Evaluating the Recovery Through Activity Framework used by occupational therapy in Mental Health Services

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Summary

This thesis evaluates the implementation of Recovery Through Activity (Parkinson 2014) as used by occupational therapists in NHS Adult Mental Health Services. Designed to support service users in recognising the long-term benefits of engaging in assorted occupations, Recovery Through Activity (Parkinson 2014) incorporates a diverse range of occupational areas. It provides occupational therapists with a flexible resource and evidence base to support activity-focused interventions.

Utilising a case study approach, this research explores both face-to-face and virtual implementations of Recovery Through Activity (Parkinson 2014), adapted to the restrictions imposed by the Covid-19 pandemic. It explores the experiences of occupational therapists using Recovery Through Activity (Parkinson 2014), the challenges associated with an occupationally focused approach, and the effectiveness of various intervention outcome measurement tools. Insights from a service user with experience in both implementation methods, enrich the study with their unique perspective.

This study is framed within a bounded relativist ontology and interpretivist theoretical perspective. This stance suggests that individuals construct their own realities and meanings within their occupations. This philosophical framework supports a detailed examination of Recovery Through Activity (Parkinson 2014) and how occupational engagements are perceived and valued differently by individuals.

Results from the face-to-face and virtual implementation case studies are analysed separately. The separate cases are then cross-examined to draw comprehensive conclusions about Recovery Through Activity's (Parkinson 2014) impact on practice. These findings inform a discussion on the wider implications of the research for occupational therapy. This discussion

emphasises the adaptability of occupational therapy practices in response to external challenges, as well as the ongoing need to enhance and develop occupation-based interventions.

This thesis not only contributes to academic understanding but also to practical approaches in mental health occupational therapy. It advocates continued innovation and evaluation of occupational therapy practices.

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Abbreviation	Meaning
MOHO	Model of Human Occupation
CMHT	Community Mental Health Team
PIS	Participant information sheet
OT	occupational therapist
NHS	National Health Service
OSA	Occupational Self-Assessment
MOHOST	Model of Human Occupation Screening Tool
OCAIRS	Occupational Circumstances Assessment Interview and Rating Scale
3B Scale	Being, belonging and becoming scale

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Chapter 1 Introduction

1.1 Introduction

This study evaluated Recovery Through Activity (Parkinson 2014) as used by occupational therapists in adult mental health services in an NHS Health Board. Recovery Through Activity (Parkinson 2014) aims to support occupational therapists to enable service users to identify the long-term benefits of engaging in a range of occupations. In addition, it offers a variety of resources, and an evidence base for activity-focused interventions. Recovery Through Activity (Parkinson 2014) encompasses the occupational areas of: vocation; creativity; technology; faith; outdoor; physical; self-care; domestic; caring; leisure; social and community. This research study explored occupational therapists' experiences of using Recovery Through Activity (Parkinson 2014) as an intervention, as well as the challenges faced in employing an occupationally focused approach. The term occupational therapy staff will be used throughout this thesis to refer to both registered occupational therapists and occupational therapy assistants/technicians/support workers. This is to protect participant anonymity. Additionally, this thesis explored the use of a range of outcome measure tools employed in occupational therapy practice, focusing specifically on gathering service user feedback and comparing changes in occupational competence and values following the implementation of Recovery Through Activity. These tools facilitated a detailed analysis of how the intervention influenced the personal development of service users, enabling a quantifiable comparison of pre- and post-intervention outcomes. This approach not only helped in determining the effectiveness of Recovery Through Activity (Parkinson 2014) but also provided valuable insights into how service users perceived and experienced changes in their occupational

engagement and overall wellbeing. In order to gain service user perspectives on themes identified by occupational therapy staff, a service user who had both experience of engaging in face-to-face and virtual Recovery Through Activity (Parkinson 2014), took part in an in-depth interview.

Mental health services provided in South Wales are heavily influenced by the Mental Health (Wales) Measure 2010, which places a legal obligation on health boards to provide timely and comprehensive support to individuals experiencing mental ill-health. This is reinforced by the Welsh Government's Together for Mental Health strategy (2019) which promotes the principles of recovery and emphasises the importance of a holistic, person-centred approach to care. In this context, occupational therapy is positioned as a key discipline within mental health services, given its emphasis on enabling service users to engage in meaningful occupations that support recovery. However, the arrival of the COVID-19 pandemic in early 2020 significantly disrupted these services, necessitating rapid adaptations to both the delivery of care and the implementation of interventions such as Recovery Through Activity (Parkinson 2014).

COVID-19 created unprecedented challenges for mental health services across Wales (Welsh Government 2020). The introduction of lockdown measures, social distancing requirements, and the redeployment of healthcare staff—including occupational therapists—to critical services resulted in major disruptions to traditional models of care (RCOT 2020). Face-to-face therapeutic interventions, which form a central part of Recovery Through Activity (Parkinson 2014), were severely impacted. In response, health boards across Wales convened a series of virtual strategy meetings, known as "driver's meetings," to coordinate their response to the pandemic. These meetings, held via video conference, brought together representatives from each of the health boards in Wales to discuss how best to continue delivering Recovery Through Activity

(Parkinson 2014) within the constraints imposed by COVID-19. As a result of these discussions, an all-Wales strategy was developed to shift the intervention from face-to-face to virtual and online platforms, ensuring that service users could continue to engage with occupational therapy in a meaningful way, despite the restrictions.

The impact of COVID-19 on the delivery of occupational therapy services, and on the implementation of Recovery Through Activity (Parkinson 2014) specifically, cannot be understated. The pandemic required not only the health board but also the research itself to adapt to rapidly changing circumstances. Originally, this research intended to focus solely on the face-to-face implementation of Recovery Through Activity (Parkinson 2014) within the NHS mental health services. However, the onset of the pandemic necessitated significant changes to both the research design and the intervention itself. The shift to virtual platforms, while necessary, introduced new challenges for both service users and occupational therapy practitioners, particularly in maintaining the therapeutic rapport and group dynamics that are often key to the success of the intervention.

This adaptation was made even more complex by the diverse nature of the population served by the health board, which includes both rural and urban areas. Internet access and digital literacy varied widely across these regions, creating additional barriers to the virtual implementation of Recovery Through Activity (Parkinson 2014). For some service users, engaging in virtual occupational therapy sessions required the development of new digital skills, while others faced challenges in accessing reliable technology or internet connections. These practical concerns were compounded by the emotional and psychological toll of the pandemic, as many service users experienced heightened levels of isolation, anxiety, and uncertainty during this period. Despite these difficulties, the health board remained committed to delivering occupational therapy services and ensuring that the recovery-oriented

principles underpinning Recovery Through Activity (Parkinson 2014) were upheld.

Yin (2018) emphasises the critical importance of context in case study research, arguing that the boundaries between the case and its context are often blurred, particularly in complex real-world settings. This research adopted a case study design precisely because of the need to understand how Recovery Through Activity (Parkinson 2014) was implemented within the specific context of the COVID-19 pandemic in South Wales. The pandemic serves as an unavoidable and defining contextual factor that shaped both the delivery of the intervention, and the experiences of the service users and practitioners involved. The changes in service delivery, the transition to virtual platforms, and the broader challenges faced by the NHS during this period, all contributed to a unique case that highlighted the adaptability of occupational therapy in the face of external pressures.

Understanding this context is critical to appreciating the significance of this research. Recovery Through Activity (Parkinson 2014) is not a static intervention but one that evolves in response to the needs of service users, the capacities of the healthcare system, and broader societal factors. By examining how the intervention was adapted in response to the pandemic, this research contributes to the growing body of knowledge on occupational therapy and recovery-oriented practices in mental health services. Moreover, it provides valuable insights into how mental health services can continue to promote recovery and engagement in meaningful activity, even during times of crisis.

This chapter introduces the key elements that are explored in depth throughout the thesis. First, it sets the scene by discussing the broader context of mental health services in South Wales, emphasising the significance of Recovery Through Activity (Parkinson 2014) as a recovery-

oriented intervention. It then addresses the impact of the COVID-19 pandemic, highlighting the specific challenges faced by the health board and the strategic response developed through the all-Wales driver's meetings. Finally, the chapter outlines the research design, which incorporates both face-to-face and virtual implementation of the intervention, reflecting the adaptations made during the pandemic.

In summary, this research examined the implementation of Recovery Through Activity (Parkinson 2014) during one of the most challenging periods in recent healthcare history. The context of COVID-19 is inextricably linked to the findings of this research, as the pandemic forced both the health board and the research to adapt in real-time. By understanding the impact of these contextual factors, this research offers a comprehensive analysis of how occupational therapy can remain relevant and effective in the face of unprecedented challenges, and it highlights the importance of flexibility and innovation in delivering recovery-oriented mental health services.

1.2 South Wales Context: An Overview of Mental Health Services

Introduction to South Wales as a Geographical Focus

South Wales, a region known for its industrial history and rich cultural heritage, faces unique socioeconomic challenges that directly influence the provision of mental health services (Wales Centre for Public Policy 2021). Mental health services in South Wales, like those across the UK, are structured around the principles of recovery-oriented care, emphasising the role of the individual in managing their own recovery (Welsh Government 2010). Within this context, Recovery Through Activity

(Parkinson 2014) is a key intervention designed to help individuals living with mental ill-health to engage in meaningful occupations that support their overall well-being. This intervention, which is grounded in the principles of occupational therapy, aligns closely with broader governmental policies such as the Mental Health (Wales) Measure 2010 and the Together for Mental Health strategy (Welsh Government 2019b).

The COVID-19 pandemic brought new challenges to the region's mental health services, exacerbating existing socioeconomic issues and creating new barriers to service delivery (Welsh Government 2021). This section explores the broader context of South Wales, the structure of mental health services in the region, and how these factors contributed to the relevance and challenges of implementing Recovery Through Activity (Parkinson 2014).

Structure of Mental Health Services in South Wales

Mental health services in South Wales are primarily delivered through the NHS, with individual health boards responsible for their respective regions. The health board examined in this thesis provides a comprehensive range of services, from acute inpatient care to community-based interventions. The health board's services are aligned with the Welsh Government's Together for Mental Health strategy, a 10-year plan aimed at improving mental health outcomes through person-centred, recovery-focused care (Welsh Government 2020b).

The Welsh Government's (2012) commitment to a recovery-oriented approach is significant for the implementation of Recovery Through Activity (Parkinson 2014). Occupational therapy plays a key role in this approach, as it emphasises the importance of enabling individuals to engage in meaningful activities that enhance their well-being (AOTA 2010). This aligns with broader principles of co-production. Co-production refers to the collaboration between service users and professionals in

designing and delivering care, ensuring that individuals have a voice in their own recovery journey (NHS Wales 2021).

Public Health Wales (2021), however, highlight the delivery of mental health services in South Wales is not without challenges. The region's combination of urban and rural areas presents logistical difficulties in ensuring equitable access to services. For instance, while urban areas benefit from relatively well-resourced services, more rural areas face barriers such as limited public transportation, fewer healthcare facilities, and difficulties in recruiting and retaining healthcare staff. These issues were exacerbated by the COVID-19 pandemic, as health boards struggled to maintain service continuity while adapting to new public health guidelines (Public Health Wales 2021).

Economic Deprivation and Mental Health in South Wales

One of the most pressing challenges facing South Wales is the high level of economic deprivation in parts of the region, particularly in post-industrial areas that have experienced significant economic decline since the mid-20th century (Morgan and Rees 2016). The closure of coal mines and other heavy industries has left many communities facing long-term unemployment, poor health outcomes, and a lack of social mobility (Foden et al. 2014).

Research has consistently shown a strong link between socioeconomic deprivation and poor mental health outcomes (Marmot et al 2020). Individuals living in deprived areas are more likely to experience mental health issues, including depression, anxiety, and substance abuse, and are also more likely to require mental health services (Mind 2024). Furthermore, economic deprivation can limit individuals' access to the resources needed to support their mental health, such as stable housing, employment opportunities, and social support networks (Office for National Statistics 2020).

The COVID-19 pandemic exacerbated these challenges, as lockdown measures disproportionately affected economically deprived communities (Mental Health Foundation 2020). Individuals living in poverty were more likely to face job losses, housing instability, and social isolation during the pandemic, all of which contributed to increased demand for mental health services (Yu et al. 2022). For the NHS health board, this meant a significant strain on resources, as the health board worked to meet the rising demand for services while also contending with the logistical challenges posed by the pandemic (Welsh Government 2020c).

Isolation and the Urban-Rural Divide in South Wales

The geographical landscape of South Wales is characterised by a mix of densely populated urban areas and sparsely populated rural regions, each with distinct challenges in terms of service delivery (Welsh Government 2020d). Rural areas, in particular, face significant barriers to accessing mental health services. Limited public transportation, fewer healthcare facilities, and greater distances between service users and providers can make it difficult for individuals in rural areas to receive the care they need (NHS Wales 2021). These challenges became even more pronounced during the COVID-19 pandemic, as lockdown measures restricted movement, and many services transitioned to virtual platforms (NHS Wales 2021).

Why South Wales as a Case Study for occupational therapy Interventions

South Wales provides a particularly interesting case study for occupational therapy interventions like Recovery Through Activity (Parkinson 2014) due to the region’s unique combination of economic, geographical, and social factors. The area’s history of industrial decline and ongoing economic challenges create a high demand for mental health services, while the

region's mix of urban and rural areas presents distinct challenges in terms of service delivery.

Furthermore, South Wales' commitment to recovery-oriented care, as outlined in the Together for Mental Health strategy (Welsh Government 2012), makes it an ideal setting for evaluating the effectiveness of occupational therapy interventions. The region's focus on co-production, empowerment, and person-centred care aligns closely with the principles of Recovery Through Activity (Parkinson 2014), making it a valuable case study for understanding how these principles can be applied in practice (NHS Wales 2021).

1.3 The Impact of COVID-19 on Mental Health Services in South Wales

Challenges Imposed by COVID-19

The COVID-19 pandemic caused significant disruption to mental health services across South Wales, as it did throughout the UK (Mind Cymru 2020). Occupational therapists, essential in delivering mental health care, encountered numerous barriers during the pandemic, including redeployment to frontline healthcare services, restrictions on face-to-face interactions, and the suspension of interventions such as Recovery Through Activity (Parkinson 2014). These challenges compounded existing pressures within mental health services and introduced new obstacles to care delivery and maintaining continuity for service users.

The Welsh Government's lockdown measures and social distancing rules meant that key therapeutic interventions reliant on face-to-face contact or community-based activities were either restricted or halted. This severely affected the ability of occupational therapists to engage with service users and provide effective care. The World Federation of occupational

therapists (WFOT 2021) highlighted how the pandemic caused widespread disruption to the delivery of mental health services, not just in South Wales but globally, making it difficult to maintain the pre-pandemic standards of care.

Redeployment of occupational therapists

During the height of the pandemic, many occupational therapists in South Wales were redeployed to frontline COVID-19 services, such as critical care units, exacerbating staffing shortages in mental health services. Occupational therapists who were not redeployed often managed larger caseloads remotely from home (RCOT 2020). This shift in service delivery was particularly challenging for interventions like Recovery Through Activity (Parkinson 2014), which relies heavily on hands-on support. Consequently, this key intervention was paused for nearly eight months, leaving service users without access to the therapeutic activities essential for their recovery.

In-person visits, which are crucial for delivering activity-based interventions, were halted unless absolutely necessary. When permitted, COVID-19 risk assessments were mandated before any visits, further delaying care and limiting accessibility (RCOT 2020). This led to service users receiving reduced mental health support, and occupational therapists expressed feeling underutilised as their scope of practice was significantly restricted (WFOT 2021). As a result, mental health service users experienced delays and discontinuity in their treatment, further exacerbating their conditions.

Increase in Mental Health Challenges

The pandemic triggered an unprecedented rise in mental health challenges across South Wales (Cardiff University 2020). Research from Cardiff University (2020) revealed that nearly half of the 13,000 Welsh

adults surveyed experienced clinically significant psychological distress during the first months of the pandemic. Of those surveyed, around 20% reported severe mental health impacts by mid-2020, reflecting the significant toll that the crisis took on the population.

This mental health surge was echoed in the sharp increase in service referrals. The Office for National Statistics (ONS 2020) reported a 25% rise in anxiety and depression referrals across the UK, with South Wales mirroring this trend. The sudden influx of mental health issues overwhelmed already strained services, leading to long wait times for assessments and care. Public Health Wales (2021) found that in some cases, individuals were waiting up to 12 weeks for an initial assessment, which had a detrimental effect on those needing urgent care.

In economically disadvantaged areas, the mental health impact of the pandemic was disproportionately severe. Service users from lower socioeconomic backgrounds were more likely to experience heightened anxiety and depression due to job losses, financial insecurity, and social isolation (Welsh Government 2020). Research conducted by Mind Cymru (2020) found that 72% of individuals who experienced employment changes during the pandemic reported a decline in their mental health, compared to 58% of those whose employment remained stable. This disparity highlights the pandemic's exacerbation of pre-existing health and economic inequalities.

Shift to Virtual Services and Barriers

The transition from in-person services to virtual platforms was necessary to maintain mental health care during the pandemic. However, this shift had it’s challenges, particularly in rural areas of South Wales, where digital connectivity and literacy posed significant barriers (RCOT 2020). Research conducted by Mind Cymru (2020) showed that 18% of adults in

Wales were unable to access mental health services due to technological barriers, including poor internet connectivity and lack of digital literacy.

Occupational therapists struggled to build rapport and maintain therapeutic relationships with service users through digital platforms, reducing the effectiveness of interventions like Recovery Through Activity (Parkinson 2014; WFOT 2021).

The Impact of Lockdown Restrictions on Practice

The restrictions imposed by the Welsh Government during the pandemic presented further challenges for the delivery of occupational therapy services. Limits on public transport, outdoor activities, and group gatherings created logistical issues for occupational therapists, particularly in delivering community-based interventions. Group outings, which used minibuses to transport service users, were halted due to social distancing rules, and the use of public transport for group activities was prohibited (Welsh Government 2020c).

Restrictions on outdoor activities, which limited outings to once a day, further hindered the ability to deliver outdoor-based interventions (Welsh Government 2020c). For example, shopping trips, which are used to help service users build social skills and confidence, became nearly impossible. Service users expressed heightened anxiety about having to queue outside shops and follow restrictions limiting the number of household members entering at any given time (Mind Cymru 2020). These additional restrictions intensified anxiety for service users who were already struggling with conditions like agoraphobia or social anxiety, making it more challenging for occupational therapists to reintegrate service users into the community (Mind Cymru 2020).

Even when restrictions eased, social distancing measures remained in place, creating further complications for group therapy sessions.

Therapists had to find larger venues to accommodate smaller, socially distanced groups, limiting the number of participants and reducing the effectiveness of group-based interventions such as Recovery Through Activity (Parkinson 2014; RCOT 2020).

Staff Shortages and Service Delivery Delays

The redeployment of occupational therapists to frontline COVID-19 services caused widespread staff shortages in mental health care (Public Health Wales 2021). Those who remained in mental health services faced increased caseloads, making it difficult to provide timely and effective interventions. According to Public Health Wales (2021), wait times for mental health assessments increased significantly during the pandemic, with some service users waiting up to 12 weeks for an initial assessment. This delay in service delivery had a detrimental impact on service users, especially those requiring urgent mental health support (Public Health Wales 2021).

Personal Reflections on the Impact

Reflecting on my own experience during the pandemic, I felt the same isolation and occupational restrictions as many of the service users I was studying. The remote work environment was particularly challenging, cutting me off from clinical settings and limiting my ability to observe and interact with service users, a key component of my research. Balancing the blurred lines between home and work was difficult, especially when my own engagement in meaningful activities like dance and swimming was restricted. Despite writing about the importance of meaningful activities, I found myself struggling to maintain the occupational balance I knew was essential for my mental health.

These personal experiences deepened my understanding of the importance of maintaining occupational balance in the face of restrictions.

When I finally began re-engaging in meaningful activities, the difference between merely existing and truly living became stark. I also saw parallels in the experiences of the service users I researched—many of whom faced similar disruptions to their activities and routines. This reflection not only reinforced the importance of my research on Recovery Through Activity (Parkinson 2014) but also highlighted the resilience needed by both therapists and service users to navigate the pandemic's ongoing impact on mental health.

1.4 Adaptations in the Research Design

1.4.1 Original Research Plan

The initial aim of the research was to evaluate the implementation of Recovery Through Activity (Parkinson 2014) within NHS mental health services through a mixed-methods approach. The original design planned to include four distinct case studies across diverse settings: older adult services, community mental health teams, inpatient settings, and forensic settings. The goal was to capture a comprehensive understanding of Recovery Through Activity's (Parkinson 2014) impact in these environments, employing data collection methods such as in-person interviews, direct observations, and questionnaires. The recruitment strategy intended to include a range of participants, including service users, occupational therapists, and other staff members involved in delivering or facilitating Recovery Through Activity (Parkinson 2014) sessions.

At the outset, the research was structured to closely examine face-to-face Recovery Through Activity (Parkinson 2014) sessions to understand their role in enhancing occupational skills, social engagement, and daily routines among participants. The face-to-face format was crucial to

capturing the nuances of interaction and therapeutic engagement, with plans to observe group dynamics and participants' reactions in real time. The study initially aimed for in-person recruitment and data collection across these settings, with data collected on-site to provide a detailed context of the Recovery Through Activity (Parkinson 2014) delivery and its impact.

1.4.2 Researcher reflection

Reflecting on conducting this research during the COVID-19 pandemic, I found that the timing and context reshaped nearly every facet of the study, revealing both the resilience and vulnerabilities within the NHS health board. Navigating rapid changes—like the shift of Recovery Through Activity (Parkinson 2014) to a virtual format—presented significant challenges, from the technological hurdles therapists faced to the sense of isolation both they and service users felt in remote settings. Personally, working remotely limited my ability to engage fully with participants and gain the clinical exposure critical to my growth as a newly qualified occupational therapist. This experience highlighted the stark contrast between studying occupational engagement and facing restrictions on my own meaningful activities. Ultimately, these challenges highlighted the importance of flexibility and support, shaping my understanding of adaptability in research and practice during unprecedented times.

1.4.3 Key Changes Due to COVID-19

The onset of the COVID-19 pandemic in March 2020 significantly disrupted the original research plan, forcing an immediate and profound re-evaluation of the methods. As the first national lockdown was announced, all in-person research activities had to cease due to safety measures, resulting in an indefinite pause in data collection. This unexpected halt occurred just as the initial phases of recruitment and

data collection were beginning, leading to a significant delay. The original timeline was no longer feasible, and the uncertainty regarding when, or if, in-person research could resume added further complications.

The decision to adapt to virtual methods emerged from necessity. By April 2020, discussions had begun on how to adapt the research design to accommodate the new reality of social distancing and lockdowns. The health board played an instrumental role during this phase, providing guidance and support in exploring remote data collection options. By May 2020, the decision was made to change the focus of the case studies to compare "face-to-face" and "virtual" Recovery Through Activity (Parkinson 2014) delivery, reflecting the changes in service provision during the pandemic. This shift also coincided with the exclusion of older adult services from the research, following confirmation from the health board's local Recovery Through Activity lead that Recovery Through Activity (Parkinson 2014) would not be used in older adult settings during the pandemic. Consequently, the number of case studies was reduced from four to two.

The change in focus required substantial revisions to the data collection methods. Initial plans for in-person recruitment were replaced with digital and remote strategies. Alternative approaches, such as online surveys, telephone interviews, and video interviews via Microsoft Teams, were explored to maintain the breadth and depth of the original design while ensuring participant and researcher safety. The adaptation to virtual data collection methods necessitated amendments to ethical protocols, including changes to consent processes, data security measures, and participant recruitment materials. Obtaining consent remotely required new documents and procedures to ensure participants understood the process and could provide digital consent securely.

1.4.4 Researcher reflection

Reflecting on the use of a case study design in this research, I found Yin's methodology essential for navigating the complex, real-world settings that shaped the implementation of Recovery Through Activity (Parkinson 2014). This approach allowed me to examine the intricate interactions between therapy practices, service user experiences, and contextual influences, particularly through the MOHO (Kielhofner 2008), which provided both structure and depth to the analysis. The flexibility inherent in the case study design was invaluable during the pandemic, as it supported ongoing adjustments to meet evolving realities without losing sight of the study's core aims. The dynamic environment brought its share of challenges, especially in maintaining consistency amidst shifting settings and health board adaptations but collaborating with the health board was vital in keeping the research grounded. Ultimately, the case study design underscored the importance of adaptability and contextual sensitivity in capturing the full scope of occupational therapy in action.

1.4.5 Ethical and Practical Adjustments

Ethical amendments became a recurring necessity throughout the research. Multiple submissions were made to account for changes in data collection methods, including adjustments to data security protocols to protect participants' privacy during virtual sessions. The initial ethical approval did not cover virtual data collection, so substantial modifications were needed to ensure compliance with guidelines. These amendments included a revised consent process to facilitate remote participation, additional privacy agreements, and safeguards for securely storing digital recordings.

Practical adjustments were also critical. With face-to-face sessions suspended, recruitment efforts shifted to virtual environments, utilising emails, digital newsletters, and virtual staff meetings to reach potential

participants. The health board's support was crucial during this transition, as senior staff actively promoted the research through internal communications and virtual events, encouraging occupational therapists and staff to participate. The recruitment strategy focused initially on healthcare staff, who were more accessible through virtual channels, while outreach to service users required more tailored approaches due to digital literacy challenges and varying levels of engagement.

There was a phase during the spring and early summer of 2020 when research activities were largely paused. This was due to both the logistical challenges of transitioning to virtual methods and the need to secure updated ethical approvals. It took approximately six to eight weeks to develop new protocols, pilot virtual consent processes, and test remote data collection methods for feasibility. This period of adaptation was marked by uncertainty, as the ongoing pandemic made it difficult to plan a definitive timeline for resuming full-scale research activities.

1.4.6 Hybrid and Ongoing Adaptations

The gradual easing of restrictions in mid-2021 presented an opportunity to explore hybrid data collection methods, combining virtual and limited in-person engagement under strict safety protocols. This approach aimed to address the accessibility issues encountered during purely virtual recruitment, as some participants, particularly service users, found it challenging to engage digitally. The hybrid model included attending in-person Recovery Through Activity (Parkinson 2014) sessions when safe to do so, allowing direct outreach and facilitating recruitment efforts.

The transition to hybrid methods required further ethical amendments to accommodate flexibility in data collection. New guidelines were developed for safe in-person interactions, and additional protocols ensured that data collection could continue without compromising participants' safety. Recruitment strategies expanded to include more personalised follow-ups,

such as follow-up emails and phone calls to potential participants who had shown initial interest but had not completed the process.

Throughout the research, the health board's continued support was evident. Emails from senior management and ongoing discussions in team meetings helped sustain recruitment momentum, even as the pandemic evolved. The health board also granted access to anonymised outcome data from Recovery Through Activity (Parkinson 2014) sessions, which enriched the quantitative aspects of the analysis. This support was vital, especially during the final push for data collection in 2022, when recruitment was broadened to include participants from previous years to compensate for earlier disruptions.

1.4.7 Justifications for Changes

The move to virtual and hybrid methods was driven by a need to prioritise the safety of participants and the researcher while complying with public health guidelines. The unpredictability of the pandemic meant that service delivery models, including Recovery Through Activity (Parkinson 2014), were continuously evolving, necessitating ongoing adjustments in the research design. Each change in method was justified by the need to maintain research integrity while accommodating the practical realities of the pandemic.

These adaptations allowed the research to continue in a manner that remained inclusive, considering participants' diverse needs, such as different levels of digital access and varying comfort with technology. Ethical and recruitment strategies were regularly updated to reflect these considerations, ensuring the research remained relevant despite the evolving landscape of mental health service delivery during the pandemic.

Ultimately, the revised research approach provided a unique opportunity to compare face-to-face and virtual Recovery Through Activity (Parkinson

2014) delivery, shedding light on the advantages and limitations of each method. While the pandemic forced significant changes to the original research design, it also allowed for an exploration of Recovery Through Activity's (Parkinson 2014) adaptability, potentially offering valuable insights for future practice in mental health settings.

1.5 The Health Board's Adaptations and Challenges

1.5.1 Shifting Service Delivery Models

With the onset of the COVID-19 pandemic in March 2020, the health board had to rapidly restructure its mental health services to adapt to the new realities posed by lockdowns and social distancing measures. Recovery Through Activity (Parkinson 2014), which had previously been delivered in-person, was immediately suspended. The abrupt lockdown prompted a shift in priorities, focusing on essential services and crisis management. Many occupational therapists were redeployed to urgent roles in acute care, significantly reducing the availability of staff for maintaining therapeutic group activities such as Recovery Through Activity (Parkinson 2014). This redeployment, coupled with restrictions on face-to-face contact, led to an indefinite pause in group sessions, directly impacting service users who relied on Recovery Through Activity (Parkinson 2014) for social engagement and skill development.

As lockdown measures continued, the health board began exploring ways to adapt Recovery Through Activity (Parkinson 2014) to a virtual format, starting in April 2020. Planning efforts included identifying suitable digital platforms like Microsoft Teams and considering barriers that could hinder service users' participation, such as limited digital literacy, lack of access

to technology, and privacy concerns. An All-Wales Recovery Through Activity (Parkinson 2014) Task and Finish Group was formed to oversee the development of a structured approach for delivering virtual Recovery Through Activity Parkinson 2014), including creating referral processes, digital privacy guidelines, and outcome measures for evaluating the effectiveness of the new format.

1.5.2 Barriers Encountered by the Health Board

The shift to virtual Recovery Through Activity (Parkinson 2014) was met with several challenges that complicated its implementation. One of the most significant barriers was the digital divide. While virtual Recovery Through Activity (Parkinson 2014) provided a potential way to continue therapeutic services, not all service users had the resources or skills to participate effectively. Many participants did not have access to stable internet connections, digital devices, or even the necessary knowledge to navigate online platforms. This disparity risked excluding vulnerable individuals who were already struggling with isolation, anxiety, or other mental health issues. Despite efforts by the health board to provide guidance and support for accessing the technology, the digital divide remained a persistent challenge throughout the adaptation process.

Staff shortages also presented an ongoing obstacle. The redeployment of occupational therapists to critical roles, coupled with increased staff absences due to COVID-19 illness and burnout, significantly limited the health board's ability to deliver consistent therapeutic activities. Even as planning for virtual Recovery Through Activity (Parkinson 2014) progressed, the availability of staff to facilitate the sessions was inconsistent, leading to temporary suspensions or reduced frequency of group activities, particularly during periods of heightened demand, such as the firebreak lockdown in October 2020. This instability affected the

continuity of care and hampered efforts to sustain engagement among participants.

Technological limitations added further complexity to the adaptation process. Early trials of virtual Recovery Through Activity indicated that some participants struggled to engage due to unfamiliarity with digital tools or anxiety about online interactions. There were also concerns about maintaining confidentiality and privacy during virtual sessions, especially when discussing sensitive mental health topics. In response, the health board implemented measures to address these issues, such as secure log-in processes, online etiquette guidelines, and enhanced data protection protocols. However, these safeguards did not completely alleviate concerns, and some participants remained hesitant to engage fully in virtual group activities.

The virtual implementation also faced challenges related to participant engagement. Unlike in-person sessions, where therapists could easily adjust activities based on group dynamics, virtual Recovery Through Activity (Parkinson 2014) required more structured formats to maintain participants' attention. Initial feedback from service users indicated difficulties with staying engaged during longer sessions and a lack of spontaneous social interactions that characterised in-person groups. Efforts were made to incorporate shorter, more interactive sessions, such as quizzes and themed discussions, but maintaining a sense of community remained a challenge, as some participants felt the virtual format could not fully replicate the social benefits of face-to-face sessions.

1.5.3 Virtual Implementation of Recovery Through Activity as a Solution

Despite these challenges, the transition to virtual Recovery Through Activity (Parkinson 2014) offered a crucial solution for maintaining therapeutic support during a time when in-person services were

restricted. By July 2020, the health board launched the first virtual Recovery Through Activity (Parkinson 2014) sessions, incorporating elements such as pre-recorded videos, online group discussions, and interactive activities designed to replicate the core components of in-person therapy. The virtual sessions provided an accessible option for many service users, enabling them to receive support from the safety of their own homes and reducing barriers associated with travel or mobility issues.

The virtual implementation also allowed for greater flexibility in service delivery, with the potential to reach participants who may have struggled to attend in-person sessions due to geographical or logistical limitations. The health board continued to refine the virtual approach based on participant feedback, making ongoing modifications to improve the digital experience and foster a sense of connectedness among group members. Planning for a hybrid model began in early 2021, combining in-person and virtual options to accommodate diverse needs and preferences. This hybrid approach aimed to maximise the accessibility of Recovery Through Activity (Parkinson 2014), offering a choice between face-to-face interaction and virtual participation.

1.5.4 Continued Challenges and Adaptations

Throughout the latter half of 2020 and into 2021, the health board faced ongoing challenges in sustaining virtual Recovery Through Activity (Parkinson 2014). Staffing shortages persisted, exacerbated by the demands of the pandemic and the redeployment of occupational therapists to acute settings. As a result, some regions experienced disruptions or temporary pauses in group activities, impacting the consistency of service delivery. Additionally, the hybrid model introduced in mid-2021 required careful logistical planning to comply with safety

protocols, including social distancing, suitable venue selection, and managing fluctuating attendance.

The digital format continued to present engagement challenges. Although modifications were made to incorporate more interactive elements, some participants expressed that the virtual sessions still lacked the depth and immediacy of face-to-face group therapy. The health board's ongoing efforts to address these concerns included securing funding from the Welsh Government to develop resource packs that complemented the virtual sessions. These packs contained materials related to occupational identity, coping strategies, and skill development, providing tangible tools for participants to use at home and helping bridge the gap between digital and physical engagement.

1.5.5 Researcher reflection

Reflecting on my collaboration with the NHS Health Board during this research, I gained a deep appreciation for the insights that direct interaction with occupational therapists and support workers offered, particularly before COVID-19 restrictions. The initial support from the Research and Development team was invaluable in shaping my approach, yet recruitment proved challenging. Limited visibility and the reliance on busy health board staff to disseminate recruitment materials underscored the need for more active engagement strategies. Restricted access to case data highlighted the operational complexities of working within health board protocols. Attending the All Wales Drivers meetings was an insightful experience, providing a unique view into how Recovery Through Activity was adapted for virtual delivery. Although confidentiality limitations prevented me from fully utilising meeting records, these interactions enriched my understanding of the dynamic adjustments required within healthcare settings. Overall, this collaboration was both

challenging and enlightening, strengthening my adaptability and respect for the intricate processes at play in healthcare research.

1.5.6 Conclusion

The health board's experience of adapting Recovery Through Activity during the COVID-19 pandemic highlights both the resilience and limitations of mental health service adaptations in times of crisis. While virtual Recovery Through Activity (Parkinson 2014) emerged as a necessary solution for maintaining therapeutic services, it was not without significant barriers. Technological limitations, staff shortages, digital access disparities, and fluctuating participant engagement posed ongoing challenges that required continuous adjustment and innovative approaches. The introduction of a hybrid model in 2021 represented a significant step toward addressing diverse needs and improving accessibility, allowing the health board to provide a more flexible and comprehensive approach to therapeutic support during an unprecedented period of disruption.

1.6 Why the Research Remained Crucial

Despite the considerable disruptions caused by the COVID-19 pandemic, the importance of researching the adaptations of Recovery Through Activity (Parkinson 2014) within occupational therapy remained vital. The pandemic significantly altered how mental health services were delivered, with social distancing measures and lockdowns forcing a rapid pivot away from traditional in-person approaches. This research offered crucial insights into how therapeutic interventions, such as Recovery Through Activity (Parkinson 2014), could be effectively adapted to virtual and hybrid formats during a time of crisis. It highlighted both the strengths and limitations of digital approaches in maintaining therapeutic support,

providing valuable lessons for future service delivery and crisis response planning.

The urgency to adapt occupational therapy services became clear early in the pandemic. With face-to-face services abruptly halted in March 2020, there was an immediate need to find alternative ways to support individuals experiencing mental health challenges. The transition to virtual Recovery Through Activity (Parkinson 2014), although fraught with barriers, provided an essential means of maintaining some level of therapeutic engagement during a time when isolation, anxiety, and stress were escalating. This research remained crucial as it documented the processes, challenges, and innovations involved in delivering virtual occupational therapy, offering a framework for adapting services in future crises, whether they be health-related or otherwise.

Moreover, the research played a key role in exploring the evolving nature of therapeutic needs and service accessibility during the pandemic. With in-person services unavailable, understanding how individuals responded to virtual interventions provided valuable insights into how digital formats could be used to complement traditional face-to-face therapy, even beyond the pandemic context. For some participants, virtual Recovery Through Activity (Parkinson 2014) offered greater flexibility, reducing barriers associated with travel, mobility issues, or geographical location. This shift opened up new possibilities for occupational therapy service delivery that could extend beyond the immediate response to COVID-19, potentially transforming how mental health support is accessed and delivered in the long term.

1.6.1 Understanding the Virtual Implementation of Recovery Through Activity

The implementation of virtual Recovery Through Activity (Parkinson 2014) during the pandemic was not merely a stopgap measure but an

opportunity to rethink how occupational therapy could be delivered under restrictive conditions. This research has highlighted the complexities involved in adapting therapeutic activities to a digital format, including challenges related to participant engagement, technological limitations, and the digital divide. It also emphasised the potential benefits of virtual Recovery Through Activity (Parkinson 2014), such as increased flexibility in service delivery and the ability to continue providing support during periods of disruption. By systematically documenting the shift to virtual Recovery Through Activity (Parkinson 2014), this research has contributed to a growing body of knowledge on how occupational therapy services can be resilient and adaptable in times of crisis.

The ongoing disruptions caused by COVID-19 underscored the necessity of understanding virtual therapy delivery in real-world contexts. As new waves of the virus emerged and restrictions fluctuated, the research provided timely insights into how service adaptations could be sustained and optimised. The findings emphasised that while virtual Recovery Through Activity (Parkinson 2014) could not entirely replicate the experience of in-person sessions, it could still provide meaningful support, especially when adapted to include interactive elements and tangible resources like activity packs. These adaptations helped bridge some of the gaps associated with digital therapy, making the virtual implementation a viable option for reaching service users who might otherwise have been left unsupported during the pandemic.

The research also shed light on the limitations of virtual occupational therapy, which were important to acknowledge for realistic service planning. The challenges faced by participants, such as digital fatigue, anxiety about using online platforms, and difficulties engaging in a virtual format, highlighted the need for ongoing refinement and customisation of digital interventions. This was particularly relevant for service users with lower digital literacy or those experiencing significant mental health

challenges, who may require additional support to benefit from virtual therapy. Documenting these limitations was essential, as it informed not only the adaptation of Recovery Through Activity (Parkinson 2014) during the pandemic but also the future design of digital occupational therapy interventions, ensuring that they are inclusive and accessible.

1.6.2 The Role of occupational therapy in Crisis Adaptation

Occupational therapy is uniquely positioned to play a key role in adapting mental health services during crises due to its holistic approach to well-being, which encompasses not only symptom management but also social engagement, routine development, and skill-building. This research demonstrated how Recovery Through Activity (Parkinson 2014), a core therapeutic intervention within occupational therapy, could be adapted to meet the evolving needs of service users during the pandemic. The ability to pivot to virtual methods highlighted the profession's flexibility and resourcefulness, emphasising the value of occupational therapy in managing the broader psychosocial impacts of crises.

