthermore, they used a variety of other concepts, some related to MOHO, some not, in their practice. This suggested that theories were better seen as tools for use in practice and not keys to any one certain answer or knowledge, an early pragmatist view (Whetsell, 2012). Therefore to have an organisational mandate to 'base' all practice on one model, even if only to start occupational therapy, sets up a 'lens' that may not necessarily be the best way to view the service user. Both Liz and Tess were very experienced in forensic mental health and occupational therapy. Gladys was more experienced in physical health occupational therapy and less so in forensic practice. She did however, show how she could incorporate other theory into her practice and not entirely rely on MOHO.

Such a situation as noted above may become problematic for new graduates. My anecdotal experience from doing practice placement visits to students at mental health trusts across London shows they have to understand MOHO as part of their learning objectives to learn about practice in a given setting. They often do not get the chance to experience practice with other models because of the emphasis on using MOHO in practice. Some mental health practice areas however, are beginning to look at using the South African Creative Abilities Model (http://www.vdtmocaf-uk.com, no date). The impact of such a situation for new graduates requires further research. An area related to theory use and development in the literature concerned how occupational therapists worked with service user's criminal activities, a consideration discussed next.

Liz believed occupational therapists needed to develop an understanding of the meaning of crime for service users. Spybey and Morgan (2003) suggested that

service users' past interests may be a way to find a link to their current volition. This could include both criminal (Cronin-Davis, 2010) and non-criminal interests. Both Tess and Liz discussed how they worked with service users to explore their criminal interests and the potential impact for their future. The practitioners needed to understand that it was not a simple matter of seeing the service users as perpetrators of crime, even within the context of mental health problems. Although originally discussed in relation to women in secure services, there was not a clear cut victim-perpetrator split (Jeffcote et al, 2004). Indeed, the Corston Report (2007) identified that research existed that suggested a correlation between criminality and victimisation of women. This was not explored further in the discipline's literature, or by Tess and Gladys, so further exploration for the implications for conceptualising and understanding why service users engage in criminal acts that might not be a causal relationship with their mental health problems, might be beneficial.

Victim-perpetrator union had implications for the practitioners' blending of the personal and professional with service users who were both challenging to others and challenged by others. The literature indicated the workers' mistrust of inmates and service users within prisons and special hospitals respectively, due to their involvement in criminal activities (Freeman, 1982, Dressler and Sniveley, 2005). In personality disorder services the attitudes of occupational therapists needed to be non-judgemental and non-confrontational (Cronin-Davis, 2010). In forensic mental health care in general, compassion of therapists was identified by White et al (2011) however, Fairhead (1997) described the need to be "dispassionately compassionate" (p. 388) in order to try and not be affected by the nature of service users' crimes. These matters are also related to developing the service users' narrative and therapeutic use of self, all of which require further research in order to explore their relationship and implications for practice knowledge. There has been some discussion in the literature about the nature of occupation and its relationship to crime, discussed next.

5.3.15 Criminogenic occupations

Liz was the only practitioner who used the term "criminogenic occupations". Liz may have developed her knowledge through her practice, but ultimately it is unclear

where she first learnt about criminogenic occupations. She used the term in order to think about helping service users to move away from criminal occupations, but she did not explicitly define the term. Her examples included using illegal or legal substances that could lead to crime and additionally, thinking about what criminal occupations did for service users. This suggested the term was about those occupations that were labelled as crimes and were seen as a form of occupational participation.

The occupational therapy literature indicated the term criminogenic had been used in various ways. Cronin-Davis (2010) used the term criminogenic occupations in her PhD, but she used it interchangeably as criminogenic behaviour (Cronin-Davis, 2006, p. 116). Cronin-Davis (2006) provided examples of criminogenic behaviours when used in her application of a case example of Paul. She stated "stealing to obtain food or drugs, resorting to violence against a person he found threatening or challenging" (p. 74) were criminogenic behaviours used as a means to organise and sustain his life patterns. Cronin-Davis (2010) implied that there was a relationship to occupational participation.

Criminogenic need was defined explicitly only once in the occupational therapy literature. It was in a list of slang terms used in some United States Correctional settings in White et al (2011). Criminogenic needs were empirically derived and were changeable risk factors, also known as dynamic needs, which included two forms. Stable dynamic needs were long-standing attitudes conducive to violence, chronic alcoholism or sexual preference to small male children. Acute dynamic needs included stress, recent divorce, hostility or acute symptoms of drug use (White et al, 2011). They did not justify why those examples were provided, or reference their explanation. They noted that criminogenic needs were present in an offender upon assessment, which were used for risk assessment, prison classification and reclassification, treatment and release (White et al, 2011).

The use of the term criminogenic linked to occupation may arise from the term criminogenic needs. Those needs were defined as needs known to affect offending according to the Offender Assessment System (OASys) used by offender managers for offenders on a Community Order in the UK (Cattell et al, 2013). Criminogenic needs have been categorised as anti-social thinking and behaviour, pro-criminal attitudes, social supports for crime (anti-social associates), drug and

alcohol misuse, family/marital relationships, work, anti-social lifestyle, a lack of positive recreation/leisure activities and homelessness (Cattell et al, 2013). The definition and categories of criminogenic needs did not incorporate the effect of mental illness upon offending actions. That would be an area needing development for those people in the community. Furthermore, the large proportion of inmates in prison who also had mental health problem (Nacro, 2007) and those too with learning disability needs as described in the Bradley Report (DH, 2009) may not be represented by the definition and categories. Liz and Cronin-Davis's (2006) ideas suggest a possible relationship between criminogenic needs and occupational participation. Those relationships may have represented their practice knowledge, however the work was not developed enough to support their view. Furthermore, it was also unclear whether there was a relationship between criminogenic needs and occupational participation, so further research would be required to explore that area.

Some definitions of criminogenic need from other disciplines looked more at risk in relation to crime. Latessa and Lowenkamp (2005) defined it as "crime producing factors that were strongly correlated with risk" (p. 15). More explicitly, Andrew and Bonta's model of Psychology of Criminal Conduct (cited in Burke and Hart, 2000, p75-77) explained that criminogenic needs were an association between dynamic risk factors (i.e. risks that could change over time) and criminal conduct. Examples, similar to Cattell et al (2013) included antisocial personality, antisocial companions, antisocial attitudes, interpersonal conflict, social achievement, substance abuse, personal distress (Burke and Hart, 2000). There was a relationship with those examples and occupational participation. It therefore makes sense that occupational therapists would want to explore them.

Liz made the assumption that crime could be an occupation. The phrase criminogenic in relation to occupations was too vague and required further delineation before it could be of further use in practice. For example, how could crime be conceptualised as an occupation in terms of how occupational therapists see occupational participation? Was it simply a matter of transposing crime as a form of work (Piehl, 2003), leisure or both? Hammell (2009), a British occupational therapist academic working in Canada, suggested a more critical approach to occupational therapy concepts and exploring the meaning behind why people do what they do, rather than a focus on the implied ableism, class bound and cultural

specificity of categorisations of occupation. Thus the question to ask is what was the experience of and meaning of, committing a crime for the person with a diagnosis of a mental health problem, or a personality disorder? That question, albeit in a slightly different form, was considered by Tess and Liz. They therefore formed their practice knowledge around what they considered to be relevant to develop their knowledge in order to use it for intervention planning (Cook and Wagenaar, 2012). Their knowledge may have been partially derived from reading the literature or indeed part of their reflection on practice in the forensic setting. In those settings they had tried to create ways to understand the place of crime in a service users' life because the focus on crime implied it could be a form of occupation. Those aspects of their practice knowledge were not explored in this study, and require further research. The idea of crime being an occupation has been explored theoretically in the discipline and is discussed next.

A conceptualisation of offending behaviour developed through MOHO was presented by Duncan (2003). His key point was that offending activities and life patterns impaired service users' functioning. Duncan (2003) developed his ideas using the key concepts in the third edition of MOHO (2002) that included volition, habituation and performance capacity; which operated within a person's context of their physical and social environments. Due to confidentiality, I could only compare some the service users' history to Duncan's conceptualisations, as follows.

Duncan (2003) explored volition and service users' motivation for participating in activities that were related to their offending (Duncan, 2003). Both Liz and Tess discussed service users' actions that could indicate their volition for activities that were criminal or could lead to criminal activities.

Habituation related to the historical and current restricted life roles, such as an incomplete worker or disrupted and damaged familial role history (Duncan, 2003) such as Claire's experience. There could be difficulties identifying a future pro-social occupational identity, and the change to that from a criminal identity was part of occupational therapy practice (Duncan, 2003). A criminal identity led to maladaptive roles and associated routines and patterns of occupations that became habitual (Duncan, 2003). Using the criminal identity concept to explain Claire's harm towards others was not convincing, even though she had a long history of such actions. Indeed, there was an assumption in Duncan's (2003) work

that all service users with mental health problems have a criminal history that extended beyond their index offence. My practice experience included working with service users with those kinds of experiences. I also worked however, with service users who had no prior criminal convictions or history, had successfully held a worker role, who had some developing mental health problems, but had maintained a life in the community until their index offence.

Duncan (2003) conceptualised the social environment as problematic for many service users to maintain close, positive relationships. That was due to dysfunctional family relationships discussed by all the practitioners about their service users. Service users who had such a family dynamic or who had mixed with other offenders could reinforce choices, routines and expectations for the future (Duncan, 2003). The most convincing explanation in this conceptualisation was for the family dynamic. There was also some relationship with Duncan's view and Zach's experience of being in a local gang in his community. Being part of a social group of offenders (making the presumption Zach's gang had been involved in crime) was not the experience of most of the service users discussed. The physical environment could be about a peripatetic existence, possibly mixing with other offenders, using accommodation that was below healthy requirements and limited experience in school and work environments (Duncan, 2003). Two of the service users had held successful employment. Two had a less successful education experiences.

All the service users had performance capacity problems, however Duncan (2003) highlighted particular issues for offenders. One was difficulty problem solving impacting occupational choices and patterns, which were a problem for Zach and Claire. Communication and interaction skills could be problematic in terms of hostility towards others based on a limited perception of self and others (Duncan, 2003). This was a problem to varying degrees for all of the service users.

Neither Liz nor Tess used MOHO as part of their technical rational (Schön, 1991) or practice knowledge (Cook and Wagenaar, 2012) in the way explored by Duncan. Given their need to use MOHO in practice Duncan's work was potentially a useful resource for them. It is clear however, whether the use of MOHO to explain offending behaviour required a much more rigorous explanation. Why there was a lack of other literature exploring Duncan's work further from a practice, theory or

empirically was unclear. It may be because Duncan's (2008) work was based on a conference presentation and then used as a part of a chapter of one of the foremost UK occupational therapy and mental health texts (Creek and Lougher, 2008). Duncan did not complete further work on his ideas or write a chapter in later editions of the book. Tess and Liz may well have not had access to that edition of the book and so missed that theoretical conceptualisation. Students however, might have read that chapter and discussed it with the practitioners. In any event, I would argue that it needs more development if it is to provide the theoretical framework to support clinical reasoning (Duncan, 2008) that he claims that it does. Duncan used the term pro-social in relation to occupational therapy in the forensic setting, as have others in the literature, which is discussed now.

5.3.16 Pro-social occupations

The occupational therapist was in the secure environment to help the service user to develop effective participation in the community. This included being able to work, care for one-self, develop and maintain leisure pursuits (Gooch and Living, 2004; Falardeau, Morin and Bellemare, 2014), and relationships with friends and family and support systems (Eggers et al, 2006; Helbig, 2005). Those occupational forms were probably what the literature referred to as pro-social occupations (Duncan, 2003, cited in Duncan, 2008, p. 529); Jones & McColl, 1991) pro-social occupations (Blackburn, 1993, cited in Cronin-Davis, 2010, p. 21) pro-social linked to important pre-illness occupations (O'Connell et al, 2010) such as through the worker role (Stelter, 2007). O'Connell et al (2010) however, did not acknowledge that service users could be involved in criminal or anti-social activity prior to illness.

Descriptions of pro-social occupations were given by Twinley and Adidle at a conference in 2011. They reported suggestions that included engaging in work (productivity) activities, going on holidays to rest and relax, playing sports, pampering ourselves, socialising with friends, cooking meals for other people, heterosexual people may have sex in order to procreate (Twinley and Adidle, 2011). There was no explanation as to why those occupational forms were chosen, for example why they included the focus on sex only for procreation. There was also no commentary to explain them. The suggestions appear to be the opposite of anti-social occupations, such as: gang (organised crime group) members,

violence (all forms), theft, fraud, drug use and/or supplying, prostitution/sex work, terrorism and career offenders.

The literature provided some details for how the term pro-social had been used in research about occupational therapists. Cronin-Davis (2010) noted that service users with a personality disorder diagnosis needed to have the interpersonal and intrapersonal skills to assert their needs in pro-social ways. She also reported how an interviewee OT, Lesley reviewed previous criminogenic roles of service users to see if she could assist service users through OT to adopt pro-social roles in the community. Alice an OT interview identified the need to focus on pro-social lifestyles by identifying past criminal behaviour patterns and occupations that had contributed to what went wrong (Cronin-Davis, 2010). She also considered the habituation concept from MOHO in relation to how far pro-social roles were internalised as service users with personality disorder had daily routines consistent with criminogenic lifestyle (Cronin-Davis, 2010). She did not however, define the term criminogenic lifestyle and neither was there an explanation for how that related to pro-social lifestyle and criminogenic needs. Cronin-Davis (2012) made one link with the practice knowledge of occupational therapists in that their role was to facilitate service users' mastery of occupations in order to accomplish tasks they wished to achieve in life that were not anti-social, manipulative or destructive. The latter one is context dependent, for example whether someone demolished structures for their work. Occupational therapists therefore had the potential to start a coherent exploration for how they could help to develop service users' pro-social occupations, which can be started with publishing case studies about them. A recent development about dark occupations adds to the debate, discussed next.

5.3.17 The dark side of occupations

A new area of debate had developed about how current conceptualisations do not consider the dark side of occupation and their impact on health and well-being. The so-called 'dark-side' of occupation has only recently been mooted as another facet of occupation. The dark-side referred to one of, or a combination of "anti-social; criminal; deviant; violent; disruptive; harmful; unproductive; non-health-giving; non-health-promoting; addictive and politically, socially, religiously or culturally extreme" acts (Twinley, 2013, p. 302). Indeed, Liz and Tess's exploration of their

service user's risks and offending behaviours related to Twinley's view in terms of the various acts. They did not indicate they had knowledge of that literature, but it suggested that they had reflected on those matters as part of their practice experience and therefore became part of their practice knowledge. They would develop that knowledge further as they continued to engage service users in a dialogue about the topic. The difficulty was that Liz and Tess may have assumed that the foregoing acts could be seen as forms of occupation and occupational participation. They did not however, capture the intricacy of the topic. That was a reflection of their developing practice knowledge that needed to be linked to the existing technical rational knowledge (Schön, 1991). They also were in a position where there was only one exploration of how concepts of occupational injustices experienced by service users could be enacted in forensic practice by using MOHO assessments leading to an intervention plan (Cronin-Davis, Lang and Molineux, 2004). There was no empirical research in the areas of occupational therapy, occupational science and their relationship to crime. The recent work is considered now.

The recent discussion in the literature had focussed in part on whether violence could be categorised as an occupation. Liz and Tess's knowledge gathering meant they were aware of the context in which crimes were perpetrated and were aware of societal and subjective interpretations about the use of violence (Morris, 2012). It was suggested that violence was not an occupation in itself (Morris 2012) but Tess and Liz did not indicate their view about that. The criminological literature demonstrated that violence could be carried out as an instrument, in the process of participating in another crime, a means to some end (Aldrich and White, 2012). Indeed, Aldrich and White (2012) invoke how Gray (1998) conceptualised occupation as a means and an end. Violence could only rarely be seen as an end in itself, therefore violence did not constitute both a means and an end and could not be defined as an occupation (Aldrich and White, 2012). Liz and Tess gave no indication of whether they saw violence in that way, but their discussion implied they saw other forms of crime as a means and end, such as law-violating occupations representing a criminal career (Blumstein et al, 1986 cited in Aldrich and White, 2012, p528). The difficulty with such a view was that it did not take account of the interaction between mental health problems and the nature of the crimes committed, and even whether a criminal career was possible with the challenges that mental health problems had on occupational participation. For

instance the service users that the practitioners discussed in my research had all shown a great level of difficulty achieving their goals in occupational therapy. Suggestions for dealing with that situation are presented next.

Greber (2013) helpfully expanded and clarified the discussion by differentiating between the interests of occupational therapy and occupational science. He noted occupational therapists would be interested in occupation as a positive impact on health and well-being, reflected in the wider literature (Doble and Caron Santha, 2008, Wilcock, 2005, Law, Steinwender and Leclair, 1998). It was suggested that engaging in the dark side of occupation may achieve a sense of meaning, relaxation, creativity, celebration and entertainment (Ferrell et al, 2008 cited from Twinley and Addidle, 2012, p. 203). Furthermore, health and well-being may be derived from criminal acts, for which further research was required. Occupational scientists would be interested in crime as one of a range of occupations. Indeed, occupational forms refer to "objective physical and sociocultural circumstances external to the person that influences his or her occupational performance" (Nelson, 1996, p.776) that elicited, guided and structured occupational performance (Nelson, 1988). Crime could therefore be an occupational form according to Nelson's definition which needed to be considered along with the foregoing conceptualisations of occupation. The dark side of occupation was a new concept and it required further development for a clearer operational definition. Greber (2013) and Twinley and Addidle (2012) noted the need to understand the meaning and effects on people of participating in the dark side of occupation.

The preceding discussion highlighted how the practitioners' practice knowledge and possibly of the foregoing authors, was a part of the early reflections on the relationship of occupational participation and crime because there was very little of any form of knowledge available in occupational therapy literature. Furthermore, the idea that there is no victim-perpetrator spilt with the service users and the place of concepts of pro-social and criminogenic occupations are other dimensions that should be incorporated into the exploration. The relevance of such discussion and research needed to link with how occupational therapists could provide ways to create participation in occupations that the service users and society found acceptable and in ways that could be maintained.

5.3.18 Theory from other disciplines

The practitioners used theories other than those from occupational therapy that were mostly psychological, but also included multi-disciplinary and psychiatric terminology and approaches. The practitioners all described in what ways they used psychiatric terminology and combined this with occupational therapy theory. Liz and Tess said their team were not very focussed on the diagnosis, but used the signs and symptoms of mental health problems to describe what they observed of service users. Gladys however, found the diagnosis was also a useful way to think about service users' presentation. A practitioner in Cronin-Davis' (2010) research concerning working with service users with personality disorder stated how she saw it as important to know service users' diagnosis, and how the pathology linked to their occupational history. There was a mixed picture of the degree to which psychiatric terminology was helpful to the practitioners.

The literature went as far as to state that therapists should be expected to integrate their practice and potentially their theory with the overall team approach. Lloyd (1995) stated that occupational therapy theory needed to complement the perspectives of other team members. From the practitioners' discussion they implied this level of theoretical integration was not the case, though Liz and Gladys expressed how attachment theory was useful to their understanding of service users' personality types and emotional responses. Liz went as far as to say to the CQC assessors that she did not advocate more use of cognitive and dialectical behaviour therapy or other behavioural methods to manage the women's challenging actions. For the practitioners and the discipline of occupational therapy the theoretical and practice orientation was occupational participation.

The literature may well have been suggesting that MOHO fitted well with the range of theories of the team (White et al, 2011; Munoz, 2011; Hunter and McKay, 2008; Walsh and Ayres, 2003; Lloyd & Hall, 1988; Lloyd, 1987a), but that level of detail was missing from that literature. Having such flexibility with theoretical integration was a big expectation of one occupational therapy theory, such as MOHO, to fit with so many other theories and as such requires further research as to its feasibility. Flood (1993) stated how the forensic environment might affect the therapist's ability to use a model due to their need for increased awareness of risks

and their management. Flood, however, did not clarify in what ways that might occur. She may have been referring to how any model of practice that was not specific to a forensic, or particular practice setting, would require critical exploration as to how it could explain occupational participation for the service user. The practitioners did not discuss whether they were expected to use other research, theory and associated interventions at the expense of occupational therapy theory. Ultimately a therapist would be in a position to make a professional judgement as to the most effective model to use, alongside discussion and choices made by the service user, as with Liz's choice of sensory theory and Claire's choice not to complete a sensory assessment. Liz's practice then included a combination of artistry, science, craftsmanship and compassion (Higgs, Titchen and Neville, 2001).

5.3.19 The recovery approach in secure settings

All the practitioners spoke of their views about recovery and how they tried to integrate recovery into their practice. The organisation was integrating the recovery approach but it was at different stages for each service area. Some of the terminology of recovery was used by the practitioners, particularly that of 'hope' (Drennan and Alred, 2012). Tess used terms about the service users' journeys, possibly linked to personal recovery journey (Deegan, 2001) through secure services and optimism for their future (Drennan and Alred, 2012; Shepherd, Boardman and Slade, 2008). Recovery and its meaning in mental health and in forensic settings, however, was not uncontested (Drennan and Aldred, 2012) and the practitioners did not indicate that they were using a definition of recovery that had been adopted by the organisation for all services to follow. Indeed, their use of the term recovery was for the most part linked to the direct ways in which they could work with their service users, expecting the service user to try to make changes for themselves with support from the therapists in incorporating a recovery approach. They were therefore incorporating it into their practice knowledge (Cook and Wagenaar, 2012).

The recovery approach had been criticised however, for being too focussed on neoliberal values, ignoring the wider social inequalities impacting on service users' mental health (Harper and Speed, 2012). An analysis of the recovery discourse in

various government and recovery literature found a focus on an expectation that the individual service user must take responsibility for their mental health problems and the need to change in order to improve themselves, abnegating any responsibility of the state for dealing with social inequalities that impact upon mental health (Harper and Speed, 2012). Indeed, Liz was aware of the wider socio-cultural and economic impacts upon service users. Those difficulties were compounded in the community by stigma about mental illness and association with their offences. From her perspective she saw occupational participation problems were not totally a reflection of the service users' constraints. Her views therefore were part of her practice knowledge (Cook and Wagenaar, 2012) that she used particularly when she assessed the reasons for service users' occupational participation constraints and worked with them to create an intervention plan.

Liz and Tess have been mildly critical of a recovery approach. Tess was reluctant to see her practice linked to recovery as in her view the recovery approach was another form of a client-centred approach. Choice in recovery principles became a source of new practice knowledge as a problem arose when working with Claire. Claire was referred to a special hospital because her actions were becoming increasing difficult to manage and she had attacked many staff, including those with whom she had a good therapeutic relationship. The team however, found that she could not cope with the sense of feeling unwanted by them and the uncertainty of knowing whether or not she would be accepted by the hospital. Liz explained that the recovery perspective says a service user should be fully engaged in and encouraged to make decisions about their treatment. In this instance the recovery principles were causing distress to Claire and as a result, she was not able to cope. That was an example of a new practice context created out of practice knowledge (Cook and Wagenaar, 2012) of where practice did not fit with recovery principles. Liz created a new knowledge from her practice (Cook and Wagenaar, 2012) about how such principles were not always best followed in full and could need modifying.

5.3.20 Strengths

Gladys identified how she looked for service user's strengths rather than focus on constraints and problems. She gained that knowledge through guidance from her colleagues when she worked in older people's health services, which she

incorporated into her practice knowledge in that setting (Cook and Wagenaar, 2012). Gladys did not identify technical rational knowledge (Schön, 1991) associated with a strengths based approach. She did however, make links with recovery principles related to hope (Drennan and Alred, 2012) and identified how MOHO (Kielhofner, 2008) could incorporate a way of viewing the service user by their strengths. Gladys transposed her practice knowledge from a different practice area to use in the forensic setting and created a new practice knowledge for use in the forensic setting (Cook and Wagenaar, 2012). The features that make practice a knowledge are now considered in the fourth and final question.