The findings from this research provided practical guidance for occupational therapists on how to deliver effective virtual therapy, offering strategies for maintaining engagement, addressing digital access barriers, and adapting activities for online formats. By showcasing how Recovery Through Activity (Parkinson 2014) could continue to deliver therapeutic benefits despite significant service disruptions, the research underscored the importance of occupational therapy in crisis response and recovery. It illustrated that with the right adaptations, therapeutic interventions could be delivered in a way that was not only safe but also meaningful and supportive.

1.6.3 Researcher reflection

Reflecting on my PhD journey through the pandemic, I found the experience both deeply challenging and enriching. The isolation and blurred boundaries of working from home tested my resilience, yet my passion for occupational therapy, particularly Recovery Through Activity, kept me motivated. Remembering the benefits I had seen firsthand in my previous NHS roles—how meaningful activities could enhance engagement and well-being—reinforced my commitment to this research. This journey taught me invaluable lessons about adaptability and balance, highlighting the impact that well-implemented therapeutic activities can have on people's lives.

1.6.4 Conclusion

The significance of this research extended beyond the immediate response to COVID-19, providing a blueprint for how occupational therapy services could adapt to future challenges. The insights gained from the virtual implementation of Recovery Through Activity (Parkinson 2014) during the pandemic contributed to a broader understanding of how therapeutic support can be sustained in times of crisis, particularly when traditional service delivery models are no longer feasible. By documenting the processes, challenges, and successes associated with adapting Recovery Through Activity (Parkinson 2014), this research highlighted the resilience of occupational therapy as a profession and its crucial role in supporting mental health during periods of upheaval.

1.7 Timeline

1.8 Pre-COVID (Pre-2020)

Before the pandemic, Recovery Through Activity (Parkinson 2014) was routinely delivered across various settings, including forensic and community mental health environments. Sessions focused on helping participants develop occupational skills, routines, and social engagement. Groups ran several times annually, tailored to specific settings, with high levels of face-to-face interaction.

The study initially aimed to evaluate Recovery Through Activity (Parkinson 2014) implementation across four different settings: older adult services, community mental health teams, inpatient settings, and forensic settings. The goal was to collect data using a mixed-methods approach, including in-person interviews, observations, and questionnaires.

Recruitment was intended to include service users, occupational therapists and staff who participated in or facilitated Recovery Through Activity (Parkinson 2014) sessions.

Older adult services were initially a part of the study, as Recovery Through Activity (Parkinson 2014) was used in those settings before the pandemic.

1.9 1. First Lockdown (March 2020)

On March 23rd, 2020, Prime Minister Boris Johnson ordered the first national lockdown in response to the escalating COVID-19 crisis. This was a significant moment in public health history, as people were required to remain at home except for essential reasons, such as buying food, medical needs, or one hour of daily outdoor exercise. Schools, non-essential retail, pubs, restaurants, and entertainment venues were closed,

marking it the most severe restrictions on public life in living memory. Headlines such as "UK in Lockdown: Schools Shut, Shops Closed" (BBC News, 23 March 2020) and "Britain Goes into Lockdown to Combat Coronavirus Spread" (The Guardian, 24 March 2020) reflected the shock and gravity of the situation.

In Wales, these restrictions were even more stringent. Outdoor exercise was limited to one hour per day, and travel was restricted to local areas. Non-essential businesses, including garden centres and smaller retail outlets, remained closed longer than in England, demonstrating the Welsh Government's more cautious approach (BBC News, 25 March 2020). This period was characterised by uncertainty and confusion as residents tried to adapt to the new rules.

NHS services in South Wales quickly restructured to manage the surge in COVID-19 cases. By April 2020, 164 critical care beds were occupied by COVID-19 patients, with hospitals forced to delay non-essential surgeries and outpatient services (Welsh Government 2020). Cardiff hospitals reached near-full capacity, prompting headlines such as "Hospitals Brace for COVID-19 Surge: Non-Essential Surgeries Cancelled" (Wales Online, 15 April 2020), illustrating the enormous pressure on healthcare systems in the region.

The mental health impact of the first lockdown was immediate and severe. In Cardiff and surrounding areas, the demand for mental health crisis services increased by 50%, as isolation, financial insecurity, and anxiety about the virus took their toll (Mind Cymru 2020). Nationwide, 30% of people in Wales reported experiencing severe anxiety, a figure that highlights the mental strain of the pandemic (Mind Cymru 2020). Headlines like "Mental Health Crisis Grows as Lockdown Drags On" (Wales Online, 25 April 2020) underscored the growing psychological burden on the population.

By mid-April, over 1,000 deaths were recorded in South Wales, many of them occurring in care homes, where vulnerable residents were particularly susceptible to the virus. Cardiff and the Vale were especially hard hit, with care facilities bearing the brunt of the pandemic. Headlines such as "South Wales Sees Spike in COVID Deaths, Care Homes Hardest Hit" (The Guardian, 15 April 2020) reflected the escalating mortality rates.

1.9.1 Health Board Adaptations:

Abrupt Cessation of In-Person Groups: All Recovery Through Activity (Parkinson 2014) groups were immediately halted due to lockdown measures. Therapists quickly transitioned to crisis management, focusing on essential services, supporting patients in urgent need, and responding to the rapidly changing health landscape. Group sessions, which relied heavily on face-to-face engagement, were considered unsafe under new public health guidelines.

Staff Reallocation and Remote Work: Many occupational therapists were redeployed to other essential roles, impacting the availability to maintain group therapy services. Therapists also began working remotely, introducing new logistical challenges such as managing remote caseloads and finding ways to engage service users without in-person contact.

1.9.2 Research Adjustments (March 2020):

Immediate Impact of Lockdowns: When the first lockdown began in March 2020, all in-person research activities had to stop. Lockdowns disrupted access to research sites and limited participant recruitment to remote methods. This resulted in significant delays, as the original timeline for recruitment and data collection was no longer feasible due to restricted access to healthcare settings. The Health Board informed the researcher that older adult mental health services would not be using

Recovery Through Activity (Parkinson 2014) during the pandemic, leading to the exclusion of this setting from the research. As a result, the case studies were reduced from four to two.

Changes in Case Study Focus: The original case studies, which focused on different Recovery Through Activity (Parkinson 2014) settings, were replaced with a comparison of "face-to-face" and "virtual" Recovery Through Activity (Parkinson 2014) to reflect the shift in service delivery during the pandemic.

Health Board Support: The health board began assisting by exploring options for continuing research safely, initiating discussions on possible remote data collection methods.

1.10 2. First Easing of Restrictions (May–June 2020)

As the first wave of the pandemic began to recede, the UK government cautiously moved towards easing restrictions in May and June 2020. England allowed people to exercise more than once a day, and outdoor spaces like parks began to reopen. Non-essential retailers resumed operations in June, albeit with strict social distancing measures in place. However, there was public frustration at the ongoing restrictions, which was evident in headlines like “Lockdown Restrictions Ease But Social Distancing Remains” (The Telegraph, 10 June 2020).

Wales took a more measured approach to easing restrictions. Non-essential retail reopened on June 22nd 2020, and social gatherings were still restricted to outdoor meetings between two households (Welsh Government 2020). This cautious reopening led to confusion and concern

among the public, as captured in “Wales Reopens Shops as Public Cautious About Safety” (BBC News, 23 June 2020).

Despite the gradual easing, the NHS in South Wales continued to struggle with high patient numbers. Hospitals in Cardiff were still operating at near capacity due to a backlog of non-COVID treatments, with long waiting lists for elective surgeries (Welsh Government 2020). Media coverage reflected this ongoing strain: “NHS Faces Uphill Battle to Clear Surgery Backlog” (Wales Online, 28 June 2020).

The psychological toll of the pandemic persisted during this period. Mental health services across South Wales reported a 30% increase in crisis referrals, as anxiety and economic uncertainty continued to affect residents (Mind Cymru 2020). Headlines such as “Anxiety High as Economic Uncertainty Lingers” (Wales Online, 15 June 2020) highlighted the long-lasting emotional and psychological challenges.

The death toll in South Wales continued to rise, particularly among older adults and those with pre-existing health conditions. By June, over 2,500 deaths had been recorded in the region, with care homes remaining highly vulnerable to outbreaks (Public Health Wales 2020). Reports such as “Wales Records 2,500 COVID Deaths as Lockdown Eases” (BBC News, 29 June 2020) painted a sombre picture of the ongoing crisis.

1.10.1 Health Board Adaptations (April–July 2020):

Planning for Virtual Transition: During this period, therapists spent approximately 6-8 weeks planning a transition to virtual Recovery Through Activity (Parkinson 2014) sessions. They explored digital platforms like Microsoft Teams and assessed service users' digital access and familiarity with technology. Challenges included addressing the digital divide, ensuring privacy, and overcoming users' limited internet access or digital skills.

No Active Recovery Through Activity (Parkinson 2014) Groups During Planning: Throughout this planning phase, Recovery Through Activity (Parkinson 2014) groups remained on hold as efforts concentrated on developing a virtual format to replicate the benefits of in-person sessions.

1.10.2 Research Adjustments (April – June 2020):

Exploring Alternative Data Collection Methods: The researcher explored different virtual and remote data collection methods, including online surveys, telephone interviews, and video interviews via Microsoft Teams, to ensure the study could continue despite pandemic restrictions. Ethical protocols were amended to reflect the shift to virtual data collection, with new documents prepared to secure digital consent from participants.

Development of Digital Recruitment Strategies: Recruitment moved to online channels, including emails, virtual staff meetings, and digital flyers. The health board supported these efforts by promoting the research through internal communications and newsletters.

Pilot Testing Virtual Methods: Initial testing of remote data collection methods was conducted to assess feasibility, including testing virtual consent processes and refining interview questions for online settings.

Ethics Submissions and Approvals: Multiple amendments to ethical approval were submitted to accommodate new data collection methods, which included updates to the consent process, data security protocols, and recruitment materials.

1.11 3. Firebreak Lockdown (October 2020)

In response to rising COVID-19 cases in the autumn of 2020, Wales implemented a 17-day firebreak lockdown from October 23 to November 9 2020. This temporary lockdown saw the closure of non-essential retail and restrictions on travel, designed to curb the spread of the virus ahead of the expected winter surge (Welsh Government 2020). Headlines such as "Wales Locks Down Again: Firebreak Aims to Halt COVID-19 Spread" (The Independent, 23 October 2020) conveyed the gravity of the situation.

Hospitals in South Wales, particularly those in Cardiff and nearby areas, faced renewed pressure. By October, 2,800 hospital beds were occupied by COVID-19 patients, pushing hospitals to the brink (Welsh Government 2020). Elective procedures were postponed once again as hospitals converted wards into COVID-19 treatment units. The strain was evident in headlines like "Hospitals Near Capacity as Second Wave Hits South Wales" (Wales Online, 28 October 2020).

The firebreak lockdown also worsened mental health issues. South Wales experienced an 88% increase in calls to mental health crisis helplines, driven by loneliness, economic uncertainty, and the stress of the ongoing pandemic (Mind Cymru 2020). Media reports such as "Mental Health Crisis Looms as Lockdown Returns" (The Guardian, 1 November 2020) captured the severity of the situation.

By November, the death toll in South Wales had risen to over 3,000, with many fatalities concentrated in Cardiff and the surrounding areas. Care homes once again experienced outbreaks, contributing to the rising death rate. Headlines like "COVID Death Toll in South Wales Rises to 3,000

During Firebreak" (BBC News, 9 November 2020) reflected the ongoing struggle against the virus in the region.

1.11.1 Health Board Adaptations (August–October 2020):

All-Wales Recovery Through Activity (Parkinson 2014) Task and Finish Group Initiatives: The task group formalised processes for virtual Recovery Through Activity (Parkinson 2014) delivery, including developing a flowchart for group referrals and using structured questionnaires to assess digital access. Early testing of virtual program elements involved pre-recorded videos, interactive tools, and feedback to identify resource accessibility and improve user experience.

Temporary Service Pause During Firebreak: The 17-day lockdown in October caused a brief pause in some Recovery Through Activity (Parkinson 2014) services as therapists balanced remote working and crisis response.

1.11.2 Research Adjustments (June – October 2020):

Amended Timeline: The project timeline was extended to account for delays in adapting the research to virtual formats and securing ethical approval for amended protocols. Recruitment timelines were modified to reflect the extended period needed for remote recruitment and ongoing COVID-19 impacts on service users and staff.

Revised Recruitment Strategy:

Recruitment of service users was challenging which may have been due to digital access issues and limited engagement during the pandemic. Telephone interviews were offered as an alternative for participants struggling with online platforms.

Support from the Health Board:

The health board helped promote the research, sending emails to occupational therapists and mental health teams. Senior staff also raised awareness during team meetings.

Access to virtual staff meetings and face-to-face Recovery Through Activity (Parkinson 2014) sessions was granted, allowing the researcher to promote the study directly to potential participants.

1.12 4. Winter Lockdown (December 2020–March 2021)

As a new, more transmissible variant of COVID-19 spread rapidly in late 2020, the UK government introduced a third national lockdown in December 2020. This lockdown was more stringent than previous ones, with schools closed and non-essential retail, hospitality, and entertainment venues shuttered until March 2021 (Public Health England 2020). Headlines like "Christmas Cancelled as UK Enters Third Lockdown" (The Guardian 20 December 2020) reflected the public's growing frustration.

Wales entered Alert Level 4 on December 20th 2020, implementing similar restrictions. Schools remained closed, and household mixing was prohibited except for support bubbles (Welsh Government 2020). The severity of the situation was highlighted by headlines like "Wales Locks Down After Variant Emerges" (BBC News 20 December 2020).

During the winter months, South Wales hospitals faced unprecedented pressure. By January 2021, 2,049 hospital beds were filled with COVID-19 patients, representing 26% of the region's total hospital capacity (Welsh

Government 2021). Headlines such as “South Wales Hospitals Overwhelmed as COVID-19 Cases Soar” (Wales Online, 18 January 2021) highlighted the immense strain on healthcare services.

The winter lockdown also exacerbated the mental health crisis. Healthcare workers, in particular, reported significant burnout, with 50% experiencing stress and anxiety due to the relentless pressure (Mind Cymru 2021). South Wales saw a significant increase in demand for mental health services, with many struggling due to the ongoing isolation, financial uncertainty, and fear of the virus. By the end of the winter lockdown, mental health services reported a 50% rise in crisis calls, as both healthcare workers and the general population faced increased psychological pressures (Mind Cymru 2021). Headlines like “Mental Health Crisis Deepens in South Wales as Lockdown Strain Grows” (Wales Online 20 February 2021) captured the severity of this growing issue.

The region's death toll continued to climb during the winter lockdown. By March 2021, South Wales had recorded over 5,500 deaths, with Cardiff and nearby areas hardest hit (Public Health Wales 2021). Many of these deaths were linked to outbreaks in care homes and delayed access to critical care due to the overwhelming strain on hospitals. The scale of the crisis was reflected in headlines such as “South Wales Sees Highest COVID Death Toll in Wales Amid New Variant Surge” (The Guardian, 2 March 2021).

1.12.1 Health Board Adaptations (November 2020–February 2021):

Development of Guidelines and Securing Funding: The health board worked on outcome measures, group behaviour guidelines, and privacy agreements for virtual Recovery Through Activity (Parkinson 2014) groups. Funding from the Welsh Government enabled the creation of

resource packs for virtual and 1:1 sessions, focusing on themes like coping strategies and occupational identity.

Pushback of Virtual Launch: The launch of virtual Recovery Through Activity (Parkinson 2014) groups was delayed to early March 2021 to accommodate participant recruitment and finalise resource packs.

Staffing Challenges: Continued pressure from COVID-19 exacerbated staffing shortages, affecting the ability to deliver services consistently.

1.12.2 Research Adjustments (November 2020 – March 2021):

Launching the Virtual Recruitment and Data Collection Phase: Virtual recruitment began in November 2020, targeting occupational therapists involved in Recovery Through Activity (Parkinson 2014) programs. Participants were recruited through email invitations, digital newsletters, and virtual staff meetings. A virtual consent process was implemented to ensure secure electronic consent. Easy-to-understand guides were developed for participants to navigate virtual interviews and digital consent forms.

First Virtual Data Collection Activities: Initial virtual interviews commenced in late 2020, focusing on staff experiences of adapting Recovery Through Activity (Parkinson 2014) during the pandemic. Interviews captured changes in service delivery, challenges faced, and innovative solutions implemented by occupational therapists.

Ethical Amendments and Ongoing Pilot Testing: Additional ethical amendments were submitted to accommodate remote data collection challenges, including data security adjustments and flexible approaches to

virtual consent. Pilot testing continued, refining interview formats and data collection methods based on participant feedback.

Health Board Support for Recruitment: Senior management within the health board continued to promote the study, sending reminders and raising awareness during team meetings.

1.13 5. Gradual Easing of Restrictions (Spring 2021)

As the UK's vaccination program gained momentum, the government began easing restrictions in April 2021. On April 12th 2021, non-essential retail and outdoor hospitality reopened, marking the beginning of a return to normalcy (Public Health England 2021). Schools also resumed in-person teaching, and small outdoor gatherings were permitted. Headlines such as "UK Reopens as Vaccination Rollout Accelerates" (The Guardian, 12 April 2021) captured the cautious optimism of this phase.

Wales adopted a similar approach, with non-essential retail and outdoor hospitality reopening on the same day. Travel within Wales was once again allowed, and schools fully reopened. This cautious approach to reopening was reflected in headlines like "Wales Begins Cautious Reopening as COVID Cases Fall" (BBC News, 12 April 2021).

However, despite these positive developments, South Wales hospitals continued to operate under significant strain. The backlog of non-COVID treatments remained a major issue, with hospitals across the region struggling to meet the demand for postponed surgeries. Media reports like "South Wales NHS Faces Uphill Battle to Clear Treatment Backlog"

(Wales Online, 18 April 2021) highlighted the ongoing challenges faced by the healthcare system.

The psychological toll of the pandemic remained profound. Even as restrictions eased, 75% of people with pre-existing mental health conditions reported worsening symptoms, reflecting the long-term emotional effects of the pandemic (Mind Cymru 2021). Headlines like "Mental Health Woes Persist Despite Easing of Lockdown" (Wales Online, 27 April 2021) highlighted the ongoing struggle to address the population's mental health needs.

By mid-2021, South Wales had recorded over 5,500 deaths, with Cardiff and surrounding areas being the hardest hit. This grim milestone was reflected in headlines such as "Death Toll in South Wales Reaches 5,500 as Lockdown Eases" (Wales Online, 30 May 2021).

1.13.1 Health Board Adaptations (March 8 2021 – July 2021):

Virtual Recovery Through Activity (Parkinson 2014) Groups Officially Launched on March 8th 2021: Virtual sessions began with activities focused on mental health management and skill development. Sessions used interactive elements such as pre-recorded videos, discussions, quizzes, and themed activities to replicate aspects of in-person group dynamics.

Hybrid Model Planning: As restrictions eased, preparations began for a hybrid model integrating both in-person and virtual options, catering to participants unable to attend virtual sessions or preferring face-to-face interaction.

Use of Microsoft Teams: Teams became the main tool for managing resources, sharing documents, and coordinating activities across different regions.

1.13.2 Research Adjustments (April – December 2021):

Hybrid Methods Introduced: With easing restrictions, hybrid data collection was considered, allowing some in-person data collection while still prioritising virtual methods. Hybrid methods aimed to improve accessibility for participants who struggled with digital platforms. Opportunities for in-person engagement included attending Recovery Through Activity (Parkinson 2014) sessions when possible, enabling direct outreach to potential participants.

Adjusting Participant Follow-Up Strategies: Follow-up strategies were intensified, including personalised outreach to participants who had shown initial interest but had not yet joined the study. Recruitment efforts expanded to include both service users and staff who could provide insights into the changes in Recovery Through Activity (Parkinson 2014) delivery due to the pandemic.

Project Extensions: A formal extension was requested to account for the disruptions caused by COVID-19, allowing data collection to continue through the end of 2022.

1.14 6. NHS COVID Pass (October 2021)

As the pandemic continued, the Welsh Government introduced the NHS COVID Pass on October 11th 2021. This pass, which required proof of vaccination or a negative test for entry into nightclubs and large events, aimed to curb the potential resurgence of COVID-19 during the winter

months (Welsh Government 2021). The introduction of the COVID pass was met with mixed reactions, as reflected in headlines like "COVID Pass Now Needed for Large Events and Nightclubs in Wales" (BBC News, 11 October 2021).

While the COVID pass helped to mitigate some pressures on hospitals by reducing the number of severe cases, South Wales hospitals continued to grapple with the backlog of non-COVID treatments. Staff shortages and delays in elective surgeries remained significant challenges, as reported in headlines like "South Wales Hospitals Still Reeling from COVID Fallout, Struggling with Backlogs" (Wales Online, 25 October 2021).

The mental health services in South Wales, particularly for children and young people, faced ongoing pressure. By the end of 2021, 40% of young people in Wales were experiencing mental health challenges due to the prolonged isolation and educational disruptions (Mind Cymru 2021). The continued mental health crisis was reflected in headlines such as "Young People Facing Mental Health Crisis Post-Lockdown" (Wales Online, 22 October 2021).

By the end of 2021, the death toll in South Wales had surpassed 6,000, with the bulk of fatalities occurring earlier in the pandemic (Public Health Wales 2021). Cardiff and the Vale remained among the hardest-hit areas, as reflected in reports such as "South Wales COVID Death Toll Rises to 6,000 as Cases Continue" (BBC News, 15 December 2021).

1.14.1 Health Board Adaptations (July–December 2021):

Adjustment of Virtual Program Based on Feedback: Virtual group formats were refined to make sessions more interactive and shorter, addressing digital fatigue. Feedback led to ongoing adjustments in session length and content to better accommodate participants.

Staffing and Capacity Issues: Regions faced staffing shortages, which impacted the frequency and availability of group sessions. The ongoing COVID-19 pressures resulted in the temporary suspension of some virtual Recovery Through Activity (Parkinson 2014) groups.

1.14.2 Research Adjustments (January – December 2022):

Last Push for Data Collection: The focus was on maximising participant recruitment through various methods, including direct outreach at virtual Recovery Through Activity (Parkinson 2014) sessions, personalised follow-ups, and in-person visits where feasible. Recruitment was broadened to include participants from past years to expand the potential pool of service users, considering pandemic-related recruitment challenges.

Extensions and Data Analysis Preparations: An extension was requested to allow for thorough data analysis. The health board provided anonymised outcome data from Recovery Through Activity (Parkinson 2014) sessions, which contributed quantitative data for analysis.

Health Board Support in Final Phase: Senior health board staff continued to advocate for participation, sending reminders and promoting the research during team meetings. This support was crucial for the final recruitment phase.

1.15 7. End of Legal Restrictions (March 2022)

On March 28 2022, the UK government lifted most remaining COVID-19 restrictions as part of its "living with COVID" strategy. The responsibility for managing the virus shifted to individuals, with vaccinations and

personal precautions seen as the primary tools for protecting public health. Face masks were no longer legally required in most settings, although they remained recommended in healthcare environments (Public Health England 2022). Headlines like “Living with COVID: UK Ends Restrictions, but Concerns Remain” (The Guardian, 28 March 2022) reflected both relief and ongoing caution.

Wales followed suit, lifting most legal restrictions on the same date, though mask mandates in healthcare settings remained in place until May 2022 (Welsh Government 2022). The media reflected Wales' cautious approach, with headlines like “Wales Ends Most COVID Restrictions, Masks Still Required in Healthcare” (BBC News, 28 March 2022).

Despite the lifting of legal restrictions, South Wales hospitals continued to face significant challenges in addressing the backlog of non-COVID treatments. The ongoing staff shortages and burnout among healthcare workers exacerbated the strain on services. This was highlighted in media reports such as “South Wales NHS Struggles to Clear Backlog as Restrictions End” (Wales Online, 30 March 2022).

By mid-2022, South Wales had recorded over 7,500 deaths related to COVID-19. Although the number of fatalities had significantly decreased, the long-term impact of the pandemic continued to affect communities in the region (Public Health Wales 2022). Headlines such as “South Wales COVID Death Toll Tops 7,500, But Virus Still Lingers” (BBC News, 30 June 2022) reflected the ongoing challenges.

1.15.1 Health Board Adaptations (January 2022 – July 2022):

Temporary Suspension and Restart of Groups: COVID-19 outbreaks in clinical settings like Talygarn led to the postponement of group

activities. The health board aimed to restart face-to-face groups in February 2022 while maintaining virtual options.

Continued Hybrid and Virtual Programs: By mid-2022, hybrid and virtual Recovery Through Activity (Parkinson 2014) groups were operational across regions, catering to various needs. Ongoing improvements were made to Teams-based resources for better administration and participant engagement.

Emphasis on Teams-Based Coordination: Efforts to streamline documentation, feedback tools, and participant resources on Teams continued to support the administration of Recovery Through Activity (Parkinson 2014) effectively.

1.15.2 Research Adjustments and Justifications for Changes:

Continual Ethical and Recruitment Strategy Adaptations: Ethical and recruitment strategies were continuously adjusted to account for participants' diverse needs, including varying levels of digital access, comfort with technology, and engagement willingness during a challenging period.

1.16 Conclusion

The COVID-19 pandemic brought about unprecedented challenges that profoundly influenced the design, implementation, and outcomes of this research. Initially conceived to evaluate Recovery Through Activity (Parkinson 2014) within traditional, in-person settings across multiple service environments, the study had to adapt dramatically due to the

health crisis. As lockdown measures were implemented and face-to-face services ceased, the original research plan became untenable. These constraints necessitated a shift in focus towards understanding the virtual implementation of Recovery Through Activity (Parkinson 2014), as well as an exploration of the adaptive strategies employed by the health board in delivering occupational therapy under drastically changed circumstances.

The need to quickly adjust the research design to a virtual model was not without difficulties. The transition highlighted ethical and practical considerations that had to be addressed, including digital consent processes, data security, and participant recruitment under restrictive conditions. With the exclusion of older adult services due to the health board's decision not to use Recovery Through Activity (Parkinson 2014) in that setting during the pandemic, the research was further refined to focus on two case studies: comparing face-to-face and virtual Recovery Through Activity (Parkinson 2014). This shift required a reconsideration of data collection strategies and an extended timeline to accommodate the evolving situation, demonstrating the research's adaptability and resilience in response to external pressures.

The health board's adaptations to service delivery played a significant role in shaping the research context. The interruption of in-person group activities, redeployment of staff, and shift towards remote working meant that the usual methods of occupational therapy delivery were no longer feasible. These changes highlighted the challenges faced by healthcare services in maintaining therapeutic support during a crisis, including technology limitations, staffing shortages, and the need to engage service users through unfamiliar digital platforms. The health board's efforts to implement virtual Recovery Through Activity (Parkinson 2014) not only provided an alternative means of support but also served as a case study for understanding how occupational therapy can adapt in times of crisis.

Despite the disruptions, the research remained highly relevant, as it provided valuable insights into the capacity of occupational therapy to adapt to evolving service needs and delivery methods during a global crisis. It offered a critical evaluation of how virtual Recovery Through Activity (Parkinson 2014) was implemented and identified areas where future adaptations could be made to ensure service continuity and accessibility. The documentation of these adaptations highlighted the role of occupational therapy as a flexible and responsive field, capable of addressing the complex needs arising from crises such as the COVID-19 pandemic.

This introduction has set the stage for the subsequent chapters by illustrating the multifaceted impact of the pandemic on both the research and the health board’s services. The chapters that follow will delve deeper into the adaptations in research design, the health board’s service delivery changes, and the implications for occupational therapy practice in times of crisis. Through this exploration, the thesis provides a comprehensive understanding of how Recovery Through Activity (Parkinson 2014), as a therapeutic intervention, evolved during the pandemic and the broader lessons learned for occupational therapy's role in supporting mental health and well-being in challenging circumstances.

Chapter 2 – Recovery Oriented approaches and occupational Therapy

2.1 Introduction

This second chapter situates the research within the surrounding literature. It provides an overview of mental health, its impacts on physical health, and the associated financial implications. The chapter then discusses the Recovery-Oriented approach in relation to mental health and its connection to occupational therapy. To further contextualise the research, a definition of occupational science and activity-focused interventions is provided, followed by an explanation of Recovery Through Activity (Parkinson 2014).

This research is situated within a bounded relativist ontology (Guba and Lincoln 1994), subjectivist epistemology (Foley 1987) and interpretivist theoretical perspective (Weber 1978). The research comes from the view that individuals construct their own mental construct of reality and create meaning which they place on an occupation. This is discussed further in chapter 2.

This study takes a case study research design and comprises of two case studies. The first case study explores how Recovery Through Activity (Parkinson 2014) was implemented face-to-face and the second how it was implemented virtually. Both case studies are set within the Adult Mental Health Services across an NHS Health Board. This research was carried out during the Covid-19 pandemic. The dynamics of the occupational therapy team, wider society and how Recovery Through Activity (Parkinson 2014) was implemented was significantly impacted by the Covid-19 pandemic. This led to changes in the research process to

reflect these impacts. This will be discussed in chapter 3 which explains the choices of data collection methods used.

Results from the face-to-face and virtual cases are presented separately within chapters 3 and 4. The results of both cases are then cross analysed to draw conclusions and presented in chapter 6 where case study propositions are revisited.

Chapter 7 discusses the research findings in relation to the surrounding literature. It provides a detailed analysis of how the results align with or differ from existing studies and theoretical frameworks in the field. The chapter critically examines the implications of these findings. It highlights their contribution to the current body of knowledge on mental health, the Recovery-Oriented approach, and occupational therapy. By integrating the research results with established literature, this chapter offers an understanding of the impact and effectiveness of Recovery Through Activity (Parkinson 2014) across differing mental health contexts.

Chapter 8 serves as the conclusion of this research, offering a comprehensive reflection on several key aspects. It begins with an analysis of the case study research design, shedding light on its strengths and challenges. The chapter then delves into the unique experience of conducting research during the COVID-19 pandemic. It addresses the obstacles encountered and the adaptations made in response. It also discusses the collaborative efforts with an NHS health board, highlighting both the benefits and complexities of such partnerships. Additionally, a personal researcher reflection provides a candid account of the research journey. The chapter outlines the study's limitations and identifies areas for further research. Furthermore, it details the contributions of the study to the existing body of knowledge and presents the study's implications and recommendations for practice and policy.

2.2 Mental Health

This research study has taken a case study approach, and the context is a Health Board in Wales. The Mental Health (Wales) Measure (2010) places a legal duty on local authorities and health boards to support people with mental ill health. The Welsh Government has set out a mental health and wellbeing strategy, Together for Mental Health (2012), to promote mental wellbeing and prevent mental ill health developing, where possible, for people in Wales. In addition, the Wellbeing of Future Generations (Wales) Act (Welsh Government 2015) aims to improve the social, cultural, economic and environmental wellbeing of Wales. This study has considered this ambition by exploring how these various environmental factors interact with one's wellbeing and Recovery Through Activity (Parkinson 2014).

The provision of mental health services over the past 30 years has become more community-based, with inpatient treatment decreasing (Welsh Assembly Government [WAG] 2016b). This research study explored both community and inpatient settings, as well as face-to-face and virtual Recovery Through Activity (Parkinson 2014), in keeping with the changes to the health boards service provision during Covid-19.

2.3 Physical wellbeing

Mental ill health can also impact on one's physical wellbeing (Mo et al. 2016). Mental ill health is a key cause of health inequalities and can have a significant impact on one's life expectancy (WAG 2012). For example, in comparison to the general population, people with severe and enduring mental ill health die on average ten years earlier (WAG 2012).

The Samaritans (2016) state that suicide prevalence amongst males is 15.3 per 100,000 compared with females at 3.4 per 100,000, possibly

due to the finding that females are more likely to access services. Those at highest risk of suicide within the male group are aged 40-44 years, whereas the age group for females is 50-54 years (The Samaritans 2016).

These statistics also show that the highest suicide rate is amongst the adult age range. The health board's adult mental health services encompass the age ranges of 18-65 years. As this research is focused on data collected from the health board's adult mental health services, this means that the demographic with the highest suicide rate will be captured in the research.

2.4 Financial impacts

Currently, only 5.5% of health research funding in the UK is allocated towards mental health research (Mental Health Foundation 2016). This is particularly concerning given the substantial financial repercussions associated with mental health challenges. For instance, Elmontsri et al. (2018) have highlighted how such challenges can lead to income loss for individuals. Moreover, those residing in socioeconomically deprived areas are documented to utilise mental health services more frequently (WAG 2016), and Jenkins et al. (2008) found a direct correlation between increased debt and a higher likelihood of experiencing mental ill health.

These findings emphasise a complex interplay between mental health, financial circumstances, and broader socioeconomic factors. The higher frequency of mental health service utilisation in economically deprived areas suggests a significant relationship between socioeconomic status and the demand for mental health services.

2.5 Recovery-Oriented Approach

The evolution of mental health services has undergone a significant transformation. This is marked by a paradigm shift from a traditional

medical model focused on treatment and cure to a recovery-oriented approach. As articulated by Slade (2008), this contemporary approach views recovery as a personal journey toward leading a meaningful life that contributes to society, which may persist regardless of the presence or absence of mental health issues. This perspective emphasises recovery as a holistic process that encompasses more than simply symptom alleviation.

However, the implementation of a recovery-oriented approach encounters several barriers in practice. Crowe and Deane (2018a), along with Roberts and Boardman (2014), identify risk-averse practices as a significant impediment. These practices, influenced by traditional methods of risk assessment, can stifle the flexibility and responsiveness necessary for a recovery-oriented approach.

In defining the concept of recovery, distinctions are made between personal, clinical, and functional recovery. Clinical recovery is often defined by the remission of symptoms and a general stabilisation of the mental state (Robinson et al. 2004). Functional recovery extends to the restoration of roles and abilities within occupational, community, and social spheres. In contrast, personal recovery is a deeply subjective process derived from the service user's experience, characterised by psychological states of hope, empowerment, and self-direction (Shanks et al. 2013).

Leamy et al. (2011) further expand on personal recovery by developing a framework through a systematic review, which they termed CHIME (Connectedness, Hope and optimism about the future, Identity, Meaning in life, and Empowerment). These five processes capture the core aspects of personal recovery, emphasising the non-linear and individualised nature of the journey toward recovery.

The recovery paradigm has gained international traction, with various countries, including Sweden, adopting recovery-oriented practices as central to their mental health policies (National Board of Health and Welfare 2018). Despite its widespread acceptance, there remains no universal consensus on the exact definitions of recovery, which reflects its inherently individualistic nature. Clinical recovery, for example, focuses predominantly on symptom reduction from a medical standpoint (Macpherson et al. 2016), whereas personal recovery is about discovering new meaning and engagement within the community, often seen as complementary to clinical recovery (Law et al. 2016)

The role of occupational balance is central in the context of recovery. Individuals with mental health conditions may experience imbalances, such as being over or under-occupied, or experiencing fluctuations between the two, which can adversely affect their recovery process (Bejerholm 2010; Eklund, Leufstadius, & Bejerholm 2009; Leufstadius & Eklund 2008). Research by Eklund and Argentzell (2016) shows that not having a structured routine or paid work significantly contributes to this imbalance. This highlights the importance of integrating a range of active, restful, and meaningful activities into the daily lives of those with mental health conditions.

In conclusion, the recovery-oriented approach in mental health represents a shift towards a more holistic, person-centred paradigm. It requires an understanding of the complex interplay between clinical symptoms and the broader psychological and occupational needs of individuals. The research suggests embracing this approach necessitates overcoming systemic barriers.

2.6 Occupational Science

The recovery-oriented approach in mental health is congruent with the principles of occupational science. This makes occupational therapists uniquely positioned to facilitate this approach effectively. Occupational science, a discipline that emerged to enhance the theoretical foundations of occupational therapy, investigates the complexity of occupation—its form, function, and meaning—as central to human wellbeing (Wilcock 2005).

Historically, occupational therapy faced periods of uncertainty about its direction and purpose. This was particularly evident during the mid-20th century when practices under medical directives became reductionist and less occupationally focused. This shifted following Mary Reilly's seminal 1961 lecture, which advocated for a renewed focus on occupation as the cornerstone of occupational therapy (Reilly 1961). The development of occupational therapy theory, particularly from the 1980s onwards, brought about a range of models designed to reconnect theory with practice (Christiansen 1999; Reed & Sanderson 1999; Kielhofner 1995, 2002, 2008; Townsend et al. 1997 2002; Polatajko et al. 2007). These models support practitioners in maintaining a theoretically informed practice that is viewed and respected as a professional discipline (Turpin & Iwama 2011; Duncan 2006; Forsyth et al. 2005).

In the context of mental health, the recovery-oriented approach aligns closely with occupational science. Both emphasise the significance of meaningful activity in promoting health and wellbeing. Occupational science posits that engagement in meaningful activities not only enhances personal wellbeing but also promotes a sense of purpose and community participation (Wilcock 2006; Shimitras et al. 2006). This is particularly relevant for individuals with mental health challenges, who often face

social exclusion and a lack of structure in their daily lives that can hinder their recovery (Social Exclusion Unit 2004; Lund et al. 2019b).

Furthermore, the Model of Human Occupation (MOHO) (Kielhofner 2008), which has been extensively adopted across various health boards, including where this research was conducted, provides a comprehensive framework. MOHO's focus on volition, habituation, and performance capacity supports the recovery principles by emphasising personal choice, routine, and the capacity to perform occupations (Kielhofner 2008).

In summary, the alignment of occupational science with the recovery-oriented approach provides a solid theoretical and practical foundation for occupational therapists. This alignment ensures that interventions are not only therapeutic and supportive but also enriching and empowering, reflecting a deep understanding of the transformative power of occupation in individuals' lives.

2.6.1 What is meant by occupation?

The concept of 'occupation' has long been a subject of extensive debate and discussion within the field of occupational therapy. Numerous scholars have attempted to define the term yet failing to reach a uniform consensus (Wilcock and Hocking 2015; Hasselkus 2002). Hasselkus (2002) articulates that occupation is deeply entwined with meaning, asserting that for an individual to live a purposeful life, engaging in meaningful occupations is essential.

Further expanding on this, Law and Baum (2005) describe occupations as encompassing all aspects of life, including being, thinking, activities, and tasks, emphasising that health and wellbeing are closely linked to engagement in these occupations. This view is supported by Yerxa (1998), who agrees that there is a consensus of the positive impact of occupational participation on health and wellbeing.

The Royal College of occupational therapists (RCOT/COT 2017) categorises occupations into practical or purposeful day-to-day activities and tasks, which are grouped into areas of self-care, productivity, and leisure. They highlight that occupations not only reflect an individual's identity but are also central for wellbeing (COT 2017).

Creek (2010) observes that while the term 'occupation' lacks a precise, universally agreed definition, common themes such as 'daily activities,' 'everyday life,' 'tasks,' and 'personal meaning' recur across various definitions, indicating a convergence of opinion about the essence of occupation.

Building on this foundation, Pentland et al. (2018) offer a more contemporary definition that updates Creek's earlier work (2003), aligning with Wilcock's (2006) definition of occupation as encompassing the things we want, need, or are obligated to do. This definition emphasises that occupation extends beyond mere tasks and activities to include individuals' needs and goals, highlighting the relationship between occupation, the individual, and their context. Pentland et al. (2018) conclude that occupations are dynamic and complex, constantly evolving in response to an individual's changing needs and circumstances.

For the purposes of this thesis, occupation refers to activities that are purposeful and meaningful to the individual. This captures the dynamic and multifaceted nature of how people engage with their world in ways that are personally significant and contextually driven.

2.6.2 Occupational balance

The concept of 'occupational balance' has undergone several redefinitions over the years, reflecting its evolving understanding within the field of occupational therapy. Initially, Meyer (1922) described occupational balance in terms of the time an individual allocates to rest, play, and

work. However, Townsend and Wilcock (2004) expanded on this definition, arguing that occupational balance should also consider an individual's personal preferences and capabilities, suggesting a deeper, more personalised approach to understanding how people manage their time and activities.