5.4 WHAT CAN PRACTICE EPISTEMOLOGY ADD TO OCCUPATIONAL THERAPY PRACTICE IN FORENSIC MENTAL HEALTH?

I now explore the practice epistemology approach of Cook and Wagenaar (2012) and their three concepts of 'actionable understanding', 'on-going business' and 'eternally unfolding present', in relation to the findings to establish in what ways they can be used to explain and develop occupational therapy practice knowledge in forensic mental health. This directly links to one of my research aims to critically analyse and explain in what ways, and how, a practice epistemology can inform the practice of occupational therapy in forensic mental health. At the end of each discussion about the three Cook and Wagenaar (2012) concepts I present a
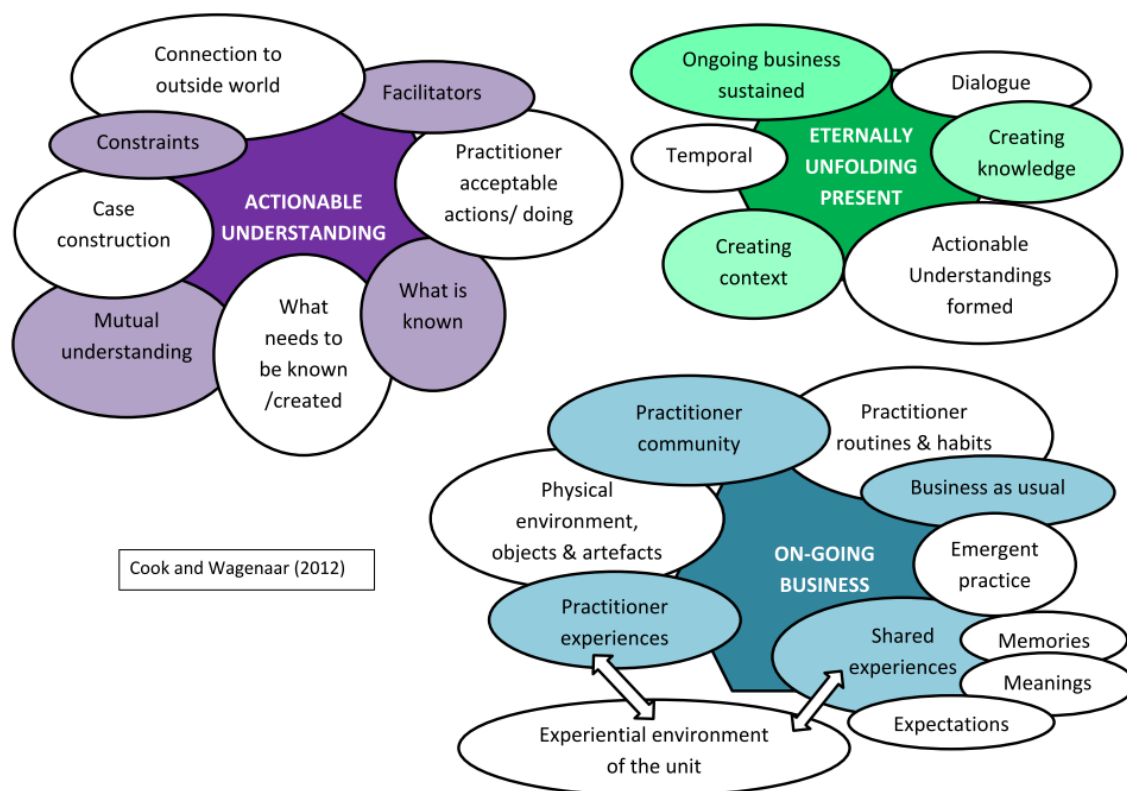
Figure 22. Toward an epistemology of practice (source: Cordingley 2015, adapted from Cook and Wagenaar, 2012)

summary of how they each relate to the three categories of steps of practice, rules for practice and blending of the personal and professional from my grounded theory of the practitioners' practice knowledge. I include a figure 22 based on Cook and Wagenaar's (2012) work, to clarify the facets of each of the three key concepts.

5.4.1 Actionable understanding

Now I consider how 'actionable understanding' (Cook and Wagenaar, 2012) and other perspectives on practice epistemology manifested in the practitioners' practice knowledge. The facets of 'actionable understanding' include: the connections to the outside world; practitioners' acceptable actions/ doing; case construction, mutual understanding, what is known, what needs to be known/ created, facilitators and constraints.

The practitioners were alert to the 'outside world' (Cook and Wagenaar, 2012) which included the Ministry of Justice and wider public safety concerns, along with the specific service in which they worked. The 'outside worlds' required the organisation to provide security and meet health care needs. On a local level, there were commonalities and differences between each of the work settings, such as single or mixed gendered wards and being women's and adolescent's forensic services or slow stream rehabilitation. The social aspects of the working world were composed of both service users and workers, with a small degree of contact for the practitioners with the service user's family. Whether the service users or practitioners were in no direct contact, the importance of family roles and their maintenance were built into the service users' occupational therapy where relevant, as Liz had done with Claire. The cultural aspects of the service user's experience with their family were considered by all practitioners and were incorporated into their assessment and intervention plan when relevant.

There were 'constraints' (Cook and Wagenaar, 2012) to occupational therapy practice in the forensic setting where included procedural requirements either limited or blocked practice if used rigidly. For example risk assessments and management, evidence based practice and the use of MOHO as well as standardised assessments. The 'facilitators' (Cook and Wagenaar, 2012) that assisted practice included outside world influences such as pre-registration training, the subsequent practice experiences of practitioners and other colleagues, scientific research, academic literature and access to the internet for resources to use for practice.

The foregoing constraints and facilitators provided 'what is known' about practice and the forensic setting, which were then used to develop knowledge about the service users. For example: security policies and procedures, diagnosis, signs and symptoms; occupational therapy core skills and theory; and the occupational therapy process. The practitioners used the process to take acceptable actions in order to engage service users in occupational therapy. What was already known included the practitioners' codified disciplinary knowledge, which was also a form of technical rational knowledge (Cook and Wagenaar, 2012; Higgs, Andresen and Fish, 2004; Schön, 1991).

'What is known' (Cook and Wagenaar, 2012) also included knowledge and concepts adults learn during the course of their everyday lives, which was essentially unskilled and did not require discretion in their performance (Friedson, 2001). Everyday knowledge was seen as the foundation for all other kinds of knowledge and skill and which is often subsumed within them (Freidson, 2001). This could be taken for granted (Schutz, 1970 and Garfinkel, 1967 cited in Freidson, 2001, p.28) and could be tacit and not self-consciously taught so that it appeared to be common sense (Geertz, 1983 cited in Freidson, 2001, p28).

There could be missing, inadequate or incomplete knowledge. An example of inadequate knowledge from all the practitioners was when the MOHOST and parts of MOHO did not define and explain the service users' occupational participation strengths and constraints. Also some service users were reluctant to engage with the practitioner, making knowledge gathering problematic. Such limitations created a new practice context that had to negotiate the 'swampy lowlands' (Schön, 1991), demonstrating the uncertainty and unpredictability of the practice context (Eraut, 1994). Those situations required a new knowledge to be created from practice (Cook and Wagenaar, 2012). Another example included Gladys's limited knowledge about the exact focus and approach of the slow stream rehabilitation service and also her limited knowledge about the forensic setting when she first worked there, so a new knowledge about her uncertainty and knowledge gaps became apparent, along with a practice context that arose from that new knowledge. The context therefore included a mixture of what Gladys knew and could enact as well as the new practice knowledge about her limited knowledge

about the settings and consequently what she needed to know (Cook and Wagenaar, 2012).

The findings suggested practice knowledge was created from 'what is not known' or 'needs to be known' (Cook and Wagenaar, 2012). For example the practitioners had to create a way to engage in risk management because the codified work on the subject was inadequate. Their new knowledge was a combination of their core occupational therapy skills of activity analysis and grading and environmental adaptation and grading 'what is known' with what was risk assessed to create a plan about what was not known about risk management and graded and adapted risk taking. Service users were then provided with opportunities for risk taking through occupational participation.

The foregoing were examples of creating new knowledge about risk management by combining 'what is known' with 'what needs to be known' (Cook and Wagenaar, 2012). 'What is known' included technical rational knowledge (Schön, 1991) and experiential (procedural) knowledge of practice experiences (Higgs, Andresen and Fish, 2004). Furthermore, emancipatory knowledge was also used and came from a critical paradigm. Such knowledge questioned the historical and social traditions (Higgs et al, 2004) of a culture (Higgs and Titchen, 1995), for example the restrictions of secure environments and the limitations that impacted service users. The practitioners therefore used risk management that on the surface appeared a technical rational knowledge (Schön, 1991) on which to base practice. They combined this however, with a critical paradigm that challenged the organisational status quo and empowered them in their practice (Higgs, Andresen and Fish, 2004). Those paradigms were possibly not consciously combined but, how they manifested in risk management and other areas of practice in forensic mental health requires further research.

The early stages of case construction (Cook and Wagenaar, 2012) involved the use of blanket referral. It was an intricate practice and without practice experience could not effectively be known and practiced based purely on the codified explanations in the literature. This meant the practitioners needed to create new ways of knowing (Cook and Wagenaar, 2012) about blanket referral in order to effectively develop their knowledge about their respective service users. This was

part of procedural knowledge creation that included professional craft knowledge (Higgs, Andresen and Fish, 2004; Titchen and Ersser, 2001 a and b).

Actionable understanding (Cook and Wagenaar, 2012) could be seen as the starting point for developing practice knowledge. The practitioners first knew of the service user's admission to the ward following their admission or via pre-assessment meetings and reports by other team members from their assessments prior to service user admission. From those procedures the practitioners' case construction started before they met their service users. The official procedure, however, for case construction to start was through the automatic referral of service user to the therapist due to the blanket referral approach. Until the therapists had knowledge about their service users each case remained to be built.

Case construction reflected the early stages of referral and assessment from the occupational therapy process (Lloyd 1985; 1987 a, b, c and d). The therapists' practice of blanket referral was influenced by their working context and the point when they had first contact with the service users on their ward. All three therapists described where blanket referral was different to each other. Case construction therefore occurred at different points for each of the practitioners depending on when and how the service users were admitted to the units. Deciding when to start assessment with service users following blanket referral could be what Bullock (2014) identified as screening referrals in her schematic of the process, but she did not explain that further in her text.

The referral was linked to the need to make a connection with the service user in order to further construct their case. This led to the exploration of the service users through assessments and narrative construction. Such knowledge creation in the form of story making (Mattingly and Fleming, 1994) helped practitioners to understand the specific needs of their service users at that time, place and whichever new situation arose. This led to the practitioners to gain a nuanced understanding of the service users and helped to create an empathy towards them. Case construction therefore incorporated the service user's narrative and was a good fit with knowledge creation from occupational therapy practice.

There was an understanding by the team about the occupational therapy role to varying degrees. Team referrals of service users to Gladys were relevant. Their

development of team practice knowledge about what interventions could work was also a dynamic process, for example joint work between Liz and the team using sensory interventions in the seclusion room and in team meetings. Also Gladys's work with the psychologists developed her understanding of their role with Leila and Andy. As to the mutuality of that understanding, it was more implied in the practitioners' discussions. There were no examples of where the practitioners misunderstood the other team member's roles and the impact on their work with the service users they discussed. Indeed, it was more apparent how some team members did not understand the ways in which occupational therapists worked, to the degree that Liz was asked to engage a service user in occupational therapy who had severe restrictions to any objects that could be used for it.

In summary, the concept of actionable understanding illustrated occupational therapy practice in the early stages of case construction. Technical rational knowledge that included theory and standardised assessments could not provide all of the knowledge necessary for practice. Therefore 'what is known' and what 'needed to be known' demonstrated explicitly how knowledge was, and needed to be created from practice in order to effectively practice. The next section considers how Cook and Wagenaar's (2012) concept related to my grounded theory categories.

The facets in a*ctionable understanding* (Cook and Wagenaar, 2012) have most in common with my grounded theory categories of steps of practice and rules for practice, and are summarised here. Case construction (Cook and Wagenaar, 2012) was associated with my grounded theory category steps of practice. In particular, the concept of occupational therapy process and its related concepts of assessment and interventions, including risk assessment and management, provided a framework for the practitioners' acceptable actions (Cook and Wagenaar, 2012). The process also represented what is known (Cook and Wagenaar, 2012) by the practitioners, which facilitated gaining knowledge about the service users. The process was also used to identify knowledge that needed to be created (Cook and Wagenaar, 2012), for instance with the occurrence of unexpected practice situations. Another concept, blanket referral, was related to creating knowledge because of the need for practitioners to develop their knowledge of blanket referral through practice. Indeed, constraints to practice (Cook and Wagenaar's, 2012) was related to knowledge creation through

knowledge gaps. For example those linked with the limitations of standardised assessments and the limits of the research available for use for practice. My seeing change category in steps for practice became apparent as service users' cases were constructed and moved along their trajectory (Cook and Wagenaar, 2012) as therapeutic work progressed.

My grounded theory category rules for practice category, was broadly about the practice that needed to occur. Examples included meeting various national and local practice expectations such as risk assessment and Care Programme Approach meetings. The expectations of attending meetings provided opportunities to form mutual understandings between team members (Cook and Wagenaar, 2012) which were linked to my concept of the multi-disciplinary team. Indeed, specific pieces of work between the practitioners and another discipline were likely to form a mutual understanding between them, but those examples were not fully explored during the interviews and remain an area for further research. My concepts of sources for evidence for use in practice, the medical model, a model of practice, strengths, recovery and client-centred approaches, with my concept of risk taking all related to Cook and Wagenaar's (2012) connection with the outside world and were intended to facilitate practice (Cook and Wagenaar, 2012). They could however, constrain practice (Cook and Wagenaar, 2012), for example where MOHO, some assessments and the current evidence did not provide the practitioners with knowledge for working with some of their service users. Indeed, the limitations of the MOHOST and sensory assessments in providing knowledge about some service users was a constraint in practice that provided a catalyst for the practitioners to create new knowledge and a new context from their practice (Cook and Wagenaar, 2012), along with a return to fundamental skills of observation. There are also some stable aspects of practice, discussed next.

5.4.2 On-going business

Cook and Wagenaar's (2012) concept of 'on-going business' included the facets of: physical environment, business as usual, practitioners' habits, the emergent nature of practice, practitioner's experiences, shared experience of practitioners that includes memories, expectations and meanings, as well as the practitioner community.

The physical environment (Cook and Wagenaar, 2012) of the forensic setting had a particular appearance, with variations depending on the level of security. In my experience they have locked doors and the windows can only be opened a few inches. Lockers with keys were provided to store personal objects such as toiletries, pens, keys and other items that were classed as contraband and/ or secure in this setting. There were reception areas that led to an air lock and thence to a range of rooms and wards. The workers wore a bunch of keys on a belt to access different places in the setting, as well as to access locked cupboards holding restricted objects. The access to these was therefore controlled by the workers and were limited for their potential to be used to harm oneself or others. There were seclusion rooms and de-escalation suites for holding service users who presented with challenging actions.

Procedures were a part of the physical environment (Cook and Wagenaar, 2012) and so Ministry of Justice, security and NHS policies and procedures that were national and local were enacted in the practitioners' and team's practice. The occupational therapy process was also a disciplinary specific procedure used by all of the practitioners. Those policies and procedures could be modified for various reasons (Cook and Wagenaar, 2010), such as the impact of changes in criminal law, the Mental Health Act and government requirements for the care of service users. A finding from my research indicated the occupational therapy process had to change to incorporate risk assessment and management. Wider social changes have thus impacted the profession's use of the process that previously had not been fully been codified in the literature.

The practitioners discussed how aspects of their practice were used regularly and across all working contexts and so constitute business as usual and practitioner habits and routines and predictable behaviours (Cook and Wagenaar, 2012). For example the occupational therapy process and some features that had a particular resonance in the secure environment, such as risk assessment and management. This predictability appears to facilitate the respective team members' understanding of each other's role and links with 'actionable understanding' (Cook and Wagenaar, 2012). This was suggested in the findings but needs to be confirmed by further research.

There were, however, an array of complicated decisions about how to practice with each service user, which stemmed from times when business was not so usual. For example the practitioners' progress in making a connection in order to start assessing the service user depended on various features. The features included the service user's presentation, possible lack of trust and not knowing the practitioners, legal matters relating to the service user's admission and discharge. Also risk taking, which was the only way to check whether the service user would engage in risk activities, as well as trying to predict when risks would occur. The various possible permutations of situations, people, physical environment and their relational and dynamic nature made them inherently uncertain, as to whether service users would want to engage with the practitioners. This was therefore always an emergent practice (Cook and Wagenaar, 2012) which became new practice knowledge through each therapeutic encounter.

Emergent practice (Cook and Wagenaar, 2012) was also apparent for the practitioners as they stopped using the MOHOST. The practitioners used observations instead and from this emerged the specific needs of the service users, rather than from fitting to a formula provided by MOHO and MOHOST. This is not to say that the MOHOST was entirely abandoned by the practitioners as they still had the theoretical concepts from the model to map against their observations. Emergent practice was apparent when the practitioners found MOHO provided some theory to use in their knowledge about the service users' occupational participation. They therefore had to pursue other concepts such as locus of control and confidence and approaches such as a sensory frame of reference; or make additions to the model such as the strengths-based and recovery approaches.

The practitioners' practice experiences (Cook and Wagenaar, 2012) that informed their current practice were from their history. This included times when they were occupational therapy students, new practitioners following qualification and as they developed their experience in whatever areas they subsequently practiced. So Liz used knowledge from her student placement with children and a practice experience with an adult with substance misuse problems about sensory modulation. Gladys used work from one forensic service with Leila to another with Andy and her practice experience from older people to the forensic setting. This

also demonstrated the experiences gained from particular situations of practice with specific service users, a part of professional craft knowledge (Titchen, 2000; Titchen and Ersser, 2001 a and b) gained through such experiences.

Practice experiences and their connection to practice knowledge that elucidated current practice implied that reflection was required. All of the practitioners spoke of how they valued reflection, but did not get the time they felt they needed for it. None of the practitioners identified a particular approach to reflection, other than their broad sense of 'thinking' about practice and their sense of community of the team working and reflecting together, sometimes creating a team practice knowledge. The blend of professional and personal was a key area that required reflection, given embodied knowledge of themselves and their emotions, the practice environment and their agency as practitioners (Cook and Wagenaar, 2012). This area needs further research.

The practitioner community (Cook and Wagenaar, 2012) was evident in the practitioners' practice in their respective communities composed of various disciplines. The findings suggested the practitioners felt supported in their teams, could ask questions and could try interventions with which the team were unfamiliar. The practitioners also noted the team reflective practice meetings that they attended. A development in the operationalisation of Cook and Wagenaar's (2012) concept about practitioner community is that even though the team can operate with one or two members missing, they do not comment on how the community functions when two workers do collaborative work with a particular service user as with Gladys's experience with psychologists when working with Leila and Andy. This raises the need for further exploration theoretically and empirically about how is the practitioner community affected when there are splinter dyads, or smaller teams within teams of discrete work? Also how does this impact upon the shared experiences of the team? Discussed next.

There were shared experiences (Cook and Wagenaar, 2012) with nurses, psychologists with specific joint work, and more broadly with the whole team. Reflective practice meetings with the team gave the members a chance to share their emotional responses to the service users, for example the frustration and being stuck in knowing what to do with Zach and the anxiety engendered by Leila. There were examples of increased hope for Andy's increase in going outside of the

ward. Some team member's experience of working with Claire at different points was described as ambivalent and being fearful of her unpredictability. Indeed, shared memories (Cook and Wagenaar, 2012) were of many of the team's experience, including Liz's, of being harmed by Claire, although not at one and the same time, but a commonality of experience existed. How Liz interpreted and emotionally responded to that experience of being harmed by Claire was not explored in my research.

By the nature of the team working together expectations about a service user created a shared memory through each of the team members working to meet that expectation (Cook and Wagenaar, 2012). So the team agreed with Liz's suggestion of using interventions for Claire's sensory modulation in team meetings and when in seclusion. What has been extended in Cook and Wagenaar's (2012) concept through the operationalisation of the characteristic of shared experiences was how new and old team members' experiences become combined. For example, Gladys was new to the slow stream rehabilitation team so she and the team had no shared experiences. She used those experiences of the team about Andy previously using community leave as the starting point for a new expectation linked to occupational therapy for him. Gladys also had no shared experiences with the low secure women's service, but she created one though her work with Leila's physical needs. These were examples where if a team member did not have a history, there were instances where they could collaborate to incorporate others' previous shared experiences into the new team to create new shared experiences. Those shared experiences were all examples taken from the practitioners' perspective there was no way to know from the data the other team members' perspective. Research is required to explore this with every member represented. Shared memories also created shared meanings, discussed next.

'Shared meanings' were apparent in the team's practice knowledge (Cook and Wagenaar, 2012). For instance Liz's team eventually used sweets and weighted blankets during seclusion reviews with Claire when Liz was not there. Also the consultant psychiatrist, prior to working with Liz, had no experience of sensory functioning difficulties. Subsequent to Liz's sensory work with Claire he discussed his observations that there were possibly other women on the ward with sensory constraints.

In summary, the practitioners in the forensic setting included their interactions with team members in 'ongoing business'. The ongoing dialogue with team members formed part of the creation of a team community of practice knowledge. Team practice knowledge included their shared experiences that incorporated memories, meanings and expectations. The latter one was related to the team's practice habits. The practitioners' occupational therapy process was one habit and the series of cycles associated with it were a form of procedure in the physical environment. My grounded theory categories also show a relationship with on-going business (Cook and Wagenaar, 2012), considered next.

The steps of practice and rules for practice categories from my grounded theory are particularly relevant to Cook and Wagenaar's (2012) *on-going business* in that they form part of the practitioner's business as usual with their routines and habits of practice (Cook and Wagenaar, 2012). The steps of practice concept of the occupational therapy process provided a recognisable direction for practice. That, combined with the category rules for practice with one of its concepts of a model for practice in the form of MOHO, supplied guidance for what the practitioners needed to look for, in that particular conceptualisation of service users and human occupation. Indeed my grounded theory concept of environment in rules for practice fitted well with Cook and Wagenaar's (2012) facet of physical environment and associated objects.

On-going business has a facet that identifies the emergent nature of practice (Cook and Wagenaar, 2012) which was required when the steps of and rules for practice could not be met. For example when the practitioner could not identify particular difficulties such as sensory functioning and occupational participation with MOHOST, or when MOHO could not explain what was happening with service users' occupational participation and those who refused to connect with practitioners. Thus a new or adapted practice had to happen in order for the therapy to move forward and service users' occupational participation to be met. Such ways of working provided new practice experiences (Cook and Wagenaar, 2012) for the practitioners such as adapting a bedroom for Claire when making cookies without secure items and to improve Leila's ability to reach for objects to reduce her pain. They did however, use previous practice experiences discussed later in relation to *the eternally unfolding present* (Cook and |Wagenaar, 2012). These practice experiences and the shared experiential environment from Cook and Wagenaar

(2012) are facets that relate to the practice experience concept in my grounded theory of the blending of personal and professional category.

Having an occupational therapy process and model for practice would also be common to other disciplines and thus form a broad shared experience (Cook and Wagenaar, 2012). Thus the team members would know that each had their own structures for their practice. More specific shared experiences included sharing practice examples about each service user in team meetings and completing risk assessments. Specific shared experiences that incorporated memories, meanings and expectations (Cook and Wagenaar, 2012) would be developed during each case construction from *actionable understanding* (Cook and Wagenaar, 2012). These were created with the team as a whole, or in small groups, working together with the service users. From such work a practitioner community (Cook and Wagenaar, 2012) develops. The different teams that practitioners could be part of such as the team of different disciplines, or the discipline specific occupational therapy team, provide different practitioner communities and should be explored for their separate and combined effects on practice knowledge creation.

Despite such habits and procedures, practice was inherently uncertain, thus habits and procedures had to be modified in order to meet the service users' needs. The practitioners therefore experienced an emergent practice as they developed their practice knowledge, which was related to the final concept of 'the eternally unfolding present' discussed next.

5.4.3 Eternally unfolding present

The 'eternally unfolding present' was practice happening in the present (Cook and Wagenaar, 2012) and formed 'actionable understanding' and sustains 'on-going business'. The combination of these conceptualised knowledge and context as taking their form and meaning from practice. Other characteristics included temporal elements and dialogue. Cook and Wagenaar (2012) therefore have a fundamental epistemological position that means knowledge is not reified over practice and so knowledge does not underlie and enable practice.

The practitioners made reference to various ways in which dialogue (Cook and Wagenaar, 2012) occurred between them and other team members. The expectation that the practitioners must attend clinical team meetings and was the

key forum for discussing each service user on the ward. It was in these meetings that the presentation of the service user from the previous week was discussed and plans for the next week were reviewed. There were variations in the practice of each team about whether service users attended the meeting. The adolescent ward was the only service that did not permit their attendance at the weekly team meeting, but all services permitted their service users to attend their CPA meeting. There were examples of specific collaboration between the practitioners, other workers and the service users. Gladys and psychologists liaised and shared information about both Leila and Andy. Liz collaborated at various points with nurses, doctors and a drama therapist. It was apparent from the findings that a wider team dialogue and specific work between a small group of disciplines was a core feature of their practice. The sharing of observations, assessment results and how the various sources of knowledge were combined for future practice decisions were core processes with working with a team and each service user.

The time of how often such discussion occurred was a temporal aspect of practice epistemology and was practice situated in the present (Cook and Wagenaar, 2012). Making risk assessments and decisions about risk management when Liz met on a half hourly daily basis with some team members and assessing Claire with the nurses and doctors in seclusion were examples. The dialogue between team members and Claire and her multidimensional needs illustrated how practice created context and knowledge about her and the team's specific events at those times. The combination of events, people and environments could not be dealt with by using standardised risk assessments, as they would be too crude to manage such a dynamic, fast moving and particular context. The risk assessment and management had to be explored through dialogue in the present that is in a seclusion room, or with Liz doing an immediate risk assessment as part of her daily sensory interventions with Claire.

Practice knowledge was formed through the connection between the 'eternally unfolding present', how 'on-going business' was sustained and 'actionable understandings' were created (Cook and Wagenaar, 2012). To illustrate this further, dialogue in the present had to incorporate what was known by a practitioner. Taking the example of Liz and the daily interventions above, Claire's and Liz's specifically created set of questions, as well as Claire's risk history were known to Liz. What was not known was in the 'eternally unfolding present' would

Claire respond with the same risks as at other times, with other people in her history, when Liz worked with her? Her history suggested a strong possibility of this. There was however, through the set of questions, a dialogue between Liz and Claire. The answers to those questions were aligned with Liz's observations of Claire's actions in the bedroom environment, where the sensory work was done. That created the context of practice at that time and thus the 'actionable understandings', where Liz could do the interventions with Claire or not, depending on the risk assessment at that time.

Liz routinely used of the set of questions to establish the risks, so this formed part of her practitioner habits, her 'business as usual' and thus 'on-going business' was sustained. Liz's and Claire's work formed Liz's practice habits up until the point something changed. There would be a risk management plan to use should Claire carry out risk acts. Another example of change in habits was when Claire refused to participate because she felt she may be a risk to herself or others. Liz needed to use a plan if one was established, or act more in the moment. What would move this situation from 'business as usual', would be a change in Claire's reaction to the intervention, such as feeling physically unwell, or she was not in the mood, then a new context would be created from practice. Liz would assess and observe Claire's changes and try to understand or interpret the observations to establish whether there were ways to modify the intervention or situation, using 'what is known' about her core skills. The practice therefore rolls on in the 'eternally unfolding present' and shows the relationship with the occupational therapy process cycles that occurred simultaneously (Mattingly and Fleming, 1994) and the creation of new practice knowledge. There is a relationship with reflection-in-action (Schon, 1991), moving beyond habits and creating practice knowledge, discussed next.

Reflection-in-action

Until now I have referred to the various situations where the practitioners acted in the moment when a practice event had no specific knowledge linked to it, whether that be technical rational (Schön, 1991), practice knowledge (Cook and Wagenaar, 2012), or a combination. Such practices were indicated by Schön's (1991) concept of reflection-in-action of "thinking about something while it is being done" (p. 54). Mattingly and Fleming's (1994) interpreting facet of their process of observation in

practice bore some relationship to reflection-in-action, but they did not explore the potential relationship. Indeed, reflection-in-action was a dialectical relationship between action and reflection (Kinsella, 2009). Therefore, the practitioners' "action-seeing-observing-interpreting-acting" (Mattingly and Fleming, 1994, p321), was a form of reflection-in-action (Schön, 1991).

An important element to Schön's concept was that a practice event had to be a surprise to the practitioner in order to invoke reflection-in-action (Schön, 1991). Schön however, also noted that his examples of various practitioners indicated they "think about what they are doing while doing it" (Schön, 1991, p. 275). There was again a similarity to Mattingly and Fleming that observation in practice was a constant feature during therapeutic work with the service user. The time frame in which reflection-in-action could be completed was limited by the "action-present" (Schön, 1991, p. 62) the time zone available to make a difference to the situation. Schön suggested that the action-present could extend over any time frame depending on the pace of activity and situational boundaries of the activity (Schön, 1991). Gladys provided examples of Andy attempting to change the established intervention plans and her interview discussion about the event suggested her response occurred very quickly. Tess's observations of Zach's constraints in washing-up in the cookery group occurred in the moment, but she also held those observations and potential interpretations as part of her practice knowledge as it changed and developed over subsequent cookery sessions. These were brief examples and there is a need to further explore occupational therapists' reflection-in-action its embodied nature (Kinsella, 2012) and the relationship to creating practice knowledge. Creating contexts from practice knowledge is the next part of the discussion.

The creation of contexts through the practitioners' practice was apparent from where they had to change or work within the limitations of a physical environment to facilitate connecting with and developing rapport with a service user and facilitating occupational participation within restricted secure environments. Liz was faced with having to change the physical environment using both physical objects of weighted blankets and sweets, and her therapeutic use of self, to facilitate therapeutic work in the seclusion review, an unusual practice in occupational therapy. Liz therefore created a different and new therapeutic environment in the seclusion room in order for Claire to process her sensory experiences more

effectively to enable her to become calmer in mood. Liz also created a new therapeutic physical environment in Claire's bedroom to make cookies. Liz used the cover of protective plastic sheeting to do no-tool cookery, rather than access the more risky environment of a kitchen. Gladys and Tess worked within the limitations of the physical environment. Gladys built her therapeutic rapport with Andy and observed his occupational participation in the ward garden that he was starting to access to have a cigarette. Gladys used whatever was available to her and adapted her work with Andy according to where he was engaged. Gladys also had to find a way to make a connection with Leila, which was ultimately done by considering Leila's neck pain and how her bedroom environment could be adapted to facilitate Leila's physical functioning.

In summary, Cook and Wagenaar's (2012) three concepts of eternally unfolding present, actionable understanding and ongoing business provided conceptualisations that could explain the form that practice knowledge took in occupational therapy in forensic mental health. I go further now to consider the relationship between my grounded theory categories and the *eternally unfolding present*.

My grounded theory categories of the steps of practice and rules for practice are associated mostly with actionable understandings and on-going business (Cook and Wagenaar, 2012). They are therefore, also related in part with the final concept of the *eternally unfolding present* (Cook and Wagenaar, 2012), which is also associated with blending of the personal and professional category from my grounded theory.

The temporal facet (Cook and Wagenaar, 2012) was apparent at the time frame required for carrying out the occupational therapy process, for example when assessments were expected, from my steps of practice grounded theory category. The use and completion of assessments however, were also part of the emergent nature of practice (Cook and Wagenaar, 2012). For example, nearly all of the service users could not be assessed with MOHOST. The practitioners therefore required other ways to assess such as with observations of occupational participation, gaining the service users' history and narrative creation, sensory assessments with sweets and adapting the environment to facilitate occupations such as cookie making, in which the service users could be observed.

The dialogue facet (Cook and Wagenaar, 2012) was a primary way of communicating between team members in meetings and potentially through joint interventions that the practitioners did with other team members, though this latter one requires further research. Cook and Wagenaar's (2012) dialogue facet of the practice used examples from police officers as team members, who discussed a case (Cook and Wagenaar, 2012). This could be developed further because my research indicated that dialogue was required in part for my concept of narrative building from the category of blending the personal and professional, where the practitioners' communication with the service users helped create their narrative. Thus dialogue in the forensic setting is engaged between not only between practitioners, but also with service users.

Through the service users' narratives, my other concepts of trust, rapport and empathy of the practitioners for their service users grew. This was again in part from the practitioners' use of Cook and Wagenaar's (2012) facet of dialogue. My foregoing concepts also formed part of what is known, in actionable understanding and practitioner experiences, from on-going business (Cook and Wagenaar, 2012). So the practitioners had both personal and professional experiences that constituted what is known. Furthermore, my blending the personal and professional category highlights the combination of those concepts required for effective practice, which includes my concept of practitioners' emotions in practice. Another of my concepts, occupational therapy is not fluffy and therapists' identity, is related to dialogue (Cook and Wagenaar, 2012). It was the practitioners' discussion with service users and their occupational participation in relation to crime and their risk assessment and risk taking that showed knowledge creation from their practice. This further supports the relationship between Cook and Wagenaar's (2012) work and my grounded theory. Thus practice knowledge and context is created through dialogue with service users, as well as between team members.

I have now demonstrated that the concepts of the eternally unfolding present, actionable understanding and on-going business (Cook and Wagenaar, 2012) and their relationship with each other can be combined with my grounded theory categories of steps of practice, rules for practice and blending the personal and professional. This provides a strong support for seeing practice as having an epistemological component. This now leads to the concluding chapter.

6. CONCLUSION

My final chapter considers the conclusions drawn from my research and includes a summary of my grounded theory, sections on new insights and practice implications followed by the limitations of my research and suggestions for future investigations.

6.1 A grounded theory of occupational therapy practice knowledge in forensic mental health

I now summarise my grounded theory that presents the ways in which practice knowledge manifests in occupational therapy practice in the forensic mental health setting. The steps taken in practice category refers to a structure that occupational therapists use in order to guide and enact the practice of occupational therapy. The structure of the occupational therapy process has to be flexible so that it can be used at any point that is relevant to the practice situation at any given time. The cycles of the structure are used simultaneously and within the context of that use they can create a new practice knowledge. The therapist's knowledge of the structure is formed from many knowledge sources that are also combined with the structure in the enactment of practice.

Rules for practice encompass what has to be done, what is required and expectations for practice to be carried out. The rules may be required through professional standards, government requirements, and organisational expectations as well as from societal expectations of practitioners. Occupational therapists are expected to use theory in practice because this can drive practice and provide explanations for service users' occupational participation constraints. Therapists are expected to know of theory from other disciplines as a part of the health care context in which they work. When actually enacted in situations of uncertainty or knowledge gaps, the rules for practice have to be modified. The practice of risk management and risk taking that are core to therapeutic work in the forensic setting are carried out with technical rational knowledge gaps. Therefore to fill those gaps knowledge is created from practice about the service user's particular occupational participation constraints and risks. Such practice knowledge creation may also use elements of technical rational knowledge, in the

instance of risk and occupational therapists' cores skills, but technical rational knowledge did not drive knowledge creation. Furthermore, a new practice context was created with service users who required risk management and risk taking to enable occupational participation.

The blending of the personal and professional means that occupational therapists use their personal narrative from their life experience and related values and beliefs along with their emotional responses towards the service user. That narrative was combined with the therapists' practice experiences and subsequent reflection, to form a knowledge for practice. A therapeutic relationship firstly needs a connection to be created between the therapist and service user. That relationship builds the trust and rapport over time through therapeutic cycles that can also halt or plateau. The therapists create a nuanced narrative with the service user whenever possible, and consequently they develop empathy and a compassionate practice towards the service user. Therapists needed such an approach in forensic practice because of the service users' crimes and challenging actions. Stereotypes of the therapists' identity as an occupational therapist were confronted because they had to develop practice knowledge about criminal acts that up until recently, went beyond the current literature about occupational participation. They then had to incorporate that into discussions about the place of crime in a service user's life and how that would impact on their future narrative and the aim of discharge from forensic services to community living.

In summary, occupational therapists working in forensic mental health use a combination of the three categories of steps taken in practice, the rules for practice and blending the personal and professional. Practice situations are unpredictable, therefore practice has to be modified in order for service users' occupational participation to be achieved. Thus occupational therapists' practice knowledge from the forensic mental health setting is created by using the three categories and any modifications that are required to fill their knowledge gaps.

6.2 Research question and aims

In my research I explored: what does a practice epistemology contribute to our understanding of occupational therapists' practice in forensic mental health? The answer to the question is elucidated though the research aims, noted below, for which I will provide an overview of how far they have been met.

Theoretical aims:

1. To critically analyse and explain in what ways, and how, a practice epistemology can inform the practice of occupational therapy in forensic mental health.

The question 'what can practice epistemology add to occupational therapy practice knowledge in forensic mental health?' in the discussion speaks directly to this aim. Cook and Wagenaar's (2012) approach to practice epistemology could provide a language for occupational therapists' practice in forensic mental health. My research was the first empirical exploration of occupational therapy practice knowledge in relation to Cook and Wagenaar's (2012) work and needed to be extended to other areas of occupational therapy. A crucial aspect of Cook and Wagenaar's (2012) work that supported the idea that knowledge was created from practice. Occupational therapists could start to make an underground practice (Mattingly and Fleming, 1994) explicit. In the aspect of 'what is known' in 'actionable understanding' (Cook and Wagenaar, 2012), therapists can take an inclusive view as to what can constitute knowledge for use in practice. 'What is not known' (Cook and Wagenaar, 2012) provided a vehicle for knowledge derived from practice and prompted the search for other forms of knowledge and creating that knowledge that 'needs to be known'.

2. To identify in what ways the occupational therapy forensic literature can contribute to a practice epistemology.

Overall the literature highlighted in aim two, provided examples from practice, which is to be expected of occupational therapy which is a practice. There is an occupational therapy practice guideline for use in forensic settings however, that takes the view that practice is underpinned by such guidelines. What is interesting

is how that guideline incorporates a range of research methodologies and not just the 'gold standard'. In that sense the guidelines represent the best available evidence provided by research, on which to base practice. Other forensic literature did not however, provide explicit and cogent explanations of the relationship of the practice examples with epistemology. Indeed, that is the value of my research which has explored that topic. Moreover, I have used literature from the wider discipline and related health care disciplines to explore epistemology, considered in the next aims.

Research aims specific to the advancement of work on practice epistemology:

1. To explore what occupational therapy-related and other theory are used in forensic settings;
2. To analyse how theory is used in practice and its relationship with knowledge.

The aims above were discussed with the practitioners in relation to their various attempts to use of theory (which I use in its widest sense). It became clear that the practitioners used a range of theory, including the organisation's expectation that MOHO should be used. Indeed, the wider disciplinary literature expected that theory should underpin practice. What emerged from the findings was that they did not always use all of the MOHO concepts and they incorporated other theory as demanded by any given practice situation. This latter point suggested that the practitioners created knowledge from a combination of using theory for practice, as well as practice that incorporated the individual service user's narrative and occupational participation strengths and constraints. All of these facets created a new practice context for the practitioners. The following aims look further at the relationship between practice and knowledge creation.

3. To investigate in what ways occupational therapists' practice in forensic mental health creates a knowledge;
4. To investigate how therapists develop and adapt their practice to create knowledge.

Aims three and four were linked in that there were particular disciplinary core skills that the practitioners used to create knowledge in order to enact risk management

and risk taking. Other examples were when the practitioners had to enact the blanket referral in practice because the disciplinary literature had no codified details. The MOHOST did not assess each service users' occupational participation strengths and constraints. As a result the practitioners used fundamental observation skills and the flexibility of interviews to create the service users' narrative, whenever possible. Furthermore, not all of the MOHO concepts could explain those aspects of the service users either. Consequently the practitioners sought other theory from within and beyond the discipline.

I do not to suggest that theory was separate from the doing of practice, as seems to be expected in practice, but that there was technical rational knowledge that was used. In the practitioners experience here however, they had to compare theory with practice experiences. It was when the two separately, and together, did not explain the service user's occupational participation reflection-in-action and reflection-on-action were ways to understand the situation. Thus, when theory fell short of explaining the service users' circumstances, or a new practice experience was encountered, a new knowledge was created. Consequently practitioners had to find a way for theory to make sense in relation to their service users. Indeed, this in turn created a new practice context of working in subtly different ways with their service users at each contact.

5. To explore what forms knowledge takes in different forensic clinical specialties.

The practice context of each service and the way the team worked provided different ways in which practice knowledge took subtly different forms. For example Tess developed an informal waiting list to manage the short time that the adolescents were admitted to her unit, so her practice knowledge developed to a specific practice. Gladys had to adjust her working approach on the basis of new practice experiences that created new practice knowledge of how to work in slow stream rehabilitation. Liz worked with Claire on a daily basis and in the unusual setting of a seclusion room, both were not Liz's previous practice experience; consequently she developed new practice knowledge for working with Claire in those ways.

6. To investigate the conditions that create knowledge.

There were a variety of practice situations that formed the conditions for knowledge creation. The practitioners experienced knowledge gaps of various types that were one condition. For example, an absence of technical rational knowledge, such as research and codified sources about occupational therapy practice, and missing historical details in multi-disciplinary clinical notes. Also from practice situations, the tools for assessment did not provide the knowledge necessary to understand the service user. Finally knowledge was created when the practitioners had no prior occupational therapy experience. Another condition was when the practitioners experienced an unusual practice situation. Indeed, all the practitioners discussed service users who were unusual in their practice experience to that point. My research has therefore created some new ways of thinking about occupational therapy practice in general and in forensic mental health as well.

6.3 New Insights

1. Occupational therapy practice knowledge in the forensic mental health setting can be conceptualised according to Cook and Wagenaar's (2012) approach to practice epistemology. The combination of the three key concepts of actionable understanding, the eternally unfolding present and on-going business explain how practice can create knowledge and my findings support those concepts.
2. Occupational therapists therefore need to develop an understanding of how Cook and Wagenaar's (2012) approach to practice epistemology and my research are relevant to their practice.

6.4 Practice Implications

The practice implications for occupational therapy in the forensic setting are now presented. Although my research has been focussed around a particular practice setting, there are implications for having a different way of seeing and explaining how practice, research and theory can be combined that could go beyond the forensic setting. There are therefore implications for the wider profession.

The key implication is that occupational therapy practice in forensic mental health is a form of knowledge. Practice knowledge is not based on evidence, or driven by theory. It is more correct to say that theory and research are forms of knowledge to be 'used for' practice but not the base of practice. Furthermore, it is a more inclusive and flexible way of explaining the relationship between knowledge and practice.

Another implication is that standalone standardised measures and those linked to one model of practice should not be used as one way of gathering knowledge about a service users' occupational participation strengths and constraints. Indeed, this may well go beyond the forensic setting to all other occupational therapy practice areas, but this requires further research. Moreover, to focus on one way of knowledge gathering, with such assessments, to the exclusion of other ways of gathering knowledge, creates a hegemony. It is also naïve to think that the multifaceted nature of the service users' needs can be ascertained with such a focus on one model and associated assessments. Practitioners require knowledge of the nuances of a service user's history and their occupational participation and so they need to use a variety of tools to do so. There is a place however, for research to be used for practice when that research incorporates various methodologies, not just those required for testing intervention effectiveness or producing reliable and valid standardised assessments.

There is an implication for how a practitioner starts practice with a service user. Little knowledge gathering can occur directly between the service user and practitioner unless a connection can be made. The need to find such a connection is important as it leads to exploring and creating the service user's narrative. To make a connection required the blending of the personal and professional, which was developed through practitioners' personal life and practice experiences and reflections on them. The practitioners could then use the service users' narratives to develop empathy and build a therapeutic relationship.

Practitioners need to engage in reflection and two forms play a part in the creation of practice knowledge. The first is reflection-on-action that is required to explore the relationship between various forms of knowledge that includes technical rational, associated with evidence based practice and theory, along with practice experience and including practitioner's emotional reactions. Reflection-in-action is

required so that there is no separation between thinking and doing and emotional reactions are incorporated. Both forms of reflection need to be combined so the perceived thinking and doing gap is eliminated. Furthermore, emotional experiences need to be explicitly acknowledged and incorporated as relevant forms of knowledge for practice.

Implications specific to forensic practice include how the occupational therapy process needs to reflect the use of that structure by practitioners in the forensic practice context. Thus risk assessment needs to be incorporated into the assessment cycle and risk management into the intervention cycle of the process. Another key implication for practice is in relation to occupational therapists' core skills. The practitioners actively combined their core occupational therapy skills of activity and environmental analysis in their risk assessment and core occupational therapy skills of activity and environmental grading and adaptation in risk management and positive risk taking in their interventions.

The implications for the wider occupational therapy profession are about the ways in which the occupational therapy process is used and viewed. The process needs to be recognised that it can guide practice, but not drive it. It is a multifaceted framework because the cycles of the process can work simultaneously. In particular blanket referral is an approach that is much more intricate than previously discussed in the literature. As such, any therapist new to a blanket referral approach, would learn how it works through their practice and would require focussed reflection and support in supervision to explore their practice knowledge about blanket referral.

Acknowledging that practice has an epistemological component itself will hopefully encourage occupational therapists in forensic mental health who are, after all, practitioners, to openly acknowledge the need to use practice knowledge first and foremost. Seeing practice as a knowledge also permits practitioners to be flexible and to deal with events as they occur in the moment. This is an aspect that evidence based practice does not acknowledge.

6.5 Limitations of my research

My critique consists of possible limitations created by my research methods, in particular the framework for the interviews and timeline and the use of the probes. Also I consider how far I was able to be reflexive with the data generation and analysis.

The research method was closely aligned to the occupational therapy process in that practitioners were asked to use the process as a framework for discussing the service users. This may have forced the practitioners to immediately structure their discussion around the process, but they may not have done so in practice. Thus my use of the process as a familiar framework to the practitioners may have imposed a structure that they did not use. I have therefore been attentive to how each practitioner described their work in relation to the process and considered ways in which their practice followed and varied from the codified view on the process.

I therefore plotted their discussion about what they did and decisions made in their practice on the timeline up to the point they were currently working. This was done over the first two interviews as required for the Critical Decision Method (Crandall, Klein and Hoffman, 2006), for each practitioner. The timeline then provided the main focus for discussion on historical practice with their service user. There were no updates made to the timeline as the practitioners work moved forward due to the focus on discussions about their earlier practice. This may be in part due to the occasional times that the practitioners discussed current work with their service users in interviews that were still about the historical events. To me this was a point of comparison for the practitioners about what they were currently doing in relation to what history told them about their practice. The historical practice therefore acted as a counterpoint to current work and reflected practice in that the practitioners needed to review their service users' engagement with occupational therapy in order to evaluate it.

Furthermore, in discussing the historical and current work in the data generation I also had to complete data analysis. This meant that theoretical sampling required that I follow-up with particular questions on a specific topic related to their practice.

This therefore took us away from the discussion of the timeline as their practice occurred in chronological order. This may well be part of the process of grounded theory however I had combined two methods that had not been used before, the critical decision method along with grounded theory. I made an effort to get as close to the current and real-time practice of the practitioners as possible. The nature of grounded theory however may not have facilitated arriving at current practice, due to the need to get to fine detail through theoretical sampling and saturation of data on a topic.

One benefit however, was the ability of using grounded theory and the ongoing interviews to present some of the developing ideas and analyses to the practitioners in subsequent interviews. I could seek clarification and develop further questions as the practitioners gave their perspective on my ideas from the analysis. I used this approach to seek the practitioners' views that my analysis to that point, on some subjects, was a fair reflection of their experience.