Pentland et al. (2008) further emphasise the significance of occupational balance, describing it as an essential element of human existence that plays a central role in survival, life-span development, and societal construction. Pentland et al. (2008) highlight the complex relationship between occupation and health, noting that while some occupations may enhance physical and mental health, others might lead to distress or pain. The impact of any given occupation can vary greatly depending on how individuals engage with their activities within their unique circumstances.

Modern perspectives on occupational balance acknowledge that occupations do not occur in isolation but within the dynamics of various groups, such as therapeutic groups, communities, families, and social circles (Pentland et al. 2018). This broader recognition aligns with the principles of Recovery Through Activity (Parkinson 2014), which emphasises the importance of understanding occupational engagement within group settings. Pentland et al. (2018) argue for a more comprehensive understanding of how vital elements interact within these contexts to ensure that beneficial aspects are maximised, and potential negative impacts are minimised.

2.6.3 occupational therapy

Occupational therapy plays a vital role when an individual experiences an occupational interruption or dysfunction, which can negatively impact one’s roles and identity (Kielhofner 2008). To address these challenges, occupational therapists collaboratively explore an individual’s values and participation in various activities to understand their perceived

occupational balance (Backman 2010). This understanding allows both the occupational therapist and the service user to identify factors that enhance or inhibit health and well-being, forming the basis for person centred interventions.

Adams et al. (2011) emphasise that improved wellbeing can be achieved not only through role replacement but also by engaging in a diverse range of activities. These activities may be solitary, involving lone engagement, formal, through participation in organised settings, or informal, such as interactions with family and friends. Molineux (2004 p.7) highlights that for occupational therapy to effectively enhance performance and wellbeing, it must be "authentic," with practitioners maintaining an occupational perspective and ensuring that individuals engage in occupations that are meaningful to them.

Reagon (2012) suggests that occupational therapists should leverage relevant research, client feedback, occupational therapy values, and occupational science to inform their evidence-based practice. This approach, according to Taylor (2017), enables occupational therapists to achieve person-centredness and understand the evidence in a holistic manner. Boniface (2012) also stress the importance of employing an occupational therapy model to maintain a holistic view and gain a holistic perspective on an individual’s strengths and needs.

To ensure that occupational therapy practice is both appropriate and client-centred, occupational therapists must work together with their clients and adhere to ethical and professional standards. The Professional Standards for occupational therapy practice, conduct, and ethics (RCOT 2021) provide a framework for Occupational therapists to offer an ethical and occupationally focused service. These standards guide occupational therapists in delivering services that promote the individuality and complexities of each service user. This ensures that therapeutic

interventions are effectively tailored to meet their unique needs and enhance their overall quality of life. This holistic and person-centred approach is fundamental to the practice of occupational therapy and is essential for supporting individuals in achieving a balanced and fulfilling life.

2.6.4 ‘Doing’ being’ ‘becoming’ and ‘belonging’

In respect of ‘occupations’, Wilcock (1999) describes the concepts of 'doing', 'being' and 'becoming' and states that they affect ones "survival, health and wellbeing" (Wilcock and Hocking 2015 p.138). 'Doing' is described as the carrying out of an occupation (for the purpose of this example dance is used) (Wilcock 1999). 'Being' relates to the essence, meaning and presence an occupation can give to a person (Wilcock 1999). This could be viewed in terms of the Model of Human Occupation’s volitional component, which relates to an individual’s values and beliefs (Kielhofner and Burke 1980). The reasoning for 'doing' an activity such as dance varies and thus this changes the ‘being’. Occupations can be categorised in 'self-care', 'leisure' and 'productivity'. Thus, an individual could associate the 'doing' of an occupation (such as dance) to any of these domains depending on their reasoning for doing that activity and the meaning they attribute to it. For example, dance could be seen as self-care if it helps an individual to manage their stress levels. It could be seen as leisure if an individual enjoys the activity and engages for fun. It could be seen as productive if one is engaging in dance for a theatre show or work. One or all these categories may apply at any given time, and they may change over time depending on why a person is engaging in an occupation at that time. Finally, the 'becoming' element relates to an individual’s growth through transforming and self-actualisation (Wilcock 1999). Through applying a macroscopic understanding of these terms, an occupational therapist can assist service users in addressing some of the occupational issues impacting individuals, including occupational

imbalance and occupational injustice (Wilcock 1999). At a later stage another domain was added by Hitch et al. (2014). 'Belonging' refers to a sense of connectedness to people and places, cultures and communities, as well as times (Hitch et al. 2014). For example, in relation to dance, one might feel a sense of connectedness to the dance community. A sense of connectedness however is not always an end goal for individuals (Hitch et al. 2014). For example, the end goal with dance might be to maintain fitness, so the goal may not be to feel connected.

2.6.5 The Model of human occupation (MOHO)

The Model of Human Occupation (MOHO; Kielhofner 2008). will be used as the conceptual model to articulate and maintain focus on the factors that surround occupational participation, engagement and meaning in relation to this research study. The MOHO is a conceptual model of occupational therapy which details how people engage in their occupations through the interaction between their volition, habituation and performance capacity, as well as environmental influences (Kielhofner 2008). The MOHO (Kielhofner 2008) details one's level of doing (participation, performance, and skills) as well as occupational adaptation arising from occupational identity and competence influences (Kielhofner 2008). These domains are discussed in more detail below.

In this thesis, references to the Model of Human Occupation (MOHO) (Kielhofner 2008) are drawn from various editions of the manual, reflecting the updates and revisions made over time. The health board did not specify a particular version, so references encompass insights from multiple editions to capture the evolving understanding of the model's theoretical and practical applications.

The 1st edition (Kielhofner and Burke 1980) introduced the foundational concepts of volition, habituation, and performance capacity, emphasising the relationship between individuals and their occupations. The 2nd

edition (Kielhofner 1995) expanded on these ideas by incorporating the dynamic interaction between the person, their occupations, and the environment, while introducing assessment tools like the Occupational Self-Assessment (OSA). By the 3rd edition (Kielhofner 2002), the focus shifted to evidence-based practice, integrating research and refining assessments to support clinical needs more effectively. The 4th edition (Kielhofner 2008) included updates on the influence of cultural, social, and environmental factors on occupational engagement, refining concepts of volition and occupational identity. Finally, the 5th edition (Taylor 2017) emphasised person-centred care, cultural competence, and the integration of technology in occupational practice.

By referencing different editions, this thesis reflects the ongoing development of MOHO (Kielhofner 2008) to ensure alignment with both foundational principles and contemporary practice.

The MOHO (Kielhofner 2008), as opposed to other occupational therapy conceptual models, was chosen as it emphasises the reality of individual patterns of performance and highlights the influence of environmental factors, as well as the volitional powers that impact on occupational performance (Taylor 2017). An advantage to the MOHO (Kielhofner 2008) is that it reinforces the understanding, that when conducting an occupational analysis, all person centred and environmental factors that influence the performance of occupations, should be carefully considered by the occupational therapist (O'Toole 2011). In addition, the Recovery Through Activity manual (Parkinson 2014) was based on the principles from the MOHO (Kielhofner 2008).

Volition

Volition relates to what individuals find enjoyable and important, as well as how effective they think they are (Parkinson 2014).

Taylor (2017) states volition is a dynamic process involving anticipation, interpreting, making decisions, experiencing engagement in occupations and evaluating this experience. Within the MOHO (Kielhofner 2008), volition is sectioned into three elements, the first being personal causation which refers to one's sense of capacity and self-efficacy. The second being 'values', which refers to one's sense of obligation and personal convictions which are based on their life values. The third is 'interests' which refers to one's interest patterns and what one considers as enjoyment and pleasure (Taylor 2017).

Habituation

Habituation refers and individuals process of acquiring and repeating patterns in relation to their roles and routines which make up everyday life (Parkinson 2014).

Taylor (2017) outlines that habituation is guided by one's habits and roles and consistent patterns of behaviour. There are three types of habit that are outlined in the MOHO (Kielhofner 2008): style; routine and performance. The MOHO (Kielhofner 2008) also considers one’s role identification. It considers both how an individual identifies with a role and separately, the wider expectations and traits society have placed on a role (Taylor 2017).

Performance capacity

Performance refers to the interaction between one’s perception, neurological and cognitive abilities as well as musculoskeletal phenomena (Parkinson 2014).

Taylor (2017) outlines how the MOHO conceptualises 'performance capacity' into three elements. The 'objective' element considers psychological and physical factors. The 'subjective' element considers

one's subjective experience of an objective component. The 'lived body' element considers one's lived experience and its influence on one's performance (Taylor 2017).

Environment

Taylor (2017) outlines three environmental domains considered by the MOHO and a further three layers of environmental context to each domain. The three environmental domains are: social; physical and occupational. The three contexts are: immediate; local and global. In relation to the social environment, the immediate context considers relationships and interactions, the local context considers social networks, and the global context considers laws and policies, attitudes and economic factors. In relation to the occupational environment, the immediate context considers activities and their properties, the local context considers recreational activities, and the global context considers options for living and livelihood. In relation to the physical environment, the immediate context considers space and objects, the local context considers community facilities, and the global context considers climate, geography and ecology (Taylor 2017).

The environment impacts occupational participation through creating conditions that put demands on an individual and also through providing resources and opportunities (Parkinson 2014).

2.7 Activity focused interventions

Previous research has found that people with mental ill health often do not have a balance of meaningful occupations that they participate in (Shimitras et al. 2006). People experiencing mental ill health are often under-occupied or are engaging in passive activities that are not meaningful to them as individuals (Shimitras et al. 2006). An occupational therapist aims to support and enable people to participate in meaningful

activities or occupations, however occupational therapists in mental health teams are negotiating the balance between their occupation-focused roles and their generic roles (Pettican and Bryant 2007; Fox 2013).

2.7.1 Volition

A scoping review was carried out exploring occupational therapists and service user experiences of activity-focused interventions. Please see Appendix 1, along with the scoping review protocol in Appendix 2. An overview of the findings will be discussed here to add context.

Activity-focused interventions have many therapeutic benefits in relation to mental health and recovery. Existing research suggests that activity focused interventions promote a more positive sense of self by encouraging people to challenge their internalised views (Lund et al. 2019a). It has also been found that people develop more self-compassion, as well as increased self-worth and competence as a consequence of activity focused interventions (Lund et al. 2019b). Activity-focused interventions result in people feel more connected to the world and their future self (Peterson et al. 2019), as well as feeling a sense of satisfaction (Lund et al. 2020). However, to benefit from activity-focused interventions, readiness for change is an important factor to consider (Lund 2020). Some of the factors to consider in relation to this are energy levels, general symptoms, fears, previous experiences, and readiness to try something new (Lund et al. 2020; Lund et al. 2019b). It is also important to consider the relatability of the activity-focused intervention to the individual person to increase one's perceived achievability and empower self-engagement post intervention (Wooley et al. 2020). The factors considered here relate back to the MOHO's (Kielhofner 2008) volitional elements of personal causation.

Research has also found that group activity focused interventions promote building connections with oneself and others, increase a sense of

validation in one’s thoughts and feelings, and offer a sense of belonging (Wooley et al. 2020). The group activity social environment can increase a sense of accountability, support and help people work towards their goals (Lund et al. 2019b). The elements here can be viewed in light of the MOHO's (Kielhofner 2008) volitional element of the importance of one's values.

2.7.2 Habituation

The following factors relate to the MOHO's (Kielhofner 2008) habituation element, more specifically, habits and routines. Activity focused interventions have been found to support people to reflect on their occupational daily patterns (Lund et al. 2019b), support people to establish routines, promote productivity and engagement and support people to prioritise taking care of themselves (Wooley et al. 2020). Activity-focused interventions also improve occupational balance, levels of functioning and increase activity engagement (Eklund et al. 2017; Peterson et al. 2019).

2.7.3 Performance capacity

The following factors can be considered in terms of the MOHO's (Kielhofner 2008) performance capacity domain. Activity-focused interventions have been found to improve social functioning, cognition and prioritisation skills (Peterson et al. 2019; Lund et al. 2019a). Additionally, they have been found to improve development of skills to self-manage one's mental health and achieve goals (Rebeiro Gruhl et al. 2021). Research has shown that group activity-focused interventions support people with mental ill health to develop skills in breaking old patterns, to understand recovery concepts and to better understand themselves (Lund et al. 2020; Chang et al. 2020). Additional skills that activity focused interventions promote include: reflection; pacing;

strategies for balance; prioritising and breaking down goals (Lund et al. 2019a).

In addition to promoting skill development, activity-focused interventions have also been found to support symptom management. Research has shown that people self-rate their recovery as better following activity-focused interventions (Argentzell et al. 2020). The strongest mediators for recovery were found to be activity engagement, mastery and satisfaction (Argentzell et al. 2020). Activity focused interventions have also had a positive impact on suicidal ideation, psychopathological outcomes, symptom severity and functioning (Peterson et al. 2019; Eklund 2017).

2.7.4 Environment

The following can be considered to reflect the MOHO's (Kielhofner 2008) environmental domains, one of which is the social environment. Research has shown that the facilitating factors for implementing activity focused interventions in relation to the social environment are: service users being on an equal standing with therapists; developing friendships within the group; valuing others and understanding peers; being in a similar phase in one's life and having similar functioning levels to peers in the group (Lund et al. 2020). Supportive group dynamics surrounding activity-focused interventions have also been found to create a sense of comfort to socialise, create a sense of belonging and purpose, (Rebeiro Gruhl et al. 2021). In addition, it has been found to reduce loneliness (Lund et al. 2019a) and enable service users to discuss struggles and challenges (Wooley et al. 2020). On a separate note, there have also been benefits found for occupational therapists, in that occupationally focused interventions have helped them to clarify their role to the wider team and improve working dynamics (Lund et al. 2020).

In relation to the occupational environment, research has found that both service users and occupational therapists enjoy having occupationally

focused topics for group interventions (Lund et al. 2020). It was also found that occupational therapists appreciate a framework when carrying out activity focused interventions, although flexibility was identified as desirable to meet varying individual needs, functioning levels and timelines (Chang et al. 2020).

2.7.5 Levels of doing

In the Model of Human Occupation (MOHO), Kielhofner (2008) outlines three levels of doing: participation, performance, and skills, each contributing uniquely to how individuals engage in their occupations. Participation is defined as involvement in occupations or life roles, capturing the broad spectrum of one's engagement in various activities. This level of doing encompasses the general involvement in life roles and daily activities that define one's routine and lifestyle.

Performance, as described by Kielhofner (2008), is more specific and pertains to the engagement in particular activities and tasks that comprise an occupation. For example, while an individual may participate in the broader occupation of personal care, this can be broken down into specific performances such as washing hair, brushing teeth, or getting dressed. Each of these performances involves a series of steps and actions that are carried out to complete the task effectively.

At the most detailed level, skills are essential for carrying out these specific activities. Kielhofner (2008) identifies various types of skills necessary for performance, including communication and interaction skills, processing skills, and motor skills. For example, the act of brushing teeth involves several skills: interaction skills might be used in purchasing toothpaste and conversing with the store clerk; processing skills are applied in selecting the correct items like a toothbrush and toothpaste, and in sequencing the actions of applying toothpaste and water; and

motor skills are vital in manipulating the toothbrush and coordinating the brushing motion.

By understanding these three levels—participation, performance, and skills—outlined by Kielhofner (2008), occupational therapists can better assess and address the various factors that contribute to successful engagement in occupations. This framework helps to pinpoint where interventions are needed, whether in enhancing specific skills, improving performance of tasks, or promoting broader participation in life roles.

2.7.6 Adaptation, identity and competence

The Model of Human Occupation (MOHO), as delineated by Kielhofner (2008), emphasises that participation in occupations promotes occupational adaptation. This form of adaptation is essential for responding effectively to life's challenges, contributing to a state of wellbeing. It is rooted in the concepts of occupational identity and competence, which evolve through ongoing participation in various activities.

Occupational identity reflects how individuals view their occupations as extensions of their sense of self and aspirations of who they aim to become. This identity is inherently subjective, representing a personal interpretation of how occupations fit into one's life narrative. In contrast, occupational competence is more objective and refers to the ability to maintain a pattern of occupation that reinforces one's sense of self. It encompasses the capability to meet responsibilities and obligations effectively (Kielhofner 2008)

According to Kielhofner (2008), the development of identity and competence occurs over time and through stages of change within the context of participation. The first stage, exploration, involves trying new activities and learning more about oneself. This phase is vital for

individuals to experiment with and discover occupations that resonate with their interests and values. The subsequent stage, competence, is characterised by the development and refinement of skills, facilitating new and more effective ways of engaging in these activities. Finally, the achievement stage is reached when individuals have acquired the necessary skills and resources to fully participate in their chosen occupations (Kielhofner 2008).

2.7.7 MOHO's guide to therapeutic reasoning

Following the discussion on occupational adaptation as detailed in MOHO (Kielhofner 2008), it is essential to consider how these concepts are applied through MOHO's guide to therapeutic reasoning (Forsyth and Kielhofner 2008), which is structured into six pivotal steps (Figure 1). This guide serves as a practical framework to apply the theoretical concepts of occupational identity, competence, and adaptation in therapeutic settings.

The initial step in MOHO's guide to therapeutic reasoning (Forsyth and Kielhofner 2008) involves presenting MOHO-based questions to better understand the service user. This initial step ensures that occupational therapists begins with a clear perspective of the service user's occupational engagement and identity, which are central to formulating effective interventions (Kielhofner 2008). Following this, the second step focuses on collecting detailed service user data, which supports the development of a comprehensive view of the service user's occupational history, preferences, and current challenges.

The third step involves formulating a clinical hypothesis that explains the service user's difficulties in occupational performance (Kielhofner 2008). This is vital for targeting specific areas where occupational identity or competence may be hindered, directly influencing the client's capacity for occupational adaptation. The fourth step then builds on this understanding by setting specific, measurable goals alongside strategies

for occupational therapy. These goals are designed to address the identified issues, promoting enhancements in occupational engagement and performance (Forsyth and Kielhofner 2008).

As therapy progresses, the fifth step entails monitoring the service user's therapeutic progress. This ongoing assessment is important to ensure that the interventions remain aligned with the service user's evolving needs and continue to support their occupational adaptation effectively. Finally, the sixth step in the MOHO's therapeutic reasoning guide (Forsyth and Kielhofner 2008) involves evaluating the outcomes of therapy. This evaluation determines the extent to which the therapy has impacted the client's occupational identity, competence, and overall wellbeing (Kielhofner 2008).

These steps, as noted by Forsyth and Kielhofner (2008), are not rigidly sequential but are part of a dynamic process. occupational therapists may find themselves revisiting earlier steps based on new insights or changes in the client's condition or environment, reflecting the dynamic nature of occupational therapy and the complex dynamics of human occupations. This flexible approach ensures that occupational therapy remains responsive and tailored to individual needs. In turn this enhances its

effectiveness in facilitating occupational adaptation and improving quality of life.

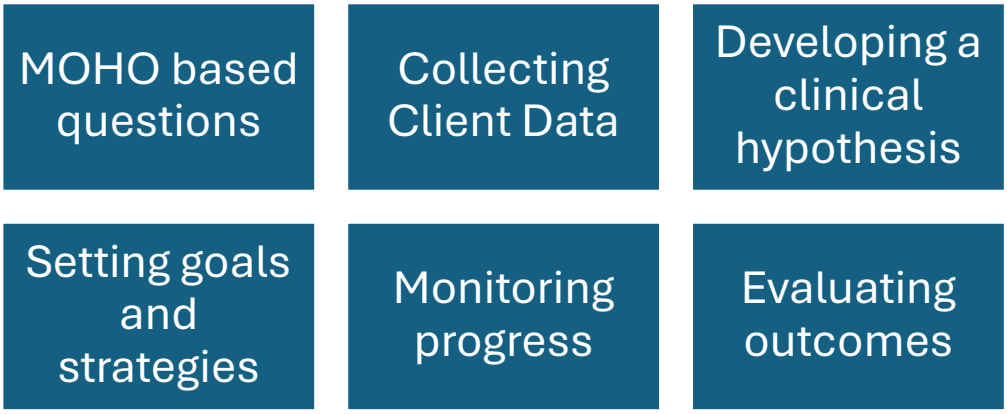


Figure 1- MOHO's guide to therapeutic reasoning (Forsyth and Kielhofner 2008)

2.8 Recovery Through Activity

A relatively new recovery-oriented approach within the field of occupational therapy is Recovery Through Activity (Parkinson 2014), which is underpinned by the MOHO (Kielhofner and Burke 1980). Recovery Through Activity aims to serve as a tool for occupational therapists to evidence the value of meaningful activity, support therapists' attributes and core skills, as well as providing resources to plan and implement activity-based occupation focused interventions and enhance participation in everyday life (Parkinson 2014). Recovery Through Activity aims to explore the value of a range of activities and promote the long-term benefits of occupational participation (Parkinson 2014). The Manual (Figure 2) was designed to support adults

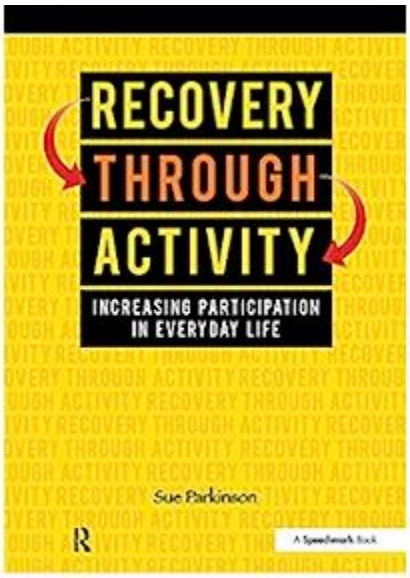


Figure 2 Recovery Through Activity Manual (Parkinson 2014)

in both inpatient and community mental health services. The Recovery Through Activity Manual outlines examples and ideas for both discussion-based group sessions as well as opportunities to experience activities within a group. Parkinson (2014) explains how the group sessions are complemented by also carrying out one-to-one assessment and treatment planning, as well as reflecting on strengths in the discussion sessions rather than focusing on personal barriers.

2.8.1 Supporting occupational therapists

Recovery Through Activity (Parkinson 2014) aims to support occupational therapists core skills and support the implementation of activity focused interventions. This meets a need in the current climate whereby occupational therapists are experiencing difficulties in retaining their professional identity (Farnworth 2003), due to having to balance generic clinical roles alongside their occupation focused roles (Lloyd et al. 2002). Parkinson (2014) identifies that there could be a risk of occupational therapists not reinforcing the value of occupations themselves and focusing on coping strategies and symptom reduction. The Recovery Through Activity (Parkinson 2014) manual addresses this risk by outlining and evidencing the value of occupations and meaningful activities. Each of the 12 activity types outlined in the manual are accompanied by an introduction, a breakdown of the activity type and supporting evidence for the value of each activity type. This can be used as a tool by occupational therapists to refer to, reinforcing the value of occupational participation to the therapist and enabling them to promote the value of occupational participation to service users and colleagues. Additionally, it may serve as a tool to support occupational therapists in articulating their role, which has been identified as a need, as it has been suggested that occupational therapists find it difficult to articulate their contribution to health promotion (Tremblay and Brousseau 2011).

2.8.2 Supporting service users

Recovery Through Activity shares its aims with a Japanese wellness programme for older people (Yamada et al. 2010). The aims are to provide a platform for people with mental health conditions to reflect on their occupational lives and the impact on their health, as well as to discuss lifestyle choices that can meet people's health and occupational needs (Yamada et al. 2010). There are many manuals that have been published over the years that focus on older adults, however the Recovery Through Activity (Parkinson 2014) manual was designed with working age adults in mind, with the aim of providing a flexible framework for intervention (Parkinson 2014).

2.8.3 Contents

The Recovery Through Activity (Parkinson 2014) manual has a question-and-answer section for facilitators, options for formal and informal one-to-one assessments to be offered alongside groups, a group protocol, sample flyer and pre-post group interview and evaluation. The main body of the manual is separated into 12 sections which are separate categories of activity, although these may be combined. The 12 activity types are: leisure; creative; technological; physical; outdoor; faith; self-care; domestic; caring; vocational; social and community. Each section includes key messages, evidence for the value of each activity, suggestions for facilitation of the group, resources for photocopying and discussion starters, as well as ideas for practical activities (Parkinson 2014).

2.8.4 Research need

To the best of my knowledge there is no research to date that evaluates occupational therapists' and service users' experiences of Recovery Through Activity within the field of mental health.

2.8.5 Recovery Through Activity in the midst of Covid-19

The COVID-19 pandemic significantly influenced the research, affecting every aspect from data collection to the experiences of staff and service users within the NHS Health Board. Many staff, including occupational therapists, were redeployed to critical services, facing increased workloads and health risks. Standard care procedures were disrupted, and Recovery Through Activity (Parkinson 2014) sessions, central to the study, shifted online. This transition posed challenges in engaging service users. Service users faced isolation and reduced access to community resources, with virtual sessions lacking the immediacy of in-person interactions. The research scope was narrowed due to intense service demands and restrictions, impacting the study's breadth. The virtual environment inhibited direct observation and rapport-building, essential for qualitative research. Additionally, this limited the researcher's clinical experience and professional development. These challenges highlighted the necessity for adaptable research approaches and emphasised the significant impact of the pandemic on health services and their service users.

2.9 Chapter Summary

In conclusion, this first chapter sets the stage for a detailed exploration of Recovery Through Activity (Parkinson 2014) within adult mental health services, integrating a framework grounded in the MOHO (Kielhofner 2008). It has laid out the foundation of the intervention's purpose, which is to enhance occupational therapists' ability to facilitate meaningful engagement in various activities for service users, supporting their journey toward occupational competence and improved wellbeing.

The chapter has outlined the diverse range of activities included in Recovery Through Activity (Parkinson 2014), from vocational and creative

pursuits to self-care and community involvement, reflecting the diverse needs and interests of service users. Additionally, it has introduced the study's methodological approach, shaped by a bounded relativist ontology and a subjectivist epistemology within an interpretivist theoretical perspective. This approach is fundamental as it allows for an in-depth understanding of individual experiences and the contextual nature of occupational therapy and Recovery Through Activity (Parkinson 2014).

Furthermore, the impact of the Covid-19 pandemic on the delivery and dynamics of mental health services has been highlighted to highlight the relevance and timeliness of this study. This context not only influences the implementation of Recovery Through Activity (Parkinson 2014) but also affects the overall engagement and outcomes for service users, making this research particularly significant.

By examining how occupational therapists navigate these challenges and opportunities, this chapter sets the foundations for subsequent analyses of the effectiveness and adaptability of Recovery Through Activity (Parkinson 2014) in both face-to-face and virtual settings.

Chapter 3 – Literature review

3.1 Introduction

3.1.1 Context

Mental health conditions continue to significantly impact individuals both globally and in Wales. In the UK, approximately one in six adults experience a common mental health problem, such as anxiety or depression, in any given week, with anxiety disorders affecting 6 in 100 people and depression impacting 3 in 100 (Mind 2024; BMA 2024). In Wales, similar trends are observed, where 32% of adults report low mental well-being, as indicated by an average score of 48 on the Warwick-Edinburgh Mental Wellbeing Scale for 2022-23 (National Survey for Wales 2023).

The financial burden of mental health issues is immense, with an annual cost to the UK economy estimated at £300 billion (Centre for Mental Health 2024). This includes direct healthcare costs, lost productivity, and the broader human cost of reduced quality of life (Centre for Mental Health 2024). In Wales, mental well-being scores are lower in deprived areas, indicating that socioeconomic factors strongly influence mental health outcomes (Public Health Wales 2024). These disparities echo global trends where low-income populations face higher risks of mental health problems and significant barriers to accessing mental health services (World Health Organization 2022).

Globally, individuals with severe mental health conditions, such as depression and anxiety, have a reduced life expectancy of 10-20 years compared to the general population, primarily due to coexisting physical health issues like cardiovascular disease and diabetes (World Health Organization 2022; Mo et al. 2016). In Wales, around 46% of people with

mental health problems also live with a long-term physical health condition, exacerbating the challenges they face in managing their overall health (National Survey for Wales 2023). The COVID-19 pandemic further increased these difficulties, with global cases of major depressive disorder rising by 28% and anxiety disorders by 27.9%, attributed to social isolation, economic hardship, and uncertainty (Institute for Health Metrics and Evaluation 2020).

Mental health conditions are among the leading causes of disability worldwide, with depression and anxiety ranking as top contributors to years lived with disability (YLDs) interventions (World Health Organization 2022). In 2019, approximately 970 million people globally were living with a mental health disorder, highlighting the widespread need for mental health interventions (World Health Organization 2022). The COVID-19 pandemic added about 54 million new cases of major depressive disorder and 83 million cases of anxiety, creating an even greater demand for enhanced mental health services (Institute for Health Metrics and Evaluation 2020). Despite this growing burden, global spending on mental health remains low, with most countries allocating less than 2% of their health budgets to mental health services (World Health Organization 2022).

The demand for mental health services is increasing in Wales and globally. In 2024, more than 1.9 million adults in the UK were in contact with mental health services, while Wales continues to see rising mental health support needs, highlighting the importance of integrated, community-based mental health services (NHS Digital 2024; Public Health Wales 2024). This trend reflects a worldwide struggle to meet the growing demand for mental health care, particularly in low- and middle-income countries where resources are scarce (World Health Organization 2022).

Slade 2008 notes that over recent decades, there has been a significant shift in mental health care from a medical model focused primarily on symptom management to a recovery-oriented approach. The traditional medical model often views mental illness through a lens of diagnosis and treatment, aiming to alleviate symptoms and restore individuals to a state of "normal" functioning. However, this model has been criticised for its limitations, particularly its focus on deficits and the passive role it can impose on individuals receiving care (Slade 2008).

In contrast, the recovery-oriented approach reframes mental health as a holistic process in which individuals strive to live meaningful and fulfilling lives, regardless of the presence of ongoing symptoms (Slade 2008). Recovery is conceptualised not as a cure but as a personal journey of growth, empowerment, and social inclusion. The aim is to enable people to achieve goals and engage in valued activities, rather than focusing solely on the reduction of symptoms (Stickley & Hall 2017).

This shift aligns well with the principles of occupational therapy, which emphasise the importance of engaging in meaningful activities to promote health and well-being. Occupational science supports the notion that humans are inherently occupational beings, with participation in valued activities linked to enhanced quality of life and personal satisfaction (Wilcock 2005). Recovery-oriented practice integrates these principles by empowering individuals to take an active role in their own recovery and build a sense of purpose through meaningful occupation.

Recovery approaches also emphasise the social determinants of mental health, including factors such as social inclusion, housing, employment, and education, which are often overlooked in traditional models (Crowe & Deane 2018b). Policies across the UK and other countries now advocate for recovery-focused mental health services that prioritise person-centred

care, peer support, and the integration of mental health within community-based settings (Department of Health and Social Care 2021).

3.1.2 Recovery-oriented practice

Occupational therapists are uniquely positioned to facilitate recovery-oriented practices in mental health due to the alignment between occupational therapy principles and the values underpinning recovery-oriented approaches. Recovery in mental health emphasises the importance of enabling individuals to lead meaningful and fulfilling lives, moving beyond the traditional medical model's focus on symptom management. This approach aligns with the core tenets of occupational therapy, which view individuals as "occupational beings" who derive health and well-being from engaging in meaningful activities (Wilcock 2005; RCOT 2021a).

At the foundation of occupational therapy is the recognition that humans are inherently occupational beings, meaning that participating in meaningful activities (occupations) is essential for health and well-being. This concept is supported by occupational science, which posits that engagement in valued activities provides a sense of identity, purpose, and social connectedness (Wilcock 2005). When individuals face disruptions in their ability to perform these activities—due to mental ill-health, disability, or environmental barriers—they experience occupational deprivation, which can exacerbate mental health issues and diminish quality of life. Occupational therapists aim to address this by promoting engagement in activities that are meaningful to the individual, thereby supporting recovery through skill development, social participation, and a sense of empowerment (Kielhofner 2008; RCOT 2021a).

In mental health settings, individuals often experience limited opportunities for engaging in meaningful occupations. For instance, research indicates that people with severe mental health conditions may

find themselves under-occupied or engaging in passive activities that do not contribute to a sense of purpose (Shimitras et al. 2006). Occupational therapy interventions address this gap by facilitating participation in activities that enhance life satisfaction, promote a sense of identity, and encourage social connections.

The principles of recovery-oriented practice—such as person-centred care, autonomy, hope, and social inclusion—closely align with occupational therapy's emphasis on holistic, client-centred approaches. Occupational therapists adopt a strengths-based perspective, focusing on the individual's capacities and aspirations rather than deficits, empowering them to take an active role in their recovery journey (Stickley & Hall 2017; RCOT 2021). This approach not only addresses clinical symptoms but also considers broader social determinants of health, such as access to housing, employment, and community inclusion, which are crucial for sustained recovery (Crowe & Deane 2018b).

The integration of recovery principles into occupational therapy is further demonstrated through conceptual models of practice like the MOHO (Kielhofner 2008), which helps practitioners design interventions that align with clients' personal goals and values while taking into account the environmental factors that influence occupational performance (Kielhofner 2008). Using MOHO (Kielhofner 2008), therapists can develop tailored interventions that promote engagement in meaningful activities, thus enhancing the individual's autonomy, well-being, and sense of purpose.

RCOT emphasises that occupational therapists play a critical role in reducing health inequalities by working across various sectors, including health, social care, and community services. Their expertise in assessing and addressing the impact of social determinants on health enables them to advocate for equitable access to care and support individuals in overcome barriers to recovery (RCOT 2021a). For example, community

rehabilitation services led by occupational therapists can improve functional outcomes, enhance quality of life, and support the timely return to meaningful activities for individuals affected by long-term conditions or mental health challenges.

The profession's commitment to recovery-oriented practice extends beyond symptom management to supporting social justice and health equity. By promoting participation in meaningful activities, occupational therapists help individuals manage their symptoms while also enabling them to reconnect with their communities and build meaningful lives. This approach aligns with the broader goals of recovery-oriented practice, which emphasises living well with mental health conditions rather than simply eliminating symptoms (Stickley & Hall 2017).

The movement towards recovery-oriented practices in mental health represents a significant paradigm shift from the traditional medical model. While the medical model focuses on symptom alleviation and restoring individuals to a "normal" state, the recovery-oriented approach emphasises living a meaningful life despite the presence of ongoing symptoms (Slade 2008). This shift is supported by UK policy changes and guidelines that advocate for person-centred, recovery-focused care within mental health services (RCOT 2021a). The goal is to empower individuals, provide hope, and support them in achieving social inclusion and vocational opportunities, which are key components of the recovery model.

While recovery-oriented practices in mental health services are recognised for their potential to empower individuals, significant barriers persist. One key challenge is the prevalence of risk-averse approaches in clinical management, where concerns over safety and liability can limit opportunities for service users to engage in meaningful, therapeutic activities (Crowe & Deane 2018a).

Risk-averse policies often focus on minimising harm, resulting in restrictive practices that limit the types of activities available to mental health service users. According to the ONS, there was a 24% increase in restrictive interventions in the UK between 2020 and 2021, with practices such as physical restraints or seclusion being employed more frequently (ONS 2021). Additionally, nearly 60% of mental health professionals report that risk management measures, such as restricting community-based activities, are common, especially in inpatient settings (Mental Health Foundation 2024).

While prioritising safety is essential, these approaches can inadvertently reduce opportunities for recovery by discouraging activities that pose potential risks but also offer substantial therapeutic benefits. For instance, access to outdoor programs, social activities, and even creative therapies is often restricted, limiting the scope of interventions that can promote meaningful engagement and social integration (RCOT 2021b).

The restrictive nature of risk-averse practices has significantly impacted the availability and effectiveness of activity-based interventions, which are essential to recovery-oriented occupational therapy. As of 2020, only around 33% of mental health services consistently offered structured, activity-based rehabilitation programs, with the remaining services citing safety concerns as the primary barrier (RCOT 2021a). This can deprive individuals of opportunities to develop skills, resilience, and coping mechanisms that support long-term recovery.

Overly restrictive practices can lead to occupational deprivation, where individuals are unable to engage in meaningful activities that promote growth and recovery. ONS data indicates that nearly 70% of service users in inpatient settings reported limited access to engaging in therapeutic activities during the pandemic, contributing to feelings of stagnation and helplessness (ONS 2021). Furthermore, the prevalence of depressive

symptoms among adults in the UK rose from 10% before the pandemic to 21% in early 2021, underscoring the need for more holistic, engaging approaches in mental health care (ONS 2021).

Addressing these barriers requires a shift towards a balanced approach to risk. Recovery-oriented practices promote "positive risk-taking," where the benefits of therapeutic activities are considered alongside potential risks. Evidence suggests that adopting a positive risk-taking approach has led to improved outcomes in 40% of cases, with service users reporting increased confidence and autonomy (RCOT 2021a). Occupational therapists can facilitate this by designing graded activities that allow for safe participation while promoting meaningful engagement.

By moving away from overly restrictive measures and promoting more inclusive practices, mental health services can better align with the principles of recovery-oriented care, improving the quality and outcomes of mental health interventions.

3.2 Introduction to Activity-Based Interventions and occupational therapy

Occupational therapy plays an essential role in supporting individuals with mental health conditions by facilitating their engagement in meaningful activities, which are crucial for promoting well-being, life satisfaction, and social connections. This practice is rooted in the concept that engaging in valued occupations is integral to developing a sense of purpose, identity, and mental resilience, especially for those dealing with mental health challenges (Wilcock 2005; RCOT 2023).

Occupational therapists help individuals identify and address barriers to participating in everyday activities, which promotes holistic recovery

beyond merely alleviating symptoms. This approach has gained increased relevance as demand for mental health services rises; in the RCOT's 2023 survey, 86% of occupational therapists reported a marked increase in mental health cases, highlighting the growing need for accessible, person-centred care in the UK (RCOT 2023). Recent statistics show that one in six adults in the UK experiences a mental health issue, such as anxiety or depression, each week (Mind 2024). These findings highlight occupational therapy's role in providing supportive, recovery-focused services.

Activity-based interventions, which use purposeful activities to achieve therapeutic goals, are core to occupational therapy. These interventions, which may include physical exercise, creative arts, social engagement, and vocational training, are tailored to individual preferences and goals. A 2023 overview of systematic reviews showed that physical activity interventions could effectively reduce depression, anxiety, and distress in diverse populations (Singh et al. 2023). This study emphasised that physical activity may be more effective than pharmacological approaches in certain cases, as the latter can have side effects like weight gain and blood pressure issues, which can hinder adherence to treatment.

Engaging in structured, meaningful activities offers numerous therapeutic benefits. Skill Development: participating in purposeful activities helps individuals build essential skills, such as time management and problem-solving, in supportive environments. Approximately 70% of occupational therapy clients report improved daily functioning through these interventions (RCOT 2023). Social Connections: social isolation remains a significant challenge for those with mental health conditions; an estimated 5% of adults in the UK report severe loneliness (ONS 2021). Activity-based interventions, such as group gardening and art projects, promote social inclusion by reducing loneliness in nearly 60% of participants (RCOT 2021a). MOHO (Kielhofner 2008) provides a framework for designing these interventions, emphasising the importance

of personal motivation, social environments, and habitual patterns in promoting meaningful engagement (Kielhofner 2008).

Engaging in routine activities has shown promising effects in managing symptoms of anxiety and depression. A 2024 review found that regular physical activity can reduce depression symptoms by up to 35% over a three-month period (Mental Health Foundation 2024). Additionally, incorporating physical activity has been associated with moderate-to-large effects on improving mental health outcomes, particularly for anxiety and depression (Singh et al. 2023). This supports Wilcock's assertion that structured occupations positively influence physical, mental, and social well-being, aligning with the goals of occupational therapy in mental health (Wilcock 2005).

The RCOT's 2023 Workforce Survey highlights increased complexity in mental health cases, attributed in part to delayed interventions during the COVID-19 pandemic. This aligns with ONS data showing a 24% rise in depressive symptoms in the UK during the pandemic, further underscoring the need for comprehensive, activity-based therapeutic approaches (ONS 2021). The RCOT advocates for integrating social prescribing within mental health services, connecting individuals to community-based activities that align with their interests and promote social connection and recovery (RCOT 2021b; RCOT 2023).

The evidence base supports expanding activity-based interventions within occupational therapy, reinforcing their central role in promoting sustainable recovery and improving overall quality of life for individuals with mental health conditions.

Recovery Through Activity (Parkinson 2014) is a structured, activity-focused framework developed for use in occupational therapy. This framework emphasises the therapeutic potential of meaningful activities, guiding therapists in designing interventions that encourage clients to

participate in daily tasks and pursuits that resonate with their values and goals. By focusing on real-world activities, Recovery Through Activity (Parkinson 2014) aims to enhance mental health through engagement in purposeful occupations that promote a sense of accomplishment, connection, and personal growth.

Recovery Through Activity (Parkinson 2014) draws on principles from the MOHO (Kielhofner 2008), which highlights the importance of volition (motivation), habituation (routine), performance capacity, and environmental influences in shaping a person's engagement in meaningful occupations (Kielhofner 2008). Recovery Through Activity (Parkinson 2014) aligns with these MOHO (Kielhofner 2008) components by enabling therapists to create client-centred interventions that reflect an individual's preferences and strengths. Research supporting MOHO (Kielhofner 2008) demonstrates that occupational engagement can improve daily functioning, mood, and overall life satisfaction, which are essential aspects of mental health recovery (Kielhofner 2008).

The RCOT promotes occupation-based, client-centred practices that prioritise social inclusion and equity. According to the RCOT's 2023 Workforce Survey, the demand for mental health services in occupational therapy has risen, with 86% of therapists noting an increase in mental health cases (RCOT 2023). Recovery Through Activity (Parkinson 2014) aligns with RCOT's standards by providing an adaptable framework that therapists can tailor to individual needs, promoting meaningful engagement and autonomy in mental health care.

In line with recovery-oriented practices, which prioritise helping individuals build lives filled with purpose and meaning, Recovery Through Activity (Parkinson 2014) provides people with opportunities to engage in valued activities that support mental health. A recent study indicates that structured, activity-based interventions can lead to reductions in

depressive symptoms by up to 35% and improve overall life satisfaction by 25% within three months (Mental Health Foundation 2024). By promoting autonomy, connection, and skill-building, Recovery Through Activity (Parkinson 2014) emphasises the importance of self-directed recovery, where clients play an active role in managing their well-being and reintegrating into their communities.

To set the foundation for research evaluating the use of Recovery Through Activity (Parkinson 2014), a scoping review was necessary to map existing research on activity-based interventions within mental health care, focusing specifically on how occupational therapists and service users experience these interventions. This review provided a comprehensive overview of available evidence, helping to identify the strengths and limitations in the current research and guiding the design of this thesis.

The scoping review was particularly relevant because while Recovery Through Activity (Parkinson 2014) has demonstrated potential in facilitating recovery-oriented practices, there has been limited research evaluating its direct impact in mental health settings. By systematically reviewing studies related to activity-based interventions, the review highlighted gaps in knowledge, particularly regarding service users' perspectives and the measurable outcomes of using structured, activity-focused frameworks. This informed the research design by identifying areas that required further exploration, such as the specific mechanisms through which activity engagement promotes well-being and the role of personalised, activity-centred interventions in supporting sustainable recovery outcomes.

3.2.1 Rationale for scoping review

In this research, a scoping review was selected as the most suitable approach for systematically mapping the existing literature on activity-

based interventions in mental health. Scoping reviews are especially valuable in emerging fields where existing research is limited or varied in quality and methodology. This approach is particularly well-suited for providing a comprehensive overview that captures a wide range of evidence, including qualitative, quantitative, and mixed-methods studies, and aligns with the exploratory aims of this research. Unlike other review types, such as systematic and general literature reviews, scoping reviews allow for greater flexibility and inclusivity, making them ideal for examining diverse evidence and identifying gaps (Arksey & O'Malley 2005; Levac et al. 2010; Munn et al. 2018).

Compared to a systematic review, which is designed to address a narrowly defined research question and relies on high-quality, homogenous evidence, a scoping review is exploratory and broad in scope. Systematic reviews typically involve a rigid selection process and strict inclusion criteria, often excluding studies that do not meet specific methodological standards. This approach is ideal for fields with well-established research bases and focused questions, but it is less suitable in emerging fields with limited high-quality evidence. For this research, a systematic review would have restricted the range of studies included, potentially overlooking critical qualitative insights into occupational therapists' and service users' experiences with activity-based interventions (Arksey & O'Malley 2005; Levac et al. 2010).

General literature reviews, on the other hand, provide narrative overviews of a topic but lack the structured, transparent process that characterise scoping reviews. While literature reviews can offer valuable insights, they do not systematically identify gaps or outline future research directions, which are essential for developing fields. Scoping reviews follow a rigorous and replicable process that enables researchers to ensure all relevant literature is included and analysed, providing a foundational

overview of both established knowledge and gaps in understanding (Munn et al. 2018).

The decision to use a scoping review was particularly beneficial for this research's objectives, which involved evaluating the Recovery Through Activity framework (Parkinson 2014) in mental health occupational therapy. Scoping reviews are inherently flexible, allowing the inclusion of diverse study types, such as qualitative, quantitative, and mixed methods, without excluding studies based on strict methodological criteria. This inclusivity was essential for capturing a holistic view of both occupational therapists' and service users' experiences, which encompass both empirical data and nuanced, subjective insights. By accommodating various study designs, the scoping review provided a broad understanding of existing evidence on activity-based interventions and Recovery Through Activity (Parkinson 2014), thus setting a solid foundation for the research design.

The comprehensive nature of scoping reviews aligns well with the exploratory aims of this research, as they allow researchers to assess the "depth and breadth" of the literature (Levac et al. 2010). This approach facilitated the identification of key themes, gaps in research, and areas requiring further investigation. For example, the scoping review highlighted limited research on the direct impact of Recovery Through Activity (Parkinson 2014) on service users and the mechanisms through which engagement in meaningful activities supports mental health recovery. These insights guided the research study's focus, informing questions and objectives that address critical gaps in the literature.

Ultimately, the scoping review's structured yet flexible approach was essential for developing an evidence-informed foundation for this research, providing a comprehensive overview that other review types could not achieve. By including a wide range of evidence and mapping out

what is currently known, the scoping review ensured that this study design aligned closely with the identified knowledge gaps, supporting the development of a well-rounded evaluation of the Recovery Through Activity (Parkinson 2014) framework and its potential benefits in mental health occupational therapy.

3.2.2 Literature Gaps and Aim of the Scoping Review

The scoping review was conducted to address a significant gap in the literature regarding occupational therapists' and service users' experiences with activity-based interventions within mental health settings. While occupational therapists are well-positioned to implement recovery-oriented practices, limited evidence exists on how structured, activity-focused frameworks like Recovery Through Activity (Parkinson 2014) are perceived and experienced by both providers and service users. Research on activity-based interventions is growing, yet much of the existing literature focuses on general occupational therapy interventions without examining specific frameworks like Recovery Through Activity (Parkinson 2014) or systematically assessing their outcomes in mental health care (Lund et al. 2019a; Eklund et al. 2017). The lack of targeted research on this topic highlighted the need for a scoping review to synthesise existing studies and provide insights that would inform the design of this research.

The primary aim of this scoping review was to synthesise existing literature on the experiences, opportunities, challenges, and effectiveness of activity-based interventions in adult mental health. Specifically, it sought to explore occupational therapists' and service users' perspectives on these interventions, focusing on both their therapeutic benefits and potential barriers to implementation. By examining studies across

qualitative, quantitative, and mixed methods, the review provided a structured, comprehensive overview of key themes within the literature to clarify the role and impact of activity-based interventions in mental health and to inform future research directions.

Conducting this scoping review was instrumental in developing the design of this research, ensuring that its questions were aligned with these identified knowledge gaps. Themes and gaps highlighted in the review—particularly regarding the broader applicability of Recovery Through Activity (Parkinson 2014)—directly informed the research objectives and methodology, establishing a foundation for evaluating this framework in ways that contribute to the evidence base on recovery-oriented occupational therapy in mental health.

3.3 Methods

Data Search

This scoping review systematically explored existing literature on activity-based interventions within adult mental health, specifically examining the experiences of occupational therapists and service users. To ensure a comprehensive and rigorous search, eight major databases were included: the Cochrane Database of Systematic Reviews, OT Seeker, CINAHL via EBSCO, Scopus, Web of Science, Medline via Ovid, PsycINFO, and Embase. Each database was chosen for its relevance to occupational therapy, psychology, and health sciences, covering essential fields that intersect with mental health intervention studies. Search terms were organised around core concepts—such as “occupation,” “occupational therapy,” “manual,” and “mental health”—and Boolean operators were used to refine these terms further. The search was limited to studies published between 2014 and 2021, with only English-language articles

included to maintain accessibility and ensure consistency across the dataset (Arksey & O'Malley 2005; Levac et al. 2010).

The inclusion criteria targeted studies that focused on adults aged 18-64 to ensure age-related relevance to adult mental health intervention outcomes. Studies involving children or older adults were excluded due to differences in developmental, social, and cognitive factors that could affect generalisability to the target adult population. The review included studies involving both occupational therapy staff and service users within mental health services, which allowed for a comprehensive view of the perspectives of both providers and recipients regarding activity-based interventions, particularly those related to Recovery Through Activity (Parkinson 2014).

To capture a broad range of insights, the review included qualitative, quantitative, and mixed-methods studies. Qualitative studies provided in-depth perspectives of the lived experiences of participants, while quantitative studies offered measurable outcomes related to the interventions. Mixed-methods studies combined both approaches, contributing a holistic view of the impacts and perceptions surrounding these interventions. The focus was exclusively on studies that examined activity-centred, occupational therapy interventions to ensure relevance to the review's aims, especially in evaluating Recovery Through Activity's (Parkinson 2014) therapeutic potential in adult mental health.

Several exclusion criteria helped refine the selection process further. Studies focused on children, adolescents, or older adults were excluded to ensure findings were specific to adults aged 18-64 years. Additionally, studies that did not centre on occupational therapy-led or activity-based interventions were excluded to maintain the data’s relevance and specificity to the review’s objectives. An automated tool filtered out studies with keywords indicating irrelevant topics—such as “children,”

“adolescents,” “elderly,” and unrelated conditions like “stroke” or “dementia”—in their titles or abstracts. This tool streamlined the search, reducing an initial pool of 18,645 articles to a more focused subset, thereby enhancing the relevance and efficiency of the selection process.

Lastly, only studies in English and those available in full text were included to maintain consistency in data interpretation and ensure comprehensive analysis.

PRISMA Flowchart

The PRISMA (Preferred Reporting Items for Systematic Reviews and Meta-Analyses) (Page et al. 2021) flowchart visually represents the step-by-step process used to identify, screen, and select studies for inclusion in this scoping review. The purpose of the PRISMA (Page et al. 2021) flowchart is to enhance transparency by clearly outlining each stage of the selection process, from the initial search to the final inclusion of studies. This structured approach helps readers understand how studies were filtered and the rationale for excluding certain records, ensuring that the methodology is both replicable and comprehensive.

Flowchart Details

The review began with an extensive search across eight databases—Cochrane, Scopus, Medline via Ovid, Web of Science, OT Seeker, CINAHL via EBSCO, PsycINFO, and Embase—yielding a total of 18,645 records. During the initial identification phase, automation tools were employed to exclude 14,171 records based on irrelevant keywords, such as “children,” “adolescents,” “elderly,” or unrelated conditions like “stroke” and “dementia.” This automated filtering helped reduce the pool to a more manageable 4,474 records for further screening. Duplicates were managed through EndNote software, removing 93 redundant entries,

which ensured that only unique and relevant studies proceeded to the next phase.

Following this, records underwent a title and abstract screening, where an additional 4,340 records were excluded for not meeting the review's specific criteria, leaving 41 articles.

The remaining 41 articles were then retrieved in full text and assessed for eligibility. Studies were excluded at this stage if they did not focus on occupational therapy-led, activity-based interventions central to the review's aims. This assessment led to the exclusion of 31 articles, as they did not meet the criteria of being occupational therapy-led or activity-focused. Consequently, 10 studies were retained for inclusion in the final review.

The PRISMA flowchart in figure 1. provides a clear, visual breakdown of this systematic filtering process, illustrating how the review reached its final set of included studies through a rigorous and transparent methodology.

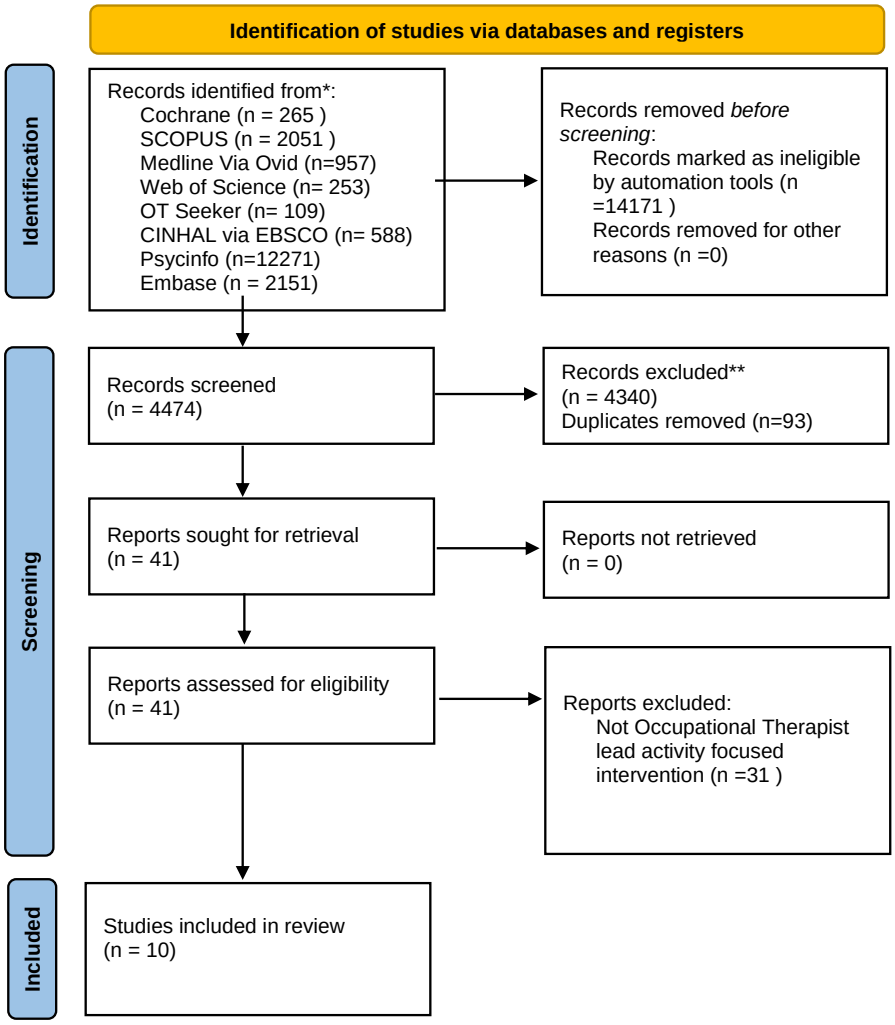


Figure 3 Flowchart of study retrieval and selection process (adapted from PRISMA)

Data extraction

In the scoping review, a rigorous data extraction process was employed to capture relevant insights and themes aligning with the review's objectives. Data extraction was conducted manually to ensure that important study details and findings, such as population, intervention type, and key outcomes, were thoroughly examined. This manual approach allowed for nuanced interpretation, ensuring that the subtleties of each study's findings were preserved and interpreted within the context

of the review's focus on Recovery Through Activity (Parkinson 2014) and similar frameworks in adult mental health settings.

To assess the quality of each study, the Critical Appraisal Skills Programme (CASP 2024) tools were used, which provided a structured approach for evaluating methodological rigor. CASP tools, tailored to different study designs, helped ensure consistency across qualitative, quantitative, and mixed-method studies. Through a series of critical questions, CASP (2024) was used to evaluate study credibility, relevance, and rigor by examining aspects such as sample selection, data collection, and analysis methods. Using CASP (2024) in this way allowed the review to not only ensure the inclusion of quality studies but also to highlight methodological limitations, which informed the synthesis and interpretation of findings in a way that acknowledged each study's context and constraints.

This combined use of manual data extraction, deductive thematic analysis, and CASP (2024) appraisal tools contributed to a systematic, structured analysis, ensuring that the scoping review's findings were both comprehensive and critically evaluated. Together, these methods provided a solid foundation for interpreting the evidence surrounding occupational therapy-led, activity-based interventions in mental health.

In the data recording and organisation phase, data from each included study was systematically recorded and organised to ensure accurate and structured analysis.

Once data recording was complete, a manual coding process was employed to identify and categorise themes within the data. Thematic analysis followed a deductive approach, focusing on pre-identified domains within the Model of Human Occupation (MOHO) (Kielhofner 2008). The MOHO (Kielhofner 2008) provided a structured lens for organising themes, with four core domains—volition, habituation,

performance capacity, and environmental context—each offering specific insights into the occupational therapy-led, activity-based interventions being studied.

- Volition captured themes related to personal motivation, self-concept, and readiness for change, aspects that are critical in recovery-oriented mental health interventions.
- Habituation included themes on routines and roles, exploring how individuals established consistent engagement in meaningful activities as part of their recovery journey.
- Performance Capacity focused on skills and abilities, encompassing both the physical and psychological aspects of performing everyday tasks.
- Environmental Context considered the social and physical environments influencing participation, covering factors like group dynamics and resource availability.

This process of categorising themes using MOHO's (Kielhofner 2008) domains facilitated a cohesive synthesis of the findings, linking study outcomes to well-established theoretical constructs in occupational therapy. Through this structured organisation, the review presents a comprehensive and organised summary of the evidence on activity-based interventions in mental health settings, supporting a deeper understanding of how such interventions align with Recovery Through Activity (Parkinson 2014).

Data Analysis and Theme Development

In the data analysis process, theme identification began with an initial review of data, where key concepts emerged consistently across studies. Central themes included sense of self, occupational balance, group dynamics, skill development, and symptom management. Each of these areas relates directly to essential aspects of mental health recovery and engagement in therapeutic activities. For instance, the theme of "sense of

self” highlighted how participation in activity-based interventions impacted individuals' self-concept and their readiness for change, illustrating how engagement in activities can build confidence and motivation to embrace recovery. Similarly, occupational balance emphasised the importance of finding stability between different life roles and routines, which can be disrupted by mental health challenges (Parkinson 2014).

The themes identified were refined through an iterative review process to ensure alignment with the review’s primary aims, focusing specifically on the experiences and therapeutic outcomes of activity-based interventions for both service users and occupational therapy staff. By continuously revisiting and grouping these themes, the analysis preserved coherence and depth, creating a structured narrative of how each theme contributes to the therapeutic process.

This approach was inductive because the themes were not predetermined but emerged organically during the data analysis. By carefully reviewing the data, recurring concepts such as 'sense of self' and 'occupational balance' became apparent. These themes were developed through an iterative process, allowing the analysis to stay rooted in the experiences described within the studies, rather than being guided by pre-existing frameworks.

3.4 Findings

Introduction

This section presents the key findings from the scoping review, organised around themes and subthemes that emerged from the literature on occupational therapy-led, activity-based interventions within adult mental health settings. It provides a descriptive account of the data, maintaining

a factual focus without engaging in analysis or interpretation. Please see table 1 for general article characteristics.

Table 1 - Summary of articles

Summary of Articles		
Study Title	**Author**	**Methods and appraisal**
Effectiveness of Balancing Everyday Life (BEL) versus standard occupational therapy for activity engagement and functioning among people with mental illness – a cluster RCT study – 2017	Mona Eklund, Carina Tjörnstrand, Mikael Sandlud and Elisabeth Argentzell	Cluster randomized control trial. Participants were split into two groups. The BEL group (activity focused lifestyle intervention) included 133 participants and the Care as usual group (CAU). Participants completed self-report questionnaires targeting activity and well-being. OT specific and non-OT specific outcome tools used. In settings where there was only once occupational therapist in situation, other professionals co-facilitates the sessions, it is important to note this as it could have influenced the intervention outcomes. It is also important to note that both groups were

		largely represented by females, which may impact generalizability.
Recovery Programs for People with Mental Illness in Taiwan: A Feasibility Study - 2020	Yen-Ching Chang, Ming-De Chen, Susan A. Pickett, Po See Chen, Wen-Chen Sul	Action research evaluating a recovery program, which was carried out over 18 weeks, 1 hour a week. The stages of recovery scale were carried out pre-test, mid test and post-test. A questionnaire was completed, and a 30-min discussion was carried out at the end of each phase The majority of participants in this study were female and had a high level of education. This is important to note when considering generalizability.

Group leader and participant perceptions of Balancing Everyday Life, a group-based lifestyle intervention for mental health service users – 2020	Kristine Lund, Jenny Hultqvist, Ulrika Bejerholm, Elisabeth Argentzell & Mona Eklund	This study was part of a larger scale study which was conducted to evaluate the BEL intervention. This study focused on Staff and service user perspectives. Focus groups and interview carried out. 12 group leaders were interviewed and 19 service users. This study was carried out in Sweden. It is important to consider transferability to other areas which may differ in physical, social and/or occupational environments.
"I'm not alone": Women's experiences of recovery-oriented occupational therapy	Woolley, H. et al.	Semi- structured interviews carried out over the course of a month with 10 women who attended recovery-oriented groups focused on facilitating return to work.

groups following depression – 2020		This study focused on the experiences of women, this should be considered in regard to transferability to female groups and mixed gender group interventions.
Evaluation of an occupation-based, mental-health program: Meeting being, belonging and becoming needs - 2021	Rebeiro Gruhl, K.L. et. al	NISA (Northern Initiative for Social Action) - an occupation-based, mental health program 113 participants completed a questionnaire including demographic information, the 3Bs scale and rating intervention satisfaction This study was carried out in Canda. It is important to consider transferability to other areas which may differ in physical, social and/or occupational environments
Occupational therapy interventions in mental health: a scoping review	Petersen et al	The scoping review involved searching six databases, covering articles from 2003 to 2018. A total of 21 original studies and 4 systematic reviews were included in this review. Interventions, approaches, programmes,

of recent evidence - 2019		training, and activities such as cooking, artwork, crafts, pottery, sports, calligraphy, horticulture, and music, organised individually or in groups, were investigated in the included studies. Only quantitative studies were included in this study. The study identified that qualitative. studies could help identify from the patients' perspective interventions of importance.
The experiences of people with severe mental health conditions participating in the Occupation.	Newport and Clarke	Semi-structured interviews and Interpretative phenomenological analysis exploring the service users experience of the Occupation Matters Programme. Four participants were interviewed. The researcher was located within the trust where the study was located. The researcher is also the lead on the Occupation

Matters Programme: Interpretative phenomenological analysis - 2020		Matters Programme. It is important to note this in regard to bias and researcher influence. In order to minimize these impacts, the researcher had not worked in the community team, did not facilitate the intervention or know the participants.
Joining, belonging, and re-valuing: A process of meaning-making through group participation in a mental health lifestyle intervention - 2019	Lund et al	26 interviews with 19 participants from 10. BEL groups were completed from June 2013 through May 2017. Fifteen participants (12 women and 3 men) were interviewed one week to six months after the BEL course end. Four participants (2 women and 2 men) were interviewed in the middle of the course and then again one month after the end.

		Both interviewers were experienced occupational therapists, which may have had an influence on the interview, however they were blind to the BEL manual contents.
Breaking a cycle of perceived failure: The process of making changes toward a more balanced lifestyle - 2019	Lund et al	Participants were interviewed after completing. the BEL intervention. Intensive interviews were used as a means of collecting data with 19 BEL participants. A total of 29 interviews took place. In addition, seven follow- up interviews with five participants took place one and one half to two years after the intervention to gain a longitudinal perspective on making changes and to give feedback on the emerging theory. It is important to consider that there could potentially be positive bias from the participants who agreed to be interviewed. In addition, all participants grew up in Sweden.

Exploring mediators of the recovery process over time among mental health service users, using a mixed model regression analysis based on cluster RCT data – 2020	Argentzell et al.	This study included people who had participated in an RCT study and consisted of two subsamples; those who had received the activity-based intervention BEL and those who had received Standard occupational therapy. A total of 226 participants were included: 133 from BEL units and 93 from SOT units. Self-report and interview-based instruments were administered. It is important to consider that the standard occupational therapy is quite broad, and it is difficult to make a comparison without know what interventions were being carried out.

The scoping review aimed to address four primary areas: occupational therapists' experiences in delivering activity-based interventions, the opportunities and challenges of implementation, service users' perceptions, and the interventions' effectiveness in mental health contexts. The themes drawn from the studies reflect core aspects of how these interventions influence both service users and therapists. Each of the primary themes—Sense of Self, Occupational Balance, Group Dynamics, Skill Development, Symptom Management, Structure and Flexibility, and Physical Environment—illustrates a unique facet of recovery-oriented occupational therapy, with subthemes that add specificity to the findings.

To provide a structured perspective on these themes, the findings are organised according to the MOHO (Kielhofner 2008) as seen in table 2. This conceptual model of human occupation categorises themes under four domains: *Volition, Habituation, Performance Capacity,* and *Environmental Context.* Within *Volition,* themes such as Sense of Self and Building Connections emphasise aspects like identity reconstruction, readiness for change, and shared experiences that reinforce personal agency and motivation. *Habituation* addresses Occupational Balance, highlighting the importance of routine, priority-setting, and self-care in promoting stability and well-being. *Performance Capacity* encompasses Skill Development and Symptom Management, capturing the practical skills and emotional regulation strategies that empower participants in their daily lives. Finally, the *Environmental Context* includes themes related to Group Dynamics, Structure and Flexibility, and the Physical Environment, emphasising the impact of social and physical settings in supporting recovery and engagement.

By framing the findings through the MOHO (Kielhofner 2008), this section demonstrates the multidimensional impact of activity-based interventions on mental health recovery. This structure serves as a foundation for the interpretative analysis that will follow in later sections, illustrating how these interventions align with recovery-oriented principles in occupational therapy and support the goals of Recovery Through Activity (Parkinson 2014).

Table 2 - Summary of findings

MOHO Domain	Theme	Subtheme	Brief Description
Volition	Sense of Self	Readiness for Change	Participants expressed a readiness to reflect and adapt, a precursor to identity shifts through intervention participation.
		Identity Reconstruction	Transformation from illness-centred to a self-affirming identity.
		Self-Compassion and Self-Acceptance	Developing a forgiving, supportive self-view that enabled positive self-discovery.

		Personal Agency and Empowerment	Engaging actively in recovery, increasing independence and decision-making confidence.
	Building Connections	Peer Support	Participants valued mutual support from others on similar journeys, providing encouragement and validation.
		Shared Experiences	Shared struggles reduced isolation, creating empathy and unity within groups.
Habituation	Occupational Balance	Routine Establishment	Structured routines created stability, with daily rhythms reducing uncertainty and enhancing focus.
		Priority Setting	Learning to prioritize tasks helped participants manage stress and focus on well-being.

		Self-Care and Boundaries	Participants integrated self-care and established boundaries to sustain mental health and avoid burnout.
Performance Capacity	Skill Development	Coping Mechanisms	Participants developed strategies for managing stress and emotional challenges.
		Self-Management	Gaining control over routines and proactively setting recovery goals enhanced self-efficacy and daily functionality.
	Symptom Management	Emotional Regulation	Techniques to moderate symptoms through structured engagement and support systems.
		Stress Relief	Physical and creative activities provided an outlet for tension, aiding mental clarity and reducing intrusive thoughts.

Environmental Context	Group Dynamics	Peer Support	Group settings created a foundation for building relationships and validating experiences.
		Facilitator Role	Facilitators who promoted openness and relatability strengthened trust and group cohesion.
		Shared Experiences	Hearing others' stories and participating in group activities promoted unity and normalized mental health struggles.
Occupational Context	Structure and Flexibility	Adaptability to Individual Needs	Flexible intervention structures allowed participants to adjust their engagement based on their needs, promoting accessibility and personalized support.
		Session Length and Structure	Extended or flexible session lengths provided space for participants to deeply engage and process recovery activities without feeling rushed.

		Supportive Framework and Goal Setting	Participants valued structured frameworks that set personal goals and milestones, promoting stability and individualized pacing in the intervention.
		Booster Sessions and Post-Intervention Support	Booster sessions and group outings offered continuity, reinforcing learned skills and providing continued support beyond formal intervention periods.

3.5 Volition

Taylor (2017) states volition is a dynamic process involving anticipation, making decisions, experiencing doing occupations, interpreting, and evaluating. Volition is framed as three key elements within the MOHO (Kielhofner 2008); these are personal causation, values and interests. Personal causation considers self-efficacy, as well as one's sense of capacity. Values considers one's personal convictions and sense of obligation based on life values. Interests considers enjoyment and pleasure, as well as one's interest patterns (Taylor 2017). The key themes that were identified in the literature in relation to volition were: sense of self and building connections (which links in with the MOHO's volitional aspect of personal causation) and building connections (which links with the MOHO's volitional aspect of values). Each theme had sub themes which are explore further below.

Sense of Self subthemes:

Readiness for Change: Emphasis on participants' preparation for self-reflection and adaptation through activity-based interventions.

Identity Reconstruction: Transformation of self-concept, reclaiming identity beyond mental health challenges.

Self-Compassion and Self-Acceptance: Learning to approach oneself with kindness, reducing self-criticism.

Personal Agency and Empowerment: Gaining control, independence, and confidence through activities.

Building Connections sub themes:

Peer Support: Mutual understanding and shared journey among participants.

Shared Experiences: Value in common struggles and collective healing within groups.

3.5.1 Volition - Sense of Self

The theme of "sense of self" reflects how participants engaged in activity-based interventions reported shifts in their self-concept, identity, and motivation. This theme captures the transformative journey that individuals experienced as they reclaim or redefine their sense of identity and self-worth, often compromised by mental health challenges. In the context of mental health recovery, this change in self-perception is essential, as it supports individuals in seeing themselves beyond their diagnoses, promoting confidence and agency (Parkinson 2014; Kielhofner 2008).

The studies reviewed provide numerous examples of how sense of self emerged as a significant outcome of activity-based interventions. For instance, Lund et al. (2019a) highlighted that participants reported feeling a stronger connection to their identities and a sense of purpose, which they attributed to participating in meaningful activities. This renewed sense of self was often accompanied by personal revelations about one's abilities and value, moving away from a self-perception dominated by illness to one marked by capability and hope.

Several participants in Eklund et al. (2017) and Woolley (2020) mentioned concepts such as "identity reconstruction" and "readiness for change." These concepts illustrated how individuals saw themselves evolving through engagement in activities that encouraged self-expression and self-compassion. This redefinition of identity, supported by structured, goal-oriented activities, contributed to a stronger foundation for recovery and motivation (Lund et al. 2019b).

Sense of self subtheme 1: Readiness for Change

Readiness for change emerged as an important subtheme in participants' journeys toward redefining their sense of self. This subtheme reflected participants' emotional and psychological preparation for engaging in activities that required self-exploration and adaptation. Many studies show that readiness to change is often a precursor to the positive shifts in self-identity that activity-based interventions aim to promote (Lund et al. 2019b; Rebeiro Gruhl et al. 2021).

Lund et al. (2019a) found that participants in the *Balancing Everyday Life* (BEL) intervention exhibited a readiness to confront ingrained beliefs about themselves, and this openness laid the groundwork for personal growth. Participants described this phase as a moment of permission to fail, indicating a more compassionate, patient approach to self-evaluation. This acceptance of vulnerability was vital for participants to engage meaningfully with activities that challenged their self-concept, gradually promoting a new perspective on their identities (Lund et al. 2019a).

Rebeiro Gruhl et al. (2021) observed that participants who were prepared for change were more likely to benefit from social interactions in a supportive group setting. This readiness allowed individuals to step out of their comfort zones, participate fully, and relate to others through shared experiences, reinforcing their journey toward self-redefinition (Rebeiro Gruhl et al. 2021).

Sense of self Subtheme 2: Identity Reconstruction

Identity reconstruction captured the process participants underwent in redefining who they were beyond their diagnoses. This subtheme reflects a significant shift from a limited, illness-centred identity to one that encompasses broader, self-affirming characteristics. In the context of mental health, redefining identity involves a transformative self-view that

promotes agency, resilience, and a deeper connection to personal strengths and aspirations (Parkinson 2014; Newport & Clarke 2020).

Woolley et al. (2020) noted that women participating in recovery-oriented occupational therapy groups experienced a type of "identity rebirth," where they moved beyond feeling defined by depression to seeing themselves as capable individuals with new possibilities. For these participants, activities such as art and group discussions provided a safe space to explore and rebuild their identities, reclaiming a sense of self-worth that was independent of their mental health challenges (Woolley et al. 2020).

Similarly, the findings from Newport and Clarke (2020) in the *Occupation Matters Programme* indicated that participants found themselves through connecting with others and engaging in meaningful projects. As participants reframed their sense of self within a non-medicalised setting, they developed a more empowered identity, ultimately recognising themselves as valued and contributing members of their communities (Newport & Clarke 2020). This process is closely aligned with the MOHO, where volition and identity are reinforced by occupational engagement (Kielhofner 2008).

Sense of self subtheme 3: Self-Compassion and Self-Acceptance

Self-compassion and self-acceptance described the gentle, forgiving view of oneself that participants began to cultivate through these interventions. As individuals engaged in structured activities, they learned to view their limitations and failures more compassionately. This shift often acted as a foundation for participants to explore their abilities without fear of judgment, creating a supportive inner environment for self-discovery and growth (Parkinson 2014).

Eklund et al. (2017) observed that participants developed self-compassion as they engaged in activities that challenged but did not overwhelm them. Many described learning to be "kinder to themselves," a critical step that reduced self-criticism and made room for positive self-perception. For these participants, accomplishments within the BEL program promoted a sense of self-worth, which allowed them to accept their mental health journey without attaching negative self-judgments to it (Eklund et al. 2017).

In Lund et al. (2019a), self-compassion emerged as participants spoke about forgiving themselves for setbacks. This mindset enabled them to engage in the BEL program with openness, viewing each small success as part of a larger journey rather than a final judgment of their abilities. (Lund et al. 2019a).

Sense of self subtheme 4: Personal Agency and Empowerment

Personal agency and empowerment referred to the increased control and independence participants felt as they engaged in activities that allowed for self-direction and self-expression. This subtheme highlights the transition from passive recipient of care to active participant in one's own recovery, reinforcing participants' belief in their own abilities and choices (Kielhofner 2008).

According to Chang et al. (2020), participants in Taiwan's recovery program noted a significant rise in their sense of agency. By taking ownership of their activities and accomplishments, individuals described feeling "empowered" to pursue additional personal goals. This empowerment was particularly evident in the way participants began setting realistic goals for themselves, reflecting an enhanced sense of control over their lives (Chang et al. 2020).

Argentzell et al. (2020) similarly found that agency was a core outcome of activity-based interventions. As participants engaged in structured tasks, they developed practical coping skills and gained confidence in decision-making. The ability to make small choices within the interventions—such as choosing the order of activities or setting personal goals—reinforced their sense of agency and contributed to a lasting belief in their own efficacy (Argentzell et al. 2020).

3.6 Volition - Building Connections Theme

The theme of "Building Connections" reflected the powerful role of social support and shared experiences in promoting recovery within activity-based occupational therapy. Engaging in group interventions allows participants to form bonds with others who share similar journeys, creating a safe space for mutual validation and encouragement. This theme is critical in mental health recovery, where isolation and stigma often hinder individuals' ability to feel seen and understood. Building connections within these groups supports participants' self-esteem, emotional resilience, and sense of belonging, which are essential for a sustainable recovery process (Parkinson 2014; Kielhofner 2008).

Studies consistently emphasised the positive impact of forming connections within group-based interventions. Lund et al. (2019b) found that participants in the BEL intervention reported feeling supported and validated by their peers. This experience of building connections helped participants develop a renewed sense of purpose and acceptance, promoting a therapeutic environment that extended beyond the sessions (Lund et al. 2019b). Similarly, Woolley (2020) highlighted that women participating in recovery-oriented groups described the unique comfort they felt in the presence of others who understood their struggles. This mutual empathy contributed to a foundation of trust and openness, which

many participants found crucial for their emotional well-being and recovery journey (Woolley 2020).

Newport and Clarke (2020) further found that participants in the Occupation Matters Programme valued the shared journey with peers. Being able to discuss common challenges and achievements promoted a sense of community, reducing isolation and creating a supportive network. Participants expressed feeling a collective strength from their group, which encouraged them to stay committed to their recovery. This sense of connection reinforced the therapeutic power of group-based activity interventions, demonstrating how the social aspect of occupational therapy can enhance individual resilience (Newport & Clarke 2020).

Building connections Sub theme 1: Peer Support

Peer support captured the sense of camaraderie and mutual understanding that develops between participants as they navigate their recovery journey together. For many, the experience of being around others who share similar experiences provides unique validation and support, which may not be achievable through individual interventions. Peer support is particularly beneficial for individuals with mental health challenges, as empathy from those facing similar struggles promotes a safe space for open expression, creating a foundation for self-discovery and healing.

In Argentzell et al. (2020), participants emphasised the importance of peer support in activity-based interventions, describing how the knowledge that others were “in it together” offered reassurance and strength. This sense of solidarity helped participants feel less isolated in their struggles, and they often drew motivation from the achievements of others in the group. Statements like “others get it too” highlight how the experience of being supported by peers contributed to participants’ resilience and promoted a sense of shared responsibility toward each

other's growth (Argentzell et al. 2020). Woolley (2020) also found that women in occupational therapy groups appreciated the supportive environment that peers created, as it allowed them to feel understood and accepted without stigma. This validation within peer support was instrumental in reducing feelings of loneliness and fear, creating a trusted network that many found integral to their recovery (Woolley 2020).

In Newport and Clarke (2020), participants described how peer support provided essential encouragement and comfort. Group discussions and activities allowed participants to bond over shared experiences, creating a community that promoted collective resilience. The act of supporting each other, as well as receiving support, created a balanced dynamic that strengthened individuals' sense of agency and emotional resilience, showing how peer support within a group setting could be a critical factor in effective mental health interventions (Newport & Clarke 2020).

Building connections Sub theme 2: Shared Experiences

Shared experiences refer to the collective journey that participants undergo within group interventions, where individuals can see their own challenges reflected in the lives of others. This aspect of building connections enabled participants to relate to each other's struggles and achievements, promoting a strong sense of unity and mutual understanding. In the context of mental health recovery, shared experiences provide validation, help reduce feelings of isolation, and normalise participants' struggles as part of a common journey.

The value of shared experiences was highlighted across multiple studies, with participants often noting the comfort and connection that came from recognising their own struggles in others' stories. In Petersen et al. (2019), participants in group-based activity interventions reported a sense of relief and acceptance as they saw peers facing similar challenges. One participant noted, "It's like we're all in this together,"

which highlights how shared experiences promoted a collective resilience and strengthened social bonds within the group (Petersen et al. 2019).