The probes from the critical decision method did not prove as useful in data generation as I had thought. They were used in two slightly different ways because Tess chose to be interviewed both in person and by email and Gladys and Liz had face to face interviews. By way of context, in the first month I interviewed Tess face to face. In the second month I completed email interviews at approximately one per week. In my first email I asked too many questions (approx. 22) based on the probes, which was overwhelming according to Tess and came across as de-contextualised. Tess however, answered as many questions as she was able. In subsequent emails sent over that month I provided some context prior to asking each question and these were limited to six questions per email. The experience of using emails generated far less data than face to face interviews. As a broad example, the total word count for all the emails in the first month was 2328 words (including my responses) compared to 5073 words (including my responses) in the first face to face interview. This type of pattern was repeated in each of the subsequent forms of interview.

The probes were not used to the extent that the critical decision method required. Part of the reason for this was that I had interviewed Tess with one face to face interview and further email interviews two months prior to meeting with Liz and four months prior to first meeting with Gladys. This provided the experience that

theoretical sampling in conjunction with the timeline became more effective for data generation and analysis. They allowed me to be more reflexive in working with the data, than using the pre-specified probes in the critical decision method. That said, the probes sensitised me to what might have an impact upon the practitioners' practice. So even though I did not use the specific probe questions, I was attentive to how I might explore events described by the practitioners and how they related to any of the probes in general and specific terms.

Reflexivity was important for data generation and analysis as they were informed by my existing knowledge from previous practice and reading. I therefore had to be mindful of whether I was biased too much by my experience and that which was not emergent from the research. This was relevant to the occupational therapy process and the use of standardised tools in practice. Also there was very little critique in the literature about the use of MOHO in practice and apparently overwhelming support for the model and MOHOST so much so that I could doubt what might be arising from the data and my analysis of it. The findings have confirmed some questions I had of my practice but I had no empirical study to compare against. I was alert to being drawn to or drawing the data into my ideas. I was therefore careful to check and recheck my reading and analysis of the data and relate this back to the literature to confirm or reject my analysis. The challenge here was the very limited empirical work available in the literature. I did however, have the use of a critical friend, a qualified nurse, currently in practice, who I could ask questions and compare practice issues between his experience and the practitioners. Even though they were different disciplines, the points of comparison proved useful in clarifying my thinking. One last point in my reflexivity is my position as a male researcher and the female practitioners which has been briefly considered. There has been however, been limited exploration of the gender differences and how they may have influenced the research.

One of the practitioners engaged in a member check to a degree. She provided some feedback about her service and the ways risk can be viewed, but she did not provide feedback about the ways I had interpreted her interview data and presented them in the findings. I achieved a small peer review by using a Twitter discussion to explore the finding about connection, which created some useful exploration that I have incorporated into my discussion.

6.6 Future research

Suggestions for further research have been made throughout the thesis. This section however, highlights more substantive topics that have not been covered in sufficient detail or at all in my research, but that could be developed.

Embodied knowledge was not explored, but the practitioners' emotions were discussed. A range of emotional responses occur given the combination of service users, occupations, environmental factors of people, places and objects available. Emotions happen in the moment, cannot be planned for, and so exploring how they are integrated into practice as a means of informing the practitioner about the progress of therapy is required. This is counter to the belief that evidence based practice can inform all aspects of practice. Such an approach cannot account for the dynamic nature of practice and needs researching. The nursing literature may provide a useful resource for further exploration.

Reflection and embodied and emotional knowledge and its relationship to practice knowledge needs to be investigated further. Indeed, recent work by Kinsella (2012) develops Schön's work on reflection and the dialogue between pre-reflection, reflection and reflexivity that incorporates embodiment. A particular model 'Strands of Reflection' (Fish, Twinn and Purr, 1990 and 1991 cited in Fish, 1997, p. 136) would be a useful approach to exploring the depth and complexity of reflection. It may well have a strong relationship with practice knowledge as it was partly developed in response to illuminate forms of knowledge other than the technical rational that are used in practice (Fish, 2012). Even though the four strands of the model are meant to be used together, I highlight one here as a justification to use the model. The 'sub-stratum strand' assists the practitioner to make explicit their assumptions, values and beliefs about practice events. Indeed Fish and Cossart have developed the 'sub-stratum strand' into a new contribution called 'The Invisibles' for which there are eight elements (Fish, 2012). The practitioners would still be challenged to look at what lies underneath their practice, below the surface (Fish, 1997) to their thinking about the context of a practice event, their use of forms of knowledge and critiquing their professional judgements (Fish, 2012). Both models have a strong cognitive element, so the emotional responses specific to challenging practice situations needs more acknowledgment and exploration.

The emotional experience of occupational therapists in secure settings and the sociological concept of emotional labour have not previously been explored. Hochschild (2012), researched how an Airline company used their cabin crew employees' emotions in the performance of their work, in effect paying employees for the use of their emotions in their work. There are obvious connotations for health care and subsequent work by a nurse, Theodosius (2008) developed Hochschild's work for the physical health care setting. The broader occupational therapy literature has very little work on emotional labour apart from discussion by an Australian occupational therapist, Fitzgerald (2012) who has called for a consideration of emotional labour and occupational therapy. In terms of the forensic setting, the form that emotional labour takes for occupational therapists, especially in relation to therapists' therapeutic use of self and practice knowledge could be explored further.

Clinical reasoning and its relationship with the knowledge used in and created from practice has not been discussed. There are two forms of reasoning that are pertinent. Firstly, three track reasoning and how it has been proposed by Roberts (1996) as not being about reasoning, but about what is used, the content i.e. the knowledge and not processes of reasoning with the knowledge, such as problem solving. If this is the case, then further research is required to clarify the conceptualisation of the three tracks, how they are used in practice and their relationship with practice epistemology. Furthermore, these proposals need to be extended to the mental health setting in particular, as this area has not been substantially researched. Secondly pragmatic reasoning needs exploring in relation to its conceptualisation of internal personal and external environmental facets of reasoning (Schell, 2008) and how these relate to practice knowledge and the confluence of the personal and professional.

Professional practice judgement artistry includes knowledgeable risk taking in collaboration with service users to create something new and better for them (Paterson, Higgs, Wilcox, 2005; 2006). The place of positive risk-taking in occupational therapy has been clarified in my research and its relationship with practice knowledge has been explored. Further investigation into those topics alone would be of value to explore the nuances.

Reflexivity and its relationship with reflection and the development of new practice knowledge would benefit from further research. There may also be links with those aspects and between novice and experienced or expert practitioners to clinical reasoning and practice knowledge that could not be explored in my research due to having no new graduate practitioners in my practitioner group.

To conclude, a practice epistemology approach can explain occupational therapy practice in forensic mental health. It would also be useful for other areas of the discipline. Indeed, a key finding is that practice is not based on technical rational knowledge, but knowledge is created from and used for practice.

GLOSSARY

Key terms	Definition	Reference/source
Band five, six, seven	Staff are placed in one of nine pay bands on the basis of their knowledge, responsibility, skills and effort needed for the job.	http://www.nhsemployers.org/your-workforce/pay-and-reward/pay/agenda-for-change-pay/how-agenda-for-change-works (accessed: 24.6.15)
Care Programme Approach (CPA)	The purpose of the CPA is to improve the delivery of care to people with severe mental illness. It aims to identify who these people are and what their needs are. Services and resources can then be prioritised and allocated.	DH (2009)
Care Quality Commission (CQC)	The Care Quality Commission was established by the Health and Social Care Act 2008 to regulate the quality of health and social care and look after the interests of people detained under the Mental Health Act.	DH (2009)
Handover	Occupational therapy, nursing or multi-disciplinary team meeting, where he or she may report information and receive thereof from other staff about service users.	Adapted from COT (2015)
Index offence	Index offence: recordable (on the Police National Computer) committed in England and Wales ☐ prosecuted by the police ☐ not a breach offence	Ministry of Justice (2011)
Korsakoff's dementia	Alcohol related illness	
Occupation	A group of activities that has personal and sociocultural meaning, is named within a culture and supports participation in society. Occupations can be categorised as self-care, productivity and/or leisure.	(Consensus definition from ENOTHE 2004)
Service user	Refers to any individual in direct receipt of any services/interventions provided by a member of occupational therapy personnel.	COT (2015)
SHO – senior house officer	Title given to doctors in their second year following qualifying in their under-graduate study used until 2002.	Wikipedia (last modified 11.06.14)

REFERENCES

Abbott, A. (1988) *The System of Professions An Essay on the Division of Expert Labour.* Chicago: University of Chicago Press.

Aldrich, R.M. and White, N. (2012) 'Reconsidering violence: a response to Twinley and Addidle (2012) and Morris (2012)'. *British Journal of Occupational Therapy*, 75(11), 527-529. [Online]. DOI: 10.4276/030802212X13522194760057 (Accessed: 15 June 2014).

Alred, D. (2003) 'Programme planning', in L Couldrick, D Alred, eds. *Forensic Occupational Therapy.* London: Whurr, pp. 45-53.

American Occupational Therapy Association. (2014) 'Occupational therapy practice framework: Domain and process' (3rd ed.) *American Journal of Occupational Therapy*, 68(Suppl. 1), pp. 1–48. [Online]. http://dx .doi .org/10 .5014/ajot .2014 .682006 (Accessed: 15 November 2014).

Ashby, S, E. (2013) An exploration of the different forms of theoretical knowledge valued and used by occupational therapists in mental health practice. PhD thesis. University of Newcastle, Australia [Online]. Available at: http://hdl.handle.net/1959.13/1043117 (Accessed: 20 October 2014).

Baker, S. and McKay, E, M. (2001) 'Occupational Therapists' Perspectives of the Needs of Women in Medium Secure Units'. *British Journal of Occupational Therapy.* 64(9), pp. 442-448.

Ballinger, C. and Wiles, R. (2001) 'A critical look at evidence-based practice. *British Journal of Occupational Therapy',* 64(5), pp. 253-255.

Bampton, R. and Cowton, C. J. (2002) 'The E-Interview'. *Forum Qualitative Sozialforschung / Forum: Qualitative Social Research*, 3(2), Art. 9. [Online] http://nbn-resolving.de/urn:nbn:de:0114-fqs020295. (Accessed: 4 November 2008).

Bannigan, K. (1997) 'Clinical Effectiveness: Systematic Reviews and Evidence-Based Practice in Occupational Therapy', *British Journal of Occupational Therapy.* 60(11), pp. 479-483.

Barton, C. (2003)' Assessment'. in Couldrick, L. and Alred, D. eds. Forensic Occupational Therapy. London: Whurr, pp. 30-44.

Baum, C. M. and Christiansen, C. H. (2005) 'Person-environment-occupation-performance: an occupation-based framework for practice'. In: CH Christiansen, CM Baum, J Bass-Haugen, eds. *Occupational Therapy: performance, participation, and well-being.* 3rd ed. Thorofare, NJ: Slack, pp. 242-66.

Bazeley, P. and Jackson, K. (2013) Qualitative Data Analysis with NVivo. 2nd edn. Available: www,amazon.o.uk/kindle-ebooks (Accessed: 13 August 2013).

Bazeley, P. (2013) *Qualitative Data Analysis.* Available: *http://play.google.com/store/books/google-ebooks (Accessed: 16 August 2013).*

Beeston, S. and Higgs, J. (2001) 'Professional practice: artistry and connoisseurship', in Higgs, J. and Titchen, A. (eds.) *Practice Knowledge and Expertise in the Health Professions*. Oxford: Butterworth Heinemann, pp. 108-117.

Birks, M. and Mills, J. (2011) *Grounded Theory A Practical Guide.* Los Angeles: Sage

Boniface, G. and Seymour, A. (2012) 'Introduction', in Boniface, G. and Seymour, A. (eds.) *Using Occupational Therapy Theory in Practice.* http://www.amazon.co.uk/kindle-ebooks (Accessed: 24 January 2013).

Breines, E. (1986) *Origins and Adaptations A Philosophy of Practice*. Lebanon, NJ: Geri-Rehab Inc.

British Association of Occupational Therapists (1990) 'Code of Professional Conduct'. *British Journal of Occupational Therapy.* 53(4), pp. 143-148.

Brown, C. and Dunn, W. (2002) *Adolescent/Adult Sensory Profile*. Harcourt Assessment.

Brown, S., McIntyre, D. and McAlpine, A. (1988) *The Knowledge Which Underpins the Craft of Teaching.* [Online] Available at: http://www.eric.ed.gov/ (Accessed 14 May 2010).

Bullock, A. (2014) 'Assessment and Outcome Measurement', in Bryant, W., Fieldhouse, J. and Bannigan, K. (eds.) *Creek's Occupational Therapy and Mental Health*. 5th edn. Edinburgh: Churchill Livingstone Elsevier, pp. 72-85.

Burke, H. and Hart, S. D. (2000) 'Personality disordered offenders: Conceptualization, assessment and diagnosis of personality disorder, in Hodgins, S. and Muller-Isberner, R. (eds.) *Violence, crime and mentally disordered offenders: Concepts and methods for effective treatment and prevention.* New York: John Wiley & Sons, pp.63-85.

Cattell, J., Mackie, A., Prestage, Y. and Wood, M. (2013) *Results from the Offender Management Community Cohort Study (OMCCS): Assessment and sentence planning*. London: Ministry of Justice [Online] (Accessed: 13 June 2015)

Chacksfield, J. D. (1997) 'Forensic occupational therapy: is it a developing specialism?' *British Journal of Therapy and Rehabilitation*, 4(7), pp. 371-74.

Chacksfield, J. D. (2003) 'Forensic addictive behaviours'. In: Couldrick, L. and Alred, D. (eds.) *Forensic Occupational Therapy*. London: Whurr, pp. 182-94.

Charmaz, K. (2006) *Constructing Grounded Theory A Practical Guide Through Qualitative Analysis.* Los Angeles. Sage.

Christiansen, C. (2007) 'Adolf Meyer Revisited: Connections between Lifestyles, Resilience and Illness'. *Journal of Occupational Science*, 14(2), pp 63-76. [Online] DOI:10.1080/14427591.2007.9686586 (Accessed: 28 February 2009)

Clarke, C. (2003a) 'Clinical application of the Canadian Model of Occupational Performance in a forensic rehabilitation hostel'. *British Journal of Occupational Therapy,* 66(4), pp. 171-74.

Clarke, A. (2003b). 'Situational Analyses: Grounded Theory Mapping After the Postmodern Turn'. *Symbolic Interaction.* 26(4), pp. 553-576.

Clarke, A. E. (2005) *Situational Analysis Grounded Theory After the Postmodern Turn*. Thousand Oaks. Sage

Clarke, A. E. and Friese, C. (2007) 'Grounded Theorizing Using Situational Analysis', in Bryant, A. and Charmaz, K. (eds.) *The Sage Handbook of Grounded Theory*. Los Angeles: Sage, pp.363-397.

Cochrane, A. L. (1972/1999) *Effectiveness and Efficiency Random Reflections on Health Services.* London: The Royal Society of Medicine Press Ltd.

College of Occupational Therapists (2002) *Standards for Practice for Occupational Therapy in Forensic Residential Settings.* London: College of Occupational Therapists

College of Occupational Therapists (2006) *Risk management.* London: COT.

College of Occupational Therapists (2015) *Code of Ethics and Professional Conduct.* London: College of Occupational Therapists.

College of Occupational Therapists (2012) *Occupational therapists' use of occupation-focused practice in secure hospitals Practice guideline.* London: College of Occupational Therapists.

Collins, M., Harrison, D., Mason, R. and Lowden, A. (2011) 'Innovation and creativity: exploring human occupation and professional development in student education'. *British Journal of Occupational Therapy*, 74(6), pp. 304-308.

Connell, C. (2015) 'An integrated case formulation approach in forensic practice: the contribution of Occupational Therapy to risk assessment and formulation', *The Journal of Forensic Psychiatry & Psychology,* 26(1), pp. 94-106. [Online] DOI: 10.1080/14789949.2014.981566 (Accessed:

Cook, S. D. N. and Wagenaar, H. (2012) 'Navigating the Eternally Unfolding Present: Toward an Epistemology of Practice', *The American Review of Public Administration.* 42(1), pp. 3–38. [Online] DOI: 10.1177/0275074011407404 (Accessed: 14 March 2012).

Corbin, J. and Strauss, A. (2008) *Basics of Qualitative Research: Techniques and Procedures for Developing Grounded Theory.* 3rd edn. http://www.amazon.co.uk/kindle-ebooks (Accessed: 23 March 2012).

Cordingley, K. (2013) Email to Jeannie Mee, 27 November.

Cordingley, K. and Ryan, S. (2009) 'Occupational therapy risk assessment in forensic mental health practice: an exploration', *British Journal of Occupational Therapy,* 72 (12), pp. 531-538.

Couldrick, L. and Alred, D. (eds) (2003) *Forensic Occupational Therapy*. London: Whurr Publishers.

Craik, C. Bryant, W. Ryan, A. Barclay, S. Brooke, N. Mason, A. and Russell, P. (2010) 'A qualitative study of service user experiences of occupation in forensic

mental health', *Australian Occupational Therapy Journal,* 57(5), pp.1-6. [Online] DOI:10.1111/j.1440-1630.2010.00857.x (Accessed: 4 November 2011).

Crandall, B., Klein, G. and Hoffman, R. R. (2006) *Working Minds: A Practitioner's Guide to Cognitive Task Analysis.* Massachusetts: MIT Press.

Creek, J. (2010) *The Core Concepts of Occupational Therapy A Dynamic Framework for Practice.* London: Jessica Kingsley.

Creek, J. (2008) 'The Knowledge Base of Occupational Therapy', in Creek, J. and Lougher, L. (eds.) *Occupational therapy and mental health.* 4th edn. Edinburgh: Churchill Livingstone, pp.31-56.

Creek, J. (2003) *Occupational therapy defined as a complex intervention.* London: College of Occupational Therapists.

Corston, J. (2007) *The Corston Report.* London: Home Office

Creek, J. (2014) 'Approaches to Practice', in Bryant, W., Fieldhouse, J. and Bannigan, K. (eds.) *Creek's Occupational Therapy and Mental Health.* 5th edn. Edinburgh: Churchill Livingstone Elsevier, pp. 50-71.

Creek, J. and Lougher, L. (eds.) *Occupational therapy and mental health.* (4th edn). Edinburgh: Churchill Livingstone

Creek, J. and Feaver, S. (1993a) Models for Practice in Occupational Therapy: Part 1, Defining Terms. *British Journal of Occupational Therapy,* 56(1), pp. 4-6.

Creek, J. and Feaver, S. (1993b) Models for Practice in Occupational Therapy: Part 2, What use are they? *British Journal of Occupational Therapy,* 56(2), pp. 59-62.

Critical Appraisal Skills Programme Available at: http://www.casp-uk.net/ (no date) (Accessed: 17 May 2013)

Cronin-Davis, J. (2006) 'Personality disorder: occupational therapy inclusion'. In Long, C. and Cronin-Davis, J. eds. *Occupational therapy evidence in practice for mental health.* Oxford: Blackwell, pp. 99-120.

Cronin-Davis, J. (2010) *Occupational therapy practice with male patients diagnosed with personality disorder in forensic settings: a qualitative study of the views and perceptions of patients, managers and occupational therapists.* Unpublished PhD thesis. The University of Leeds York St John University.

Cronin-Davis, J., Lang, A. and Molineux, M. (2004) 'Occupational Science: The Forensic Challenge', in Molineux, M. (ed.) *Occupation for Occupational Therapists.* Oxford: Blackwell Publishing, pp. 168-179.

Cronin Mosey, A. (1996) *Applied Scientific Inquiry in the Health Professions: An Epistemological Orientation.* 2nd edn. Bethesda, MD: The American Occupational Therapy Association, Inc.

Cronin Mosey, A. (1986) *Psychosical Components of Occupational Therapy.* Philadelphia: Lippincott-Raven

Cross, K. (2000) 'Forensic psychiatry: the search for a standardised assessment', in *Occupational Therapy News.* London: British Association of Occupational Therapists, p.16.

Cusack, L., Phillips, L. and Singh, S. (1990) 'The Role of the Occupational Therapist in HIV Disease and AIDS', *British Journal of Occupational Therapy,* 53(5), pp. 181-183.

Cutchin, M, P. (2007) 'From Society to Self (and Back) Through Place: Habit in Transactional Context', *OTJR: Occupation, Participation and Health,* 27(Fall), pp. 50-59.

Dawes, M., Summerskill, W., Glasziou, P., Cartabellotta, A., Martin, J., Hopayian, K., Porzolt, F., Burls, A. and Osborne, J. (2005) Sicily statement on evidence-based practice, *BMC Medical Education,* 5 (1) pp. 1-7. [Online] DOI: 10.1186/1472-6920-5-1 (Accessed: 6 April 2010).

Deegan, P. E. (2001) 'Recovery as a Self-Directed Process of Healing and Transformation', *Occupational Therapy in Mental Health*, 17(3/4), pp. 5-21. [Online] http://www.haworthpress.com/ (Accessed: 3 May 2007)

De las Heras, C. G., Llerena, V. and Kielhofner, G. (2003) *Remotivation Process: Progressive Intervention for Individuals with Severe Volitional Challenges.* Chicago: University of Illinois.

Dennhardt, S. and Laliberte Rudman, D. (2012) 'When occupation goes 'wrong': A critical reflection on risk discourses and their relevance in shaping occupation', in Whiteford, G. E. and Hocking, C. (eds.) Occupational Science, Society, Inclusion, Participation. http://www.amazon.co.uk/kindle-ebooks (Accessed: 14 September 2013).

Great Britain. Department of Health (2011) *No Health Without Mental Health: A Cross-Government Mental Health Outcomes Strategy for People of All Ages.* [Online] http://www.dh.gov.uk/mentalhealthstrategy. (Accessed: 1 April 2011)

Denshire, S. (2002) 'Reflections on the confluence of personal and professional'. *Australian Occupational Therapy Journal.* 49, pp. 212-216.

Dewey, J. (1922) 'Human Nature and Conduct An Introduction to Social Psychology', in *The Collected Works of John Dewey.* www.amazon.co.uk/kindle-ebook. (Accessed: 1 May 2015)

Doble, S. E. and Caron Santha, J. (2008) 'Occupational well-being: Rethinking occupational therapy outcomes'. *Canadian Journal of Occupational Therapy.* 75(3), pp. 184-190

Donskoy, A., Stevens, R. and Bryant, W. (2014) 'Perspectives on Using and Providing Services', in Bryant, W., Fieldhouse, J. and Bannigan, K. (eds.) *Creek's Occupational Therapy and Mental Health*. 5th edn. Edinburgh: Churchill Livingstone Elsevier, pp. 163-175.

Drennan, G. and Alred, D. eds. (2012) *Secure Recovery: Approaches to Recovery in Forensic Mental Health Settings.* Abingdon, Oxon: Routledge.

Dressler, J. and Sniveley, F. and (2005) 'Occupational therapy in the criminal justice System', in Cara, E. and MacCrae, A. (eds.) *Psychosocial occupational therapy: a clinical practice.* 2nd edn. Clifton Park, NY: Thomson Delmar Learning, pp. 568-90.

Duncan, E. (2011a) 'Routine outcome measurement in practice: Overcoming challenges, seeking solutions, demonstrating impact'. *Australian Occupational Therapy Journal,* 58, p. 221 [Online] DOI: 10.1111/j.1440-1630.2011.00951.x (Accessed: 8 August 2011).

Duncan, E. A. S. (2011b) 'Introduction'. *Foundations for Practice in Occupational Therapy.* www.amazon.co.uk/kindle-ebook. (Accessed: 9 October 2014)

Duncan, E. A. S. (2008) 'Forensic occupational therapy', in Creek, J. and Lougher, L. eds. *Occupational therapy and mental health.* (4th edn). Edinburgh: Churchill Livingstone, pp. 513-34.

Duncan, E. A. S. and Murray, J. (2012) 'The barriers and facilitators to routine outcome measurement by allied health professionals in practice: a systematic review', *BMC Health Services Research*, 12(96). [Online] DOI:10.1186/1472-6963-12-96 (Accessed 8 May 2015)

Duncan EAS, Munro K, Nicol M (2003) 'Research priorities in forensic occupational therapy'. *British Journal of Occupational Therapy*, 66(2), pp. 55-64.

Dunn, W, Brown, C. and McGuigan, A (1994) 'The Ecology of Human Performance: A Framework for Considering the Effect of Context'. *American Journal of Occupational Therapy*, 48(7), pp. 595-607.