Rebeiro Gruhl et al. (2021) also observed that shared experiences encouraged participants to open up about their own lives, feeling secure in knowing that others had faced comparable challenges. This openness contributed to a shared journey of empathy and support, allowing individuals to draw strength from each other's resilience. Lund et al. (2019a) further emphasised the importance of shared experiences in promoting a sense of belonging. Participants expressed feeling "part of something bigger," which played a pivotal role in their recovery by creating a space where they felt both seen and supported within a community (Lund et al. 2019a).

3.7 Habituation

Taylor (2017) explains habituation is guided by one's habits and roles and refers to one's readiness to exhibit consistent patterns of behaviour. Three types of habit are considered: habit of style; habit of routine and habit of occupational performance. In relation to roles, the MOHO (Kielhofner 2008) considers role identification and how one identifies with the interpretation they have placed on a role and what society have placed on the role (Taylor 2017). The theme identified here was "occupational balance" which links with the MOHO's habitational element of habits and routines. The occupational balance subthemes are as below:

Routine Establishment: Developing consistent schedules to create stability in daily lives.

Priority Setting: Learning to discern essential tasks, setting boundaries to focus on well-being.

Self-Care and Boundaries: Integrating self-care and setting boundaries to avoid burnout.

3.7.1 Habituation - Occupational Balance theme

The theme of *occupational balance* reflects participants' efforts to establish a stable and healthy equilibrium among their various life roles and responsibilities. In the context of mental health, disruptions to daily routines are common, often leading to feelings of disorientation and loss of control. Achieving occupational balance through structured interventions helps participants regain a sense of order and productivity, directly supporting their mental well-being. This balance is a fundamental goal in recovery-oriented occupational therapy, aligning with the principles of Recovery Through Activity, as it enables individuals to manage their time and energy effectively and promotes a sense of agency (Parkinson 2014; Kielhofner 2008).

The studies consistently emphasised the role of activity-based interventions in facilitating occupational balance, showing how participants were able to reintegrate structure and intention into their daily routines. For instance, Eklund et al. (2017) report that the BEL intervention enabled participants to develop regular routines that provided a sense of stability and control. One participant described this newfound balance as “starting the day with purpose,” underscoring the importance of routines that provided an organised start to each day, reducing uncertainty and improving focus (Eklund et al. 2017).

Similarly, Lund et al. (2019a) found that participants experienced a renewed sense of control and empowerment through establishing balanced routines, which contributed to a foundation of stability and self-regulation. Participants in Lund’s study also mentioned how structured activities promoted a rhythm that helped them manage their energy

levels throughout the day, creating a more sustainable lifestyle (Lund et al. 2019a).

Occupational balance subtheme 1: Routine Establishment

Routine establishment was a core subtheme, illustrating how participants used consistent schedules to create predictability and stability in their daily lives. This subtheme highlighted the importance of routines in mental health recovery, where repeated, structured activities help individuals regain a sense of normalcy and calm.

The BEL intervention promoted routine building as a strategy for managing time effectively, with participants using set schedules to "bring a sense of order" to their day (Eklund et al. 2017). For many, this included daily rituals, such as setting aside time each morning for reflection, which allowed participants to feel more grounded before tackling the day's tasks. According to Woolley (2020), participants in recovery-oriented groups also reported that regular group sessions served as an anchor, providing a consistent point in their week where they could assess and adjust their progress toward achieving balance in life's various areas (Woolley et al. 2020).

Occupational balance subtheme 2: Priority Setting

Priority setting is another key subtheme, reflecting participants' learned ability to discern essential from non-essential tasks, enabling them to focus their energy on what truly supported their well-being. This aspect of occupational balance is essential in mental health recovery, as it prevents individuals from becoming overwhelmed by competing demands.

In the study by Argentzell et al. (2020), participants described how prioritising activities helped them set clear boundaries around their time, promoting a stronger sense of control and reducing stress. One

participant shared, “I finally learned to put myself first,” a statement that resonates with many in recovery who had previously neglected personal needs in favour of external obligations (Argentzell et al. 2020). Woolley et al. (2020) adds that prioritising tasks helped participants feel empowered to manage their energy more wisely, allowing them to focus on fulfilling, meaningful activities without feeling overburdened (Woolley et al. 2020).

Occupational balance subtheme 3: Self-Care and Boundaries

The subtheme of self-care and boundaries captures participants' efforts to integrate self-care practices into their routines and establish boundaries around energy-draining commitments. Setting these boundaries allowed participants to nurture their well-being actively, helping them maintain a healthier, more balanced lifestyle.

Rebeiro Gruhl et al. (2021) found that participants who engaged in the *occupation-based mental health program* reported learning to integrate personal time for rest and relaxation into their schedules, which promoted sustainability in their daily routines. Statements like “I make sure to recharge” and “I give myself permission to take breaks” reflect the significance of self-care in supporting a balanced mental state (Rebeiro Gruhl et al. 2021). Additionally, Lund et al. (2019a) highlighted that participants who actively set boundaries—such as limiting engagement in socially or emotionally taxing situations—were able to avoid burnout and focus more intently on activities that aligned with their recovery goals (Lund et al. 2019a).

3.8 Performance capacity

Performance capacity is considered by the MOHO (Kielhofner 2008) in three elements. The objective element considers ones physical and psychological factors. The subjective element considers one’s experience of an objective component. The third element is the ‘lived body’ which is

ones lived experience and its influence on performance (Taylor 2017). Two themes were identified from the literature in relation to performance capacity: skill development (links with all three MOHO elements of performance capacity (objective, subjective and lived body) and symptom management (links with the objective component of MOHO's performance capacity domain). Within these two themes, subthemes were identified as explained below:

Skill Development

Coping Mechanisms: Developing strategies for managing stress, emotions, and challenging situations.

Self-Management: Gaining control over routines, managing energy levels, and setting recovery goals.

Symptom Management

Emotional Regulation: Techniques to moderate anxiety, anger, and depressive symptoms.

Stress Relief: Using physical and creative activities to manage tension and maintain mental clarity.

3.8.1 Performance capacity - Skill Development Theme

The theme of *Skill Development* highlights the essential acquisition and enhancement of practical and social skills that empower individuals to navigate their daily lives with greater confidence and independence. For those experiencing mental health challenges, skill-building is critical, as it enables them to interact more effectively with others, manage symptoms, and carry out daily tasks with a renewed sense of control and agency. Activity-based interventions create a structured environment for practicing and refining these skills, which supports personal growth, promotes resilience, and improves functional capabilities, directly

contributing to individuals' recovery and quality of life (Parkinson 2014; Kielhofner 2008).

The studies reviewed provided substantial evidence of the skill-building benefits of activity-based interventions for mental health recovery. In Rebeiro Gruhl et al. (2021), participants reported marked improvements in social skills, including communication and emotional regulation, which helped them engage more effectively in both therapeutic and non-therapeutic settings. One participant noted feeling "better equipped" to handle social situations, reflecting how interventions designed to support social interactions could ease relational anxieties and promote interpersonal confidence (Rebeiro Gruhl et al. 2021).

Similarly, Petersen et al. (2019) found that participants experienced substantial progress in social and practical skills, including managing personal boundaries, handling stress, and improving conflict resolution. These enhanced skills allowed participants to interact with others more positively and build stronger support networks, which played a vital role in reinforcing their recovery journeys (Petersen et al. 2019). In the study by Eklund et al. (2017), participants emphasised how they developed crucial abilities in organising and prioritising tasks, promoting a renewed sense of self-sufficiency and autonomy. One participant described learning "to pace myself," illustrating how the intervention helped them develop practical strategies for managing time and energy—key to sustaining mental well-being and avoiding burnout (Eklund et al. 2017).

Skill development subtheme 1: Coping Mechanisms

Coping mechanisms emerged as a fundamental subtheme, demonstrating how activity-based interventions facilitated the development of strategies for managing stress, emotions, and challenging situations. Effective coping mechanisms are vital in mental health recovery, providing individuals with tools to handle daily stressors and maintain emotional

equilibrium, thus supporting their capacity to face adversities with resilience.

In Lund et al. (2019a), participants described gaining practical techniques for managing stress, such as relaxation exercises, grounding techniques, and mindfulness practices, which allowed them to regulate emotions more effectively and prevent emotional overwhelm. Lund et al. (2019b) highlight the empowering effect of these strategies, demonstrating how participants developed the ability to recognise and manage triggers and stressors proactively. Newport and Clarke (2020) also found that participants benefited from specific coping tools, which they integrated into their routines to manage emotional fluctuations, helping them navigate complex interpersonal situations more calmly and effectively (Newport & Clarke 2020).

Skill development sub theme 2: Self-Management

Self-management skills were another prominent subtheme, reflecting participants' growing ability to exercise control over their routines, manage their energy levels, and take proactive steps in their recovery. Self-management is crucial for maintaining mental health stability, as it encourages individuals to set and achieve personal goals, monitor their progress, and engage in self-care activities consistently.

Eklund et al. (2017) observed that participants developed essential self-management skills, such as planning their days to balance work, self-care, and relaxation, which enabled them to maintain a steady and manageable daily rhythm. One participant highlighted the importance of "knowing when to slow down," reflecting a newfound awareness of their own limits and the ability to prioritise rest and recuperation (Eklund et al. 2017). This study also noted how participants learned to structure their days to align with their mental health needs, promoting a sustainable

approach to managing energy and reducing the risk of burnout (Petersen et al. 2019).

Lund et al. (2020) further supported these findings, showing how self-management skills like time management, task prioritisation, and self-reflection contributed to participants' sense of autonomy and control. Statements such as "I feel more in control of my time" illustrate the impact of these skills, as participants developed the confidence and practical know-how to direct their recovery journey and maintain mental well-being proactively (Lund et al. 2020). These self-management abilities provided participants with a structured approach to self-care, reinforcing their agency and commitment to recovery.

Through the development of coping mechanisms and self-management skills, participants in activity-based interventions were able to build a toolkit for managing both the practical and emotional demands of daily life. This focus on skill development was not only transformative in the immediate context but also promoted long-term resilience, empowering individuals to manage their mental health proactively.

3.8.2 Performance capacity - Symptom Management

The theme of *Symptom Management* encompasses participants' ability to regulate, alleviate, or reduce the intensity of mental health symptoms through structured, activity-based interventions. This theme highlighted how engagement in purposeful activities can play a crucial role in emotional regulation, stress relief, and overall symptom reduction, all of which contribute significantly to mental health stability and enhanced quality of life. For individuals facing persistent mental health challenges, the opportunity to manage symptoms through constructive activities offers not only immediate relief but also promotes a sustainable approach to long-term wellness (Parkinson 2014; Kielhofner 2008).

Evidence from the reviewed studies highlights the positive effects of activity-based interventions on symptom management, with participants consistently reporting a reduction in distress and an improved ability to handle symptoms more effectively. For instance, Eklund et al. (2017) demonstrated that participants involved in the BEL intervention experienced a noticeable decrease in symptom severity. Structured activities such as these provided an effective and supportive context for participants to channel mental and emotional challenges, enabling them to regain a sense of control over their well-being (Eklund et al. 2017).

In a similar vein, Argentzell et al. (2020) found that participants involved in recovery-focused interventions reported a measurable reduction in symptom intensity, particularly when activities facilitated social connection and engagement. The emphasis on routine, supportive activities helped participants to diminish emotional distress, achieve functional improvements, and promote resilience. This process was particularly evident for those who felt isolated or struggled to maintain emotional stability outside structured environments, highlighting the value of regular, meaningful engagement in promoting emotional equilibrium (Argentzell et al. 2020).

Studies by Chang et al. (2020) and Woolley et al. (2020) further identified the powerful impact of “emotional regulation” and “stress relief” provided through activity-based interventions. Activities requiring concentration and physical engagement, such as gardening, art, or group-based exercise, allowed participants to experience an immediate reduction in anxiety and tension. These activities, described by participants as “helping me feel centred” or “giving me a break from my thoughts,” promoted a profound sense of calm and provided participants with tools to better manage their emotional states during difficult moments (Chang et al. 2020; Woolley et al. 2020).

Symptom management sub theme 1: Emotional Regulation

One of the strongest subthemes within symptom management was emotional regulation, wherein participants developed techniques for moderating anxiety, anger, and depressive symptoms through regular activity-based engagement. Eklund et al. (2017) and Woolley et al. (2020) both highlighted how structured sessions facilitated by occupational therapists helped participants cultivate emotional control and resilience. Eklund et al. (2017) and Woolley et al. (2020) illustrate how these interventions significantly enhanced participants' emotional regulation, promoting improved self-management skills and enabling them to respond more calmly and effectively to daily stressors).

Newport and Clarke (2020) observed that participants who initially struggled with emotional dysregulation began to develop mindfulness skills and self-soothing techniques, which helped them handle overwhelming emotions. One participant expressed having learned ways to calm themselves down without feeling out of control, highlighting how activity-based interventions facilitated personal growth by enabling individuals to develop coping mechanisms within a therapeutic context. This alignment between structured activities and emotional stability reflects the core principles of recovery-oriented occupational therapy, which aim to provide individuals with the necessary tools to manage their mental health independently (Newport & Clarke 2020).

Symptom management sub theme 2: Stress Relief

Stress relief emerged as a vital subtheme, with participants regularly describing how activity-based interventions provided an outlet for releasing built-up tension and managing chronic stress. In Chang et al. (2020), participants reported that engaging in physical or creative activities, such as movement-based exercises or crafting, helped to release stress in a way that feels productive, enabling them to maintain

better mental clarity and emotional balance. The grounding effect of these activities allowed participants to escape intrusive thoughts and focus on the present, promoting a calmer mental state that contributed positively to their overall well-being (Chang et al. 2020).

Lund et al. (2019a) echoed these findings, noting that participants who initially reported high levels of anxiety and frustration experienced a reduction in these symptoms through regular involvement in group-based, activity-focused sessions. Statements indicating feeling less anxious and more grounded demonstrate how routine engagement in meaningful activities served as a natural stress buffer, empowering participants to establish sustainable routines for stress management. These stress-relieving effects went beyond the sessions themselves, providing participants with tools they could apply in other areas of their lives, supporting a lasting impact on mental health (Lund et al. 2019a).

The research shows that through the development of emotional regulation and stress relief skills, activity-based interventions allowed participants to adopt a proactive approach to managing their mental health symptoms. This not only enabled immediate relief but also laid the foundation for long-term stability, equipping individuals with strategies to navigate daily challenges with confidence and resilience. Symptom management, as supported by structured, activity-focused interventions, highlights the therapeutic value of occupational therapy in promoting sustainable mental health improvement.

3.9 Social Environment

Taylor (2017) outlines that the MOHO (Kielhofner 2008) considers the environment in interaction with the person and outlines three layers of environmental contexts. The immediate social context considers relationships and interactions. The local context considers social networks.

The global social context considers economic aspects, attitudes, laws and policies (Taylor 2017). The key theme identified in this domain was "group dynamics" which links with the MOHO's immediate social context involving relationships and interactions. The theme group dynamics is further broken down into sub themes:

Peer Support: Validation and resilience building through shared journeys and mutual encouragement.

Facilitator Role: The influence of facilitators in promoting a supportive, non-judgmental group environment.

Shared Experiences: Building connections through hearing others' stories, reducing isolation.

3.9.1 Social environment - Group Dynamics theme

The theme of *Group Dynamics* encapsulates the social and relational interactions that occur within group-based activity interventions, particularly focusing on elements like peer support, the facilitator's role, and shared experiences among participants. These dynamics are critical to mental health recovery, offering participants a platform to build connections, share personal stories, and feel part of a supportive community. The experience of interacting in a group can be transformative, allowing participants to relate to others facing similar challenges, ultimately reinforcing a sense of mutual respect and empathy. Group-based interventions highlight the importance of community in recovery, showing how shared experiences can act as a buffer against isolation and provide an anchor of support and motivation for participants (Parkinson 2014; Kielhofner 2008).

Across studies, the influence of group dynamics on participants' recovery processes is consistently highlighted. For instance, Lund et al. (2019b) found that group participation promoted a strong sense of belonging among participants, often providing them with essential emotional support that would be difficult to replicate in an individual setting.

Participants expressed sentiments like not feeling alone, highlighting the importance of a shared, collective journey in recovery. This connection not only created a supportive foundation but also offered validation of their experiences, as participants could see their own struggles reflected in others' stories (Lund et al. 2019b).

Similarly, Woolley et al. (2020) documented that participants in recovery-oriented groups frequently described the value of social connections within the group as feeling seen and heard. This safe environment promoted by peer support allowed participants to share vulnerabilities without fear of judgment, which many found crucial to their emotional well-being. Such interactions allowed individuals to feel supported and understood, reducing the isolation that can often accompany mental health challenges (Woolley et al. 2020).

Lund et al. (2020) also noted that the role of facilitators was key to effective group dynamics, especially when facilitators contributed personal insights, which helped bridge the gap between leader and participant. The facilitators who modelled openness and relatability, when appropriate, created an atmosphere of trust and equality, further empowering participants to engage openly. This dynamic of shared experiences, reinforced by a skilled facilitator, provided a collective sense of purpose within the group, strengthening bonds among participants (Lund et al. 2020).

Group Dynamics sub theme - Peer Support

Peer support subtheme, highlighted the power of camaraderie and mutual understanding among participants. This aspect of group dynamics is particularly meaningful, as it validates participants’ experiences and offers reassurance that they are not alone in their recovery journeys. Being surrounded by peers with shared experiences promotes a sense of

community and allowed participants to feel understood and accepted without stigma.

In Argentzell et al. (2020), participants reported that knowing others were experiencing similar challenges provided significant emotional support, and they frequently drew strength from the progress and encouragement of their peers. Statements reflecting shared experiences reemphasised the impact of peer support on participants' resilience and self-acceptance. This supportive network contributed to a sense of accountability, with participants often motivated to stay on track with their goals as they saw others striving alongside them (Argentzell et al. 2020). Similarly, Newport and Clarke (2020) found that participants in the *Occupation Matters Programme* valued the shared journey with others, viewing the group as a supportive community where they could discuss challenges and successes freely (Newport & Clarke 2020).

Group dynamics sub theme: Facilitator Role

The role of the facilitator was consistently highlighted across studies as a critical factor in shaping effective group dynamics. Facilitators who embodied empathy, attentiveness, and inclusivity were instrumental in promoting a safe, trusting environment. The facilitator's guidance often set the tone for the group, helping participants feel secure enough to explore and express their vulnerabilities without fear of judgment.

In Woolley et al. (2020), participants praised facilitators who created an inclusive, non-judgmental space that encouraged openness and honesty. Facilitators who shared personal insights, when relevant, were particularly valued, as this practice helped break down barriers and establish a sense of equality within the group. Statements suggesting that sharing was easier due to the facilitator's openness highlight how the facilitator's relatability positively influenced group cohesion and participant engagement.

Similarly, Lund et al. (2020) observed that facilitators who took an active, approachable role made participants feel supported and empowered, further enhancing the overall group experience (Lund et al. 2020).

Group dynamics sub theme: Shared Experiences

The subtheme of shared experiences captured the deep sense of connection that participants felt by hearing others' stories and seeing their own struggles mirrored in the lives of their peers. This shared experience promoted a sense of unity within the group, which was particularly important for participants who had previously felt isolated by their mental health conditions. Engaging in shared activities within a supportive group provided participants with a sense of normalcy and reduced feelings of isolation. Newport and Clarke (2020) reported that participants found value in shared activities, describing how seeing others' successes and setbacks reflected their own experiences, which helped normalise their struggles. Participants described the experience as akin to seeing themselves in others, emphasising the importance of collective experience in reducing isolation and providing perspective on their own journey. In Petersen et al. (2019), shared experiences in the group promoted a collective sense of resilience, as participants reported feeling stronger and more motivated when seeing the progress of others in the group.

3.10 Occupational Environment

The immediate occupational context within the MOHO (Kielhofner 2008) would include activities and their properties. The local context considers recreational activities. The global context considers options for living and livelihood (Taylor 2017). The key theme identified within this domain was "structure and flexibility" which links with the MOHO's immediate environment as it would include the structure of and properties of the

activity focused intervention. The structure and flexibility theme has been further broken down into sub themes below:

Adaptability to Individual Needs: Flexibility in tailoring interventions to individual needs and abilities was essential for accessibility and effectiveness.

Session Length and Structure: Extended or flexible session lengths supported participants' understanding and implementation of recovery principles.

Supportive Framework and Goal Setting: Structured frameworks with goal setting and progress reflection provided stability and individualised support within interventions

Booster Sessions and Post-Intervention Support: Booster sessions and follow-up activities were valuable for reinforcing skills and providing continuity post-intervention.

3.11 Occupational Environment - Structure and Flexibility theme

The theme of "Structure and Flexibility" encompasses the balance between providing a structured framework for activity-based interventions and allowing the adaptability necessary to meet individual participant needs. For mental health recovery, maintaining a structured intervention process is crucial as it offers consistency, clarity, and an organised path for participants to follow. However, flexibility within this structure is equally important, as it ensures that interventions are responsive to the varied needs, abilities, and recovery stages of each participant. By blending structure with adaptability, these interventions provide a foundation for sustainable change and individualised growth (Parkinson 2014; Kielhofner 2008).

The studies reviewed highlighted how both structured content and the option for flexibility play a significant role in effective activity-based interventions. For example, Lund et al. (2020) reported that participants and facilitators valued having a structured framework, which provided a dependable approach to the intervention while promoting a sense of security. However, this structure was most effective when it allowed for adjustments according to participants' individual goals and needs. Similarly, Chang et al. (2020) found that longer, more flexible sessions were beneficial, as they gave participants the time needed to explore and integrate recovery concepts fully, suggesting that flexibility was essential to deeper engagement and understanding.

Structure and flexibility sub theme 1: Adaptability to Individual Needs

The subtheme of adaptability reflected the need to customise interventions to the unique needs and functioning levels of each participant. Adaptability within a structured intervention helps ensure accessibility and relevance, which are particularly important for mental health recovery, as individuals may face fluctuating symptoms and varying levels of motivation and capacity.

Lund et al. (2020) reported that participants and facilitators both recognised the value of adapting the intervention to align with each person's specific needs. This included modifying tasks or pacing to accommodate individual progress, which allowed participants to feel more supported and less pressured. Chang et al. (2020) also emphasised the importance of a flexible approach, where facilitators adapted interventions based on participants' responses, creating a more responsive and effective therapeutic environment.

Structure and flexibility sub theme 2: Session Length and Structure

Session length and structure emerged as an essential subtheme, with participants and facilitators emphasising the need for both clear organisation and extended session times. This approach ensured participants had the opportunity to delve deeply into recovery concepts without feeling rushed, supporting sustained engagement and a thorough understanding of therapeutic activities.

Chang et al. (2020) observed that participants benefited from longer sessions, which provided them with the space to explore, practice, and apply intervention concepts. This was supported by Lund et al. (2020), who noted that structured, extended sessions promoted a meaningful experience for participants, allowing them to engage in activities without time constraints that could hinder their focus or understanding. Participant statements indicating that not feeling rushed made a difference highlight the importance of session length in reinforcing the intervention's impact.

Structure and flexibility sub theme 3: Supportive Framework and Goal Setting

A supportive framework with built-in goal setting and progress reflection was an essential component of structured interventions. This subtheme highlighted how structured activities that included clear, personalised goals and a method to track progress provided participants with both accountability and motivation, contributing to a sense of achievement and progression.

Lund et al. (2020) found that participants valued having specific, attainable goals within the intervention, which helped them focus on measurable steps toward recovery. Similarly, Woolley et al. (2020) documented that participants benefited from the framework’s encouragement to set and work toward personal objectives, which added purpose to their engagement. Participant statements about the impact of

having small weekly goals illustrate how structured goal setting positively influenced their motivation and sense of accomplishment.

Structure and flexibility sub theme 4: Booster Sessions and Post-Intervention Support

Booster sessions and post-intervention support emerged as an effective way to reinforce skills learned during the intervention and offer continuity beyond the formal sessions. This subtheme reflected participants' needs for ongoing support to sustain their recovery progress, with booster sessions serving as a valuable resource for revisiting and reinforcing learned skills.

Rebeiro Gruhl et al. (2021) and Lund et al. (2020) found that participants appreciated booster sessions and follow-up support, which provided an opportunity to reconnect with the intervention material and apply it within real-life contexts. Many participants valued additional group outings and organised events as a way to transition skills from a therapeutic setting into everyday life. Participant statements about the benefits of post-intervention check-ins demonstrate how ongoing support reinforced their recovery journeys, helping them maintain progress and feel less isolated.

3.12 Physical environment

The immediate context within the MOHO (Kielhofner 2008) refers to the physical environment which would include space and objects. The local context would consider community facilities. The global context would consider the climate, geography and ecology (Taylor 2017).

There were limited findings in relation to the physical environment, but two studies identified that workbooks and materials were important to

organise the interventions (Lund et al. 2020) and for service users to create their own space for validation after the group intervention was over (Woolley et al. 2020). Lund et al. (2020) highlight that workbooks and hands-on materials were central in structuring the sessions, enabling participants to engage with interventions in a tangible way. These resources served as grounding tools, allowing participants to actively track progress and build a sense of ownership over their recovery. Woolley et al. (2020) further emphasises that creating a dedicated personal space—both during and post-intervention—was meaningful for service users. Participants noted that having access to materials even after sessions ended allowed them to continue their progress independently, helping reinforce a sense of validation and continuity.

Several studies also touch on how the spatial layout of group settings affects participant comfort and engagement. Rebeiro Gruhl et al. (2021) indicate that accessible, well-organised spaces reduced anxiety and made participants feel welcomed, a key factor in promoting an open and comfortable group dynamic. Additionally, Chang et al. (2020) note that participants in their study appreciated interventions that took place in varied physical environments, such as outdoor or communal settings, which provided a change of scenery and promoted relaxation.

These findings suggest that while the physical environment may not be as widely discussed as other themes, it plays a foundational role in enhancing accessibility, reinforcing therapeutic practices, and supporting participants in maintaining progress beyond formal sessions.

3.12.1 Summary

The findings from the scoping review highlight the substantial impact of occupational therapy-led, activity-based interventions in adult mental health settings. These interventions were shown to influence multiple facets of participants' lives, promoting personal growth, improved self-

management, and strengthened social connections. Organised according to the MOHO (Kielhofner 2008), the findings provide insight into the benefits of these interventions across four domains: Volition, Habituation, Performance Capacity, and Environmental Context.

Within *Volition,* themes such as *Sense of Self* and *Building Connections* emerged, underscoring the importance of identity reconstruction, readiness for change, and the supportive power of peer relationships. These factors enabled participants to reconnect with a more empowered sense of self, promoted through shared experiences and mutual support in group settings. In the *Habituation* domain, the theme of *Occupational Balance* emphasised the value of structured routines, priority-setting, and establishing healthy boundaries. These elements supported participants in managing competing demands on their time and energy, promoting greater stability and daily well-being.

Under *Performance Capacity,* the themes of *Skill Development* and *Symptom Management* highlighted the acquisition of practical skills for self-care and emotional regulation. Participants reported developing coping mechanisms, improved social skills, and self-management strategies that empowered them to navigate daily stressors more effectively. These skills were critical in building participants' independence and resilience, contributing positively to their long-term recovery.

Environmental Context demonstrated the role of supportive social and physical settings in enhancing engagement and accessibility. Group Dynamics emphasised the value of peer support, shared experiences, and facilitator roles in promoting a safe, inclusive environment. The Structure and Flexibility sub-theme highlighted the need for adaptable interventions that could meet diverse participant needs, with booster sessions and post-intervention support as essential for sustaining gains. Finally, considerations around the Physical Environment—such as workbooks,

accessible spaces, and varied settings—were noted for their role in reinforcing therapeutic practices and promoting comfort within the intervention space.

Overall, these findings illustrate the diverse ways in which activity-based interventions contribute to recovery, providing structure, skills, and social support that enable participants to engage more fully in meaningful, balanced lives. This structured approach aligns with recovery-oriented principles in occupational therapy and reinforces the importance of holistic, flexible, and accessible interventions in mental health care.

3.13 Discussion

Discussion and Implications

This scoping review set out to explore the existing literature on service users' and occupational therapists' experiences with activity-focused interventions. Ten studies were included, covering a scoping review, feasibility study, and a range of qualitative and quantitative studies, all focused on occupationally centred, activity-based interventions for adults within mental health settings. Although many of these studies highlighted positive aspects of such interventions, the findings also reveal limitations across different study designs, which impacts the generalisability of the evidence.

Scope and Limitations of Reviewed Studies

One noticeable finding was the heavy reliance on studies centred around the BEL program, particularly in studies like those conducted by Eklund et al. (2017), Lund et al. (2019a) and Lund et al. 2019b. The prevalence of this structured intervention type may restrict the findings to outcomes observed only in BEL, potentially overlooking the effects of less-structured interventions that might present different dynamics or outcomes.

For instance, Eklund et al. (2017) used a cluster randomised controlled trial (RCT) to compare the BEL intervention group to a Care as Usual (CAU) group, with the RCT design offering strong internal validity by controlling selection bias. However, reliance on self-reported questionnaires, while capturing participant perspectives, introduces potential response bias and limits the objectivity of the data. Additionally, the study sample was predominantly female, which might mean that some gender-specific recovery experiences, particularly among males, remain underexplored (Eklund et al. 2017). Similarly, the co-facilitation of some sessions by non-occupational therapists could have led to inconsistency in intervention delivery, affecting outcomes.

Chang et al. (2020) utilised action research to examine recovery-focused intervention, with multiple data collection points over an 18-week period, allowing for longitudinal insights. However, the sample's high education level and gender imbalance affect the generalisability of these findings, as varying educational levels may alter participants' engagement and interpretation of the intervention. Additionally, action research's close researcher-participant interaction poses a risk of researcher influence on participants' responses, introducing potential bias (Chang et al. 2020).

Service User Perspectives and Gender Representation

The reviewed studies show a common issue of gender imbalance, as seen in Woolley et al. (2020) and Rebeiro Gruhl et al. (2021), which may lead to underrepresentation of male experiences with activity-based interventions. Woolley et al. (2020) studied exclusively female participants in recovery-oriented groups, yielding insights aligned with occupational therapy's holistic model. However, by not including male perspectives, the findings may miss out on nuances of male engagement and recovery experiences. These limitations indicate that more inclusive

research, particularly with balanced gender representation, is essential for a more rounded understanding.

Rebeiro Gruhl et al. (2021) provided satisfaction ratings within a structured, occupation-based mental health program (NISA), but with a predominantly female sample. This again highlights the need to ensure studies account for a more balanced demographic to better capture recovery experiences across genders, which would contribute to a fuller understanding of recovery needs and outcomes.

Occupational therapist and Service User Experiences

There is also a notable gap in the literature concerning occupational therapists' perspectives on delivering activity-focused interventions, which are essential to fully understanding these programmes' dynamics. Lund et al. (2020) provided some insight by capturing both group leaders' and service users' perspectives within the BEL program, offering a richer understanding of group dynamics and the interpersonal aspects of activity-based interventions. However, the single-cultural setting in Sweden limits how transferable these findings might be to other cultural or socioeconomic contexts. Facilitator bias is also a consideration, as facilitators' positive personal experiences could influence findings, potentially leading to more favourable representations of the intervention.

Additionally, the reviewed literature reflects limited research on how occupational therapists assess progress and utilise specific outcome measurement tools in activity-based interventions.

Reliance on Self-Report Measures and Outcome Validity

Another key limitation in the studies was the heavy reliance on self-report measures, commonly seen in Eklund et al. (2017), Lund et al. (2019a) Lund et al. (2019b), and Argentzell et al. (2020). Self-reporting can

introduce both response and recall biases, as participants' perspectives may vary in accuracy. Argentzell et al. (2020) mitigated this to some extent by using a mixed-methods approach, combining self-reported surveys with interviews to provide a more balanced and nuanced view of participant experiences within the BEL intervention.

However, defining and comparing standard occupational therapy in the Argentzell study presented some challenges, as standard occupational therapy varies widely depending on the practitioner and context. This variability may complicate interpretations of the data, as it is unclear to what extent differences in outcomes are attributable to the BEL program specifically or to variations in standard occupational therapy practices.

Strengths and Methodological Considerations

While limitations are evident, the reviewed studies have several strengths that contribute positively to the body of evidence supporting activity-based interventions in mental health recovery. Lund et al. (2019b), for example, utilised intensive interviews with follow-up assessments, adding a valuable longitudinal perspective on the sustainability of intervention outcomes. This approach allowed for a deeper understanding of how participants' recovery journeys evolved over time, illustrating the potential long-term benefits of structured interventions.

In studies like Newport and Clarke (2020), the use of interpretative phenomenological analysis (IPA) provided rich, detailed insights into participants' experiences by allowing them to narrate their recovery journeys in their own words. However, researcher bias remains a consideration due to researchers' close affiliation with the program, which may influence participants' openness and possibly skew responses toward more favourable impressions of the intervention.

Recommendations for Practice and Future Research

Findings from this review suggest several key areas for practice and future research.

Balanced Gender Representation

The gender imbalances observed in Woolley et al. (2020) and Rebeiro Gruhl et al. (2021) suggest a need for studies that aim for balanced gender representation. This would allow future research to provide a more comprehensive understanding of recovery experiences across genders.

Objective Outcome Measures

Given the limitations of self-report data, as seen in Eklund et al. (2017) and Lund et al. (2019a), occupational therapists might consider using more objective tools for assessing outcomes. These could include observational methods, performance-based assessments, or physiological measures, enhancing the validity of findings.

Therapist Perspectives

To bridge the current gap in therapist perspectives, future research should explore therapists' views on assessment tools, intervention planning, and implementation challenges within activity-based interventions. Studies using mixed-methods designs could provide both objective and subjective insights from therapists, adding valuable data that reflect professional experiences and considerations.

Longitudinal and Mixed-Methods Designs

As demonstrated in Lund et al. (2019a) and Lund et al. (2019b), longitudinal designs provide valuable insights into how interventions influence recovery over time. Similarly, Argentzell et al. (2020)'s mixed-methods approach offers a balanced view, combining quantitative and

qualitative approaches to capture both immediate and sustained intervention impacts.

Comprehensive and Culturally Adaptable Assessments

Using standardised tools like the OSA and Role Checklist can assist occupational therapists in capturing individual motivations and tailoring interventions to specific cultural or individual needs, a consideration given cultural variations observed in the studies reviewed.

Consideration of Physical Environment and Resources

Although the role of the physical environment received limited attention, findings from Lund et al. (2020) suggest that elements like workbooks and hands-on materials are essential in grounding participants in their recovery. Future studies could explore how factors such as intervention location, resource accessibility, and environmental considerations impact engagement and outcomes.

How the recommendations informed this study

The findings from the scoping review directly informed the design and focus of this study. While recruitment was open to all, only women came forward, likely reflecting the predominantly female nature of the workforce. This highlighted the gender imbalances noted in studies like Woolley et al. (2020) and Rebeiro Gruhl et al. (2021) and reinforced the importance of understanding recovery experiences across diverse demographics. Limitations in self-report data identified by Eklund et al. (2017) and Lund et al. (2019a) shaped the choice to use a combination of tools, including a feedback questionnaire, the 3B Scale (Rebeiro Gruhl et al. 2018), and the Occupational Self-Assessment (OSA; Kielhofner 2006), to capture a fuller picture of outcomes. Additionally, the gap in therapist perspectives highlighted in the review informed the inclusion of interviews

with therapists to explore their views on assessment tools, intervention planning, and practical challenges.

Inspired by the longitudinal insights from Lund et al. (2019b) and the mixed-methods approach of Argentzell et al. (2020), this study adopted a mixed-methods design, combining qualitative data from therapist interviews with quantitative outcome data from the intervention tools. Furthermore, findings from Lund et al. (2020) regarding the importance of physical resources shaped the decision to examine recovery experiences across different environments, including hospital wards, community settings, face-to-face sessions, and virtual sessions.

3.14 Conclusion

Conclusion

This scoping review has provided critical foundational insights into the role of occupational therapy-led, activity-based interventions within adult mental health settings. By examining both service users' and occupational therapists' experiences, the review has highlighted the essential elements that facilitate recovery but has also aligned closely with the principles underlying Recovery Through Activity. This alignment reinforces the research's focus on how meaningful engagement and structured activities contribute to sustainable, person-centred recovery, establishing a robust theoretical and practical framework for this study.

A primary outcome of the review was the demonstrated utility of the MOHO (Kielhofner 2008) conceptual model of practice as an organising structure for both research and practice. By categorising findings within MOHO's (Kielhofner 2008) domains—volition, habituation, performance capacity, and environment—the review validates the choice to apply this as a framework for exploring the complex, multi-dimensional impacts of activity-based interventions on mental health recovery. MOHO (Kielhofner

2008) offers a structured lens to capture the nuanced ways that these interventions support therapeutic goals, encompassing participants' motivations, roles, physical abilities, and environmental factors. Themes such as sense of self, occupational balance, skill development, and group dynamics align well with MOHO's domains, reinforcing its relevance for understanding occupational engagement in recovery. In both research and practice, the findings highlight the importance of considering these domains in the planning and execution of interventions to create holistic, effective support for individuals in mental health settings.

Additionally, the scoping review has identified key limitations within the existing literature that have informed the methodological approach and scope of the research. A notable finding is the heavy reliance on the BEL intervention across reviewed studies. While the BEL intervention provides valuable insights into structured, activity-focused interventions, its predominance limits the diversity of activity types studied and risks overshadowing other potentially impactful approaches. Moreover, the predominance of female participants and the reliance on self-report measures present further limitations, as they restrict the generalisability of findings and may obscure the full range of recovery experiences. In response, the research was designed to address these limitations by including a more balanced sampling strategy, incorporating both subjective and objective assessment methods, and exploring the therapist's perspective alongside that of service users. This approach aims to produce a comprehensive understanding of activity-focused interventions in mental health, broadening the applicability of findings to a wider population and enhancing their practical relevance.

The review also emphasises the significant recovery principles that are central to the research, particularly self-efficacy, personal agency, and social connection. These principles are well-supported by the findings, which highlight how structured and meaningful engagement within

therapeutic activities facilitates personal growth, resilience, and relational support among participants. This evidence base reinforces the therapeutic value of occupational therapy interventions in mental health recovery. These connections strengthen the research's theoretical foundation and underline the practical implications for occupational therapists: the importance of designing interventions that not only promote individual growth but also create opportunities for supportive social interactions and skill-building within the safety of a therapeutic setting.

In summary, this scoping review has highlighted the benefits of using MOHO (Kielhofner 2008) to structure both research and practice in mental health occupational therapy, providing a comprehensive conceptual model and framework to guide the development and analysis of interventions. The insights gained establish a robust basis for the research's contributions to understanding and improving activity-focused interventions. They also highlight important areas for future research, such as the need for more inclusive participant perspectives, the integration of objective and subjective assessment tools, and the exploration of therapists' experiences in facilitating these interventions. Ultimately, this review has strengthened the research's research foundation and pointed towards further opportunities to enhance occupational therapy practices in mental health recovery, underscoring the role of activity-based interventions as a vital component in supporting person-centred, sustainable mental health outcomes.

Chapter 4 – Methodology

4.1 Introduction

This chapter will explore the philosophical principles that form the basis of this research. The core components of research include ontology, investigating what exists in the world and is accessible for knowledge acquisition; epistemology, examining how knowledge is generated; and theoretical perspective, representing one's philosophical orientation guiding action (Moon and Blackman 2014). In this research, the ontological perspective is aligned with bounded relativism, adopting a subjectivist epistemology and an interpretivist theoretical perspective. The chosen ontological perspective shapes the research's nature, the epistemological position supports the validity of diverse knowledge types and the theoretical perspective influences both research methods and the interpretation, communication and application of results (Moon and Blackman 2014).

Philosophy holds significance in healthcare sciences by providing the foundational principles of theoretical thinking, encompassing perspectives, cognition and self-awareness methods (Spirkin 1983). These aspects contribute to the acquisition of knowledge about reality (Spirkin 1983). Within healthcare sciences, two primary branches of philosophy play a vital role: ontology, the study of being and epistemology, the study of knowledge. Ancient Greek philosophers delved into inquiries about the nature of the universe, the essence of existence, the comprehension of objects and their properties, and the distinctions and similarities between them (Spirkin 1983). Therefore, ontology, in this context, relates to

understanding what exists in the world and can be comprehended by humans.

Philosophers have defined a relationship between thinking and being, attributing ontology to the realm of what exists in reality for individuals to acquire knowledge and epistemology to the processes of creating knowledge and discerning what is knowable (Moon and Blackman 2014). The interconnection of epistemology and ontology is accentuated by some, asserting that discussing meaning inherently involves deliberations about the meaning of reality (Crotty 1998). Extending from ontology and epistemology are theoretical perspectives, constituting generalised worldviews that shape beliefs and subsequently direct actions (Guba 1990). A researcher's methodological choices are reflective of their allegiance to a specific conceptualisation of the world and their stance on how one can apprehend that reality (Moon and Black 2014).

Research holds meaningful significance when the researcher possesses a comprehensive understanding of the philosophical principles and theoretical assumptions inherent in the discipline (Newing 2010). Each discipline carries its distinct principles and assumptions that shape the entire research process, from design and conduct to analysis, interpretation and outcomes (Moon and Blackman 2014). In the field of occupational therapy, the underlying assumption revolves around various factors influencing occupational wellbeing, such as the MOHO (Kielhofner (2008) domains, encompassing: volition, habituation, performance capacity and environment (Taylor 2017). This research aligns with these principles, recognising the common practice within occupational therapy of utilising intervention outcome measures and gathering perspectives from service users. The research focuses on exploring occupational therapists’ experiences of Recovery Through Activity (Parkinson 2014) and considers the varied constructs of reality and perspectives expected within the discipline. The chosen ontological position, bounded relativism,

acknowledges individual perspectives within the scope of occupational science. The subjectivist epistemological stance anticipates differing meanings assigned to Recovery Through Activity (Parkinson 2014) by occupational therapists. Furthermore, the interpretivist theoretical perspective acknowledges the diverse interpretations of the experiences, considering variations among service users, occupational therapy staff and the researcher. To accommodate these philosophical perspectives, a case study research design was implemented, aiming to capture the diverse constructions of reality, the varying meanings participants attribute to this reality and the differing interpretations they place on these experiences.

Through recognising and understanding the principles and assumptions embedded within occupational therapy, the integrity and validity of the research is not compromised (Moon and Blackman 2014). An understanding of the principles and embedded assumptions of occupational therapy is a prerequisite for the researcher and an understanding of the underpinnings from other disciplines is beneficial when interpreting research. This enabled an understanding of what we can legitimately acquire knowledge about and how we can acquire that knowledge (Moon and Blackman 2014). Philosophical literature should be considered critically however, much of the literature is inconsistent and at times impenetrable (Crotty 1998).

4.2 Ontology

Ontology, as defined by Moon and Blackman (2014), explores the nature of existence and how it is understood through knowledge acquisition. This research adopts a bounded-relativist ontology, acknowledging that while multiple realities exist, they are shaped by shared values within specific contexts such as the MOHO (Kielhofner and Burke 1980). This perspective is reflected in the thesis by examining individual perspectives within the

bounded context of MOHO (Kielhofner and Burke 1980), recognizing the subjective constructions of reality by both occupational therapists and service users.

Realism, at one end of the ontological spectrum, posits a singular, objective reality that is stable and discoverable (Moses & Knutsen 2012; Lockie 2003). Realists maintain that reality exists independently of human perceptions, which can be uncovered through systematic investigation (Lockie 2003). In contrast, relativism argues that reality is a construct of the human mind, inherently subjective and varying from one individual to another (Moon and Blackman 2014). This perspective sees each person's reality as shaped by their unique experiences, emotions, social norms, and cultural backgrounds (Moon and Blackman 2014). This makes it particularly relevant to fields like occupational therapy, where individual experience is central to practice (Taylor 2017).

The transition from realism to relativism in this research was influenced by direct experiences from attending Recovery Through Activity (Parkinson 2014) sessions and discussions with occupational therapists. It became evident that each individual's reality, influenced by their life experiences and personal contexts, differs significantly. This insight led to the embrace of relativism, particularly bounded relativism, which accommodates the notion that within a group, shared experiences can shape a common reality, yet individual variations still exist (Moon and Blackman 2014).

This bounded relativist approach is integral in occupational therapy, where understanding each client's unique perspective is vital. For example, while a realist might view self-care activities, like exercise, as universally beneficial, a relativist would consider how individual factors—such as personal history, cultural background, or physical capability—shape the perception and effectiveness of these activities. This understanding aligns

with MOHO, which emphasizes the influence of volition, habituation, performance capacity, and environment on occupational engagement (Kielhofner and Burke 1980).

The reasoning for adopting a bounded-relativist ontology is that it allows for a more comprehensive and empathetic approach to client care. It acknowledges the diversity of clients' experiences and the subjective nature of their realities, while also considering the commonalities that bind them within specific groups or settings. This approach not only enriches the therapeutic process but also ensures that interventions are deeply personalised, reflecting the unique occupational identities and competencies of each client. By recognising the varied realities of individuals, occupational therapy can more effectively address the complex, multifaceted nature of mental health challenges. This approach supports the development of tailored interventions that resonate more deeply with clients' lived experiences, promoting better engagement and more meaningful outcomes in their journey toward wellness.

4.3 Epistemology

Epistemology, as defined by Moon and Blackman (2014), involves exploring how researchers create and define knowledge, focusing on the validity, scope, and methods of acquiring knowledge. It probes into the nature of knowledge claims, the creation and attainment of knowledge, and its applicability. This research adopts a subjectivist epistemology, aligned with a relativist ontology. This suggests that knowledge is intimately tied to individual perceptions and meanings imposed on objects by individuals (Moon and Blackman 2014).

At one end of the epistemological spectrum lies objectivism, where meaning is considered inherent within objects, independent of human perception (Moon and Blackman 2014). Objectivists view reality as

external and immutable, observable through empirical investigation, assuming that truth is universal and discoverable (Crotty 1998; Pratt 1998). For instance, in occupational therapy, an objectivist might evaluate motor skills in a standardized manner, perceiving skill levels as fixed regardless of the individual's motivation or environmental influences (Crotty 1998).

Conversely, constructionism posits that meanings emerge from the interaction between the individual and the object (Bruner 1986). This view challenges the objectivist stance, proposing that truths are constructed rather than discovered, shaped through human interaction and societal engagement (Bruner 1986; Crotty 1998). Constructionism emphasizes that knowledge is actively constructed, not passively absorbed, and varies across different cultural, historical, and social contexts (Creswell 2009).

Subjectivism, the epistemological stance of this research, assumes that meaning resides within the participant and that individuals shape their reality based on their perceptions (Moon and Blackman 2014). This perspective views reality as pluralistic and plastic, molded by individuals' interpretations, symbols, and language (Powell 2001). Subjectivism holds that what one believes influences what one perceives, contending that individuals' perspectives significantly shape their understanding of the world around them (Pratt 1998).

For example, if someone observes a shadow in the sea, their interpretation might differ based on their expectations—whether they anticipate a change in weather or suspect a shark's presence. This illustrates how personal contexts and expectations influence perceptions (Moon and Blackman 2014).

In occupational therapy, this subjectivist approach is central. It acknowledges that individuals may assign different meanings to the same

occupation, such as running, which might be viewed as a productive activity by some and a leisure activity by others, depending on their personal experiences and environmental context (Taylor 2017). This is pertinent in mental health settings where the meaning attached to occupations can shift significantly following therapeutic interventions.

This research integrates subjectivism by examining the lived experiences of occupational therapy staff and service users within the conceptual model of MOHO (Kielhofner 2008), focusing on how volition, habituation, and environment impact individuals' subjective perspectives. By conducting interviews that explore these areas, the research captures how personal and environmental changes influence individuals' experiences and perceptions. This highlights the importance of understanding internal values, purposes, and interests in occupational therapy (Schwandt 1994).

In summary, adopting a subjectivist epistemology enables a deeper understanding of how individual perceptions and meanings influence engagement with and responses to occupational therapy. This highlights the significance of personal experiences in shaping therapeutic outcomes. This approach not only enriches the therapeutic process but also ensures that interventions are genuinely person-centered. This reflects the complex, dynamic interplay of individual perceptions and occupational contexts.

4.4 Theoretical perspective

The concept of a theoretical perspective is integral to understanding the relationship between thinking and being, as it shapes how an individual perceives and interacts with the world (Moon and Blackman 2014). Evely et al. (2008) describe a theoretical perspective as representative of a system of values held by a person. In occupational science research,

theoretical perspectives reveal the assumptions researchers bring to their work and influence the choice of methods (Crotty 1990). Such perspectives, often equated with paradigms (Morgan 2007) or worldviews (Creswell 2009), guide one's actions through a set of beliefs (Guba 1990).

Theoretical perspectives differ from epistemology, which deals with beliefs about knowledge. Theoretical perspectives can be characterised as frameworks of assumptions structuring a research approach, guiding not only the methodology but also the interpretation of data (Moon and Blackman 2014). Ruse (1998) points out that even the choice of what to research reflects the researcher's values, indicating how deeply personal and subjective these frameworks are. Within the context of this research, rooted in occupational science, the researcher's background as an occupational therapist and their personal values shapes their theoretical perspective. This influences every aspect of the research process, from design to data analysis (Creswell 2009; Slife and Williams 1995).

The pluralistic nature of ontologies, epistemologies, and theoretical perspectives (Moon and Blackman 2014) allows for a variety of resonating views. These views which may shift over time, influencing a researcher's epistemological and ontological stances (Moses and Knutsen 2012). This study employs an interpretivist theoretical perspective, favouring a deep exploration of individual cases within occupational therapy and occupational science. However, an element of the research adopts a positivist perspective when collecting and analysing intervention outcome data.

Positivism, which prioritises empirical observation and scientific methods, can be challenging in occupational therapy as it often disregards the subjective factors, such as values, attitudes, and beliefs, which influence occupational wellbeing (Evely et al. 2008; Crotty 1998). In contrast, interpretivism seeks to understand human and social realities,

emphasising the uniqueness of human experiences and the need for qualitative research methods (Schwandt 1994; Bryman 2008).

This research adopts interpretivism due to its alignment with the person-centred nature of occupational therapy. It acknowledges the researcher's biases and perspectives stemming from their professional background, which undeniably influenced the research design and outcomes (Patton 2002). The interpretivist approach values the context in which data is collected, emphasising how culture and history shape individuals' interpretations and meaning-making processes (Moon and Blackman 2014).

A case study research design was chosen to capture individual perspectives within the specific contexts of service, geographical area, social environment, and historical factors like the impact of Covid-19 on occupational wellbeing. This approach allows for an in-depth understanding of how occupational therapy staff and service users perceive and engage with Recovery Through Activity (Parkinson 2014), reflecting the subjectivist epistemology that underpins this research.

4.5 Summary

In this chapter, the philosophical underpinnings that guide the research are explored, specifically focusing on the adopted bounded-relativist ontology, subjectivist epistemology, and interpretivist theoretical perspective. Each of these components plays a central role in shaping the approach to the research design, methods, and analysis, ensuring that the study remains aligned with the principles of occupational therapy and occupational science.

The research adopts a bounded-relativist ontology, which recognises that multiple realities exist but are shaped by shared values within specific contexts, such as the MOHO (Kielhofner 2008). This ontological stance is

particularly suited to occupational therapy, where understanding individual clients' perspectives within the collective framework of professional practice is critical. It allows for an appreciation of diverse service user experiences and acknowledges that these experiences, while individually unique, are influenced by common professional and therapeutic environments.

Aligned with the bounded-relativist ontology, the research employs a subjectivist epistemology. This perspective suggests that knowledge is constructed based on individual perceptions and interactions with the world. In occupational therapy research, this approach is critical as it emphasises understanding how different individuals perceive their therapeutic activities and interventions. It supports the validation of diverse knowledge forms, allowing the research to capture the ways in which service users and occupational therapists experience and interpret Recovery Through Activity (Parkinson 2014).

The interpretivist perspective underpins the theoretical approach to the research. It asserts that human actions and interactions are laden with complex meanings that require interpretation within their specific social contexts. This perspective is particularly relevant to occupational therapy, where therapeutic outcomes are deeply influenced by personal, social, and environmental factors. By adopting an interpretivist lens, the research focuses on individual cases within their unique contexts, seeking to understand the subjective experiences of occupational therapy staff and service users.

Overall, these philosophical foundations support a comprehensive approach to researching occupational therapy practices. By acknowledging the complex, subjective realities of service users and Occupational therapists, the research provides rich insights into the effectiveness and personal significance of Recovery Through Activity (Parkinson 2014).

These philosophical stances ensure that the study not only captures the varied individual experiences but also situates them within broader theoretical and practical frameworks, thus enhancing the relevance and applicability of the findings to occupational therapy practice.

Chapter 5 – Methods

5.1 Introduction

A mixed methods approach was adopted, combining qualitative and quantitative techniques within a case study framework (Johnson and Onwuegbuzie 2004). This approach facilitated a nuanced understanding of the complex factors within each case, allowing for the collection of a diverse array of evidence, which provided a richer analysis than a single-method approach alone (Yin 2018).

Multiple sources of evidence were collected and triangulated to corroborate findings, aiding in the comprehensive exploration of each case (Yin 2018). This case study followed a sequential approach, beginning with interviews with occupational therapists to identify key themes. Subsequently, a prolonged, in-depth interview was conducted with a service user to explore these themes from a service user perspective. Additionally, intervention outcome data was analysed; however, the availability of this data differed between the cases, as outlined below.

Reflective observations were conducted solely for the face-to-face case, as the researcher was permitted to attend only those sessions. Access to virtual Recovery Through Activity sessions was restricted by the health board, due to expressed concerns that the researcher's presence might impose on service users and alter their experience, given the distinct dynamic of video-based group interactions compared to in-person settings. Consequently, no observations or reflections were conducted for the virtual sessions. The researcher's ability to attend face-to-face sessions was also limited due to the suspension of in-person sessions as a result of Covid-19 restrictions.

Intervention outcome data was available only for the virtual case, as no service users in the face-to-face case returned consent forms allowing their data to be used. In the virtual case, however, the health board had already issued service users a privacy notice indicating that outcome data might be used anonymously for research purposes, as part of routine protocol. Following ethical approval and agreement with the health board's research and development department, the researcher was granted access to this anonymised intervention outcome data. Importantly, the occupational therapists in the virtual case did not collect these outcome measures specifically for this research; rather, the data was gathered as part of standard operational procedures.

Many of the occupational therapy staff, as well as the service user, had experience with Recovery Through Activity across different periods: pre-Covid, during Covid, and post-Covid. Additionally, many occupational therapy staff members, and the service user had experience with both face-to-face and virtual formats. As a result, it was necessary to carefully separate the data according to each implementation mode before beginning analysis. Anticipating this need, the researcher consulted with the lead supervisor on strategies to manage this complexity before initiating the interviews. During the interviews, the researcher clarified participants' experiences by asking them to indicate which mode of implementation—face-to-face or virtual—they wished to discuss first and remained focused on one mode before transitioning to the other, if relevant. Throughout the interviews, participants were asked to specify which mode they were referring to, ensuring clarity in their responses. This approach was instrumental in the subsequent data analysis, as it provided distinct insights into face-to-face and virtual experiences.

Table 3 - Sources of evidence

Face to face case sources of evidence	**Virtual case sources of evidence**
occupational therapy staff interviews	occupational therapy staff interviews
Service user interview	Service user interview
Researcher reflections	Intervention outcome data

5.2 Aim and Objectives

The overarching aim of this research was to evaluate the efficacy and the effectiveness of the use of Recovery Through Activity (Parkinson 2014), from an occupational therapist and service user perspective.

The objectives were to:

1. Explore occupational therapists' roles and experiences of using Recovery Through Activity (Parkinson 2014).
2. Identify the opportunities and challenges faced by occupational therapists in implementing an occupationally focused approach.
3. Evaluate service user perceptions and experiences, resulting from the use of Recovery Through Activity (Parkinson 2014).
4. Evaluate the effectiveness of the implementation of Recovery Through Activity (Parkinson 2014) by analysing existing anonymised intervention outcome data.

While Yin often emphasises the importance of starting with a "how" or "why" question, the focus of this study was less about uncovering causal relationships and more about capturing the lived experiences of implementing Recovery Through Activity (Parkinson 2014) in a real-world context. This wasn’t about pinpointing a specific cause or mechanism but rather about understanding the broader landscape—how occupational therapists and service users navigate the process, what worked, what didn’t, and why it mattered to them.

The decision to avoid a strict "how" or "why" question also allowed the research to remain open to the unexpected, capturing insights that might have been missed if the focus was narrower. It was less about trying to fit the findings into a predefined box and more about letting the realities of the intervention speak for themselves. Ultimately, this approach felt truer to the exploratory nature of the study, embracing the complexity of the subject rather than forcing it into a rigid framework.

5.3 Overarching Case Study Design

A case study research design was utilized in this research to provide a structured and rigorous approach to examining the implementation of Recovery Through Activity (Parkinson 2014) within adult mental health services. As defined by Yin (2018), case study research encompasses several key components including the formulation of questions or aims, the study propositions, the delineation of cases or units, the logic linking the data to the propositions, and the criteria for analyzing findings.

The rationale for choosing a case study design lies in its ability to intensively explore complex phenomena within their real-life contexts (Gerring 2017; Yin 2018). This is particularly pertinent for this research, which sought to understand the dynamic interactions between Recovery Through Activity (Parkinson 2014) and its application within the unique

environments of an NHS health service. Case study research is distinguished from other forms of ‘case studies’ and ‘cases’ as it serves as a mode of inquiry, employing rigorous procedures to ensure methodological robustness (Yin 2018).

Yin's framework was selected due to its clear guidance on constructing a coherent structure for case study research, making it possible to manage, analyze, and draw conclusions from complex data sets effectively (Yin 2009). This framework emphasizes maintaining a strong connection between data and theory, which is necessary in validating the findings derived from the case studies.

To tackle potential misinterpretations that often occur with popular or teaching-practice case studies, which might lack academic rigor, this research emphasizes transparency and adherence to systematic research procedures as outlined by Yin (2018). This ensures that each phase of the research, from data collection through to analysis, upholds high standards of reliability and validity.

The distinction between the phenomenon being studied (Recovery Through Activity) and its context (the practice environment within the NHS Health Board) is central. The case study design facilitates an understanding of how contextual factors influence the implementation and outcomes of the framework, allowing for exploration of these dynamics (Yin 2018).

To ensure the reliability and validity of the research, multiple sources of evidence were collected and triangulated, addressing each research objective comprehensively. The internal validity was strengthened through the careful design of the research. This included identifying and addressing potential rival explanations. This approach allowed for a robust analysis of the data in relation to the theoretical framework based on occupational science. The use of a multiple case design facilitates

replication and enhances the external validity of the research, as it allows findings to be corroborated across different contexts (Yin 2009).

An in-depth protocol was developed see appendix 3, reviewed, and approved by the Cardiff University Research Ethics Committee and the Research and Development department within the Health Board, further ensuring that the research adhered to ethical and methodological standards. This rigorous approach enhances transparency and allows for its replication, increasing the reliability of the findings.

In summary, the case study research design, underpinned by Yin's methodological framework, is ideal for exploring the complex interactions between a therapeutic intervention and its practice environment. It supports the understanding of the processes and outcomes associated with Recovery Through Activity (Parkinson 2014), making a significant contribution to the field of occupational therapy by providing insights into its application and impact within mental health services.

5.4 Propositions

In case study research, propositions play a central role by guiding the researcher towards areas that require examination within the scope of the research. As described by Yin (2018), propositions reflect significant theoretical issues and direct the investigation toward pertinent evidence. For this particular case study, the propositions were rooted in principles from occupational science theory, providing a structured framework for defining the cases and shaping the data collection methods.

These carefully selected propositions were integral to maintaining a focused exploration of how Recovery Through Activity (Parkinson 2014) is applied within a real-world context. The Model of Human Occupation (Kielhofner and Burke 1980) was influential in informing these propositions. It highlights various intrinsic and extrinsic factors, such as

volition, habituation, performance capacity, and environment, that interact to influence an individual's occupational engagement. It was hypothesized that these elements would significantly impact both the utilization of Recovery Through Activity (Parkinson 2014) and its outcomes in practice.

By anchoring the research framework in these propositions, a clear directive was established on what information was necessary to extract from the cases. This approach ensured that the research remained aligned with its aims and objectives, facilitating a thorough and focused investigation into the operational dynamics and effectiveness of Recovery Through Activity (Parkinson 2014) within the NHS Health Board's mental health services.

Proposition 1 (MOHO connection – Physical and Social Environment):

Service dynamics and processes will impact on occupational therapists' experiences of Recovery Through Activity (Parkinson 2014), for example:

- Training and support
- Staff capacity
- Perceptions of other professionals
- Available resources and community links
- Client groups
- Patient/setting dynamics e.g. ward or community
- Local policies and legislations
- Service demands and organisational objectives.

Proposition 2 (MOHO connection – Occupational Environment):

The implementation method of Recovery Through Activity (Parkinson 2014) will impact on occupational therapists' and service users' experiences, e.g.:

- Face-to-face implementation vs. virtual implementation of Recovery Through Activity
- 1:1 sessions vs. groups
- Goal setting and intervention planning
- The use of an occupational therapy conceptual model
- Assessment and outcome measure tools used and how this informs the structure of Recovery Through Activity sessions.
- In service vs. community links
- The use of Recovery Through Activity (Parkinson 2014) as a programme/framework/tool
- The referral process for Recovery Through Activity (Parkinson 2014)

Proposition 3 (MOHO connection – Physical and Social Environment):

Access to community resources will impact on the effectiveness and the benefits of the use of Recovery Through Activity (Parkinson 2014), for example:

- Transitioning from Recovery Through Activity (Parkinson 2014) to community and community links
- Availability of community resources

- Transport
- Financial implications
- Impact of legislation such as the Mental Capacity Act (2005) and the Equality Act (2010).
- The impacts of covid-19 restrictions

Proposition 4 (MOHO connection – the person-specific concepts):

Individual differences will impact on the effectiveness and the benefits of Recovery Through Activity (Parkinson 2014), for example:

- Readiness for change
- Volition
- Habituation
- Performance capacity
- Client and Occupational therapist's expectations and perceptions of Recovery Through Activity
- Client expectations and perceptions of occupational therapy

Proposition 5 (MOHO elements – Occupational Environment, in Interaction with Person-Specific Concepts):

Recovery Through Activity (Parkinson 2014) will have an impact on service users' occupational participation and engagement, for example:

- Motivation for occupation
- Pattern of occupation
- Communication and interaction skills

- Process skills
- Motor skills
- Engagement with environmental factors

5.5 Potential Rival Explanations

Addressing 'rival' explanations is an important aspect when analysing case study research findings (Yin 2018). A rival explanation is a factor that may influence or provide an alternative understanding for your findings, serving as an alternative phenomenon to what you are studying. A rival explanation introduces an external element that could have affected the results. For example, opposing the assertion that Recovery Through Activity (Parkinson 2014) is the key factor explaining the phenomenon. For instance, if a service user reports improved motivation and self-confidence, a potential rival explanation might be their simultaneous participation in Cognitive Behavioural Therapy or an unrelated event, such as winning the lottery. Although there could be a number of contributing factors to explain a phenomenon, only the most plausible rivals should be addressed, rather than every possible rival (Yin 2018). When developing the cases for the case study research design, potential rival explanations were taken into consideration. Cases were selected based on their differences and commonalities to aid in addressing the potential rival explanations. Addressing the rivals was also incorporated in the data collection methods. Addressing potential rival explanations within case study research adds to the overall strength of the case study findings (Yin 2018). The potential rival explanations were revisited during the cross-case analysis. The data from each case was compared with the potential rival explanations, including theory surrounding the case study and the study propositions, to inform level two inferences. The following identified rivals were not examined to determine cause and effect, instead they

were used to inform the research design and to examine alternative explanations.

- Direct Rivals – an intervention other than Recovery Through Activity (Parkinson 2014) accounts for the results e.g. psychology input, medication, alternative therapies.
- Commingled rival – other interventions and Recovery Through Activity (Parkinson 2014) account for the results – e.g. on inpatient wards it may be important for medication to be balanced before Recovery Through Activity (Parkinson 2014) is effective.
- Implementation rival – the implementation process not Recovery Through Activity (Parkinson 2014) itself account for the results – e.g. is the implementation person centred? are goals being addressed? Both or either of these could impact on the benefits seen by service users and occupational therapists' experiences of its use.
- Rival theory – A different theory from the original theory explains the results – e.g. group theory, community psychology theory, organisational theory.

5.6 Study Cases

Cases can be compared to *units*, that have an additional implication of temporal boundaries (Gerring 2017). A case can comprise of an organisation, social group, event, or an individual, for example, if it comprises a phenomenon of theoretical significance (Gerring 2017). Yin (2018) explains a case study can include singular or multiple cases and these can be literal or theoretical in nature. Over the years there have been many typologies of cases within case study research. Eckstein (1975) proposes five types of cases: crucial case; heuristic; plausibility probes; disciplined-configurative and configurative-idiographic. Other case selection typology offered by Skocpol and Somers (1980) are: a contrast of contexts; macro-causal analysis and parallel demonstration. Similarly,

Rohlfing (2012) categorizes five case types that can be tailored for case study purposes: most-likely; least-likely; diverse; typical and deviant. None of these case typologies explicitly define rules for case selection, often involving a combination of strategies (Gerring 2017). Yin (2018) is not unique in this aspect and does not set explicit rules, however, does offer guidance on defining and bounding specific real-world cases with concrete manifestation.

The cases in this research can be characterised as theoretical replications as they have been intentionally defined to address the case study propositions, potential rival explanations and the theories surrounding this (Yin 2018). The cases were carefully selected to investigate predicted common and contrasting results and the anticipated explanations behind these.

The defined cases are as follows:

- Recovery Through Activity implemented **face-to-face** in community and inpatient adult mental health services
- Recovery Through Activity implemented **virtually** in community adult mental health services.

Initially the cases were defined and structured around inpatient services and community services separately. Previously all Recovery Through Activity (Parkinson 2014) interventions were implemented face-to-face. However, this research was conducted during the Covid-19 pandemic. During the lockdown restrictions services had to change the ways in which they were working. This meant that Recovery Through Activity (Parkinson 2014) interventions were initially stopped and then adapted on an all-Wales basis to enable the interventions to be implemented virtually. The interventions were run via Microsoft Teams during lockdown restrictions, the findings chapter will detail in depth how Recovery Through Activity (Parkinson 2014) was conducted by various occupational therapists in

different settings. This research project was initially conceptualised and designed prior to the Covid-19 pandemic and was adapted accordingly, with data collected during and post lockdown restrictions. This meant that data could be collected for interventions carried out both virtually and face-to-face. The benefits of this were that the impact of environment, group dynamics and social interaction could be closely examined.

Each case has been bound by a set of characteristics to ascertain the range of the data collection (Yin 2018). occupational therapy staff and service users were included in the case boundaries. For the purposes of this research occupational therapy staff were defined as qualified and non-qualified members of the occupational therapy team. Service users within the adult life cycle of 18-64 years were included. This age range was selected as it is the age range that encompasses adult mental health services within the organisation where the research was sited. Alternative specialist services are available to those that are younger than 18 years of age or older than 65 years of age. A central characteristic is the use of, or experience with, Recovery Through Activity (Parkinson 2014) therefore, all modes of experience have been encompassed including face-to-face, virtual, group, individual etc. This bounding tightens the link among the cases and the research aims (Yin 2018). External to the case boundaries is the case context (Yin 2018), which for these cases are the environmental context of the South Wales area and the organisational context of the NHS Health Board encompassing the geographical area.

In order for a case to be considered part of a case study, it needs to be broader than itself, thus meaning it needs to be representative of a larger population (Gerring 2017). If the case study is exploratory in nature, the representativeness refers to its unit homogeneity (Glynn and Ichino 2016), which is the value of an outcome based on its variables of interest (Gerring 2017). The variables in the cases selected for this research reflect different environmental factors, differences in implementation

method, differences in service dynamics, as well as differences in stages of service user recovery. The variables of interest in these contrasting cases increase the case study's representativeness and inform the final cross case analysis in addressing how these factors impact on the use of Recovery Through Activity (Parkinson 2014).

In contrast to randomised controlled trials for example, the cases have not been compared to determine cause and effect. Instead, the cases have been cross-examined to address theoretical propositions, as presented above, which allow an exploration of the benefits and limitations of Recovery Through Activity (Parkinson 2014), while also examining how it can be used. In relation to selecting the number of cases necessary for the case study, a power analysis would be irrelevant. Instead, the number of cases were based on what was most applicable to address the research objectives, propositions and rivals.

Within each case, attention has been directed towards embedded units of analysis. They include: occupational therapists' experiences; service user experiences; anonymised outcome data and researcher reflection. This design is defined as a multiple-case, embedded design (Scholz and Tietje 2002). As depicted in Figure 3, the embedded design (as opposed to a holistic design) was selected as most appropriate for this research as it provides structure and focus to guide the data collection and address the objectives, propositions and potential rival explanations (Yin 2018). Additionally, this was assessed as the most prudent in relation to gathering the required data with the resources available and within the given timeframe for the research completion.

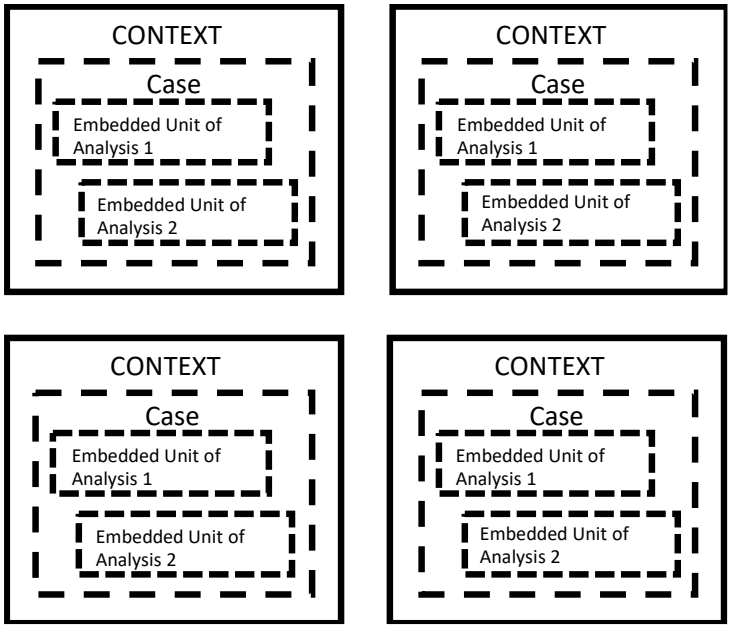


Figure 4 - Multiple case embedded design

5.7 Theoretical perspective

5.7.1 Bounded relativist perspective

This research has taken a bounded relativist perspective (Lockie 2003). This research distinctively aims to capture the perception and experiences of occupational therapists and service users (Yin 2018) and assumes no absolute truth, and thus a relativist perspective complements this notion. When planning the data collection methods and data analysis methods, the relativist perspective was significant when taking into consideration how methods capture individual perspectives. The relativist perspective was also taken into consideration when planning the research design. This case study research design complements the relativist perspective, as it recognises that there will be variants in perspectives across cases and contexts. This approach aimed to capture these complexities (Yin 2018).

5.7.2 Occupational science

This research also used occupational science theory to guide the case definitions, inform propositions, guidelines of inquiry and guide the data analysis. Occupational science suggests that humans are occupational beings and that engagement in meaningful occupations promotes health and wellbeing (Wilcock 2005), which are a requirement for leading a purposeful life (Hasselkus 2002).

Recovery Through Activity (Parkinson 2014) is underpinned by the principles and language of the Model of Human Occupation (MOHO; Kielhofner 2008). When considering the most appropriate model for articulating and underpinning the research the MOHO (Kielhofner 2008) was deemed as most appropriate to maintain focus on the factors that surround occupational participation, engagement and meaning. Not only does the model seamlessly relate to Recovery Through Activity (Parkinson 2014), it has also been adopted by the Health Board in which this research took place. Assessment tools and language used within the Health Board within mental health services by occupational therapists are underpinned by the MOHO (Kielhofner 2008). Ensuring continuity through the consistent application of a singular model not only facilitates the seamless transition between theory and practice but also allows for the concise expression of intricate concepts (Hurst 2017). Moreover, the MOHO (Kielhofner 2008) emphasises the reality of individual patterns of performance and highlights the influence of environmental factors, as well as the volitional powers that impact on occupational performance (Taylor 2017).

5.8 Rigour

In the field of case study research, Flyvbjerg (2006) tackles several prevalent criticisms—such as the idea that case studies simply confirm

researcher biases, lack scientific rigor, offer limited generalisability, and are of questionable value overall. He contends that case study research, with its close involvement and detailed exploration, can actually challenge personal assumptions and hypotheses through intensive, focused examination. By critically engaging with each layer of evidence, researchers can uncover unexpected insights, especially within complex, context-dependent situations, which builds deeper understanding and counters criticisms through establishing rigour.

One criticism is that general theoretical (context-independent) knowledge is more valuable than practical, context-dependent knowledge. Flyvbjerg (2006) acknowledges the value of context-independent knowledge for foundational understanding but argues that practical, context-rich knowledge reveals the nuances of human behaviour, showing how people may act in ways that defy predictable patterns. Learning in specific contexts not only adds depth but also challenges generalised assumptions.

In this study, context-dependent knowledge was invaluable, especially given the unique circumstances of the COVID-19 pandemic. The research explored the application of Recovery Through Activity (Parkinson 2014) and its adaptation to the constraints imposed by the health board's pandemic response. Through the MOHO (Kielhofner 2008), which considers the physical, social, and occupational environments, the study captured the intervention's real-world impact. Excluding this context would have overlooked critical elements of Recovery Through Activity's (Parkinson 2014) effectiveness and adaptability, underscoring the value of studying it within this unique period.

Another common criticism asserts that you can't generalise from a case study. Yin (2018) suggests that while direct generalisation is limited, theoretical generalisation is possible. When subsequent studies either

support or refute a case study's findings, they contribute to a growing understanding that extends beyond the original case.

This research aimed to add to theoretical knowledge around Recovery Through Activity (Parkinson 2014) within the unprecedented pandemic context. By documenting the adaptations and specific applications under such conditions, the research creates a reference point for future research, allowing for potential confirmations or expansions of these findings in similar or emergent settings. This iterative process aligns with Yin's approach, which values case studies as building blocks for broader theories through continued validation or revision by other research.

A related critique suggests that case studies are primarily useful for generating hypotheses, while other methods are better suited for testing hypotheses and building theory. Flyvbjerg (2006) argues that case studies can both generate and test hypotheses, especially when they focus on critical cases that may either support or contradict initial findings. The rigour of the research, he notes, largely depends on the researcher's claims about their findings.

This study's approach was to offer insights on how Recovery Through Activity (Parkinson 2014) was applied in response to a crisis, enhancing theoretical understanding of occupational therapy interventions during a global pandemic. By examining its use in both virtual and in-person formats, the research identifies new questions and hypotheses for future studies while providing a comprehensive view of its adaptability under crisis conditions. The findings, therefore, offer not only context-specific insights but also a basis for future hypothesis testing.

Another criticism suggests that case study research tends to confirm preconceived notions rather than challenge them. Flyvbjerg (2006) counters this, arguing that close engagement with a subject can uncover

contradictions and unexpected insights, which can lead to a genuine, in-depth understanding that often challenges initial assumptions.

To maintain reflexivity and challenge potential biases, this research incorporated reflexive practices throughout the research process, from data collection to analysis. Weekly supervisory meetings provided critical perspectives, promoting an open, iterative process that scrutinised my interpretations and upheld objectivity. This reflexive approach allowed for continuous questioning and reassessment, helping to avoid confirmation biases and enhancing the study's trustworthiness.

Finally, critics argue that case studies are challenging to summarise and make generalisable. Flyvbjerg (2006) emphasises that case studies often generate rich, narrative data, which should be preserved rather than simplified. The researcher's role is to present these findings fully, enabling readers to interpret them based on their own perspectives, rather than losing nuance through oversimplification.

In documenting the use of Recovery Through Activity (Parkinson 2014) during the pandemic, this study embraces the complexities of real-world occupational therapy practice. The goal was not to reduce findings to universally applicable statements but to provide a nuanced, context-rich narrative that offers varied insights for different readers, particularly within the fields of occupational therapy and activity engagement.

5.8.1 Reflexivity

A key aspect of maintaining rigour in this study was embracing reflexivity, given the complex interplay between my role as a researcher and my clinical background in occupational therapy. Although I conducted the PhD full-time and was not actively working as a clinician during the research, I held an honorary contract with the health board, ensuring some continuity in clinical practice, though exclusively within older adult mental health

services. This separation helped mitigate potential overlap with the adult mental health context of the research, promoting a clearer distinction between my clinical and research roles. However, I acknowledge that my clinical training in occupational therapy inevitably influenced my perspective and approach to data interpretation. Accepting this influence as a reality, I aimed to manage and reflect upon it openly, employing a reflexive diary and frequent supervisory discussions to critically examine my own biases and preconceptions. Engaging with a global research forum was also invaluable, as it allowed for dialogue with researchers from diverse fields and cultural backgrounds, further encouraging me to question and broaden my approach.

Given that my background was primarily academic rather than clinical, I took steps to recognise how this limited direct clinical experience might shape my biases and approach. The gap in clinical exposure before embarking on the PhD highlights the importance of establishing reflexive practices to maintain objectivity and transparency throughout the research process. Weekly supervision sessions provided essential support, as my supervisors encouraged rigorous reflection, helping me align my interpretation of findings with data-driven evidence rather than personal assumptions.

In interviews, it was critical to create a safe and open environment for participants to freely share their experiences. To mitigate any potential power dynamics due to my clinical background, I took several steps to build rapport and reduce the perceived hierarchy. Before each interview, I clarified my role as a researcher rather than an occupational therapist, emphasising the confidential and non-judgmental nature of the discussion. Adapting my language to match that of each participant in these semi-structured interviews also facilitated a more balanced, conversational exchange, encouraging honest input. Reflecting participants' terminology and expressions helped me build a respectful

connection, reinforcing the collaborative, rather than hierarchical, nature of the dialogue.

The timing of this research during the COVID-19 pandemic added a unique layer of contextual complexity. Conducting the study in isolation, working from home, and experiencing significant restrictions in daily life influenced my perspective, particularly around the challenges of isolation and occupational disruption. These factors closely paralleled the experiences of many participants, both service users and occupational therapists, who similarly faced isolation and limited access to meaningful occupations. This context was critical to address, as it highlights the shared impact of the pandemic on everyone involved in the study. Including a timeline of the pandemic's progression and its effects helped frame the data within this historical backdrop, emphasising the distinct realities under which this study was conducted. This reflexive approach allowed for a more nuanced, transparent interpretation of how the COVID-19 context shaped the experiences, responses, and insights of both participants and myself as a researcher.

5.8.2 Trustworthiness

Establishing trustworthiness is crucial in research, particularly in qualitative and interpretivist contexts where individual experiences and subjective realities play central roles (Finlay 2006). In line with an interpretivist stance, trustworthiness in this mixed methods study is rooted in the need to provide an accurate, nuanced understanding of the phenomenon of Recovery Through Activity. This research aimed not only to describe and explain Recovery Through Activity (Parkinson 2014) but also to reveal how contextual factors, such as the impact of the pandemic, influence the intervention's effectiveness.