Eggers, M., Muñoz, P. J., Sciulli, J., Crist, P. and Hickerson, A. (2006) 'The Community Reintegration Project: Occupational Therapy at Work in a County Jail', *Occupational Therapy In Health Care*, 20(1), pp. 17 — 37. [Online] DOI: 10.1300/J003v20n01_02 (Accessed: 11 September 2007)

Eraut, M. (1994) *Developing Professional Knowledge and Competence*. London: Routledge Falmer.

Fairhead, D. (1997) 'Occupational therapy as applied to forensic psychiatry'. In Crouch, R, B. and Alers, V, M. (eds.) *Occupational therapy in psychiatry and mental health.* 3rd edn. Cape Town: Maskew Miller Longman, pp. 382-97.

Falardeau, M., Morin, J. and Bellemare, J. (2014)'The Perspective of Young Prisoners on their Occupations', *Journal of Occupational Science*, [Online] DOI: 10.1080/14427591.2014.915000 (Accessed: 26 June 2014)

Farnworth, L., Morgan. S. and Fernando, B. (1987) 'Prison Based Occupational Therapy', *Australian Occupational Therapy Journal*, 34(2), pp.40-46.

Farnworth, L. (2000) 'Time Use and Leisure Occupations of Young Offenders', *American Journal of Occupational Therapy,* 54(3), pp.315-325.

Farnworth, L. and Muñoz, J. P. (2010) 'An Occupational and Rehabilitation Perspective for Institutional Practice'. *Psychiatric Rehabilitation Journal*, 32(3), pp. 192–198. [Online] DOI: 10.2975/32.3.2009.192.198 (Accessed: 24 November 2011).

Finlay, L. (1998) 'Reflexivity: An Essential Component for all Research?' *British Journal of Occupational Therapy,* 61(10), pp. 453-456.

Finlay, L. (2002) '"Outing" the Researcher: The Provenance, Process, and Practice of Reflexivity', *Qualitative Health Research,* 12(4), pp. 531-545. [Online] DOI: 10.1177/104973202129120052 (Accessed 15 January 2013).

Finlay, L. (2006) 'Going Exploring': The Nature of Qualitative Research. In Finlay, L. and Ballinger, C. (eds.) *Qualitative Research for Allied Health Professionals.* West Sussex: John Wiley & Sons, pp.3-8.

Fish, D. (2012) 'From Strands to The Invisibles: from a technical to a moral code of reflective practice', in Boniface, G. and Seymour, A. (eds.) *Using Occupational Therapy Theory in Practice.* http://www.amazon.co.uk/kindle-ebooks (Accessed: 24 January 2013).

Fish, D. (1998) *Appreciating Practice in the Caring Professions*. Oxford. Butterworth-Heinemann.

Fish, D. (1997) *Quality Clinical Supervision in the Health Care Professions: Principled approaches to practice.* Oxford: Butterworth Heinemann.

Fish, D. and Coles, C. (1998) *Developing Professional Judgement in Health Care.* Oxford: Butterworth-Heinemann

Fitzgerald, R. (2012) 'Occupational Therapists, Care and Managerialism', in Robertson, L. (ed.) Clinical Reasoning in Occupational Therapy Controversies in Practice. Oxford: Wiley-Blackwell, pp. 46-62.

Flanagan, J. (1954) 'The Critical Incident Technique', *Psychological Bulletin,* 51(4), pp. 327- 358.

Fletcher-Smith, J., Drummond, A., Sackley, C., Moody, A. and Walker, M. (2014) 'Occupational therapy for care home residents with stroke: what is routine national practice?' *British Journal of Occupational Therapy*, 77(5), pp. 265–273. [Online] DOI: 10.4276/030802214X13990455043601 (Accessed: 29 April 2015)

Flood, B. (1993). 'Implications for Occupational Therapy Services following the Reed Report', *British Journal of Occupational Therapy*, 56(8), pp. 293-294.

Flood, B. (1997). 'An introduction to occupational therapy in forensic psychiatry'. *British Journal of Therapy and Rehabilitation*, 4(7), pp. 375-380.

Forward, M. J., Lloyd, C. and Trevan-Hawke, J. (1999) 'The OT in the forensic psychiatric setting', *British Journal of Therapy and Rehabilitation*, 6(9), pp. 442-446.

Fontana, A. and Frey, J.H. (2008) 'The Interview From Neutral Stance to Political Involvement', in Denzin, N.K. and Lincoln, Y.S. (eds.) *Collecting and Interpreting Qualitative Materials.* 3rd edn. Los Angeles: Sage Publications, pp. 115-159.

Forsyth, K., Parkinson, S., Kielhofner, G., Kramer, J., Summerfield Mann, L. and Duncan, E. (2011). 'The measurement properties of the Model of Human Occupation Screening Tool and implications for practice'. *New Zealand Journal of*

Occupational Therapy, 58(2), pp. 5 - 13. [Online] www.otnz.co.nz/download (Accessed: 8 December 2011)

Freeman, M. (1982) 'Forensic Psychiatry and Related Topics', *British Journal of Occupational Therapy,* June, pp. 191-194.

Freidson, E. (2001) *Professionalism, The Third Logic.* Cambridge: Polity Press.

Freidson, E. (1986) *Professional Powers: A Study of the Institutionalization of Formal Knowledge.* Chicago: The University of Chicago Press.

Garland, D. (2003) 'The Rise of Risk', in Ericson, R. V. and Doyle, A. (eds.) *Risk and Morality.* Toronto: University of Toronto Press, pp. 48-86.

Gray, J. M. (1998) 'Putting Occupation Into Practice: Occupation as Ends, Occupation as Means', *American Journal of Occupational Therapy,* 52(5), pp. 354-364.

Gooch, P. and Living, R. (2004) 'The Therapeutic Use of Videogames within Secure Forensic Settings: a Review of the Literature and Application to Practice', *British Journal of Occupational Therapy,* 67(8), pp. 332-341.

Goode, W. J. (1969) 'The Theoretical Limits of Professionalisation', in Etzioni, A. (ed.) *The Semi-Professions and Their Organisation, Teachers, Nurses and Social Workers.* New York: The Free Press, pp. 266-313.

Grade Working Group (2013) Available at: http://www.gradeworkinggroup.org/index.htm (Accessed: 17 May 2013).

Grayling, A. C. (1999) 'Foundationalism' in Bullock, B. and Trombley, S. (eds.) *The New Fontana Dictionary of Modern Thought.* London: Harper Collins, p. 332.

Great Britain. Department of Health (2007) *Best practice in managing risk.* London: DH. [Online] Available at: www.dh.gov.uk/dh_076512.pdf (Accessed: 14 October 2013).

Great Britain. Nacro (2007) *Effective mental healthcare for offenders: the need for a fresh approach*, pp. 1-15. [Online]. Available at: http://www.nacromentalhealth.org.uk (Accessed: 16 April 2014).

Great Britain. Department of Health. (2009) *The Bradley Report.* London: DH

Great Britain. Department of Health (2012) *Low Secure Services Good Practice Commissioning Guide, Consultation Draft,* [Online] Available at: https://www.wp.dh.gov.uk/health/files/2012/01/Low-secure-Good-practice-commissioning-guide.pdf (Accessed: 4 June 2013).

Great Britain. Department of Health (2010) *Your Guide to Relational Security.* London: DH [Online] Available at: www.dh.gov.uk (Accessed: 7 December 2012).

Great Britain. Department of Health and Home Office (1992) *The Review of Health and Social Services for Mentally Disordered Offenders and Others Requiring Similar Services* (Reed Committee) London: HMSO*.*

Greber, C. (2013) 'Letters to the Editor Re: The dark side of occupation: A concept for consideration', *Australian Occupational Therapy Journal,* 60, pp. 458–459. [Online] DOI: 10.1111/1440-1630.12098 (Accessed: 7 July 2014).

Green, B. (2009) 'Introduction: Understanding and Researching Professional Practice', in Green, B (ed.) *Understanding and Researching Professional Practice.* The Netherlands: Sense Publishers, pp. 1-18.

Greenhalgh, T. Howick, J. and Maskrey, N. (2014) 'Evidence based medicine: a movement in crisis?' *The British Medical Journal,* p. 348. [Online] DOI: dx.doi.org/10.1136/bmj.g3725 (Accessed: 8 May 2015).

Greenhalgh, T. (1999) 'Narrative based medicine in an evidence based world', *British Medical Journal,* 318, pp. 323-325. [Online]. Available at: http://bmj.com/cgi/content/full/318/7179/323 (Accessed: 6 July 2009).

Gustavsson, B. (2004) 'Revisiting the philosophical roots of practical knowledge', in Higgs, J., Richardson, B. and Dahlgren, M. (eds.) *Developing Practice Knowledge for Health Professionals.* Edinburgh: Butterworth Heinemann, pp.35-50.

Hagedorn, R. (1995) *Occupational Therapy: Perspectives and Processes.* Edinburgh: Churchill Livingstone.

Hagedorn, R. (2000) *Tools for Practice in Occupational Therapy.* Edinburgh: Churchill Livingstone.

Hager, P. Lee, A. and Reich, A (2012) Problematising Practice, Reconceptualising Learning and Imagining Change. In Hager, P. Lee, A. and Reich, A (eds.) *Practice, Learning and Change, Practice-Theory Perspectives on Professional Learning*, pp. 1—14. http://www.amazon.co.uk/kindle-ebooks (Accessed: 28 February 2014).

Haley, L. and McKay, E. A. (2004) ''Baking Gives You Confidence': Users' Views of Engaging in the Occupation of Baking', *British Journal of Occupational Therapy,* 67(3), pp. 125-128.

Hammell, K, W. and Iwama, M. (2012) 'Well-being and occupational rights: An imperative for critical occupational therapy', *Scandinavian Journal of Occupational Therapy*, 19, pp. 385 – 394 [Online] DOI: 10.3109/11038128.2011.611821 (Accessed: 30 September 2014).

Hammell, K. W. (2009) 'Sacred texts: A sceptical exploration of the assumptions underpinning theories of occupation', *Canadian Journal of Occupational Therapy,* 76(1), pp. 6-13.

Harper, D. and Speed, E. (2012) 'Uncovering Recovery: The Resistible Rise of Recovery and Resilience', *Studies in Social Justice,* 6(1), pp. 9-25. [Online] http://brock.scholarsportal.info/journals/SSJ/article/view/1066/1036 (Accessed: 26 January 2014).

Harris, K. (2003) 'Women in secure environments', in Couldrick, L. and Alred, D. (eds.) *Forensic Occupational Therapy.* London: Whurr, pp. 151-60.

Harrison, D. and Hong, C. S. (2002) 'Who Makes the Decisions in the Occupational Therapy Referral Process?' *British Journal of Occupational Therapy,* 65(11), p. 487.

Health and Care Professions Council (2013) *Standards of Proficiency Occupational Therapists.* London: Health and Care Professions Council.

Helbig, K. (2005) 'The graded skills development programme', *Mental Health Occupational Therapy,* 10(2), pp.51-53.

Helbig, K. (2003) 'Perceptions of meaningful activity amongst male patients in a high secure forensic addictive behaviours unit'. *Mental health occupational therapy.* 8(3), pp.77-81.

Higgs, J. and Titchen, A. (1995) 'The nature, generation and verification of knowledge', *Physiotherapy,* 81(9), pp. 521-530.

Higgs, J., Titchen, A. and Neville, V. (2001) 'Professional practice and knowledge', in Higgs, J. and Titchen, J. (eds.) *Practice Knowledge and Expertise in the Health Professions.* Oxford: Butterworth-Heinemann, pp. 3-9.

Higgs, J., Andresen, L. and Fish, D. (2004) 'Practice Knowledge – Its Nature, Sources and Contexts', in Higgs, J., Richardson, B. and Abrandt Dahlgren, M. (eds.) *Developing Practice Knowledge for Health Professionals.* Edinburgh: Butterworth Heinemann, pp. 51-69.

Hinojosa, J. (2013). 'The Issue Is - The evidence-based paradox', *American Journal of Occupational Therapy*, 67(2), pp. 18–23. [Online] http://dx.doi.org/10.5014/ajot.2013.005587 (Accessed 7 March 2013).

Hochschild, A, R. (2012) *The Managed Heart Commercialization of Human Feeling.* http://www.amazon.co.uk/kindle-ebooks (Accessed: 17 July 2012).

Hoffman, R. R., Crandall, B. and Shadbolt, N. (1998) 'Use of the Critical Decision Method to Elicit Expert Knowledge: A Case Study in the Methodology of Cognitive Task Analysis', *Human Factors*, 40(2), pp. 254-276.

Holland, A, E. (1984) 'Occupational Therapy and Day Care for the Terminally Ill', *British Journal of Occupational Therapy,* 47(11), pp. 345-348.

Hooper, B. (1997) 'The Relationship Between Pretheoretical Assumptions and Clinical Reasoning', *American Journal of Occupational Therapy,* 51(5), pp. 328-338.

Hooper, B. and Wood, W. (2002) 'Pragmatism and structuralism in occupational therapy: The long conversation', *American Journal of Occupational Therapy,* 56(1), pp. 40–50.

Hooper, B. (2006) 'Epistemological Transformation I Occupational Therapy: Educational Implications and Challenges', *OTJR: Occupation, Participation and Health,* 26(1), pp. 15-24. Available at: http://www.healio.com/health-professions/journals/OTJR (Accessed: 25 March 2013).

http://www.vdtmocaf-uk.com/ (no date) (Accessed 23 October 2014).

Hunter, E. and McKay, E. (2008) ''Doing' in secure settings', in McKay, E., Craik, C., Lim, K, H. and Richards, G. (eds.) *Advancing Occupational Therapy in Mental Health Practice.* Oxford: Blackwell, pp.76-88.

Hutchison, K. J. and Rogers, W.A. (2012) 'Challenging the epistemological foundations of EBM: what kind of knowledge does clinical practice require?' *Journal of Evaluation in Clinical Practice*, 18, pp. 984–991. [Online] DOI:10.1111/j.1365-2753.2012.01905.x (Accessed: 21 March 2013).

Hyde, P. (2004) 'Fool's Gold: Examining the Use of Gold Standards in the Production of Research Evidence', *British Journal of Occupational Therapy,* 67(2), pp. 89-94.

Ikiugu, M, N..and Pollard, N. (2015) *Meaningful Living across the Lifespan.* http://www.amazon.co.uk/kindle-ebooks (Accessed: 20 March 2015).

Ikiugu, M. N. and Schultz, S. (2006) 'An argument for pragmatism as a foundational philosophy of occupational therapy', *Canadian Journal of Occupational Therapy,* 73(2), pp. 86-97.

Ikiugu, M. N. (2007) 'Measuring Occupational Performance: A Pragmatic and Dynamical Systems Perspective', *Journal of Occupational Science*, 14:3, 123-135. [Online] DOI: 10.1080/14427591.2007.9686593 (Accessed: 8 August 2014)

Jeffcote, N., Watson, T., Bragg, A. and Devereux, S. (2004) 'Sharing Strength, Wisdom, Pain and Loss', in Jeffcote, N. and Watson, T. (eds.) *Working Therapeutically with Women in Secure Mental Health Settings*. London: Jessica Kingsley Publishers, pp. 129-142.

Jones, E. J. and McColl, A. (1991) 'Development and Evaluation of an Interactional Life Skills Group for Offenders', *The Occupational Therapy Journal of Research,* 3(2), pp. 80-91.

Kaplan, K. (1988) *Directive Group Therapy.* Thorofare: Slack Inc.

Kelly, R. (2003) 'Cognitive behavioural group work within forensic occupational therapy', in L Couldrick, D Alred, eds. Forensic Occupational Therapy. London: Whurr, pp. 61-74.

Kennedy, H. G. (2002) 'Therapeutic uses of security: mapping forensic mental health services by stratifying risk', *Advances in Psychiatric Treatment,* 8, pp. 433–443. [Online] DOI: 10.1192/apt.8.6.433 (Accessed: 6 December 2004)

Kielhofner, G. (2009) Conceptual Foundations of Occupational Therapy Practice. Philadelphia: F.A. Davis Company.

Kielhofner, G. (2008) *A Model of Human Occupation.* 4th edn. Baltimore: Lippincott Williams and Wilkins.

Kinsella, E. A. (2001) 'Reflections on reflective practice', *Canadian Journal of Occupational Therapy,* 68(3), pp. 195-198.

Kinsella, E. A. (2009) 'Professional knowledge and the epistemology of reflective practice', *Nursing Philosophy,* 11(1) pp. 3-14. [Online] DOI: 10.1111/j.1466-769X.2009.00428.x (Accessed: 24 August 2011).

Kinsella, E. A. (2012) 'Practitioner Reflection and Judgement as Phronesis: A Continuum of Reflection and Considerations for Phronetic Judgement', in Kinsella, E, A. and Pitman, A. (eds.) *Phronesis as Professional Knowledge.* *http://play.google.com/store/books/google-ebooks (Accessed: 5 October 2013).*

Klein, G. A., Calderwood, R. and MacGregor, D. (1989) 'Critical Decision Method for Eliciting Knowledge', *IEEE Transactions on systems, man and cybernetics,* 19(3), pp. 462-472.

Kramer, J., Bowyer, P. and Kielhofner, G. (2008) 'Evidence for Practice from the Model of Human Occupation', in Kielhofner, G. (2008) *A Model of Human Occupation.* 4th edn. Baltimore: Lippincott Williams and Wilkins, pp. 466-505.

Krefting, L. (1991) 'Rigour in Qualitative Research: The Assessment of Trustworthiness', *The American Journal of Occupational Therapy,* 45(3), pp. 214-222.

Kromm, J., Vasile, R.G. and Gutheil, T.G. (1982) 'Occupational therapy in the assessment of a woman accused of murder', *Psychiatric Quarterly,* 54(2), Summer, pp. 85-96.

Latessa, E. J. and Lowenkamp, C. (2005) 'What are Criminogenic Needs and Why are they Important?', *Ohio Judicial Conference.* [Online] http://ojj.la.gov/ojj/files/What_Are_Criminogenic_Needs.pdf (Accessed: 28 October 2014)

Laver Fawcett, A. (2007) *Principles of Assessment and Outcome Measurement for Occupational Therapists and Physiotherapists*. West Sussex: Wiley & Sons

Law, M., Baptiste, S. and Mills, J. (1995) 'Client-centred practice: What does it mean and does it make a difference?' *Canadian Journal of Occupational Therapy*. 62(5), pp. 250-257.

Law, M., Steinwender, S. and Leclair, L. (1998) 'Occupation, health & well-being'. *Canadian Journal of Occupational Therapy*. 65(2), pp. 81-91.

Law, M. and Mills, J. (1998) 'Client-Centred Occupational Therapy', in Law, M. (ed.) *Client-Centred Occupational Therapy.* Thorofare, NJ: Slack Inc, pp. 1-18.

Law, M. (2002). 'Participation in the occupations of everyday life', Distinguished Scholar Lecture. *American Journal of Occupational Therapy*, 56, 640–649.

Law, S. W. (1999) 'Concept' in Bullock, B. and Trombley, S. (eds.) *The New Fontana Dictionary of Modern Thought.* London: Harper Collins.

Lin, N., Kirsh, B., Polatajko, H. and Seto, M. (2009) 'The Nature and Meaning of Occupational Engagement for Forensic Clients Living in the Community', *Journal of Occupational Science,* 16(2), pp 110-119.

Lincoln, Y. S. and Guba, E. G. (1985) *Naturalistic Inquiry.* Newbury Park. Sage Publications.

Lindstedt, H., Ivarsson, I-B, and Soderlund, A. (2006) 'Background factors related to and/or influencing occupation in mentally disordered offenders', *Scandinavian*

Journal of Caring Sciences, 20(3), pp. 331–338. [Online] DOI: 10.1111/j.1471-6712.2006.00412.x (Accessed 17 May 2013).

Lindstedt, H. Soderlunde, A. Stalenheim, G. and Sjoden, P-O. (2005) 'Personality traits as predictors of occupational performance and life satisfaction among mentally disordered offenders', *Nordic Journal of Psychiatry,* 59, pp. 357-364. [Online] DOI: 10.1080/08039480500320082 (Accessed 13 October 2011)

Lindstedt, H., Soderlund, A., Stalenheim, G., Sjoden, P-O. (2004) 'Mentally disordered offenders' abilities in occupational performance and social participation', *Scandinavian Journal of Occupational Therapy,* 11, pp. 118-127. [Online] DOI: 10.1080/11038120410020854 (Accessed 3 November 2011).

Livingston, J. D., Nijdam-Jones, A. and Team P.E.E.R. (2013) 'Perceptions of Treatment Planning in a Forensic Mental Health Hospital: A Qualitative, Participatory Action Research Study', *International Journal of Forensic Mental Health*, 12(1), pp. 42-52. [Online] DOI: 10.1080/14999013.2013.763390 (Accessed: 15 June 2014).

Lloyd, C. (1985) 'Evaluation and Forensic Psychiatric Occupational Therapy', *British Journal of Occupational Therapy,* May, pp. 137-140.

Lloyd, C. (1987a) 'The Role of Occupational Therapy in Treatment of the Forensic Psychiatric Patient', *Australian Occupational Therapy Journal,* 34(1), pp. 20-25.

Lloyd, C. (1987b) 'Working with the Female Offender: A Case Study', *British Journal of Occupational Therapy,* 50(2), pp. 44-46.

Lloyd, C. (1987c) 'Sex Offender Programs: Is There a Role for Occupational Therapy', *Occupational Therapy in Mental Health,* 7(3), pp. 55-67.

Lloyd, C. (1987d) 'The Use of The Bay Area Functional Performance Evaluation With A Forensic Population', *The South African Journal of Occupational Therapy,* May, pp. 6-13.

Lloyd, C. (1988) 'Occupational Therapy in Forensic Psychiatry'. In Scott, D. and Katz, N. (eds.) *Occupational therapy in mental health: principles in practice.* London. Taylor and Francis.

Lloyd C (1995) 'Trends in forensic psychiatry', *British Journal of Occupational Therapy,* 58(5), pp. 209-13.

Lloyd, C. and Guerra, F. (1988) 'A Vocational Rehabilitation Programme in Forensic Psychiatry', *British Journal of Occupational Therapy,* 51(4), pp.123-126.

Lloyd, C. and Hall, T. (1988) 'Work Preparation and the Use of Video: A Pilot Project', *The Journal of the Hong Kong Association of Occupational Therapists*, 4(2), pp. 5-8.

Lloyd-Smith, W. (1997) 'Evidence-Based Practice and Occupational Therapy', *British Journal of Occupational Therapy,* 60(11), pp. 474-478.

Macdonald, K. M. (1995) *The Sociology of the Professions.* London: Sage.

Macey, D. (2000) *The Penguin Dictionary of Critical Theory.* London: Penguin, p. 136.

Macleod, S. (2007) 'Cochrane's problem: psychoanalysis and anejaculation', *Australian Psychiatry,* 15(2), pp. 144-147.

Macleod, R. (2015) 'AMPS' *Twitter,* 28 May. Available at: http://twitter.com/RhonaMac2/AMPS (Accessed: 28 May 2015).

Martin, M. (2003) 'The foundations of good practice', in in L Couldrick, D Alred, eds. *Forensic Occupational Therapy.* London: Whurr, pp. 22-29.

Mason, K. and Adler, J. R. (2012) 'Group-work therapeutic engagement in a high secure hospital: male service user perspectives' *The British Journal of Forensic Practice*, 14(2), pp. 92 – 103. [Online] Available at: http://eprints.mdx.ac.uk/7230/ (Accessed: 30 May 2012).

Mattingly, C. and Fleming, M. H. (1994) *Clinical reasoning: forms of inquiry in a therapeutic practice.* Philadelphia: F.A. Davis Company.

Maynard-Moody, S and Musheno, M. (2003) *Cops, Teachers, Counsellors Stories from the Front Lines of Public Service.* Ann Arbor: University of Michigan Press.

McCoyd, J. L. M. and Kerson, T. S. (2006) 'Conducting Intensive Interviews Using Email: A Serendipitous Comparative Opportunity', *Qualitative Social Work,* 5(3), pp. 389-406. [Online] DOI: 10.1177/1473325006067367 (Accessed: 31 August 2012).

McNeill, S. and Bannigan, K. (2014) 'Forensic and Prison Services', in Bryant, W., Fieldhouse, J. and Bannigan, K. (ed.) *Creek's Occupational Therapy and Mental Health*. 5th edn. Edinburgh: Churchill Livingstone Eslsevier.

McQue, A. (2003) 'Self-injury or relief from overwhelming emotions', in Couldrick, L. and Alred, D. eds. *Forensic Occupational Therapy.* London: Whurr, pp. 173-81.

McQueen, J. (2011) *Towards Work in Forensic Mental Health: National Guidance for Allied Health Professionals. Scotland: The Forensic Network.* [Online]. Available at: http://www.forensicnetwork.scot.nhs.uk/groups/professional-groups/allied-health (Accessed: 25 June 2012).

Meho, L. I. (2006) 'E-Mail Interviewing in Qualitative Research: A Methodological Discussion', Journal of the American Society for Information Science and Technology, 57(10), pp. 1284–1295. [Online] DOI: 10.1002/asi.20416 (Accessed: 15 April 2009).

Miles, M. B. and Huberman, A. M. (1994) *Qualitative Data Analysis*. 2nd edn. Thousand Oaks, California: Sage Publications.

Mitchell, A.W. (2013) 'Models of Epistemic and Ontological Cognition: A New Perspective of Occupational Therapy Education', *Occupational Therapy in Health Care*, 27(1), pp. 3–19.

Morris, K. (2012) 'Considering violence', *British Journal of Occupational Therapy*, 75(5), p. 250.

Morris, K. (2015) *Twitter,* 28 May. Available at: http://twitter.com/MorrisKOT/so persistence (Accessed: 7 May 2015).

Mountain, G. (1998) *Occupational Therapy in Forensic Settings. A Preliminary Review of the Knowledge and Research Base.* London: College of Occupational Therapists.

Munoz, J. P. (2011) 'Mental Health Practice in Forensic Settings', in Brown, C, Stoffel, V. C. and Munoz, J. P. (eds.) *Occupational Therapy in mental health: a vision for participation.* Philadelphia: FA Davis, pp. 526-545.

National Institute for Health and Care Excellence (2013) Available at: http://www.nice.org.uk/ (Accessed: 7 July 2013).

Neeson, A. and Kelly, R. (2003) 'Security issues for occupational therapists working in a medium secure setting', in Couldrick, L. and Alred, D. (eds.) *Forensic Occupational Therapy.* London: Whurr, pp. 126-38.

Nelson, D. (1988) 'Occupation: Form & Performance', *American Journal of Occupational Therapy,* 42(10), pp. 633-641.

Nelson, D. (1996) 'Therapeutic occupation: a definition', *American Journal of Occupational Therapy,* 50(10), pp. 775-781.

Nicolini, D. (2013) *Practice Theory, Work and Organization.* Oxford: Oxford University Press.

Nolan, P. (2005) 'The historical context'. In Wix, S. and Humphreys, M. *Multidisciplinary Working in Forensic Mental Health Care.* London: Elsevier Churchill Livingstone. pp. 1-18.

O'Connell, M. and Farnworth, L. (2007) 'Occupational Therapy in Forensic Psychiatry: a Review of the Literature and a Call for a United and International Response', *British Journal of Occupational Therapy,* 70(5), pp. 184-191.

O'Connell, M., Farnworth, L. and Hanson, E. C. (2010) 'Time Use in Forensic Psychiatry: A Naturalistic Inquiry into Two Forensic Patients in Australia', *International Journal of Forensic Mental Health*, 9: 2, pp.101-109. [Online] DOI: 10.1080/14999013.2010.499558 (Accessed: 13 November 2011).

O'Hare, D., Wiggins, M., Williams, A. and Wong, W. (1998) 'Cognitive task analyses for decision centred design and training', *Ergonomics.* 41(11), pp. 1698-1718.

Parker, D. (2006) 'Implementing client-centred practice', in Sumsion, T. (ed.) *Client-centred practice in occupational therapy: a guide to implementation.* 2nd ed. Edinburgh: Churchill Livingstone, pp. 55-73.

Parkinson, S. (2014) *Recovery Through Activity.* London: Speechmark.

Parkinson, S., Forsyth, K. and Kielhofner, G. (2002) *The Model of Human Occupation Screening Tool.* (Version 1). Chicago Illinois: University of Chicago.

Parkinson, S., Forsyth, K. and Kielhofner, G. (2006) *The Model of Human Occupation Screening Tool.* (Version 2). Chicago Illinois: University of Chicago.

Parry, A. (2001) 'Research and Professional Craft Knowledge', in Higgs, J. and Titchen, A. (eds.) *Practice Knowledge and Expertise in the Health Professions.* Oxford: Butterworth Heinemann, pp.199-206.

Paterson, M., Higgs, J. and Wilcox, S. (2005) 'The Artistry of Judgement: a Model for Occupational Therapy Practice', *British Journal of Occupational Therapy,* 68(9), pp. 409-417.

Paterson, M., Higgs, J. and Wilcox, S. (2006) 'Developing Expertise in Judgement Artistry in Occupational Therapy Practice', *British Journal of Occupational Therapy,* 69(3), pp. 115-123.

Paterson, M. and Higgs, J. (2008) 'Professional Practice Judgement Artistry', in Higgs, J., Jones, M.A. Loftus, S. and Christensen, N. (eds) *Clinical Reasoning in the Health Professions.* (3rd edn.) Amsterdam: Butterworth Heinemann Elsevier, pp. 181-189.

Paterson, M., Higgs, J. and Donnelly, C. (2012) 'Artistry and Expertise', in Robertson, L. *Clinical Reasoning in Occupational Therapy: Controversies in Practice.* West Sussex: Wiley-Blackwell, pp.93-106.

Paulson, C. P. (1980) 'Juvenile Delinquency and Occupational Choice', *The American Journal of Occupational Therapy,* 34(9), pp. 565-571.

Pearmain, H. (2010) *Risk Management* (2nd edn.) London: College of Occupational Therapists.

Perez, M. S. and Cannella, G. S. (2013) 'Situational Analysis as an Avenue for Critical Qualitative Research: Mapping Post-Katrina New Orleans', *Qualitative Inquiry,* 19(7), pp. 505-517 [Online] DOI: 10.1177/1077800413489514 (Accessed: 11 October 2013)

Piehl, A. (2003) The Urban Institute Reentry Roundtable Discussion Paper: *Crime, Work, and Reentry,* pp. 1-15 [Online] http://www.hawaii.edu/hivandaids/Crime,_Work,_and_Reentry.pdf (Accessed: 11 May 2015).

Platt, P., Martell, D. L. and Clements, P.A. (1977) 'Level 1 Field Placement at a Federal Correctional Institution', *The American Journal of Occupational Therapy,* 31(6), pp. 385-387.

Polanyi, M. (1966) *The Tacit Dimension.* Reprint, Chicago: University of Chicago Press, 2009.

Polimeni-Walker, I., Wilson, K. G. and Jewers, R. (1992) 'Reasons for participating in occupational therapy groups: Perceptions of adult psychiatric inpatients and occupational therapists', *Canadian Journal of Occupational Therapy*, 59(5), pp. 240-247.

Porter, R. (2000) *Enlightenment.* London: Penguin Books.

Prentice, R. and Wilson, K. (2003) 'Forensic occupational therapy within learning disability services', in In Couldrick, L. and Alred, D. (eds.) *Forensic Occupational Therapy.* London: Whurr, pp. 161-172.

QSR International Pty Ltd. (2012) *NVivo qualitative data analysis software, Version 10.*

Quiroga, V. (1995) *Occupational therapy: The first 30 years.* Bethesda, MD: American Occupational Therapy Association.

Rani, S. and Mulholland, F. (2014) 'An appraisal of service users' structured activity requirements in an Irish forensic setting', *Journal of Psychiatric and Mental Health Nursing*, 21, pp. 383–390. [Online] DOI: 10.1111/jpm.12096 (Accessed: 26 June 2014).

Reagon, C., Bellin, J. W. and Boniface, G. (2010) 'Challenging the dominant voice: the multiple evidence sources of occupational therapy', *British Journal of Occupational Therapy* 73(6), pp. 284-286. [Online] DOI: 10.4276/030802210X12759925469069 (Accessed 21 June 2010)

Reed, K. L., and Sanderson, S. N. (1999) *Concepts of Occupational Therapy,* 4th edn. Baltimore: Lippincott, Williams and Wilkins.

Richardson, B. Higgs, J. and Dahlgren, M. (2004) 'Recognising practice epistemology in the health professions', in Higgs, J., Richardson, B and Abrandt Dahlgren, M. (eds.) *Developing Practice Knowledge for Health Professionals.* Edinburgh: Butterworth Heinemann, pp. 1-14.

Roberts (1996) 'Clinical Reasoning in Occupational Therapy: Idiosyncrasies in Content and Process', *British Journal of Occupational Therapy,* 59(8), pp. 372-376.

Rogers, J. C. and Holm, M. B. (2009) 'Occupational therapy practice. Occupational therapy process', in Willard, H. S., Crepeau, E. B., Cohn, E. S. and Schell, B. A. B. (eds.) Willard and Spackman's Occupational Therapy (11th edn.) Philadelphia: Wolters Kluwer Health/Lippincott Williams & Wilkins, pp.

Rogowski, A. (2002) 'Forensic psychiatry'. In: J Creek, (ed.) *Occupational therapy and mental health.* 3rd edn. Edinburgh: Churchill Livingstone, pp. 491-510.

Rycroft-Malone, J., Seers, K., Titchen, A., Harvey, G., Kitson, A. and McCormack, B. (2004) 'What counts as evidence in evidence-based practice?' *Journal of Advanced Nursing*, 47(1), pp. 81–90.

Ryle, G. (1949) *The Concept of Mind.* Reprint, London: Penguin Books, 2000.

Sainty, M. (1990) ' Effective Identification of Elderly Patients requiring Occupational Therapy', *British Journal of Occupational Therapy,* 53(2), pp. 57-60.

Saldana, J. (2009). *The Coding Manual for Qualitative Researchers.* Los Angeles: Sage.

Schell, B. A. B. (2008) 'Pragmatic Reasoning', in Schell, B. A. B. and Schell, J. W. (eds.) *Clinical and Professional Reasoning in Occupational Therapy.* Philadelphia: Wolters Kluwer, Lippincott Williams and Wilkins, pp.169-187.

Shepherd, G., Boardman, J. and Slade, M. (2009) *Making Recovery a Reality.* London: Sainsbury Centre for Mental Health.

Schindler, V. P. (2005) 'Role Development: An Evidence-Based Intervention for Individuals Diagnosed with Schizophrenia in a Forensic Facility', *Psychiatric Rehabilitation Journal*, 28(4), pp. 391-394.

Schindler VP (2000) 'Occupational therapy in forensic psychiatry', in: Fleming Cotrell, R. P. (ed.) *Proactive approaches in psychosocial occupational therapy.* Thorofare, NJ: Slack, pp. 319-325.

Schluter, J., Seaton, P. and Chaboyer, W. (2008) 'Critical incident technique: a user's guide for nurse researchers'. *Journal of Advanced Nursing*, 61(1), pp. 107–114. [Online] DOI: 10.1111/j.1365-2648.2007.04490.x (Accessed: 7 May 2008).

Schön, D. A. (1991) *The Reflective Practitioner How Professionals Think in Action*. Surrey: Ashgate Publishing.

Scott, J. and Marshall, G (eds.) (2005) *Oxford Dictionary of Sociology.* 3rd edn. Oxford: Oxford University Press.

Seymour, W. S. (2001) 'In the flesh or online? Exploring qualitative research methodologies', *Qualitative Research,* 1(2), pp. 147-168. [Online] DOI: 10.1177/146879410100100203 (Accessed: 15 April 2009)

Shah, S. (1998) 'Current Concepts and Controversies in Stroke Recovery: Rehabilitation Implications', *British Journal of Occupational Therapy,* 61(2), pp. 83-88.

Silverman, D. (2010) *Doing Qualitative Research,* 3rd edn. Available at: http://www.amazon.co.uk/kindle-ebook (Accessed: 8 March 2013).

Sim, J. and Richardson, B. (2004) 'The use and generation of practice knowledge in the context of regulating systems and moral frameworks', in Higgs, J., Richardson, B. and Dahlgren, M. (eds.) *Developing Practice Knowledge for Health Professionals.* Edinburgh: Butterworth Heinemann, pp. 127-146.

Slagle, E. C. (1934) 'The Occupational Therapy Programme in the State of New York' *The British Journal of Psychiatry*, 80, pp. 639-649. [Online] DOI: 10.1192/bjp.80.331.639 (Accessed: 27 February 2013)

Slagle, E. C. (1936) 'The past, present and future of Occupational therapy in the State Department of Mental Hygiene', *Psychiatric Quarterly,* 10(1), pp. 144-156. (Accessed: 27 February 2013) [Online] DOI: 10.1007/BF01563571

Spybey, M. and Morgan, P. (2003) 'Everyone is an artist', in: Couldrick, L. and Alred, D. (eds.) *Forensic Occupational Therapy*. London: Whurr, pp. 54-60.

Stelter, L. and Whisner, S. M. (2007) 'Building Responsibility for Self Through Meaningful Roles: Occupational Adaptation Theory Applied in Forensic Psychiatry'. *Occupational Therapy in Mental Health*, 23(1), pp. 69-84 [Online] DOI:10.1300/J004v23n01_05 (Accessed: 16 June 2015)

Stewart, P. and Craik, C. (2007) 'Occupation, mental illness and medium security: exploring time-use in forensic regional secure units', *British Journal of Occupational Therapy,* 70(10), pp.416-425.

Stiwne, D. and Dahlgren, M. (2004). 'Challenging evidence in evidence-based practice', in Higgs, J. Richardson, B. and Abrandt Dahlgren, M. (eds.) *Developing Practice Knowledge for Health Professionals*. Edinburgh: Butterworth Heinemann, pp. 147-164.

Stone, J.H., Roberts, M., O'Grady, J., Taylor, A.V. and O'Shea, K. (2000) *Faulk's Basic Forensic Psychiatry*. 3rd edn. Oxford: Blackwell Science.

Sumsion, T. (2000) 'A Revised Occupational Therapy Definition of Client-Centred Practice', *British Journal of Occupational Therapy,* 63(7), pp. 304-309.

Sumsion, T. (2006) 'Overview of client-centred practice', in Sumsion, T. (ed.) *Client-Centred Practice in Occupational Therapy a Guide to Implementation*. 2nd edn. Edinburgh: Churchill Livingstone, pp. 1-18.

Sumsion, T. and Law, M. (2006) 'A review of evidence on the conceptual elements informing client-centred practice', *Canadian Journal of Occupational Therapy*, 7393), pp. 153-162.

Taylor, M. C. (2007). *Evidence-based Practice for Occupational Therapists*. 2nd edn. Oxford: Blackwell Sciences Ltd.

Taylor, M. C. (2000) *Evidence-based Practice for Occupational Therapists*. Oxford: Blackwell Sciences Ltd.

Taylor, M. C. (1997) 'What is Evidence-Based Practice?', *British Journal of Occupational Therapy*, 60(11), pp. 470-474.

Taylor, R. R. (2008) *The Intentional Relationship Occupational Therapy and the Use of Self*. Philadelphia: FA Davis.

Tempest, S. (2015) *Twitter,* 28 May. Available at: http://twitter.com/SetG75/is finding (Accessed: 7 May 2015).

Theodosius. C. (2008) Emotional Labour in Health Care: The unmanaged heart of nursing (Critical Studies in Health and Society) [Online] http://www.amazon.co.uk/kindle-ebooks (Accessed 17 July 2012).

Thomas, A., and Law, M. (2013) 'Research utilization and evidence-based practice in occupational therapy: A scoping study', *American Journal of Occupational Therapy*, 67(4), pp. 55–65. [Online] DOI: 10.5014/ajot.2013.006395 (Accessed 9 July 2013).

Titchen, A. (2000) *Professional craft knowledge in patient-centred nursing and the facilitation of its development.* Kidlington: Ashdale Press.

Titchen, A. and Ersser, S. J. (2001a) 'The nature of professional craft knowledge', in Higgs, J. and Titchen, A. (eds.) *Practice Knowledge and Expertise in the Health Professions.* Oxford: Butterworth Heinemann, pp. 35-41.

Titchen, A. and Ersser, S. J. (2001b) 'Explicating, creating and validating professional craft knowledge', in Higgs, J. and Titchen, A. (eds.) Practice Knowledge and Expertise in the Health Professions. Oxford: Butterworth Heinemann, pp. 48-56.

Thorne, S. and Darbyshire, P. (2005) 'Land Mines in the Field: A Modest Proposal for Improving the Craft of Qualitative Health Research', *Qualitative Health Research,* pp. 1105-1113. [Online] DOI: 10.1177/1049732305278502 (Accessed: 18 March 2015).

Tomlin, G. and Borgetto, B. (2011) 'Research Pyramid: A new evidence-based practice model for occupational therapy', *American Journal of Occupational Therapy,* 65(2), pp. 189–196. [Online] DOI: 10.5014/ajot.2011.000828 (Accessed: 3 August 2011).

Twinley, R. (2013) *'*The dark side of occupation: A concept for consideration', *Australian Occupational Therapy Journal*, 60(4) pp. 301–303. [Online] DOI: 10.1111/1440-1630.12026 (Accessed: 7 July 2014).

Twinley, R. and Addidle, G. (2011) 'Anti-Social Occupations: Considering the dark Side of Occupation'. International Occupational Science Conference: OTs Owning Occupation. Plymouth: Plymouth University. [Online] Available at: http://www6.plymouth.ac.uk/files/extranet/docs/FoH/OT%20Conf%208Sep11%20 -%20Twinley%20&%20Addidle%20Violence%20and%20Occupation.pdf (Accessed 2 November 2014).

Turpin, M. and Iwama, M. K. (2011) *Using Occupational Therapy Models in Practice.* http://www.amazon.co.uk/kindle-ebooks (Accessed: 24 January 2013).

Unsworth, C. (2004) 'How do pragmatic reasoning, worldview and client-centredness fit?' *British Journal of Occupational Therapy*, 67(1), pp. 10-19.

Urquhart, G. (2003) 'Setting up a forensic occupational service', in Couldrick, L. and Alred, D. (eds.) *Forensic Occupational Therapy.* London: Whurr,pp.117-125.

Walsh, M. and Ayres, J. (2003) 'Occupational therapy in a high-security hospital – the Broadmoor perspective', in Couldrick, L. and Alred, D. (eds.) *Forensic Occupational Therapy.* London: Whurr, pp. 87-97.

Warner, L (2005) *'Review of the literature on the Care programme approach'.* London: Sainsbury Centre for Mental Health. London: The Sainsbury Centre for Mental Health.

Whetsell, T. A. (2012) 'Theory-Pluralism in Public Administration: Epistemology, Legitimacy, and Method', *The American Review of Public Administration,* XX(X), pp. 1-17. [Online] DOI: 10.1177/0275074012451311 (Accessed: 18 February 2013).

White, J. A., Grass, C. D., Hamilton, T. B. and Rogers, S. L. (2011) 'Occupational Therapy in Criminal Justice', in Cara, E. and MacRae, A. (eds.) *Psychosocial Occupational Therapy An Evolving Practice.* Australia: Delmar Cengage Learning, pp. 715-773.

Whiteford, G. (2005) 'Knowledge, Power, Evidence: A Critical Analysis of Key Issues in Evidence Based Practice', in Whiteford, G. and Wright-St Clair, V. (eds). *Occupation and Practice in Context.* Sydney: Elsevier Churchill Livingstone, pp. 34-50.

Wilcock, A. A. (2002) *Occupation for Health* (2 vols)*.* London: British Association and College of Occupational Therapists.

Wilcock, A. A. (2005) 'Relationship of Occupations to Health and Well-being', in Christiansen, C., Baum, C. and Bass-Haugen, *Occupational Therapy: Performance, Participation and Well-being.* (3rd edn.) Thorofare, NJ: Slack Inc, pp.

Wilcock, A. A. and Hocking, C. (2015) *An Occupational Perspective of Health*. (3rd edn.) Thorofare, NJ: Slack Inc.

Wulff, D. (2013) '"Research/Therapy": A Review of Adele Clarke's Situational Analysis: Grounded Theory after the Postmodern Turn', *The Weekly Qualitative Report*, 1(6), pp. 31-34. [Online]. Available at: http://www.nova.edu/ssss/QR/WQR/clarke.pdf (Accessed: 18 March 2013).

APPENDICES

Appendix 1. Admission summary sheet

The following is an example of the information to be included in the admission summary for each patient admitted to MSU at any point regardless of whether it is one of the acute wards.

Occupational Therapy Admission Summary

Information Source: (include names of professional and date of the report)

Patient's Name: DOB:

Address: DOA:

Admitted From: Ethnic Origin:

Diagnosis/Impression: Marital Status:

Religion: Section:

Alleged/Index Offence: (specify the offence type if known, but particularly important are the detail - context and circumstances, mental state and behaviour at the time)

Reason for Admission:

Psychiatric History:

Forensic History:

Drug/Alcohol History:

Medical History:

Current Mental State (Inc: Appearance and Behaviour, Speech, Mood/Affect, Thought Content, Perceptions, Cognitions, Insight, Physiological Function):

Social History:

Educational History:

Occupational History:

Signature: Name and Grade:

Appendix 2a. Research ethics permission letters

Mr Kevin Cordingley
Brunel University
Mary Seacole
SHSSC
Uxbridge
Middlesex UB8 3PH

28 April 2011

Dear Mr Cordingley

Re: The knowledge base of occupational therapists in forensic mental health
LREC Ref:
R&D Reference Number: CORKW10001

I am pleased to confirm that the above study has now received a full R&D approval, and you may continue your research in ████████████████████████ May I take this opportunity to remind you that during the course of your research you will be expected to ensure the following:

- **Patient contact:** only trained or supervised researchers who hold the appropriate Trust/NHS contract (honorary or full) with each Trust are allowed contact with that Trust's patients. If any researcher on the study does not hold a contract please contact the R&D office as soon as possible.
- **Informed consent:** original signed consent forms must be kept on file. A copy of the consent form must also be placed in the patient's notes. Research projects are subject to random audit by a member of the R&D office who will ask to see all original signed consent forms.
- **Data protection:** measures must be taken to ensure that patient data is kept confidential in accordance with the Data Protection Act 1998.
- **Health and safety:** all local health & safety regulations where the research is being conducted must be adhered to.
- **Adverse events:** adverse events or suspected misconduct should be reported to the R&D office and the Ethics Committee.
- **Project update:** you will be sent a project update form at regular intervals. Please complete the form and return it to the R&D office.
- **Publications:** it is essential that you inform the R&D office about any publications which result from your research.
- **Ethics:** R&D approval is based on the conditions set out in the favourable opinion letter from the Ethics Committee. If during the lifetime of your research project, you wish to make a revision or amendment to your original submission, please contact both the Ethics Committee and R&D Office as soon as possible.
- Please ensure that all members of the research team are aware of their responsibilities as researchers.

We would like to wish you every success with your project.

Yours sincerely

Research Governance Officer

Appendix 2b. Research ethics permission letters

NHS
National Research Ethics Service

Mr Kevin Cordingley
Lecturer in Occupational Therapy
Brunel University, Mary Seacole
SHHSC
Uxbridge,
Middlesex UB8 3PH

20 December 2010

Dear Mr Cordingley

Study Title:	**The knowledge base of occupational therapists practising in forensic mental health**
REC reference number:	10/H0707/65
Protocol number:	n/a

Thank you for your letter of 01 December 2010, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Chair.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised, subject to the conditions specified below.

Ethical review of research sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

For NHS research sites only, management permission for research ("R&D approval") should be obtained from the relevant care organisation(s) in accordance with NHS research governance arrangements. Guidance on applying for NHS permission for research is available in the Integrated Research Application System or at http://www.rdforum.nhs.uk.