In case study research, Yin (2016) suggests that a clear research protocol, rigorously applied from design through to data collection and analysis, allows readers to evaluate how well the research reflects the studied phenomenon. Stake (1995) similarly highlights the role of the researcher as an interpreter, whose responsibility is to provide comprehensive descriptions that enable readers to make their own generalisations. Rather than relying on positivist measures of reliability and validity, interpretivist research favours criteria such as credibility, confirmability, and dependability, which help to reflect the authenticity and richness of data in context (Lincoln & Guba 1985).

Credibility is strengthened in this study through the triangulation of data sources—qualitative interviews, observations, and quantitative measures—that contribute a well-rounded view of Recovery Through Activity. Additionally, member-checking was conducted where possible, allowing participants to verify their contributions, thus reinforcing the accuracy and authenticity of data interpretation (Lincoln & Guba 1985).

Confirmability involves ensuring that the findings of this research are clearly linked to the data itself, rather than reflecting the researcher's biases. This study used a reflexive approach, where I maintained reflective notes throughout the data collection and analysis phases to consciously acknowledge and examine my assumptions and perspectives. Yin (2016) emphasises that transparency in such practices enhances trustworthiness by offering readers insight into the researcher's role within the research process.

Dependability in this research was achieved by systematically documenting all procedures and adhering closely to the study design. Detailed notes on the data collection and analysis process, including any adaptations necessitated by the pandemic, support an audit trail that enables others to understand the context and decisions that shaped this

study. According to Yin (2009), such documentation allows for the evaluation of consistency in the research process, which is critical for dependability.

In conclusion, employing these criteria aligns the study with the rigor expected in case study research, providing a transparent, credible, and reliable account of Recovery Through Activity. By acknowledging the influence of context and researcher interpretation, this study contributes valuable insights into how trustworthiness can be maintained in interpretivist, context-dependent research settings.

5.8.3 Construct validity

Construct validity is essential in ensuring that research accurately captures and represents the phenomenon under study and that the data is appropriately interpreted (Yin 2016). This study employed multiple data sources to create a comprehensive "chain of evidence" that strengthens construct validity and highlights the application of Recovery Through Activity (Parkinson 2014) within adult mental health services during the pandemic. Data sources included in-depth interviews with occupational therapy staff, an interview with a service user, anonymised intervention outcome data, and personal reflections from in-person Recovery Through Activity (Parkinson 2014) sessions. Triangulating across these varied data sources helped deepen the understanding of the intervention’s use in a unique pandemic context, adding rigor to the study findings (Yin 2009).

To ensure consistency across interviews, I followed a structured interview schedule aligned with the MOHO (Kielhofner 2008) and the study’s research propositions. This schedule provided a foundational structure for addressing rival explanations, ensuring that each interview covered core questions relevant to Recovery Through Activity (Parkinson 2014) while allowing flexibility for emerging insights. This approach helped maintain a

consistent focus on the study's objectives, thereby reinforcing the reliability and construct validity of the data.

Reflexive practices were pivotal in managing potential biases throughout the research. I maintained a reflective diary to record ongoing reflections on my biases, personal background, and experiences as both an occupational therapist and researcher. These reflections, which were not included in the thesis, enabled me to consider how my perspectives might influence data collection and analysis, particularly given the unprecedented context of a global pandemic. Weekly supervision meetings with my lead supervisor, who has extensive experience in psychology and occupational therapy research, provided a critical, external perspective that helped me to question assumptions and maintain an objective approach to data interpretation. Her background, along with that of my broader supervisory team—comprising experts in mental health nursing and occupational therapy research—encouraged diverse perspectives that strengthened the rigor of the research process.

Additionally, I participated in a global online research forum for neurodiverse researchers, which connected me with colleagues from various disciplines and cultural contexts. This engagement broadened my perspective on research methods and was instrumental in refining my approach to interpreting the data on Recovery Through Activity (Parkinson 2014) in this specific context.

Instead of formal bracketing, I adopted general reflexive practices consistent with my interpretivist and bounded relativist stance. This open, flexible approach allowed me to remain attuned to the nuances within the data without rigidly separating my personal and professional perspectives. By integrating multiple perspectives and engaging in reflexive techniques, I worked to ensure that the study findings genuinely reflect the

complexities of Recovery Through Activity (Parkinson 2014) in practice, particularly within the unique and evolving context of the pandemic.

5.8.4 Internal validity

To enhance internal validity within this case study on Recovery Through Activity (Parkinson 2014), multiple sources of evidence were employed, including interviews with occupational therapy staff, a service user interview, anonymised intervention outcome data, and reflective observations of Recovery Through Activity (Parkinson 2014) sessions. This triangulation was key to corroborating themes, as Yin (2009) and Stake (1995) highlight the importance of convergence across sources to strengthen credibility and trustworthiness. By seeking consistent answers across diverse data sources, this approach aligned with Yin's (1993) concept of establishing a "chain of evidence" to reinforce the internal validity of case study findings.

The research protocol, which structured the inquiry for each unit of analysis, was essential to maintaining a clear and consistent line of questioning linked to the propositions, contextual factors, and elements of the MOHO (Kielhofner 2008). This protocol detailed specific "Level 2" questions, designed to ensure key topics—such as the impact of Recovery Through Activity (Parkinson 2014) on occupational participation and engagement—were systematically addressed across sources. The protocol's structure provided both consistency and flexibility in data collection, allowing for comprehensive exploration while ensuring that primary research themes were addressed.

Data analysis was conducted iteratively, with consistent reference to the original propositions and potential rival explanations as themes emerged. Data from each unit was organised into separate databases, creating a transparent structure that facilitated cross-referencing. This organisation, aligned with Yin's (2018) guidance on tracing data back to its original

source, enhanced the rigor of the thematic analysis. Additionally, frequent cross-referencing with the research protocol throughout data collection and analysis enabled the identification and convergence of themes across sources, building a stronger case for each finding.

In the final stages of analysis, this structured and iterative approach allowed for a detailed examination of the propositions, assessing them against identified patterns and themes across data sources. Rival explanations were also considered, such as alternative interpretations of service user engagement or occupational participation outcomes, which added robustness to the findings. This rigorous approach strengthened the study's contribution to understanding the use of Recovery Through Activity (Parkinson 2014) within occupational therapy practice, particularly through the convergence of data across diverse contexts and sources.

5.8.5 External Validity

External validity, or transferability, concerns the extent to which research findings can be applied beyond the immediate study context (Yin 2009). The goal in this research was not to produce findings that are universally generalisable, but rather to offer insights specific to the use of Recovery Through Activity (Parkinson 2014) within a particular health board during the COVID-19 pandemic. This study aimed to understand the unique dynamics of this setting, specifically addressing how Recovery Through Activity (Parkinson 2014) was adapted in response to social, political, and environmental factors.

To achieve this, the research incorporated rich descriptions, providing detailed accounts of how Recovery Through Activity (Parkinson 2014) operated within the constraints and challenges of the pandemic. These context-rich descriptions offer occupational therapists, healthcare workers, and researchers the opportunity to draw varied, situation-specific insights that align with their own practice or research needs. For

instance, readers could explore the adaptability of Recovery Through Activity (Parkinson 2014) in virtual formats or assess its potential applications across both community and inpatient settings. This emphasis on descriptive depth aligns with Stake's (1995) and Flyvbjerg's (2006) perspectives that the value of findings often lies in the unique interpretations readers can bring based on their own backgrounds and professional experiences.

In line with Yin's (2018) guidance, the study did not claim broad generalisability but instead sought to contribute to theoretical discussions on how Recovery Through Activity might evolve across diverse settings. The aim was to provide a foundation for further studies that could either confirm or expand upon these findings, thereby contributing to a cumulative understanding of the intervention’s adaptability in different healthcare environments.

Throughout the analysis, patterns within and across data sources were carefully reviewed and challenged against initial propositions and rival explanations. This iterative process, reinforced by supervisory discussions, was key in verifying that findings were both data-driven and thoroughly considered. Supervisory meetings allowed for critical reflection on alternative explanations, ensuring that insights remained robust and well-balanced (Lincoln & Guba 1985; Yin 2016).

By focusing on context and theoretical contribution, this research offers a meaningful basis for further studies that may test or extend these findings, ultimately strengthening the validity of conclusions drawn within the field of occupational therapy.

5.8.6 Reliability

In case study research, establishing reliability involves creating a transparent audit trail, allowing readers to follow and understand the

researcher’s thought processes and how findings were reached (Yin 2009). In this study, reliability was strengthened through multiple means, starting with a structured research protocol that documented each step of data collection, analysis, and interpretation. This protocol served as a guide throughout, helping to maintain a consistent approach across cases while offering a clear record of decision-making.

For data management, raw data from each unit was initially coded and then transferred into a spider diagram software, allowing for a visual representation of emerging themes. This visual approach systematically organised data in a way that facilitated in-depth analysis of themes across different cases, offering clarity and ease in tracking thematic development. After each case was analysed separately, a cross-case analysis was performed to identify converging themes and patterns across datasets. Importantly, these converging themes emerged solely from the data itself, rather than from literature comparisons, ensuring that patterns were derived from firsthand observations and interactions.

To enhance transparency, the thesis contains rich descriptions, including verbatim quotes, and a clear separation between the researcher’s interpretations and participant voices. This approach not only provides readers with a detailed view of the data but also clarifies the researcher’s influence on findings. By establishing this structured, multi-layered approach to data analysis and documentation, the study builds a reliable foundation for its conclusions, allowing future researchers to follow and critically assess the methodological pathway used.

5.9 Yin's framework supporting change during the pandemic

As discussed in chapter 1, there were many challenges and adaptations to the research due to the impacts of the Covid-19 pandemic. Guided by Yin (2018)'s framework, the research adapted flexibly to address these challenges while maintaining methodological rigor. Yin (2018)'s framework provided a structured approach to redefining the cases, while new remote recruitment strategies, including virtual interviews and online consent, were developed to ensure safe and ethical data collection.

Throughout the pandemic, Yin (2018)'s framework enabled the research to respond adaptively to evolving restrictions, maintaining a clear focus on methodological rigor while providing valuable insights into the adaptability of Recovery Through Activity (Parkinson 2014) in occupational therapy during unprecedented times.

To address the COVID-19-related shifts in the study, Yin (2018)'s case study methodology provided a robust foundation that supported flexible decision-making and adaptability, aligning well with change management theory principles. Case study research, particularly under Yin (2018)'s structured framework, is designed to explore complex, real-world contexts, allowing researchers to adjust data collection methods in response to emergent and unpredictable events. This flexibility was crucial as pandemic restrictions reshaped the study's design, requiring rapid adjustments in recruitment, data collection, and overall study focus.

Yin (2018)'s method supports change management by emphasizing a clear structure for case studies, which includes defining research questions, maintaining a strong theoretical foundation, and upholding

rigorous data collection and analysis processes. When faced with the pandemic, this structured approach enabled the research to retain coherence and focus despite substantial changes, as Yin (2018)'s guidance facilitated a systematic approach to each phase of adaptation. For instance, in re-focusing on virtual versus face-to-face Recovery Through Activity (Parkinson 2014) sessions, the study maintained alignment with its original aims and theoretical propositions, effectively managing change by integrating new methods within a consistent framework.

The principles of triangulation and multiple sources of evidence central to Yin (2018)'s approach also align with change management theory, ensuring that adaptability does not compromise methodological rigor. Through these strategies, the research team was able to incorporate virtual interviews, online surveys, and hybrid data collection methods, thereby expanding the study's scope while preserving data reliability and validity. The case study approach, informed by Yin (2018)'s emphasis on linking theory to practice, allowed the research to explore the effects of Recovery Through Activity (Parkinson 2014) in virtual environments, illustrating its adaptability to a range of healthcare settings in an evolving context.

Yin (2018)'s case study framework thus not only facilitated the research's responsiveness to change but also upheld its validity and reliability, ensuring that the study continued to provide meaningful insights into the implementation of Recovery Through Activity (Parkinson 2014) within adult mental health services, even amidst significant, unforeseen challenges.

In alignment with Yin (2018)'s case study methodology, the use of propositions provided a structured foundation for decision-making and

adaptation, ensuring that the study's focus remained consistent even as the COVID-19 pandemic necessitated substantial changes. Propositions in Yin (2018)'s framework act as guiding hypotheses, grounding the research in theoretically driven inquiries that direct data collection and analysis toward areas of central importance (Yin 2018). For this study on Recovery Through Activity (Parkinson 2014), these propositions were specifically tailored to explore the intervention's implementation and outcomes across various contexts, guided by principles from occupational science and the Model of Human Occupation (MOHO) (Kielhofner 2008).

Yin (2018)'s emphasis on propositions as a core part of case study research proved invaluable for change management, particularly as the pandemic forced rapid adaptations. By anchoring the research framework within these propositions, each of which corresponded to a specific aspect of MOHO (Kielhofner 2008), the study maintained alignment with its original objectives, focusing on factors such as volition, habituation, performance capacity, and environment. These propositions provided clear investigative pathways that helped manage the complexities of changing research methods. For example, Proposition 2—regarding the influence of face-to-face versus virtual implementations—allowed the research to pivot smoothly toward examining the virtual adaptation of Recovery Through Activity (Parkinson 2014), while Proposition 5, focusing on occupational participation and engagement, guided an assessment of the intervention's outcomes in a hybrid environment. Each proposition therefore functioned as a decision-making anchor, helping to prioritize which elements of the study should remain unchanged and which could adapt to fit new circumstances.

Additionally, Yin (2018)'s use of propositions supports change management by allowing for systematic analysis within an evolving context. Despite significant adaptations in data collection methods—shifting from in-person to online interviews, virtual consent procedures,

and even telephone interviews for participants with limited digital access—the propositions ensured that each method aligned with core research objectives. Yin (2018)’s method enabled this flexibility without sacrificing rigor, as the propositions provided a stable framework that ensured data continuity across different implementation models, thereby preserving the study’s coherence and relevance.

Ultimately, Yin (2018)’s approach to propositions enabled the research to balance adaptation with consistency, facilitating a structured, theoretically grounded response to the complex challenges posed by the pandemic. These propositions not only guided the research but also served as reference points for managing change, ensuring that each alteration to the methodology supported the overarching goal: to understand Recovery Through Activity’s impact on occupational engagement within a dynamically shifting healthcare environment.

In Yin (2018)’s case study methodology, addressing rival explanations plays a critical role in validating research findings, adding depth to the analysis, and strengthening the overall credibility of the case study (Yin 2018). For this study on Recovery Through Activity (Parkinson 2014), incorporating Yin (2018)’s framework of rival explanations helped guide decision-making and change management by encouraging consideration of alternative factors that could influence the findings. This was particularly useful during the pandemic, where complex and changing variables—such as health board adaptations, evolving service delivery models, and the introduction of hybrid formats—demanded flexibility while maintaining analytical rigor.

Rival explanations, as defined by Yin (2018), are alternative phenomena that may provide competing explanations for observed outcomes. In this study, potential rivals ranged from direct interventions, such as other therapies or medications, to implementation factors that could influence

service users’ and therapists’ experiences. For example, direct rivals included Cognitive Behavioural Therapy (CBT) or alternative therapies that participants might have accessed alongside Recovery Through Activity (Parkinson 2014), which could have contributed to observed improvements in motivation and engagement. These direct rivals underscored the importance of thoroughly examining each participant’s treatment history to ensure that any positive outcomes were specifically attributable to Recovery Through Activity (Parkinson 2014) rather than other interventions.

Yin (2018)’s method also supported change management by encouraging the study to address implementation rivals, focusing on whether the observed effects stemmed from the intervention’s design or its delivery process. This distinction became particularly relevant when shifting Recovery Through Activity from in-person to virtual formats during COVID-19 restrictions. To maintain data integrity, it was essential to consider whether implementation factors, such as the quality of virtual engagement or the degree of personalisation in goal setting, impacted outcomes rather than the intervention itself. Yin (2018)’s framework prompted continuous adjustments in data collection strategies, ensuring that the study remained attuned to these rivals. For example, interview questions and data analysis protocols were refined to capture nuanced information about participants' perceptions of both the content and format of the sessions, helping to disentangle the impact of the intervention from its method of delivery.

The incorporation of rival explanations extended to commingled rivals—cases where Recovery Through Activity (Parkinson 2014) and other factors jointly influenced outcomes. This consideration was especially important in settings like inpatient wards, where the balance of medication or other therapies could affect a service user’s readiness and responsiveness to Recovery Through Activity (Parkinson 2014). By

acknowledging commingled rivals, the study design included mechanisms for monitoring and recording these external factors, ensuring a robust approach to analysing how Recovery Through Activity (Parkinson 2014) interacted with other elements of the healthcare environment.

Finally, Yin (2018)'s framework of rival theory further enhanced the research by encouraging the exploration of alternative theoretical perspectives that could explain the observed phenomena. In addition to the Model of Human Occupation (MOHO) (Kielhofner 2008), which framed the study's primary propositions, rival theories, such as group theory and community psychology, provided supplementary lenses through which to interpret outcomes, especially within the hybrid and group-based settings. This theoretical flexibility was integral to adapting the study under the pressures of the pandemic, as it allowed for a comprehensive analysis of whether group dynamics, organisational practices, or community psychology principles offered additional or alternative explanations for the observed benefits of Recovery Through Activity (Parkinson 2014).

Furthermore, Yin (2018)'s emphasis on addressing rival explanations guided critical decision-making and adaptation throughout the research, ensuring that alternative factors were carefully considered and controlled. This approach allowed the study to maintain methodological rigor despite the complexities introduced by the pandemic, supporting a thorough and credible examination of Recovery Through Activity's (Parkinson 2014) impact across diverse settings and circumstances.

Yin (2018)'s approach to case study research provided a structured framework to manage the significant changes necessitated by the COVID-19 pandemic, enabling the study to remain adaptable in the face of unprecedented disruptions. When the first lockdown halted all in-person Recovery Through Activity (Parkinson 2014) sessions, Yin (2018)'s method supported a redefinition of cases to suit the new landscape.

Originally intended to include a variety of healthcare settings, including older adult services, the cases were restructured to focus on a comparison between virtual and face-to-face delivery methods in community mental health settings. Yin (2018)’s approach to defining and bounding cases was invaluable here, as it allowed the research to create clear parameters that could remain consistent even when the physical and operational context was forced to shift.

Amid the pandemic, Yin (2018)’s concept of multiple-case, embedded design became instrumental in structuring the study. With cases redefined to capture both virtual and face-to-face Recovery Through Activity (Parkinson 2014) sessions, the research could effectively compare outcomes and participant experiences within these differing delivery contexts. This flexibility was essential for capturing the unique effects of the pandemic on Recovery Through Activity (Parkinson 2014), and Yin (2018)’s method provided a coherent way to incorporate these contrasts into the research design. Furthermore, the embedding of units such as occupational therapist and service user experiences helped the study to delve into the impacts of the transition on the delivery and reception of the intervention, capturing the nuances and challenges of each implementation method.

The pandemic also necessitated the temporary cessation of services, followed by a shift to virtual formats, and then a gradual reintroduction of hybrid models. Yin (2018)’s emphasis on bounding cases helped maintain clarity in defining what constituted each case, supporting the study's focus and comparability despite these fluctuations. The structured approach facilitated by Yin (2018)’s framework made it possible to track the evolving nature of Recovery Through Activity (Parkinson 2014) through these transitions, highlighting how environmental shifts, digital access, and delivery format each influenced the intervention’s perceived effectiveness. This adaptability was critical in addressing the change

management challenges posed by COVID-19, ensuring the research could continue yielding insights despite the pandemic's shifting circumstances.

5.10 Methods

A mixed methods approach was adopted, merging qualitative and quantitative techniques within the case study (Johnson and Onwuegbuzie 2004). This allowed for more complexities to be addressed and stronger, richer arrays of evidence to be collected, in contrast to a single method alone (Yin 2018).

Multiple sources of evidence were collected and triangulated to corroborate findings, which aided in addressing the complexity of the cases (Yin 2018). This case study took a sequential approach. Initially interviews were conducted with occupational therapists and themes identified. Following this an in-depth prolonged interview was carried out with a service user to confirm themes from a service user perspective. In addition, intervention outcome data were analysed.

5.10.1 Interviews

Interviews served as a central method for collecting qualitative data in this research, specifically addressing the experiences of occupational therapy staff and a service user with Recovery Through Activity (Parkinson 2014) during the constraints of the COVID-19 pandemic. The platform used to conduct the online interviews was Microsoft Teams. This platform was selected as it was approved by the NHS organisation as the most secure platform to use within the service and was compatible with their servers. Conducting these interviews online via Microsoft Teams presented advantages and challenges. On the positive side, the virtual format significantly reduced logistical burdens such as travel and room bookings, and most participants could engage from the comfort of their own homes. This potentially increased their willingness to share personal

insights and experiences. However, this method also came with downsides, including technical issues like unstable connections that interrupted the flow of conversation, external interruptions, and a notable reduction in observable non-verbal cues, which are often used for interpreting respondents' emotions and engagement levels (Yin 2018).

The primary advantage of using interviews in this research was their ability to gather focused and detailed data directly relevant to the research objectives. Interviews allowed for an in-depth exploration of individual perspectives, offering rich qualitative insights into how occupational therapists and service users perceived and interacted with Recovery Through Activity (Parkinson 2014; Yin 2018). This method enabled the researcher to delve into the subjective experiences of the participants, facilitating a deeper understanding of the intervention’s impact within the real-world settings of mental health services.

Utilizing a semi-structured interview format was particularly effective in this context. It provided sufficient flexibility to pursue emerging themes or unexpected insights during the interviews, while still maintaining enough structure to ensure coverage of all relevant topics needed to address the research propositions and objectives (Moule & Hek 2011). This balance was critical for achieving both depth and breadth in the data collected.

Qualitative interviews are especially valuable for exploring the complex social realities and the meanings that individuals attribute to their experiences (Denzin & Lincoln 1994). By focusing on the personal narratives of occupational therapists and service users, the interviews illuminated the ways in which participants engage with, and are impacted by, Recovery Through Activity (Parkinson 2014). These interactions, enriched with personal anecdotes and contextual explanations, provided a robust foundation for understanding the practical applications and

outcomes of the intervention within the specific healthcare setting (Ritchie & Lewis 2003).

During the interviews, the researcher employed strategies to encourage participants to elaborate on their answers, ensuring that each response was thoroughly explored. This involved probing deeper into the participants' statements and encouraging them to expand on their thoughts, which is vital for understanding the full spectrum of their experiences and perceptions (Rubin & Rubin 2005). The interviews were designed to let participants do most of the talking, which helped minimize researcher bias and facilitated a participant led discussion. This approach aligns with the best practices in qualitative research, where the interviewer facilitates rather than directs the conversation, allowing for a natural flow of information that is less likely to be influenced by the interviewer’s preconceptions or the research agenda (King & Horrocks 2010; Robson 2002).

In summary, the strategic use of semi-structured interviews was beneficial in capturing detailed, context-rich data that highlighted the complexities of implementing Recovery Through Activity (Parkinson 2014) in varied mental health settings. This approach not only enriched the research findings with firsthand accounts but also ensured that the research reflected the authentic voices and experiences of those directly involved in Recovery Through Activity (Parkinson 2014).

5.10.1.1 Interview data collection

To collect detailed data on the experiences of occupational therapists using the Recovery Through Activity manual (Parkinson 2014), online interviews were conducted. These interviews focused on the therapists' implementation of an occupationally focused approach, addressing the first and second objectives of the research. Additionally, an in-depth prolonged online interview with a service user was conducted to gather

their perspectives on engaging with Recovery Through Activity (Parkinson 2014) both face-to-face and virtually, thus confirming themes from a service user standpoint and addressing the third objective (Yin 2018). The interviews collectively provided valuable insights into the individual views, attitudes, meanings, and perceptions related to Recovery Through Activity (Parkinson 2014).

The research considered three types of case study interviews as outlined by Yin (2018), prolonged interviews, shorter interviews, and survey interviews. Shorter interviews, typically lasting about an hour, were chosen as most suitable for this research. This duration was deemed sufficient to cover the interview schedule comprehensively while collecting the necessary data. Informal discussions with occupational therapy staff suggested that the typical duration for initial assessments is around one hour, as sessions longer than this might lead to diminished attention and engagement. The feasibility of conducting longer interviews was also constrained by the therapists' heavy workloads, particularly under the increased pressures of the COVID-19 pandemic on NHS staff.

To devise the interview questions, initially research protocol questions were devised (please see Appendix 3). These protocol questions reflect the line of inquiry when collecting data and are posed to the researcher rather than the participant. This approach helps keep the research on track throughout the data collection process. The protocol questions were grouped within their unit of analysis and linked to the research propositions. For each grouping, the unit of data collection that relates to each unit of analysis is noted. This framework was used to inform the interview schedules, ensuring that all propositions were addressed. The occupational therapy staff interview schedule can be found in Appendix 4, and the service user interview schedule is in Appendix 5. Both interview schedules are color-coded to ensure that objectives and propositions are comprehensively addressed.

Pilot interviews with two occupational therapists were conducted to evaluate the effectiveness of the chosen interview length and style. These pilots confirmed that the selected duration allowed for thorough data collection while maintaining engagement and allowing participants to comfortably express their views. Although interview times varied slightly, flexibility was maintained with a general target of around one hour.

The semi-structured nature of these interviews facilitated a guided conversation rather than rigid adherence to structured questions (Yin 2018; Rubin and Rubin 2012). This approach ensured the fluidity of the interview process. Interview schedules were carefully prepared to ensure comprehensive coverage of all necessary topics, supporting a systematic exploration of relevant issues.

Interviews were structured to accommodate two levels of inquiry. The first level involved protocol questions outlined in this chapter, with separate interview schedules prepared for occupational therapy staff and the service user. The second level of inquiry unfolded during the interviews, featuring conversational questions that responded to the flow of dialogue, such as probing with "why?" or "how?" in response to initial answers. As recommended by Becker (1998), using "how" often elicited more detailed and less defensive responses, contributing to richer data collection. It was central that these follow-up questions were framed in a non-biased manner to preserve the integrity of the data (Yin 2018).

Adhering to a bounded relativist perspective, the interviews focused on capturing the unique personal views and experiences of the participants. Their verbal reports and the meanings they conveyed formed the core evidence for the case study, aligning with the overall methodological approach of the research (Yin 2018).

5.10.1.2 Interview Analysis

Online interviews conducted for this research were audio-recorded using the encrypted speech-to-text software Otter.ai, which also assisted in the transcription process. To ensure accuracy, audio recordings were replayed repeatedly, during which the transcriptions were verified and corrected as necessary. This step also included the anonymisation of the data to protect participant confidentiality.

The data collected from interviews with occupational therapy staff and a service user were analysed using a reflective inductive approach to thematic analysis, as outlined by Braun et al. (2023b). This method was particularly suitable given the lack of existing research on occupational therapists' experiences with Recovery Through Activity (Parkinson 2014). Inductive analysis allows themes to be directly derived from the data itself, rather than being constrained by pre-existing hypotheses, thus ensuring that the findings are genuinely reflective of the participants' experiences.

Braun and Clarke (2013) define thematic analysis as a flexible method for identifying, analysing, and reporting patterns within data, which can be adapted across various theoretical and epistemological approaches. They emphasise that the identification of themes involves active decision-making by the researcher, challenging the notion that themes merely ‘emerge’ from the data without researcher influence. This perspective is critical to acknowledge in relation to the researcher’s background in occupational therapy and specific interest in Recovery Through Activity (Parkinson 2014). It is important to consider that a researcher with a different professional background, such as psychology or mental health nursing, might interpret the data differently, influenced by their own theoretical perspectives and experiences.

The process of reflexive thematic analysis as described by Braun et al. (2023a) involves six stages: reading and re-reading transcripts to provide the foundation of analysis; systematic coding of the data to manage its volume; searching for patterns that could indicate themes; reviewing these potential themes to ensure they accurately reflect the data; defining, refining, and naming the final themes; and finally, producing a comprehensive report that communicates the research findings effectively. This structured approach to analysis provides the necessary framework to address one of the critiques of case study research, which is its perceived lack of structure in the analysis phase (Yin 2018). This methodical approach ensured that the analysis is both rigorous and transparent, facilitating a deeper understanding of the occupational therapy staff's and service user's experiences with Recovery Through Activity (Parkinson 2014).

Coding Process

The initial coding phase involved manually going through each transcript line-by-line without the use of software. Significant points and phrases were highlighted on the first pass, and then codes were systematically assigned to these points during a second review. This manual approach allowed the researcher to immerse deeply in the data, ensuring that each code was accurately aligned with the participants' experiences.

Once initial codes were assigned, patterns were identified, and related codes were grouped into meaningful clusters. This process was facilitated by spider diagram software, which allowed for visual organisation and connection of codes, making it easier to form preliminary themes. Initially, a table format was attempted, but the visual format of the spider diagram proved more effective due to the researcher's learning style. As coding continued across multiple interviews, a structure in the data became apparent, which followed the semi-structured interview schedule.

Sections of questions addressed specific propositions or contextual factors, guiding the grouping of codes, as each section tended to cluster around related topics and themes.

Reviewing and Refining Themes

Following the initial pattern identification, transcripts were revisited to ensure that the identified themes accurately reflected the data. Preliminary themes were discussed with supervisors, who provided critical feedback. Supervisors advised that the initial themes appeared more as sub-themes. Based on this feedback, the researcher returned to the data and refined the groupings, using the spider diagram software to visually explore possible arrangements. From these revised groupings, overarching themes began to emerge.

During this refinement process, theme names were re-evaluated to ensure clarity and accuracy. Initial theme names did not fully capture the meaning, so the content within each theme was reviewed to create names that more accurately reflected the underlying data. This iterative review ensured that the final themes were both descriptive and representative of the participants' experiences.

To enhance transparency, an example spider diagram for one of the themes is provided in appendix 2, illustrating the progression from codes to groups, sub-themes, and themes. Additionally, an example of direct quotes and corresponding codes is included in appendix 2 to create a clear audit trail.

Justification for Thematic Analysis Approach

The choice to use thematic analysis, specifically the approach of Braun and Clarke (2013), was informed by its flexibility and adaptability across diverse datasets. This was crucial for the study, which included data from

both therapists and service users in various contexts, such as face-to-face and virtual settings. The inductive nature of thematic analysis allowed the findings to emerge directly from participants' experiences, which is essential in exploratory research within a case study framework. By employing a flexible and accessible method, the researcher was able to systematically identify patterns while ensuring that the analysis remained grounded in the participants' actual words and experiences.

The thematic analysis approach also complemented the case study design, which required a detailed exploration of phenomena within real-life contexts. The method allowed movement from raw data to meaningful interpretations, creating a coherent narrative that aligned with the theoretical propositions underpinning the research.

In summary, the semi-structured interviews enabled rich, detailed data collection, while thematic analysis provided a systematic way to identify and explore patterns within this data. This approach ensured that the analysis was reflective of participants' experiences and was suitable for the case study design.

Reflexivity and Rigour

Maintaining reflexivity was essential to ensure rigour and transparency in the analysis. The researcher’s background in occupational therapy and interest in Recovery Through Activity (Parkinson 2014) undoubtedly influenced interpretations, and conscious efforts were made to reflect on and manage this influence throughout the process. Further details on the reflexivity approach, including the use of a reflexive diary and regular supervisory discussions, are discussed in the reflexivity section of this chapter.

Validation and Iterative Process

To enhance transparency and validity, an iterative approach was employed, with transcripts being repeatedly revisited and codes refined. Supervisors played a critical role in the validation process, as emerging themes were discussed, meanings within groupings were checked, and feedback was incorporated. This iterative process ensured that the themes remained grounded in the data. Additionally, data saturation was reached, where no new themes emerged, indicating that the analysis was comprehensive. Throughout this process, research propositions, potential rival explanations, and the research protocol were revisited to ensure that all relevant areas were thoroughly explored.

5.10.2 Intervention outcome data

5.10.2.1 Intervention outcome data - data collection

To evaluate the effectiveness and benefits of using Recovery Through Activity (Parkinson 2014), existing anonymised intervention outcome data was analysed. This data, collected specifically from those who participated in virtual Recovery Through Activity (Parkinson 2014) sessions, included various tools such as a feedback questionnaire developed by the occupational therapists administering the intervention, as well as the Occupational Self-Assessment (OSA) (Baron et al. 2006) administered both pre and post intervention, and the 3B scale—Being, Belonging, and Becoming (Rebeiro Gruhl et al. 2018). This analysis aimed not only to assess the efficacy of the Recovery Through Activity (Parkinson 2014) intervention but also to provide insights into the outcome measurement tools employed, the kind of information they produce, and how occupational therapists gauge changes following interventions (Yin 2018).

An essential aspect of this analysis involved considering the conditions under which the intervention outcome data was produced. This included

whether the outcome measure tools were self-administered by service users, completed solely by the occupational therapist, or in a collaborative effort between the two. Moreover, it was important to evaluate the accuracy and relevance of these tools. Questions considered included the evidence base supporting each tool and whether they effectively measure what is necessary for both the service and the service users. Such thorough examination ensures that the data not only reflects the effectiveness of the Recovery Through Activity (Parkinson 2014) intervention but also validates the measurement tools used within this specific therapeutic context (Yin 2018).

5.10.2.2 Intervention outcome data - data Analysis

The feedback questionnaire used in the research was designed to collect qualitative and quantitative data through a mix of rating-scale and open-ended questions. This allowed for a descriptive analysis of the feedback, capturing both numerical ratings and personal insights from the participants regarding their experiences with Recovery Through (Parkinson 2014).

The 3B's scale, which includes 23 statements, was utilized to measure service users' satisfaction with their experiences during the Recovery Through Activity (Parkinson 2014) sessions. Service users rated their agreement with each statement on a five-point scale ranging from "strongly disagree" to "strongly agree." The results were numerically analyzed to calculate the percentages, identifying which statements garnered the most and least agreement, thus providing a quantitative measure of user satisfaction.

The OSA (Baron et al. 2006) consisted of 21 questions that asked service users to evaluate their self-perceived competencies in various abilities and to rate the importance they place on each. To analyze the OSA (Baron et al. 2006) data, several statistical tests were conducted. A Shapiro-Wilk

Test was first used to check the normality of the data distribution. Cronbach's Alpha was then applied to assess the internal consistency of the tool, ensuring the reliability of the measures within the OSA (Baron et al. 2006). An ANOVA was performed to explore commonalities among the responses, identifying any significant patterns or differences.

Further to this, a Wilcoxon signed-rank test was conducted to compare the total scores for confidence and values before and after participating in the Recovery Through Activity intervention (Parkinson 2014). This was to determine if the intervention had a statistically significant effect on the service users' perceptions of competence and value. Additionally, a Spearman Rho correlation test was used to examine the relationships between the ratings of competence and value both before and after the intervention, providing insights into how these aspects are interconnected and how they evolve with the intervention. These analyses helped to understand the impact of Recovery Through Activity (Parkinson 2014) on service users' self-reported abilities and values.

5.10.3 Researcher Reflection

The Covid-19 pandemic imposed significant constraints on direct observations of Recovery Through Activity sessions, limiting the researcher's ability to attend these groups in person. In the planning phase, prior to the onset of restrictions, the researcher attended two face-to-face sessions to gain initial insights into the delivery of Recovery Through Activity across diverse community settings. Following the lifting of restrictions, the researcher attended two additional sessions near the end of their respective 12-week programs, each held at various locations and involving unique groups of service users and occupational therapy staff. Together, these sessions provided a diverse—albeit limited—opportunity for reflection.

Given the constraints, a formal observational approach was not feasible; instead, a single structured reflection was conducted, capturing the researcher's real-world experiences of the Recovery Through Activity intervention. This reflection was structured using Gibbs' (1988) reflective cycle, chosen for its systematic approach to analysing experiences step-by-step. Gibbs' model begins with a descriptive stage, where the researcher recorded the objective details of each session, capturing the settings, activities, and group dynamics without any additional interpretation. This was followed by an exploration of feelings, allowing the researcher to identify subjective responses experienced during the sessions, such as a sense of welcome and relaxation promoted by the group atmosphere. The evaluation stage enabled the researcher to assess positive elements of the sessions, such as the inclusive environment and the impact of group dynamics, as well as challenges associated with variations in group size and structure across locations. In the analysis stage, insights were drawn from these observations, including the flexibility and adaptability of the Recovery Through Activity model, which emerged as a strength that allowed sessions to maintain their therapeutic purpose despite structural and contextual differences. The conclusion stage synthesised the key reflections, underscoring that social connection was a recurring theme across sessions, integral to the success of Recovery Through Activity. Finally, the action plan considered practical implications for future sessions, such as the importance of promoting environments conducive to social connections and tailoring sessions to meet service users' unique needs.

The structured approach provided by Gibbs' reflective cycle contributed rigor to this process, helping the researcher systematically examine each stage of the experience (Gibbs 1988). This structure is particularly valuable in case study research, where capturing context-specific nuances is critical to a comprehensive understanding (Yin 2018). According to Yin,

reflections enable researchers to add depth to case study analysis by identifying and examining subtle dynamics within complex settings. In this research, reflections were later triangulated with data from participant interviews and quantitative intervention outcome measures, contributing an additional layer of insight. The reflections provided a point of comparison for other data sources, allowing the researcher to observe where reflections aligned with or diverged from broader findings, ultimately strengthening the credibility of the results (Yin 2018).

However, Gibbs' reflective cycle is not without limitations. While its structured approach supports clarity, it can also constrain deeper exploration by directing reflection along a fixed path (Finlay 2008). Additionally, reflections are inherently subjective, capturing the researcher's interpretations, emotions, and experiences, which can introduce bias despite efforts at reflexivity (Jasper 2013). The researcher's own background in occupational therapy is another layer of subjectivity that, while acknowledged and managed through reflexivity practices, remains an influence on the interpretation of these reflections. Nevertheless, when used with other data sources, reflections provide a robust tool within case study research, adding valuable insight while enhancing the transparency and depth of the overall analysis (Stake 1995).

5.11 Specific procedures

5.11.1 Population

The target population that was explored included service users and occupational therapy staff across Mental Health Services within an NHS Health Board in South Wales. The geographical boundaries included five boroughs. The term occupational therapy staff encompasses qualified occupational therapists, occupational therapy assistants and technicians

and support staff that assist the occupational therapy service in the implementation of Recovery Through Activity (Parkinson 2014). The term service user encompasses individuals between the ages of 18-64 years who were engaging in Recovery Through Activity (Parkinson 2014) focussed interventions within Adult Mental Health services in the boroughs.

5.11.2 Recruitment

Multiple stages were used to ensure ethical issues were taken into consideration when recruiting potential participants. All occupational therapists that had experience with Recovery Through Activity (Parkinson 2014) were eligible. All service users that had engaged in Recovery Through Activity (Parkinson 2014) focused interventions were to participate in the research. The only exceptions were if there were issues surrounding risk, lack of capacity to consent, or if the occupational therapists felt that service user participation would be detrimental to their care. The occupational therapists 'screened' service users to exclude anyone that fell into this criterion. In addition, in order to manage risk, a research risk management plan was devised (appendix 15). Post-screening, the occupational therapist supplied a list of names and contact details to the gatekeeper. The gatekeeper's role was to initiate the first contact by sending out cover letters to service users (appendix 7) and distribute permission to contact forms (appendix 11) and an information sheet (appendix 9) to service users.