NHS

National Research Ethics Service

Where the only involvement of the NHS organisation is as a Participant Identification Centre (PIC), management permission for research is not required but the R&D office should be notified of the study and agree to the organisation's involvement. Guidance on procedures for PICs is available in IRAS. Further advice should be sought from the R&D office where necessary.

Sponsors are not required to notify the Committee of approvals from host organisations.

It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

Document	Version	Date
Protocol	1	27 July 2010
Letter of invitation to participant	1	27 July 2010
Response to Request for Further Information		01 December 2010
Investigator CV	Mr K Cordingley	
Participant Consent Form	1	27 July 2010
Evidence of insurance or indemnity		29 July 2010
REC application		29 July 2010
CV: Mr T Milewa		
Participant Information Sheet	2	01 December 2010

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Now that you have completed the application process please visit the National Research Ethics Service website > After Review

You are invited to give your view of the service that you have received from the National Research Ethics Service and the application procedure. If you wish to make your views known please use the feedback form available on the website.

The attached document "After ethical review – guidance for researchers" gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Progress and safety reports
- Notifying the end of the study

The NRES website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

This Research Ethics Committee is an advisory committee to London Strategic Health Authority

The National Research Ethics Service (NRES) represents the NRES Directorate within the National Patient Safety Agency and Research Ethics Committees in England

NHS
National Research Ethics Service

We would also like to inform you that we consult regularly with stakeholders to improve our service. If you would like to join our Reference Group please email referencegroup@nres.npsa.nhs.uk.

10/H0707/65	Please quote this number on all correspondence

With the Committee's best wishes for the success of this project

Yours sincerely
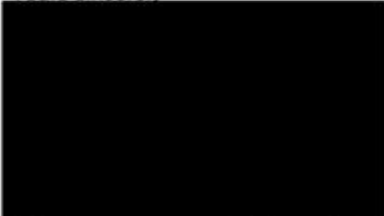
Enclosures: "After ethical review – guidance for researchers"

Copy to: Dr Timothy Milewa, Brunel University

Appendix 3. Practitioner information sheet

The knowledge base of occupational therapists practising in forensic mental health

PRACTITIONER INFORMATION SHEET
This sheet provides key information about this study. The investigator is Kevin Cordingley, an occupational therapy lecturer at Brunel University, carrying out a PhD. Participation in this study is entirely voluntary.

What is the purpose of this research?
This study explores your knowledge base by looking at your clinical decisions and approaches taken with a patient with whom you are currently working. This includes:
1. Using a form of reflection called a significant event analysis to explore the decisions, information and knowledge gained from practice, formal and informal routes.
2. The reflection incorporates a timeline of what you did and the decisions that you made. You will be asked questions about each point on the timeline.
3. Periodically you will be asked to reflect upon any changes as a result of participating in the study.

It is expected the study would take approximately one year. The investigator will meet you at your place of work in a non-secure area, or at Brunel University. Any costs incurred cannot be reimbursed. There are four choices about when and how the data will be gathered:
1. Twelve interviews lasting about an hour every month. They will be audio recorded and transcribed and notes will be written by the investigator during the meetings. Transcripts will be returned to each practitioner to review and practitioners can clarify points, or make any changes they feel are necessary
2. Six interviews lasting about one and a half to two hours every month
3. A series of emails with questions and answers lasting approximately 6 months to a year. Each new email communication will include the previous discussion with questions from the investigator seeking any clarification and additional questions to continue the discussion. For data analysis purposes the email content will be placed into a separate document with the time, date and a pseudonym.
4. A combination of interviews and emails if you wish to change the approach that you started.

The transcripts and emails will be analysed by the investigator and practitioners will be invited to review this and provide feedback to the investigator.

Data Protection:
Data will be held in accordance with the Data Protection Act (1998). Personal details will only be accessed using a password on the investigator's university based PC. Email addresses will be required to contact with practitioners. Audio recordings of interviews will be held on the investigator's password protected computer at home. All of the personal data, audio recordings and the original emails with identifying information will be destroyed at the end of the study.

Confidentiality:
Demographic information is required and information about the context in which you work, Pseudonyms are required for you and for the patient you discuss, so no identifiable information is included in the emails and audio recordings. Anything that could present some form of harm through the potential breach of confidentiality will be removed. This will be discussed with you to find a different way of presenting the information.

Ethical issues:
This research does not replace, in any way, the need for you to engage in your normal supervision and reflective practice, nor would it seek to do so. It is hoped that you explore issues of professional practice in an honest way without

fear of being exposed to your line managers. You may mention poor practice, if so, it is expected that this would have been discussed in clinical supervision, where appropriate actions have been taken. You and the investigator would need to distinguish carefully between where there is or has been a breach of the code of conduct. The investigator is bound by the COT Code of Ethics and Professional Conduct to report unethical conduct. The investigator, you and the investigator's supervisors will monitor the research process for any potential unethical practice. In this event, you can talk to the investigator or you can contact one of the investigator's supervisors at Brunel (Dr Timothy Milewa and Dr Wendy Bryant). You may withdraw from participating in the study at any point without consequence personally or professionally.

What are the benefits of participating?
There are no direct benefits of participating in this study. However, you may increase your understanding of the knowledge base that you have developed from clinical practice. This can potentially be applied to other patients with whom you work, possibly improving the service you provide. Your reflections could be evidence of new learning for your continuing professional development (CPD) and any gaps in your knowledge can be developed in your future CPD. Your contributions may add to departmental developments and the forensic occupational therapy knowledge base as a whole, as the research will be published and presented at conferences. The final PhD will be freely available from Brunel University Research Archive and you will receive a digital copy of the PhD if you wish.

In order to participate, you must meet the following criteria:
Inclusion criteria
1. Qualified occupational therapists working in forensic mental health and qualified in a WFOT approved setting.
2. The practitioners must be actively working with the patient discussed in the significant event analysis at the start of the research.
3. Currently working under supervision and line management within the trust
Exclusion criteria
1. Unqualified occupational therapy staff.
2. Employees working less than 4 days a week.
3. Currently under investigation by HPC or other body for breaches of code of professional conduct
4. Qualified occupational therapists who are not working as an occupational therapist within the organisation, for example generic roles.

Thank you for your interest in this research. Please keep this information sheet for future reference. Please contact me if you wish to discuss this further, seek clarification, or participate in the research.

E-mail kevin.cordingley@brunel.ac.uk
Telephone: 01895 268668

Appendix 4. Practitioner invitation letter

Brunel
UNIVERSITY
WEST LONDON

The knowledge base of occupational therapists practising in forensic mental health

Dear Occupational Therapist

I would like to present my proposal for a study involving qualified occupational therapists working in a forensic setting. I am Kevin Cordingley, a lecturer in occupational therapy currently doing a PhD at Brunel University. The following information briefly introduces my study and attached are information sheets with further details and a consent form. You will have the opportunity to hear more about the study during one of your OT meetings, where I will go into more detail about my study and provide the opportunity for you to have questions answered. However, I am more than happy to discuss the proposal further, outside of the meeting, if you wish.

This research is an exploration of individual occupational therapist's knowledge, both formal and informal, that is used to make clinical decisions. Also the knowledge developed from therapists' practice is explored. Practice knowledge often remains hidden or tacit, so the chance to explore this offers some potential benefits. In the research you will explore and could expand your understanding of your practice knowledge and how it has developed, which may be applied to other patients. Your continuing professional development needs may be identified from this. There are also potential benefits for departmental developments and for other forensic occupational therapy services.

I would like to explore this knowledge with all grades of occupational therapists in a variety of clinical settings. I am interested in each individual's responses and how these relate to each other. This will require being involved in monthly meetings, and/or weekly emails between approximately six months to one year.

If you are interested in being involved, then please let me know by contacting me by email, post or phone and the details are below.

Kevin Cordingley
Occupational Therapy Lecturer
School of Health Sciences and Social Care
Brunel University
Mary Seacole Building
Uxbridge
UB8 3PH

Email: kevin.cordingley@brunel.ac.uk
Telephone: 01895 268668

Appendix 5. Additional information about the research procedures for potential practitioners of PhD research

The following information helps you to make a decision about which client you want to discuss. There are also important details about how the confidentiality for yourself and the client is to be managed. Please contact me (see below) if you have questions after reading this information.

1. Choosing a client to discuss:
Choose someone that you have worked with within the past 6 months and with whom you are currently working. The choice is made on the basis of one or a number of
Significant events (described below) you have experienced working with this client.

1.1 Significant events
Required:
  • Stand out aspect/s when working with a client – times that were particularly challenging, enjoyable aspects, or a combination of these.
  • Where your decisions have had an impact upon the outcomes
Not required:
  • A client where you had no involvement in the decisions made
  • Tangential events eg death
  • To mull over the situation or rehearse it
  • To consider matters about whom and what is relevant, or try to re-order or discard events.

2. Confidentiality
  • Every effort will be made to respect confidentiality but colleagues will know of the existence and setting of the research. It therefore has to be accepted that you will co-operate with the research on the basis of that reality.
  • There may be a small possibility of identifying those of you involved in this study, but by the time it is finished it is possible you have moved from your current position.
  • Management: you will be emailed a copy of the transcript from each of your interviews, to review what you have said.
  • Identifying information on the emails will be removed from transcripts.
  • If there is anything that could present some form of breach of confidentiality to you, the organisation, or the client you discuss, it can be removed and not analysed.
  • Pseudonyms for you will be used

2.1 Demographic information required of practitioners:
  • Length of time qualified
  • Length of time working as an OT in forensic mental health
  • Gender
  • Current OT band
  • Descriptions of practice areas to provide a context of the environment the OT works in and where the client resides will be required, e.g. medium secure, adolescent services, but the specific service and ward name will not be necessary.

- It is anticipated identifiable information beyond this should not be required.

2.2 Preparation & confidentiality prior to interviews/emails:
- You choose a patient ***without*** a high profile crime/background (i.e. reported in the national media).
- You remove identifying details from the client discussed in this research, including:
    - client names
    - date of birth
    - names of specific geographical locations associated with the client (i.e. locations of accommodation, index offence, family details, forensic service etc)
    - date of admission to the service
    - names of people associated with the patient (personally and professionally)
- Pseudonyms will need to be decided by each of you to be allocated to the client discussed.

2.3 Confidentiality during interviews:
- Lists of psychiatric diagnoses and offences will be allocated a code
    - To allow you to point out to the researcher without stating on the audio recording what they are.
- Once the codes have been recorded for the client presented by each of you, the list will be shredded, but it will be digitally stored on the researcher's university based, password protected PC.
- During the interview, discussion will be monitored carefully for any information identifying the client and you.
- In the event the discussion indicates that confidential information would be required in order to give context and meaning to the issue discussed, the audio-recording device will be turned off. The information will be discussed between you and the researcher and if possible it will be altered to preserve anonymity, or left out and the audio recording will then be resumed.
- For emails the preparation guidelines in the previous slides must be followed by you prior to the start of email interviews. The researcher will allocate the codes to the diagnosis and offences in the emails prior to using them for analysis.
- In all subsequent interviews and emails only the terms "diagnosis" and "offence" will be used when referring to those aspects.

Contact details:
Kevin Cordingley, OT Lecturer & PhD student
Email: kevin.cordingley@brunel.ac.uk
Mobile: 07531242500

Appendix 6. Practitioner consent form

Brunel
UNIVERSITY
WEST LONDON

The knowledge base of occupational therapists practising in forensic mental health

Consent form

	Yes	**No**
Have you read the information sheet?	☐	☐
Have you had the opportunity to ask questions and discuss this study?	☐	☐
Have you received satisfactory answers to all your questions?	☐	☐
Do you understand that you will **not** be referred to by name in any report?	☐	☐
Do you understand that you are free to withdraw from the research:		
- at any time?	☐	☐
- without having to give a reason for withdrawing?	☐	☐
- and this will not influence your employment?	☐	☐
Do you agree to take part in this study?	☐	☐

Signature of practitioner…………………………………..Date……………………

Name in capitals………………………………………………………………………..

Researcher's contact details:
Kevin Cordingley
Occupational Therapy Lecturer
School of Health Sciences and Social Care
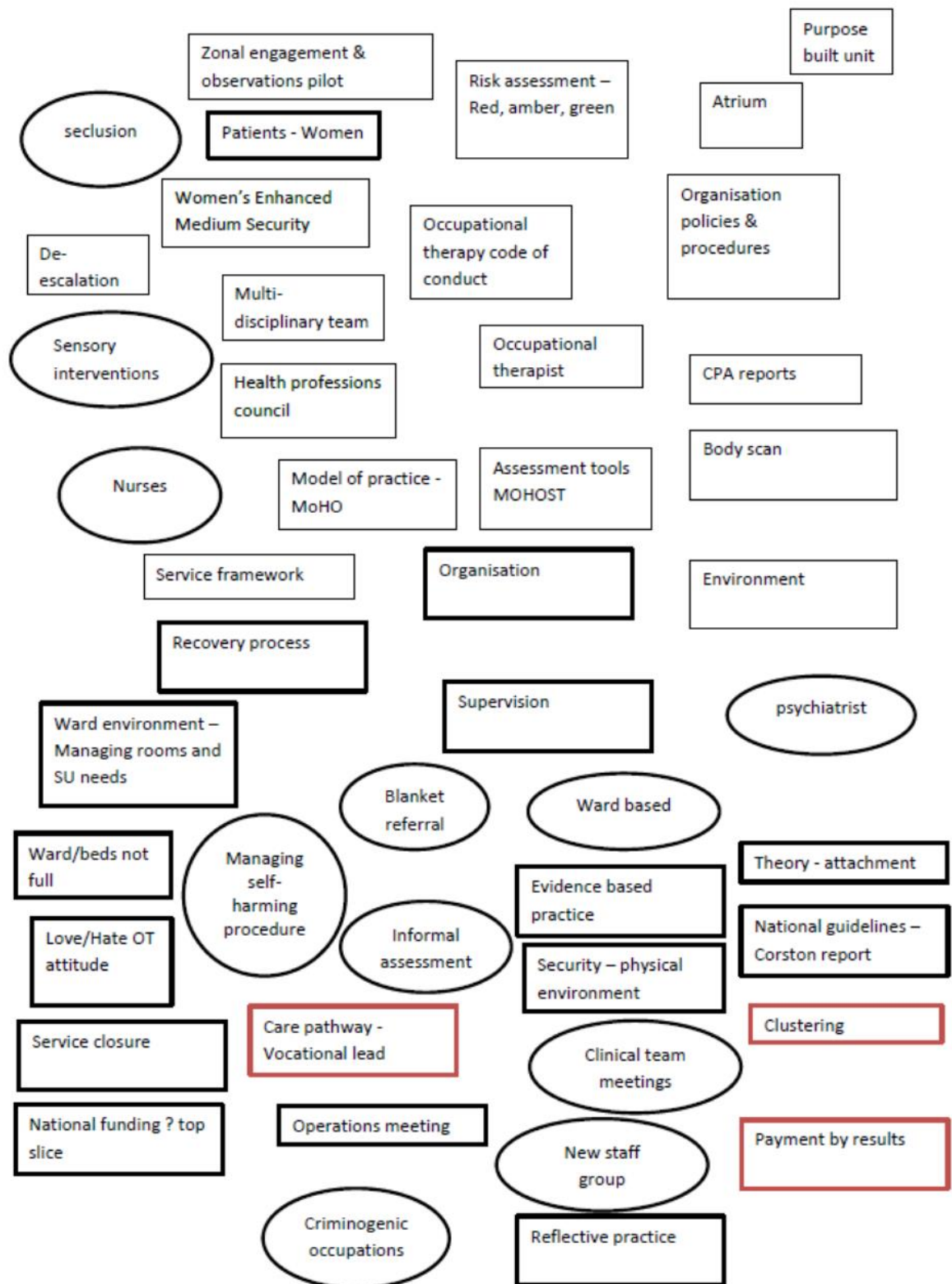Brunel University, Mary Seacole Building
Uxbridge, UB8 3PH

Email: kevin.cordingley@brunel.ac.uk
Telephone: 01895 268668

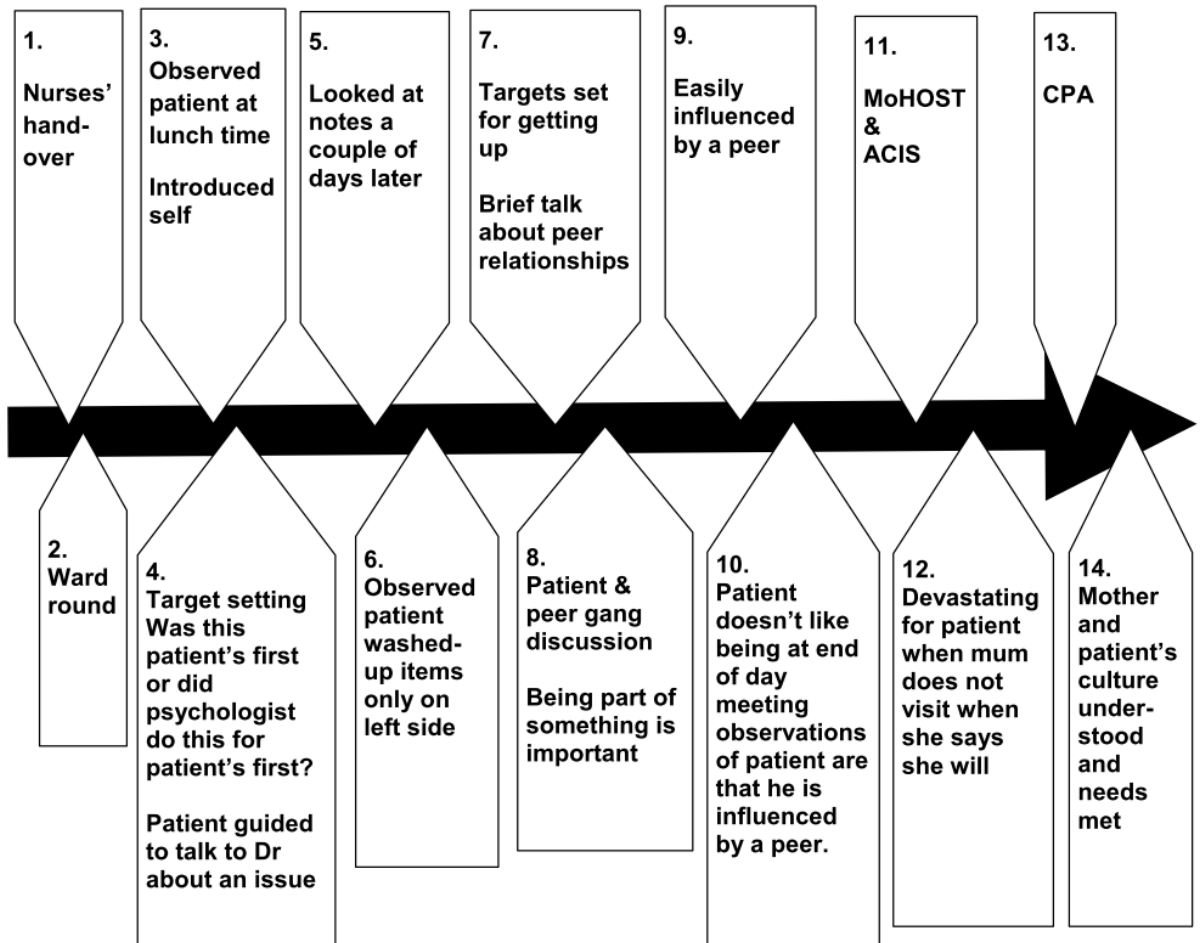Appendix 7. Probes and interview schedule/procedure

	1. Client identification & stages of OT process	*Interviewer instructions* • Identify the practitioner has a client to discuss • Gain an overview of the significant events at the relevant stage of the OT process
Ask	• Have you been able to identify a client with whom you have worked within the past 6 months and with whom you are currently working? • Have you experienced significant events or stand out aspect/s when working with a client, such as times that were particularly challenging, enjoyable aspects, or a combination of these, and where your decisions have had an impact upon the outcomes? • Please give me a summary of the significant events that occurred during [insert stage] of the OT process • Tell me about when you first started working with the client. Take me through the steps of the OT process as you worked through them (continue this for each stage of OT process). • At the intervention/treatment stage, explore specific significant events as they are discussed.	
Listen for	Significant events and decision points in which the practitioner played a key role	
	2. Timeline and decision point identification	*Interviewer instructions* • Repeat back the description of the stage of the OT process being discussed. • Construct a timeline • Record decision points, shifts in understanding, and major events • Ask clarifying questions
Ask	• Do I have this right? • Where on the timeline should I put this?	
Listen for	Decision points, shifts in understanding, places to probe, gaps in the story, gaps in the timeline, conceptual leaps, anomalies/surprises, errors, ambiguous cues, shifts in stages of OT process	
Flags	I just knew...It felt right...I guess...It was just a gut feeling...Something felt wrong...I've seen it before...It depends...	
	3. Deepening	*Interviewer instructions* • Ask questions until you understand the description • Use the timeline for clarification • Repeat back confusing points
Ask	*Experience* • *Helpful or necessary practice & personal experience* *Options* • *What actions were available, what were considered?* • *What alternatives were there?* *Guidance* • *Who did you seek information from?*	*Basis of choice* • *How did you choose and reject decisions/information?* • *What rule was used to choose this?* *Standard operating procedures* • *Does this fit with standard or typical scenario?* • *What training is there for this?* *Analogy/generalisation*

	• *How did you know to trust this?*	• *Previous experience for similar decision made?*
	Mental models	• *What is the relevance now?*
	• *Do you imagine the consequences, unfolding events*	***Cues***
	• *Do you create pictures in your head?*	• *What did you see, hear, smell?*
	Decision making	***Goals/priorities***
	• *How did you know it was the right decision to make?*	• *What goals or objectives did you have?*
	Aiding	• *Specific goals at decision points?*
	• *What knowledge, information or tools, technologies could have helped?*	• *What was most important to accomplish?*
	Time pressure	***Forms of knowledge***
	• *How much time pressure?*	• *Formal/ informal/personal/ practice knowledge used?*
	• *What was the impact?*	• *How/where obtained?*
	Expectancy	• *What knowledge or information could have helped?*
	• *Did you expect to make a decision?*	***Personal theory***
	• *What was the effect on the decision making process?*	• *Alteration of existing knowledge, how, what, & reasons?*
	Emotional context	• *Did you alter/convert or replace this with something different or new?*
	• *Did you experience heightened emotions?*	
	• *How did your emotional state influence the decision?*	
Listen for	Critical decisions, cues & their implications, ambiguous cues, strategies, anomalies/violated expectancies.	
	4. "What if" queries	*Interviewer instructions*
		• Use "what if" questions to tease out specific elements for deepening further & novice/experts
		• Ask what a new person might have done
		• Ask what mistakes might have been made earlier in the practitioner's career
Ask	• Did you consider alternatives?	• Would you have made the same decision at an earlier point in your career?
	• Might someone else in the same position have done if differently?	• Would this incident have turned out differently if you or someone with your level of skill/experience had not been there?
	• Could you have reasonably taken any other action?	
	Errors	
	• *Did you acknowledge if situation assessment or option selection were incorrect?*	
Listen for	Other possible courses of action, potential interpretations, expert-novice differences, potential errors.	

Appendix 8. Liz messy situational map

Appendix 9. Time-line Tess

1.

Nurses' hand-over

2.

Ward round

3.

Observed patient at lunch time

Introduced self

4.

Target setting
Was this patient's first or did psychologist do this for patient's first?

Patient guided to talk to Dr about an issue

5.

Looked at notes a couple of days later

6.

Observed patient washed-up items only on left side

7.

Targets set for getting up

Brief talk about peer relationships

8.

Patient & peer gang discussion

Being part of something is important

9.

Easily influenced by a peer

10.

Patient doesn't like being at end of day meeting observations of patient are that he is influenced by a peer.

11.

MoHOST & ACIS

12.

Devastating for patient when mum does not visit when she says she will

13.

CPA

14.

Mother and patient's culture under-stood and needs met

Appendix 10. Time-line Liz

1.
Pre-admission care planning report scanned admission details

2.
Introduction Begin discussions

3.
Contact previous service & OT

4.
Blanket referral

5.
Risk Assessment Environment Atrium & traffic lights

6.
Rapport building

7.
Feeling at a loss

8.
MoHOST

9.
CPA use of music & losing drama therapy

10.
Sensory modulation problems - Highly stimulated Taste Light Noise Used sunglasses, sweets

11.
Sensory profile attempted

12.
Observation: Use of environment & effects on Claire

13.
Mindfulness exercises - daily

14.
Thesis Service user needed to be held to be contained emotionally

Appendix 11a. Time-line Gladys and Leila

Top row:

1. Read Hand-over notes from previous OT

3. Ward round Discussions – psychologist, nurse, consultant

5. Mourning past life style

Balance in occupations

7. Informal interview Info gathering Physical health

9. Stuck – Patient resistance

11. Community assessment

Bottom row:

2. Read previous CPA documentation

4. Observations and discussions about physical health

6. Rapport building Actively saying 'hello' Active avoidance

8. Caution advised

10. Observed anxiety

Appendix 11b. Time-line Gladys and Andy

Timeline (top row):

1. MDT gave details – advised discuss with consultant

3. Community access – Structured graded exposure cigarette breaks, general hospital

5. CPA review – SU agreed to community access

7. Smoothie group – Why not dangerous?

9. Cigarette breaks – Hang out at room SU avoidance

11. Confronting the SU

13. Empathy, truthful reassurance

15. Agreed a new plan – unrealistic

Timeline (bottom row):

2. Condensing list – SUs for immediate work

4. Psychologist as a resource

6. Unstructured assessment

8. Gentle approach – Firm but maternal

10. Attend groups SU attended

12. Incident – OT offer to go on cigarette break with him

14. Plan to go out – female SU shouted at SU on ward

Appendix 12. Contact summary form

Contact Type: Visit/Email:_____ Practitioner & IV:_____

Site: _____   Written by: _____

Contact date: _____   Today's date: _____

1. What were the main issues or themes that struck you in this contact?

2. Summarise the information you got (or failed to get) on each of the target areas/questions you had for this contact.

3. Anything else that struck you as salient, interesting, illuminating or important in this contact?

4. What new (or remaining) target questions do you have in considering the next contact with this practitioner?

Appendix 13. Transcribing record sheet

TRANSCRIBING: RECORD OF THOUGHTS AND IDEAS

DATE: PRACTITIONER & IV:

DATE: RECORDING TIME:

COMMENTS:

Appendix 14. Concept memo example

RISK CONCEPT – created 14.6.12

The risk issues discussed by participants were all linked to the relational security, occupational therapy interventions, the environment in which they occurred and the objects available in any given environment. The specific risks presented by each service user in a particular practice area also highlighted differences in risk assessment practices. The risk assessment could be done with formal procedures or assessments, or informal approaches. The timing of risk assessments varied depending on the practice area, client and overall organisational approach. In other areas the approach was not formalised in any way and was based on the information available and practice reasoning.

Formal training had been undertaken by Tess in the Hare psychopathy checklist and HCR-20, and Liz had training in the latter and HoNOS? Gladys had not formal training and picked up her risk assessment experience by shadowing other therapists.
? Temporal, historical, current,

Also Liz highlighted minimising depriving service users from engaging in everyday occupational activity through risk assessment which in a forensic environment is a challenge

That level of complexity in maintaining appropriate risk management procedures and

The risk assessment was one designed specifically by occupational therapists the WEMS practice context to manage risk on a daily basis, linked into the wider organisational procedures of CPA, using standardised assessments.

The focus of risk assessment for Liz was around the past history of the use of tools

Liz applied occupational therapy core skills of grading and environmental adaptation to the risk assessment and management process. This approach

grades the access to environments within and around the unit via pathways of leisure, productivity, primary care access, access to the grounds and community

Liz highlighted that risk assessment 'will run concurrently with the engagement process of kind of like let me you know the blanket referral process and therapeutic engagement' (88-89, p3, Liz IV2). This stresses the therapeutic management that needs to run in tandem with risk management'.

Liz commented on the need to keep this risk assessment process 'alive' between services that a service user may be coming from or going too.

Liz took a wider view of the place of risk assessment in that it included the relational risk assessment of links between the occupational therapists and could be a way of helping the service user to feel supported and that clear risk information is communicated. In this way potential risks are minimised.
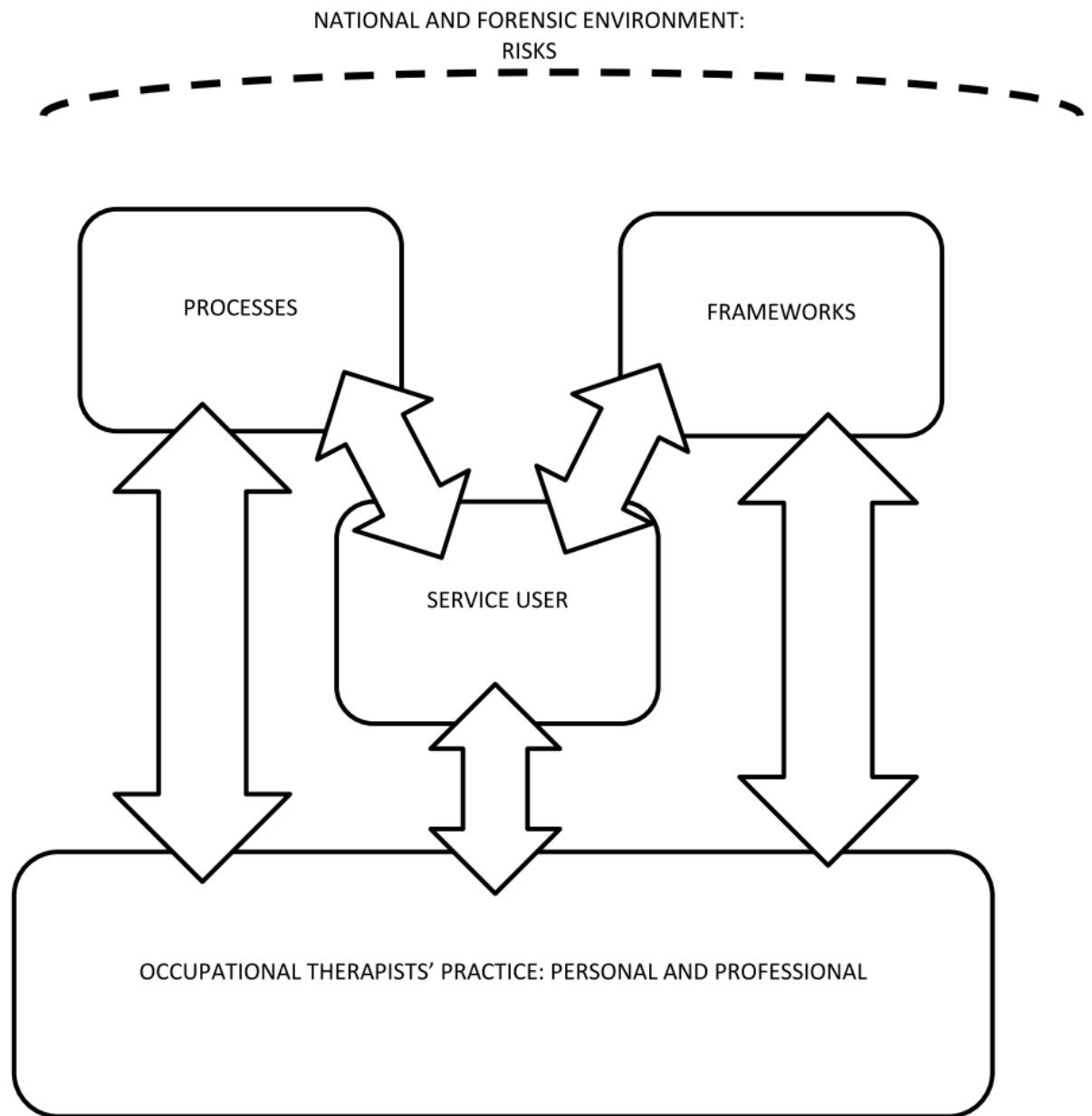
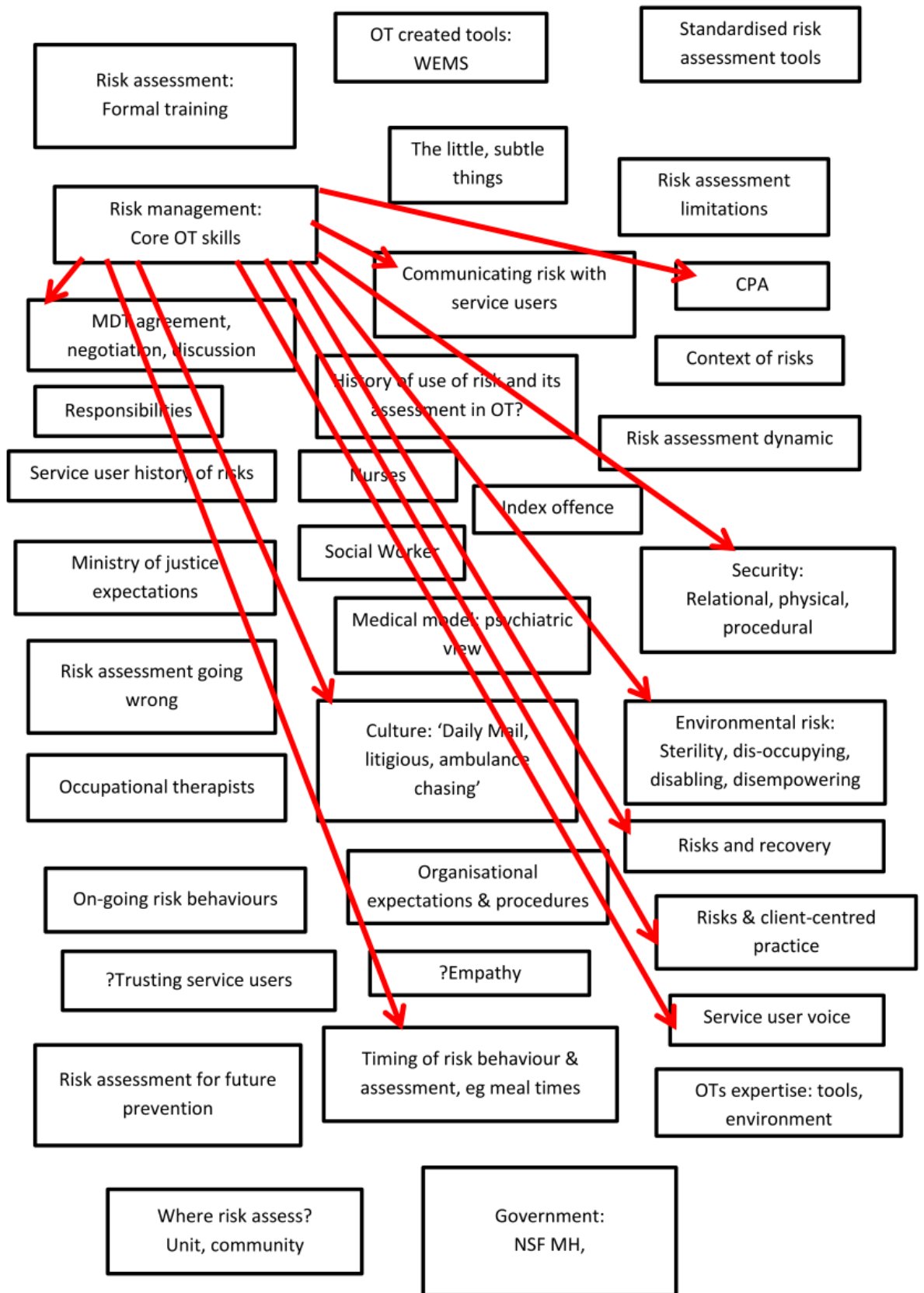Appendix 15. Grounded theory category and concept Figure one
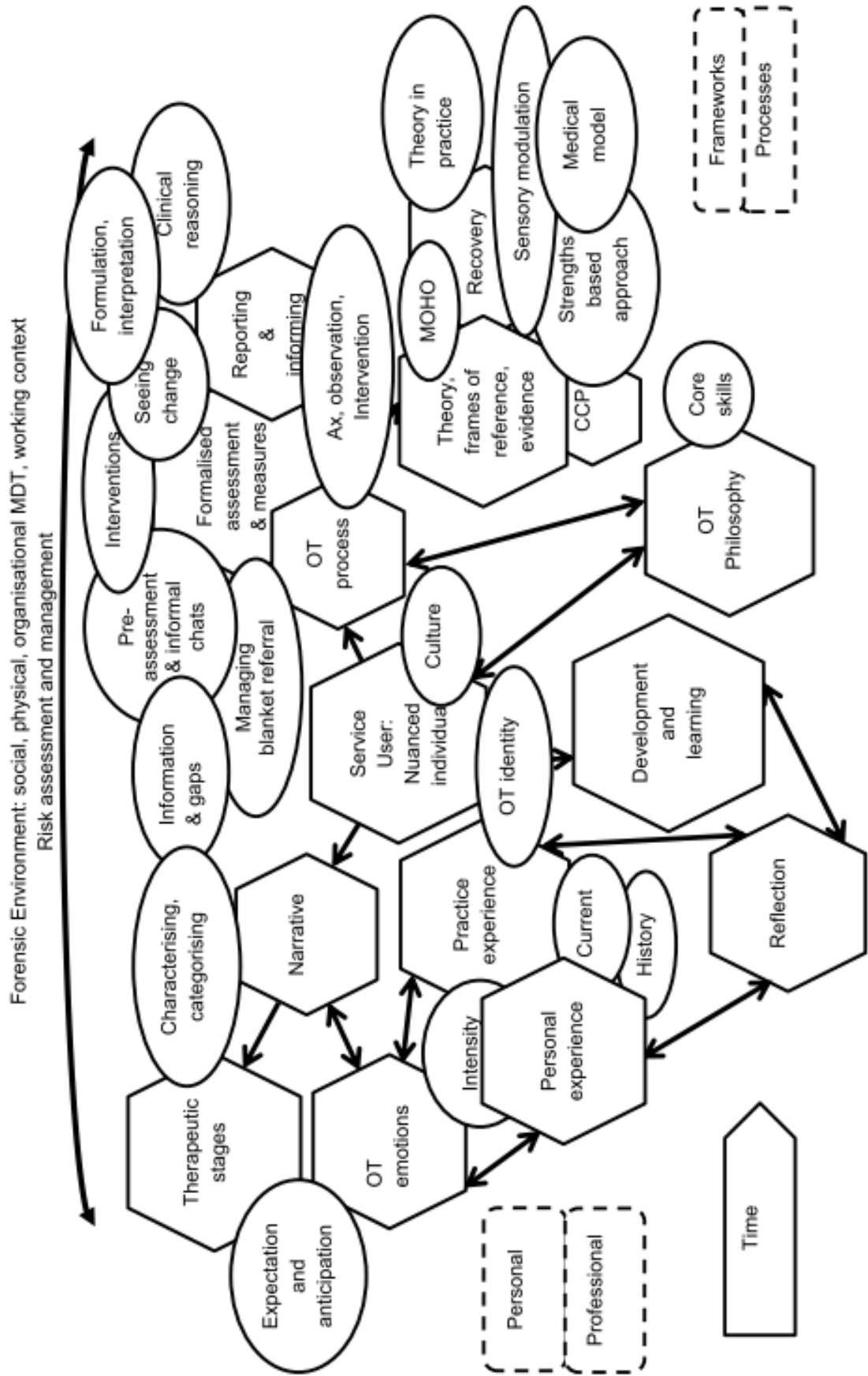
Appendix 16. Grounded theory category and concept Figure two
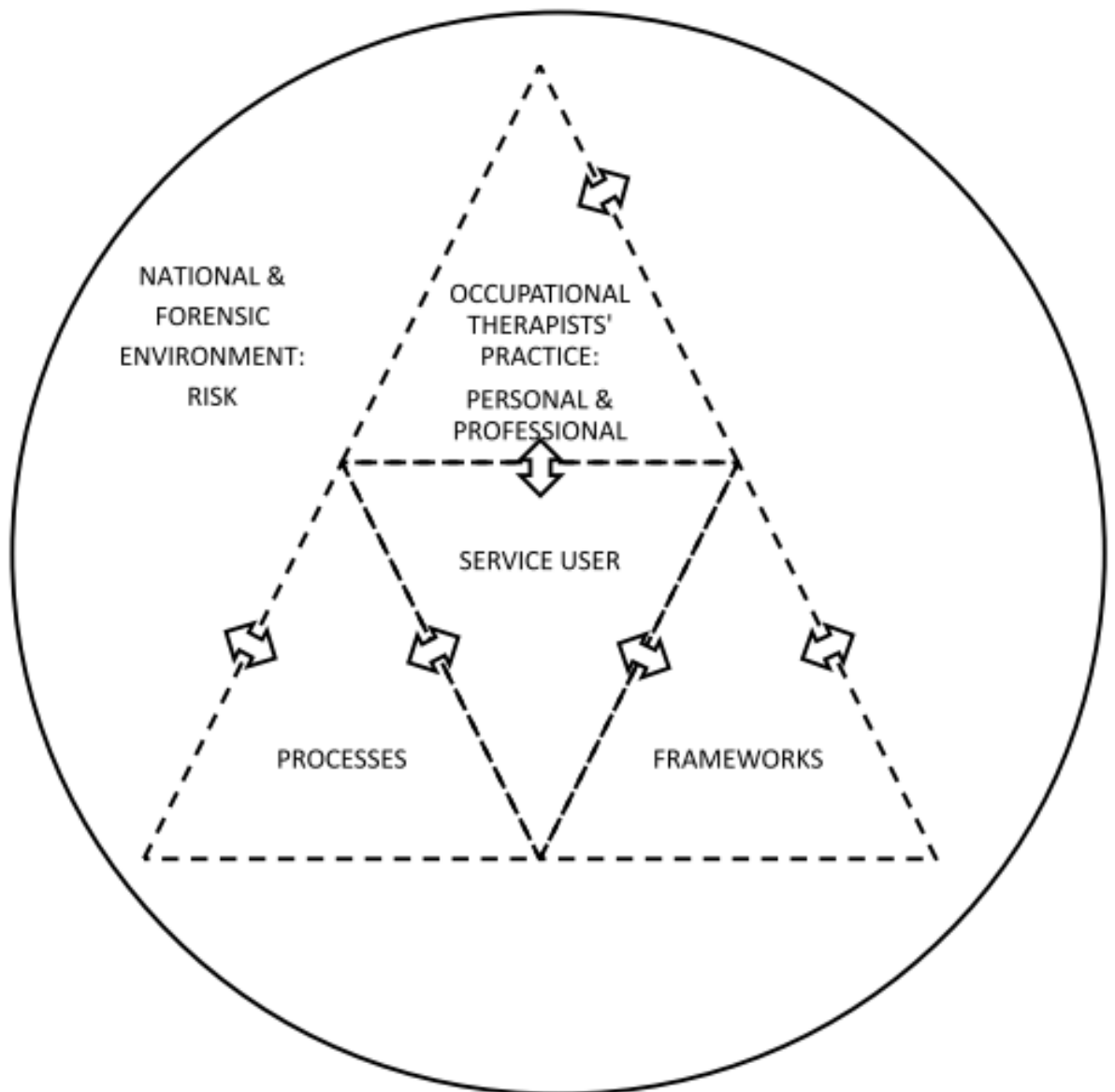
Appendix 17. Grounded theory category and concept Figure three

Appendix 18. Relational analysis of messy situational map of risk

Appendix 19. Ordered Situational Map (Clarke, 2005 & Perez, 2013) – RISK

Local to Global Elements

Sociocultural Elements (sexual, racial, class, ability, gender)
Three female OT practitioners, two with male service user and one with female service user

Symbolic Elements

Popular & Other Discourses (Historical, narrative and /or visual: a. normal expectations of actors; b. actants and/or specified elements; c. moral/ethical elements; d. mass media; e. popular cultural discourses; f. situation specific discourses)
Culture: 'Daily Mail, litigious, ambulance chasing'
Risk terminology in everyday life

Other Empirical Elements TBA

Spatial Elements & Temporal Elements (historical, seasonal, crisis, and/or trajectory aspects)
Risk assessment for future prevention
Timing of risk behaviour & assessment, eg meal times
On-going risk behaviours
Environmental risk: Sterility, dis-occupying, disabling, disempowering
History of service user risks
History of risk assessment in forensic setting

Human Elements (Individual & Collective, un/organised, organisations)
Communicating risk with service users
Service user voice
MDT agreement, negotiation, discussion
Index offence
Nurses
Social Worker
Occupational therapists – College of OT
OTs expertise: tools, environment

Nonhuman Elements (a. technologies; b. material infrastructures; c. specialised information and/or knowledges; d. material 'things')
Standardised risk assessment tools
Risk assessment: Formal training
OT created tools: Women's Enhanced Medium Secure Service (WEMS)
Risk management guidelines
Government: National Service Framework Mental Health
Professional code of ethics and conduct; Health and Care Professions Council

Political Economic Elements (a. the state; b. particular industries; c. local/regional/global orders; d. political parties; e. politicised issues)
Risk assessment limitations
Risk behaviours as predictable and preventable
Financial: expense of forensic care; costs incurred due to criminal acts

Discursive Constructions of Actions (dominant – what/who excluded & included)
The little, subtle things
Medical model: psychiatric view
Risk assessment going wrong
Security: Relational, physical, procedural
Service user history of risks
Risks & client-centred practice & recovery
Public safety/fears
OT experience in risk assessment

Organisational Institutional Elements
NHS
Organisational expectations & procedures
Care Programme Approach
Ministry of justice expectations

Major Contested Issues
?Trusting service users
?Empathy

Appendix 20. Early data analysis procedure

Type	Task	Approach
Interview	Contact summary form completed (see appendix 12)	Immediately following, or as close to the completion of each interview
Interview	Transcribing audio recording	Listening to digital recording on slow speed whilst typing.
Interview	Transcribe record sheet filled in (see appendix 13)	Completed whilst listening to digital recording and typing transcript*. Line numbers in Microsoft word document are noted at each record to link and track between documents.
Email	Collating email responses	The practitioner's responses were cut and pasted into a Microsoft word document.
Interview and email	Mistake and omission checking	Spelling & grammar check, Microsoft word facility. Listen to relevant sections in digital recording (interview only).
Interview and email	Documents imported to Nvivo 9 & 10	Word documents of the transcript, contact summary form and transcribe record sheet.
Interview and email	Review of finished transcript and minor mistake checking	Listen to the complete digital recording and read the transcript again (interview only). Read the email transcript again. Annotations in the NVivo10 used to indicate mistakes with insertions and removals made to the transcript.
Email	Reflecting on transcript	The memo journal was used to record any responses to reading the transcript in the same way the transcribing record sheet was used for the interviews.
Interview and email	Timeline Figure creation	Created during the contact with practitioners and when subsequent transcripts and emails were reviewed by the researcher.

Interview and email	Practitioner access to interview transcript	Export transcript from the interview into Nvivo10 corrected into a Microsoft word document and emailed to respective practitioners. Practitioners have copies of emails as they have sent this to the researcher.
Interview and email	Question development	Following and during the above steps, theoretical sampling, situational analysis and questions for probes are created.

Appendix 21. The presentation of the quotations in the findings

Indicator	Purpose
EM2	Interview was by email, which is numbered in the order in which it was completed
Liz, Gladys, Tess	Practitioners' pseudonym
Leila, Claire, Zach, Andy	Service users' pseudonym
Liz 1, 35-41	Number of the interview and line numbers
R: mm	Utterances made by me are removed
…	Ellipsis points indicate the quote has been taken from a larger part of a transcript, and repetitive or terms such as 'you know', and 'sort of' are removed.
[ ]	Square brackets indicate unclear interview content and points of clarification from me