The gatekeeper also made initial contact with potential occupational therapy staff participants by sending out cover letters (appendix 6), The gatekeeper sent out permission to contact forms to occupational therapy staff (appendix 10) and an information sheet (appendix 8) to all occupational therapy staff who had been involved with Recovery Through

Activity (Parkinson 2014) within the NHS organisation's adult mental health services either presently or in previous practice.

The permission to contact forms included an expression of interest section. Potential participants (both occupational therapy staff and service users) could indicate their interest in receiving more information about participating in one or multiple elements of the research including interviews and the use of anonymised intervention outcome data. Potential participants were asked to return the permission to contact forms either electronically or via post to the researcher. Potential participants were asked their preferred mode of communication (email, telephone, or post), and the researcher contacted them accordingly.

Initially the intention was that individuals who expressed an interest in participating in the interviews would be added to the database for sampling. However, due to assorted reasons, including staff redeployment and a halt in the delivery of Recovery Through Activity (Parkinson 2014) for a period due to Covid-19, there were limited respondents who expressed an interest in participating in the research. The sampling method, therefore, took more of an opportunistic approach, recruiting all who were willing, to ensure occupational therapy staff experiences were captured. Those who expressed interest were contacted by the researcher and offered an opportunity to answer any questions they had. If they wished to continue, an interview informed consent form (appendix 12) was sent to the potential participant. Additionally, an opportunistic approach was taken with service user recruitment due to low uptake. Once service users who expressed an interest and consented to be contacted, a service user consent form was sent out (appendix 13).

A consent withdrawal form (appendix 14) was also provided for participants to withdraw their consent to participate if they so wished. This could be returned via post/electronically at any stage during the

research, up until the point where data has been coded and anonymised. After this point, if participants wished to withdraw consent, previously anonymised and analysed data would still be used, however, any personal/identifiable information would be destroyed/deleted. Consent withdrawal forms would also be destroyed/deleted as they contained identifiable information. A file note would be kept for withdrawals stating "participant (ID number) withdrew on X date". No participants withdrew from the research, although this would have been the procedure if this had occurred.

5.11.3 Sample

Due to the impacts of Covid-19 on the structure and demands on the NHS as well as wider societal restrictions, Recovery Through Activity (Parkinson 2014) implementation was limited, therefore the potential sampling pool was substantially smaller. Due to this there were difficulties with recruitment, and so anyone who matched the inclusion criteria and expressed an interest were invited to interview.

Ethical considerations

The key ethical principles and human rights in research are the principles of veracity, justice, beneficence, fidelity and respect (Moule and Hek 2011).

The principle of veracity relates to honesty, sincerity and the right to full disclosure of participants (Moule and Hek 2011). This includes informed consent. Participants in this research were fully informed about the research and had an opportunity to ask questions. Written consent was provided, and participants were informed of their right to withdraw from the research. Written information was provided to participants regarding the research purpose, how participants were selected, who was financing

the research, any risks and/or benefits, as well as who to contact if there were any questions or complaints regarding the research.

The principle of justice refers to treating participants fairly, putting participant needs before research objectives and respecting equality and diversity (Moule and Hek 2011). Measures were put into place to safeguard potentially vulnerable participants. A gatekeeper for initial contact was used to reduce pressures or coercion of participating in the research. Participants were selected fairly with equal opportunities of being selected for interviews and sharing intervention outcome data.

The principle of beneficence refers to the duty of the researcher to do and prevent harm and to protect potentially vulnerable participants (Moule and Hek 2011). occupational therapists screened service users prior to providing a list of potential service user participants to the gatekeeper to exclude any service users that were unable to give informed consent, or those whose care would be impacted upon by their involvement in the research. A risk management plan was implemented with a list of services for each potential risk to signpost participants to support if required.

The principle of fidelity and respect refers to the right to anonymity and confidentiality, respect and dignity and safeguarding (Moule and Hek 2011). Participants have a right for their information to be treated confidentially and any data collected can only be disclosed with their consent (Moule and Hek 2011). Information was provided to participants on how their data would be treated confidentially. Additionally, all data were anonymized, and codes were used for each participant. These codes were kept separately and securely so that the participants would remain anonymous. This research is compliant with the Data Protection Act (1998), and the Health and Social Care Act (2001). In addition, the researcher is a registered health and social care practitioner and as such

adheres to the Health and Care Professions Council's standards of conduct, performance and ethics (HCPC 2024).

This research received favorable opinion by the North of Scotland Research Ethics Committee, ref: 21/NS/0010 on 11/03/2021 (appendix 16). As the research was conducted within an NHS organisation additional approval from the Health Research Authority and Health and Care Research Wales was sought and granted on 11/03/2021 (appendix 17). In addition, the research was reviewed by Cardiff University Research Governance and underwent quality assessment by the participating NHS organisation Research and Development department. This research was designed and conducted in line with the UK Policy Framework for Health and Social Care Research (HRA 2017).

5.12 Protocol Questions

This section delineates the guiding questions that steered the line of inquiry throughout the data collection process. Termed 'level 2' questions, these were utilised by the researcher to maintain the research's alignment with its established objectives and ensure consistency across different stages of data collection. As the line of inquiry was uniform across all cases, the same set of level 2 questions applied to each, thereby streamlining the data collection and ensuring uniformity in the approach. These questions played a critical role in probing deeper into each case, allowing for a focused and systematic exploration as highlighted by Yin (2018). This approach ensured that all aspects of the research objectives were comprehensively addressed, facilitating a thorough investigation of each individual case.

5.12.1.1 Units of analysis and data collection

The level 2 questions below have been grouped within their unit of analysis and linked to the research propositions. Below each grouping, the

unit of data collection that relates to each unit of analysis is noted. This provides transparency on how each avenue of inquiry was addressed.

Unit of Analysis: Service users' experiences

Units of data collection: Service user prolonged interview, intervention outcome data and reflection on observations

- How has Recovery Through Activity (Parkinson 2014) impacted on the service user's occupational participation and engagement? [proposition 5]
- How has the implementation method impacted on the service users' experiences of Recovery Through Activity (Parkinson 2014)? [proposition 2]
- How has access to community resources impacted on the service users' perceptions of the effectiveness and benefits of Recovery Through Activity (Parkinson 2014)? [proposition 3]
- How have individual differences impacted on service users' perceptions of the effectiveness and benefits of Recovery Through Activity (Parkinson 2014)? [proposition 4]

Unit of analysis: occupational therapy staff experiences

Units of data collection: occupational therapy staff interviews

- What are occupational therapy staff experiences of implementing an occupationally focussed approach? [contextual]
- What are occupational therapy staff experiences of using Recovery Through Activity (Parkinson 2014) to inform practice? [contextual]
- How do service dynamics and demographics impact on Therapy staff experiences of Recovery Through Activity (Parkinson 2014)? [linked to proposition 1]

- How does the implementation method of Recovery Through Activity (Parkinson 2014) impact on occupational therapy staff experiences? [linked to proposition 2]
- How does access to community resources impact on the effectiveness and the benefits of the use of Recovery Through Activity (Parkinson 2014) from an occupational therapy staff perspective? [linked to proposition 3]

Unit of analysis: Existing assessment and intervention outcome data

Unit of data collection: Anonymised service user intervention outcome data

- What assessment and outcome measure tools were/are used for Recovery Through Activity (Parkinson 2014)? [contextual]
- Do the assessment tools and outcome measure tools inform OT staff on an individual's occupational areas of volition, habituation, performance capacity and environment? [contextual]
- Based on intervention outcome data, how has Recovery Through Activity (Parkinson 2014) impacted on service users' occupational participation and engagement. [linked to proposition 5]

Unit of analysis: context of the cases

Units of data collection: occupational therapy staff interviews, service user interview.

- What Recovery Through Activity (Parkinson 2014) training and support is available?

- What resources and community links are available in the context of Recovery Through Activity (Parkinson 2014)?
- What are the demographics of the service users engaging in Recovery Through Activity (Parkinson 2014)?
- What local policies and legislations inform Recovery Through Activity (Parkinson 2014) practice?
- What is the service demands and objectives in the context of Recovery Through Activity (Parkinson 2014)?
- What are the demographics of occupational therapy staff delivering Recovery Through Activity (Parkinson 2014)?

5.13 Cross case analysis

In this research, the initial analysis of the case studies, Recovery Through Activity (Parkinson 2014) implemented both face-to-face and virtually within inpatient and community adult mental health services, was conducted separately for each mode of delivery. Data for each case were triangulated, incorporating qualitative interviews, quantitative intervention outcome data, and researcher reflections to form a comprehensive view of each implementation strategy. This approach facilitated the formation of distinct chapters within the thesis, with one chapter dedicated to findings from the face-to-face implementation and another for the virtual implementation.

Following the individual case analyses, a separate cross-case analysis was conducted to compare findings from both cases. This comparison sought to identify patterns and variations that would deepen understanding of the intervention's effectiveness and challenges across different contexts.

To ensure consistent data management, a systematic approach was used to organise and track information from each case study. Interview

transcripts, quantitative outcome data, and researcher reflections were securely stored in structured digital folders, separated by case and data type. Interview transcripts were anonymised, coded, and categorised according to thematic domains, providing a consistent framework for analysis across both cases. I documented reflections after each stage of coding and theme development to capture how interpretations may have been influenced by their occupational therapy background. These reflections, along with notes from supervisory discussions, offered insight into the interpretive process and are further detailed in the reflexivity section.

Cross-case analysis played a pivotal role in the research, enabling a comprehensive evaluation of Recovery Through Activity (Parkinson 2014) across multiple settings. This comparative analysis illuminated patterns and differences that might not have been apparent when examining each case individually, offering insights into the intervention's implementation in diverse contexts. By examining both individual and collective patterns, this analysis provided a nuanced understanding of the factors that influenced Recovery Through Activity (Parkinson 2014)'s effectiveness and highlighted the challenges encountered.

Following Yin's (2018) approach to cross-case analysis, the research first re-examined the themes identified within each case, such as occupational engagement, group dynamics, and service delivery challenges, and organised them into an evidence web. This evidence web allowed for side-by-side evaluation of how these themes manifested across different delivery modes. Throughout this comparative process, I re-evaluated and refined data entries in the web to ensure coherence across cases.

Multiple data sources, including interviews, intervention outcome data, and researcher reflections, were triangulated across the cases to validate findings. For example, service user feedback from both face-to-face and

virtual settings was compared to identify commonalities in their experiences of Recovery Through Activity, while occupational therapists' perspectives were analysed to determine any variations between delivery modes. This triangulation across cases enhanced the study's overall validity, consistent with Yin's (2009) approach to corroborating findings across contexts.

Using Yin's (2009) pattern matching technique, I compared identified patterns within each case against theoretical propositions related to service dynamics and volitional factors. Themes and sub-themes were aligned with domains of the MOHO (Kielhofner 2008), allowing the analysis to assess how each case's outcomes corresponded with the study's theoretical framework. Data were iteratively reviewed to ensure consistency in pattern matching, with adjustments made as needed to maintain alignment with MOHO constructs.

During cross-case analysis, the research revisited potential rival explanations to assess alternative interpretations of the findings. In examining differences in effectiveness, for example, contextual factors such as client readiness for change, service dynamics, or external influences were considered and compared across both cases to validate or refine the primary explanations, ultimately strengthening the reliability of the findings.

The synthesis of triangulated data enabled the derivation of broader insights applicable to both cases. Through Level 1 inferences (within-case patterns) and Level 2 inferences (cross-case patterns), generalisable conclusions were drawn about the implementation and effectiveness of Recovery Through Activity across diverse operational contexts. This approach aligns with Yin's (2018) emphasis on generalising to theoretical propositions rather than predicting outcomes across populations,

supporting the development of theoretical insights relevant to future practice.

Cross-case analysis was particularly suited to this research for several reasons. First, it enhanced validity by corroborating findings across different contexts. Yin (2018) emphasises that cross-case analysis strengthens validity by allowing researchers to verify findings within diverse settings. In comparing outcomes across face-to-face and virtual formats, the study validated the intervention's consistency while revealing any anomalies, enhancing the credibility of the conclusions.

The analysis also facilitated exploration of the complex dynamics involved in implementing Recovery Through Activity (Parkinson 2014) within mental health services, allowing the study to account for variations in service structures, staff experiences, and client demographics. This provided a comprehensive understanding of how contextual factors interacted with the intervention. Additionally, cross-case analysis supported theory-building, helping refine propositions related to MOHO, volitional factors, and service dynamics by identifying contextual influences on intervention outcomes. This synthesis led to broader conclusions and theoretical insights that could inform future practice in diverse settings.

The research's cross-case analysis also enabled the development of a holistic perspective on Recovery Through Activity (Parkinson 2014) by synthesising individual and collective patterns across cases. This comprehensive analysis highlighted the intervention's impact on occupational engagement, as well as the factors that facilitated or hindered its success across different contexts.

Through this structured cross-case analysis, three chapters were developed to present the findings: the first covered face-to-face implementation, the second virtual implementation, and the third

synthesised cross-case findings. This structure captured specific insights from each implementation mode and integrated comparative results to draw broader conclusions about the applicability of Recovery Through Activity (Parkinson 2014) in varied operational contexts. This systematic approach to cross-case analysis ensures a rigorous, transparent, and replicable research process, enhancing the credibility and applicability of the study's outcomes.

5.14 Summary

This chapter has established the comprehensive framework and methodologies employed in this research to explore the experiences of occupational therapy staff and service users with Recovery Through Activity (Parkinson 2014) within NHS adult mental health services. The research utilised a case study design, ideal for an in-depth examination of complex phenomena within their real-life contexts, as described by Yin (2018) and Gerring (2017). This approach was particularly relevant for understanding the interactions between the intervention and its application within environments of health service delivery.

The research was driven by specific objectives that sought to explore the roles and experiences of occupational therapy staff, the opportunities and challenges of implementing an occupationally focused approach, the perceptions of service users, and the effectiveness of Recovery Through Activity (Parkinson 2014) as evidenced through intervention outcome data. By employing a mixed-methods approach, the research was able to capture a broad spectrum of data, from qualitative insights through interviews to quantitative analysis of intervention outcomes.

A critical aspect of the methodology was the employment of Yin (2018)'s case study framework, which provided a structured approach to

managing, analysing, and drawing conclusions from complex data sets. This framework emphasises the importance of linking data tightly with theory, which is vital for validating the findings derived from empirical observations.

The case study design facilitated a thorough exploration of two distinct cases, Recovery Through Activity (Parkinson 2014) implemented face-to-face and virtually. Each case was analysed independently using triangulated data from various sources, including interviews, intervention outcome data, and researcher reflections. This approach ensured that each case was understood in its complexity and context.

Following the individual analyses, a cross-case analysis was conducted to identify common themes and differences, allowing for broader generalisations and theoretical insights. This step is vital in case study research as it moves beyond the descriptive to make inferential judgments that contribute to theory-building, in line with the recommendations by Yin (2018).

The findings from each case study and the subsequent cross-case analysis are systematically presented to highlight both the distinct and common outcomes of the Recovery Through Activity (Parkinson 2014) implementations. This structure not only facilitates a clear understanding of each implementation's impact but also provides a comparative perspective that enriches the overall analysis.

Overall, this chapter has laid a foundation for the subsequent empirical chapters, setting the stage for a detailed presentation of the findings that will further elaborate on how Recovery Through Activity (Parkinson 2014) is perceived and implemented across different settings within the NHS. The methodologies and case study design outlined here highlight the commitment to rigor, transparency, and relevance, ensuring that the

findings are both credible and applicable to the field of occupational therapy and mental health service delivery.

Chapter 6 – Face-to-face case findings

6.1 Introduction

This chapter delves into the implementation of Recovery Through Activity (Parkinson 2014) in face-to-face settings, offering a comprehensive view of its impact through various perspectives. Interviews conducted with both registered occupational therapists and occupational therapy support staff are explored, all of whom have hands-on experience with Recovery Through Activity (Parkinson 2014) in community and inpatient settings. Additionally, this chapter includes insights from a detailed reflection by the researcher based on observations of Recovery Through Activity (Parkinson 2014) groups in action, enhancing our understanding of the dynamics and outcomes of face-to-face interventions. Furthermore, findings from a prolonged interview with a service user who participated in the Recovery Through Activity (Parkinson 2014) sessions is incorporated, providing a unique perspective of the user's experience and Recovery Through Activity's (Parkinson 2014) effectiveness in a real-world context. Together, these elements aim to paint a holistic picture of how Recovery Through Activity (Parkinson 2014), when implemented in person, aligns with and supports the therapeutic goals of occupational therapy, highlighting its adaptability and profound impact on service users.

6.2 Occupational therapy staff interviews

Interviews were conducted with registered occupational therapists and occupational therapy support workers/assistants who delivered Recovery Through Activity face-to-face (as opposed to virtually). For anonymity, both are referred to as occupational therapy staff in this section. Interviews were carried out via Microsoft Teams. Six occupational therapy

staff were interviewed in total: Four were registered occupational therapists and two were occupational therapy support workers/assistants. All six participants had experience implementing Recovery Through Activity (Parkinson 2014) within the community, three of them also had experience implementing Recovery Through Activity (Parkinson 2014) in an inpatient setting.

Across both cases (face to face and virtual) 7 interviews were conducted. Carrie did not have experience with face-to-face Recovery Through Activity (Parkinson 2014), thus in this chapter, findings are based on occupational therapy staff Annie, Beth, Carrie, Debbie, Eve, Flo Georgia. See table 1 below.

Table 4 - Breakdown of participant interviews across implementation methods

Face to face	Virtual
Annie	Annie
Beth	Beth
/	Carrie
Debbie	/
Eve	/
Flo	Flo
Georgia	/

This chapter explores 10 key themes that emerged from the experiences of occupational therapy staff implementing Recovery Through Activity (Parkinson 2014) face-to-face:

1. Motivation Unveiled: Occupational therapy staff highlighted the importance of customising Recovery Through Activity (Parkinson 2014) to meet individual service users' needs. This tailored approach transitioned the program from a general activity group to a targeted occupational therapy intervention, helping service users identify goals, re-engage with community activities, and rediscover motivation, despite challenges posed by COVID-19 restrictions.

2. Striking a Balance: Participants emphasized balancing practical activities with educational elements in Recovery Through Activity (Parkinson 2014). Practical activities helped consolidate educational concepts, while the educational components facilitated discussions. COVID-19 restrictions posed challenges to this balance, but the Recovery Through Activity (Parkinson 2014) manual proved to be a helpful tool in promoting education alongside practical activities.

3. Navigating Group Size, Needs, and Environments: Group dynamics were vital for effective Recovery Through Activity (Parkinson 2014) sessions. Participants considered factors such as group size, service users' functioning levels, and the physical environment. Smaller groups with similar needs and functioning levels promoted supportive social environments and better engagement.

4. Maximizing Recovery Through Activity: Integrating one-to-one sessions with group activities maximized the benefits of Recovery Through Activity (Parkinson 2014). These individual sessions helped identify and build on service users' skills and needs, assess the appropriateness of group interventions, and strengthen rapport with service users.

5. Community Integration and Engagement: Connecting with community organizations was a key factor in enhancing Recovery Through Activity sessions (Parkinson 2014). Involving these organizations made sessions more engaging and provided service users with opportunities to connect with community resources, promoting long-term engagement and support.

6. Purposeful Planning, Assessment, and Evaluation: Meticulous planning, assessments, and evaluations were pivotal for the success of Recovery Through Activity (Parkinson 2014) groups. Tools like the Activity Checklist and Occupational Self-Assessment guided the planning process and measured changes in service users' perceived competence, ensuring tailored and effective interventions.

7. Adapting Recovery Through Activity to Diverse Settings and Needs: The flexibility of the Recovery Through Activity (Parkinson 2014) manual allowed it to be adapted to various settings and service user needs. Participants appreciated this adaptability, which enabled them to tailor interventions and balance educational and practical elements effectively.

8. **Shaping Recovery Through Activity for Individual Engagement and Acceptance:** Feedback from service users was vital in adapting the structure of Recovery Through Activity (Parkinson 2014) groups. The flexibility of the program allowed for modifications based on service users' preferences and needs, enhancing engagement and acceptance.

9. **The Role of Recovery Through Activity in Balancing Generic Roles and Promoting Occupational Principles:** Recovery Through Activity (Parkinson 2014) supported occupational therapists in maintaining an occupational focus amidst generic roles. The manual helped articulate the value of occupation, combine theory and practice, and promote the use of occupational therapy conceptual models.

10. **The Impact of Recovery Through Activity on Fostering Professional Understanding and Confidence:** Recovery Through Activity (Parkinson 2014) reinforced the professional identity of occupational therapists within the multidisciplinary team (MDT). It increased job satisfaction, clarified the role of occupational therapists, and built confidence in articulating their contributions to service users' well-being.

6.2.1 Themes

6.2.1.1 Theme 1: Motivation Unveiled

Occupational therapy staff reported that by tailoring Recovery Through Activity (Parkinson 2014) to the individual needs of service users, the intervention transitioned from a general activity group to a targeted occupational therapy intervention. This person-centred approach helped service users to identify their goals, re-engage with community activities, and rediscover their motivations, which often cited as the most prevalent need among service users. However, implementing personalised Recovery Through Activity (Parkinson 2014) interventions presented challenges, particularly due to Covid-19 restrictions which limited available community activities. To effectively tailor the intervention to service user needs, occupational therapists employed MOHO (Kielhofner 2008) tools, conducted detailed inquiries about service users' interests and requirements, and allocated specific planning time before starting the groups. This preparation was vital for adapting the intervention amidst the constraints imposed by the pandemic and varying community resource availability.

Empowering Engagement: Tools and Techniques

Participants felt that tailoring Recovery Through Activity (Parkinson 2014) to individual service user needs was important in ensuring an

occupational therapy intervention was delivered, as opposed to it just being an activity programme. occupational therapy staff felt that it was important to determine whether service users wanted to engage, what benefits they would get from the intervention and how they could develop skills and use these in their everyday lives.

"What patients were getting out of it, and how likely they were to kind of take on those skills and take them forward rather than it just being a nice group." – Eve

There were some tools that the occupational therapists found supported them in drawing out service user needs and tailoring Recovery Through Activity (Parkinson 2014). For example, participants discussed the Role Checklist (Scott 2019) and the Activity Checklist (Parkinson 2014), finding that this helped them to draw out what people were interested in, helped them to jointly identify goals with service users and to maintain an occupational focus. The OSA (Baron et al 2006) was also used by participants to draw out where service users perceived their strengths and limitations to be, what they perceived as important, as well as drawing out goals. Participants also reported that they created their own screening questions to be used as part of a discussion prior to Recovery Through Activity interventions (Parkinson 2014). Questions included asking service users what their interests were, what they like doing and what their future goals were. Participants felt that the sessions were more beneficial when they were planned with service users and based on service user needs and goals.

"One thing we did was actually ask 'what sort of activity you want to explore this week?' You know, really gave them their control. I think that's what was the big difference, actually giving the patient's control." – Georgia

occupational therapy staff noted that service users initially found it challenging to set goals before starting Recovery Through Activity (Parkinson 2014) interventions. They suggested that one-on-one sessions could provide valuable support in helping service users identify their goals and needs. However, due to time constraints, many occupational therapy staff indicated that it was not always feasible to conduct individual sessions along with group activities, though they believed such sessions would be beneficial.

To facilitate goal setting, occupational therapists encouraged service users to reflect on their experiences after each Recovery Through Activity (Parkinson 2014) session. This reflection was then used as a basis for setting and adjusting goals, allowing the process to remain flexible and responsive to each service user's progress. Regular reviews of these goals were emphasised as essential, particularly because service users' needs can evolve over time. This approach ensured that the intervention remained relevant and supportive, adapting to the changing circumstances and needs of the service users.

"There was a kind of push each week for people to reflect on something that they could do or add in into their lives." – Debbie

Igniting motivation

Participants observed that 'motivation' was a common challenge among service users, especially in a ward setting, where factors like energy regulation and the impact of medication could affect their engagement levels. To address this, they found that starting interventions with activities related to 'self-care' were particularly effective. They noted that self-care was a broad category that was easy to communicate and relevant to all service users, albeit to varying extents.

Additionally, participants highlighted the usefulness of arts and crafts as an initial activity in their sessions. They described it as an excellent icebreaker that facilitated conversation and interaction among service users. By engaging in such activities, which aligned closely with their interests right from the beginning, participants felt they could effectively boost motivation and participation in the sessions. This approach of targeting service user interests early was vital in encouraging sustained engagement throughout the Recovery Through Activity (Parkinson 2014) interventions.

"…that kind of piqued their interest before they before their motivation maybe dwindled." – Annie

It was felt that through tailoring Recovery Activity (Parkinson 2014) to service user needs, it enabled them to re-engage in activities, trigger old interests and supported people to re-integrate within the community. It was found that it was not only the activity itself that supported this but also the social aspects of the groups and the environment. A particular case where a participant discussed some of these factors, was where a service user had returned to swimming after the Recovery Through Activity (Parkinson 2014) session had been tailored to this interest. After visiting a local leisure centre as part of the intervention, the motivation and interest to re-engage in this occupation had led this service user to return to swimming.

".... it was it was the whole atmosphere of the place, she just hadn't been back into a leisure centre…..and the smell of the swimming pool." – Beth

Tailoring interventions: Navigating time and challenges

It was evident from the interviews that sufficient time was required prior to running the sessions to enable the interventions to be tailored to individual needs and link in with community organisations. The time

needed to plan this varied between settings, on a ward it was likely that the occupational therapist already had relationships with service users and so it was reported to be easier to identify goals and tailor sessions. In the community setting however, many service users were new referrals, and so more time was needed to build up a rapport and identify needs.

"You'd have to meet people way in advance before setting up the sessions." – Debbie

occupational therapists explained that there were some challenges in tailoring Recovery Through Activity (Parkinson 2014) to service user interests, stating that due to the Covid-19 restrictions at the time, they were limited in sourcing accessible facilities within their areas for service users. In order to overcome this, they used the Recovery Through Activity (Parkinson 2014) manual and covered each of the 12 activity domains to ensure variety.

"…It was trying to source facilities within our area that were accessible to patients, which was quite challenging during COVID." – Beth

6.2.1.2 Theme 2: Striking a balance

Participants expressed that it was important when delivering Recovery Through Activity (Parkinson 2014) to balance both practical activities and the educational elements of the interventions. They suggested that the practical activities helped to consolidate the educational elements and that the educational elements and practical activities combined helped to facilitate discussions. A challenge that arose when trying to balance practical activities and educational elements surrounded implementing practical activities while adhering to Covid-19 restrictions, as well as transport and restrictions accessing the community in a secure ward setting. Participants stated that the Recovery Through Activity (Parkinson

2014) manual was a helpful tool in promoting education alongside practical activities.

Blended Practice and learning

Participants found it beneficial to explain the theoretical underpinnings of why occupations are important to service users. However, they noted that the most significant benefits were derived from actively engaging in the practical aspects of the sessions. Participants felt that these practical activities not only reinforced the educational content but also helped service users to internalise and apply the concepts more effectively.

"It was more beneficial to be involved in the actual doing." – Annie

A supportive factor in balancing practical and educational elements was to combine both within sessions. Practical activities were used as ice breakers to facilitate discussion surrounding educational elements. Participants felt that it was difficult to maintain engagement when the sessions were focused around the educational element for too long and service users had difficulty concentrating for extended periods. The practical elements of the groups prompted conversation and interaction between service users and the occupational therapists. Another supportive factor in maintaining a balance between practical activities and education was inviting external organisations into sessions. A range of external organisations attended groups, from dieticians to Tai Chi instructors and yoga instructors, who offered practical activities and explained the benefits of engaging in these activities in their everyday life.

"Incorporating discussion into general conversation during activity and combining both. That was the other thing was that I just very much made sure I embodied. That level of conversation." – Georgia

The Recovery Through Activity (Parkinson 2014) manual was discussed as a helpful tool in promoting the educational elements alongside activities. Participants felt that it was helpful having the rationale laid out in the manual to guide discussion and explain the rationale behind the activities that they were doing. Participants felt that without the manual they may have understood knowledge as to why the activities were beneficial but may not have articulated this knowledge to service users as much. The manual therefore helped to facilitate sharing this knowledge.

I think just having it laid out with the evidence for it for the discussion, really meant that I'm making sure that I'm covering psychoeducation part, like the rational alongside." – (Eve)

Adapting Recovery Through Activity Amid Challenges

Challenges were raised by participants in relation to maintaining a balance between practical activities and education. Challenges surrounded restrictions within secure ward settings where service users did not have leave to access the community. This meant that some sessions were restricted to the ward to ensure that service users weren't excluded from the groups. Other challenges surrounded the Covid-19 restrictions. Prior to Covid-19 restrictions participants were able to source many community activities to promote practical activities, however following the restrictions it was difficult finding activities within the community. Transport was also impacted by Covid-19, and participants were unable to take service users in their cars and could not promote using public transport in a group. Prior to these restrictions service users would meet at a midway point and get the bus together to build confidence. It was felt that a lot of what could be offered within Recovery Through Activity (Parkinson 2014) sessions depended on what could be sourced and accessed within the community and that sessions were dictated by restrictions.

"The nature of recovery through activity…just the nature of the doing and we couldn't do anything. It had such an impact on so many people. You know, it really did." – Georgia

6.2.1.3 *Theme 3: Navigating Group Size, Needs, and Environments*

Participants felt that group dynamics were important to consider when delivering Recovery Through Activity (Parkinson 2014). Some of the factors they reported considering were the size of groups, service user functioning levels and needs, and the physical environment.

Optimising group size

Participants felt that groups worked best when there were between 4 to 8 service users present. Often eight service users were invited to the sessions but due to dropout rates, most groups maintained between four to six service users. It was important however, to consider service users functioning levels and communication skills when planning how many to invite to a group. Participants expressed that some smaller groups of four worked well as service users had similar functioning levels and generated a lot of discussion between them. Participants discussed that it was important to account for dropout rates in the initial planning phases of the sessions because if too few service users were invited in the initial phase, there may not be enough service users left toward the end of the course of interventions to run the groups. Participants also explained that they had to be mindful of the facilitator to service user ratio when inviting external agencies. Having too few facilitators to service users in a session meant that sessions could be difficult to manage, whereas having too many facilitators to service users was seen as potentially overbearing for service users. Participants also had to be mindful of Covid-19 restrictions, there was a period where only 10 people were able to gather as a group,

so they had to factor this in when considering external organisations joining their sessions.

"Sometimes I think it's better to have four people who can, you know, get more out of it, than six to eight where it might be struggle. It all depends on people's level of function." Debbie

Empowering Connections

Participants reported that being in a group benefitted service users from a social and peer support aspect. Conversations were described as being different in a group as opposed to a one-to-one dynamic as service users often had similar experiences and were able to offer support to one another. Service users would express that they felt that their peers understood where they were coming from. Through supporting their peers, they felt a sense of usefulness. Participants stated that it was satisfying for them to see service users blossom in a group setting. Therefore, a group dynamic where others had similar functioning levels and needs was seen as important by participants due to the perceived benefits that service users experienced. As such, participants felt that similar needs and functioning levels were key factors in promoting a supportive social environment and group dynamic.

"They weren't similar in personality traits or likes or dislikes or anything like that, but I would say in terms of their needs, from a mental health support, peer support, social interaction. They certainly gave a lot more peer support and would help each other along more." - Eve

Creating safe spaces

One of the factors that impacted on group dynamics was the physical environment. Participants felt that an enclosed area was best for group dynamics as it promoted a sense that it was a safe space for group

members. Participants felt that when the space was open and others were passing, it felt less comfortable. Libraries and community hubs were seen as good places to run Recovery Through Activity (Parkinson 2014) as they often already have a lot of other community groups taking place. This meant that participants could signpost service users and service users would be comfortable accessing a familiar venue. It was also important for groups to have access to kitchen facilities. Having tea and coffee over discussions was a facilitating factor in relation to group dynamics. Additionally, it was helpful for the venue to be spacious to enable physical activities, as well as being informal so that service users felt comfortable.

"It also gave a lot of people that lived in that area a chance to see something that was as accessible to them as a library…they run a lot of activities from there." – Beth

6.2.1.4 Theme 4: Maximising Recovery Through Activity

Whilst the benefits of one-to-one sessions with service users during goal setting have been previously discussed, participants also highlighted the added value of integrating these individual sessions alongside group activities within the Recovery Through Activity (Parkinson 2014) framework. They determined that one-to-one interventions, when conducted in conjunction with group sessions, maximised the benefits of the intervention. This dual approach facilitated a more tailored engagement, allowing occupational therapists to identify and develop individual skills, needs, and goals. Additionally, it enabled therapists to assess the suitability of group dynamics and interventions more effectively. Importantly, these individual sessions also provided valuable opportunities to build and strengthen rapport with service users, enhancing the overall therapeutic experience.

Cultivating Individualised Foundations

Participants found that one-to-one sessions prior to the commencement of groups facilitated identifying needs and goals, as well as assisting in the planning of group sessions in a person-centred way. One-to-one sessions during groups assisted in monitoring goals and needs, as well as giving the opportunity to work on individual skills. One-to-one sessions post groups also enabled participants to monitor service user progress and offer support in relation to developing skills and engaging with the community, as well as chasing up any onward referrals. Another overall benefit of one-to-one sessions was that it enabled participants to assess and evaluate the appropriateness of groups in relation to meeting service user's goals and also managing potential risks associated with activities. Participants also discussed that through building up a rapport with service users in one-to-one sessions, they were better able to encourage and motivate service users to engage in group sessions.

"Doing one to ones helped us to check the appropriateness [of groups] from kind of a goal perspective and risk perspective." Eve

Harmonising individual and group support

Participants expressed that there was a benefit in running one-to-one sessions alongside the group sessions to enable them to identify and build on individual skills and goals. Participants discussed several ways that they incorporated one-to-one contact. One way this was achieved was by having a break half-way through a course of group sessions to check in with service users and to re-evaluate the groups focus. Another method was through booking formal weekly one-to-one sessions. However, a challenge to offering one-to-one contact was time, a way to overcome this was to offer one-to-one discussions at the end of group sessions. In a ward setting participants found it easier to have one-to-one contact alongside groups as the service users were easily accessible. They did not

have to book sessions and could catch up with service users using more of an opportunistic approach.

"We had our [group] session say yesterday and then they've gone away and thought about something and then we pick it up the next day and you'd have a chat again and carry it on. There's a lot of one to one that goes along with it and that's another benefit I guess of being on the wards."- Flo.

One of the supporting factors in being able to facilitate one-to-one sessions was having enough staff. Participants expressed that group sessions were usually run with two staff, usually an occupational therapist and an occupational therapy support worker. However, in some settings a single occupational therapist facilitated the groups and in other settings there were two occupational therapists and an occupational therapy support worker. It was found that in order to facilitate one-to-one sessions, it was ideal to have more than one member of staff facilitating the groups, particularly if the groups were large.

"I think it's always handy to have extra staff. Two people's ideal with an extra person as well just as a backup is always good." – Debbie

Seamless Transitions

Participants felt that it would be beneficial to follow up with one-to-one contact after the Recovery Through Activity (Parkinson 2014) intervention had finished to oversee service user pathways going into community groups to continue the progress after groups. This one-to-one support was seen as vital in supporting and guiding service users after groups to continue to work on their needs and goals to promote occupational change, optimising the benefits of the groups.

"I think it's just better to put in the time to support people so they get the most out of the group and actually can make occupational changes." - Debbie

6.2.1.5 Theme 5: Community Integration and engagement

Involving community organisations by making connections and links with community organisations was raised as a supportive factor when implementing Recovery Through Activity (Parkinson 2014) interventions as it made sessions more engaging, it gave service users an opportunity to meet people from the community organisations and it provided an opportunity to connect with others after Recovery Through Activity (Parkinson 2014).

Collaborative Enrichment

Participants stated that they invited community organisations into their sessions, while others went out to visit organisations within the community, this provided an opportunity for organisations to introduce their service and what they offer, as well as facilitating activities in the groups. Participants felt service users engaged more in the sessions where community organisations were involved. They felt that if they spoke of community organisations themselves it only scratched the surface, as they were only proposing or informing them of a community activity. In contrast, when community organisations were involved in groups, service users had the opportunity to interact with the organisations and it piqued their interest which participants felt was more effective.

"If you have someone come in, I kind of felt that it was a bit more of an engaging session." – Annie

Community engagement for long term impacts

Some of the benefits of engaging community organisations within the groups was that they gave service users an opportunity to meet people from the organisations, provided service users with an awareness of what was available to them and an opportunity to have a taster of the activity in some instances. Linking in with community organisations was therefore seen as important by participants as it helped to promote the longevity of the benefits of Recovery Through Activity (Parkinson 2014) groups post intervention. Participants also felt that by having community organisations attend the groups, it informed them as practitioners as to what was available in the community, what people's roles were and the type of support they could offer. Participants felt it was particularly important to keep up to date with what was available due to Covid-19 restrictions because what was available was changing weekly and practitioners were losing track of what remained available. Through gaining this knowledge, it better supported participants to refer and signpost service users to appropriate community organisations.

"The third sector was so key, that without them, it would have meant nothing. That time networking to start off with was invaluable to be honest." – Eve

Building pathways through community engagement

It was reported by participants that some service users continued to engage in community groups after attending Recovery Through Activity (Parkinson 2014) sessions as they had already made connections with the organisations through the group sessions. Participants talked about many organisations that got involved within sessions, for example 'Hafal' who offered peer support and offered a pathway for service users to continue to access support and progress after Recovery Through Activity (Parkinson 2014). Another scheme that was referred to frequently was the exercise referral scheme. Many participants reported that they had

made referrals to this scheme following a group session with the organisation and that sporting organisations were reported to be popular among service users, with referrals and ongoing engagement in groups such as walking rugby. A local third sector organisation was a popular organisation that many participants linked in with for Recovery Through Activity (Parkinson 2014), expressing that many onward referrals were made to this organisation post intervention. The local third sector organisation offered a range of activities that people can engage in from woodwork and gardening to I.T and cooking. It was reported that service users felt reassured by having organisations attend Recovery Through Activity (Parkinson 2014) sessions, which led them to being more likely to engage post intervention. MIND was another organisation that many participants linked in with and that onward referrals were then made to. Participants reported that many community organisations were happy and willing to get involved and make links, which was beneficial.

"It's reassuring. It's by making that first connection with those third sectors. Letting them see who it is and having it all explained to them."

Beth

6.2.1.6 Theme 6: Purposeful planning, assessment, and evaluation.

This narrative highlights the pivotal role of meticulous planning in the success of Recovery Through Activity groups, as articulated by participants. Through strategic assessments and pre-planning, interventions were tailored to service users' needs, promoting higher engagement and retention rates. Networking with community organisations was highlighted as a time-saving measure. Assessment tools, particularly the Activity Checklist (Parkinson 2014) and OSA (Baron et al 2006), guided the planning process, while informal assessment methods provided valuable insights. The OSA (Baron et al 2006) also

served as an outcome measure, revealing changes in self-perceived competence. Various other outcome measure tools were employed, complemented by participants' feedback forms and informal insights, showcasing a comprehensive evaluation approach. However, caution was advised on the volume of tools to prevent overwhelming service users, emphasising the need for thoughtful consideration and efficient review processes.

Plan, Plan, Plan!

Participants emphasised the importance of assessments and planning prior to running Recovery Through Activity (Parkinson 2014) groups. By assessing needs and planning in advance through screening and identifying service user function, interests and goals, it enabled them to tailor Recovery Through Activity (Parkinson 2014) to service user's needs. Interventions that were tailored to service user interests and needs had better retention rates and service users were more motivated and engaging in the sessions. Another aspect of planning that was raised as important was networking with community organisations. Participants felt that through networking prior to running the groups, it then saved time in long run as they had a list of organisations that they could draw upon when the time then came to set up the groups. They described that the more planning that is done, the smoother the groups run.

"Plan! plan plan plan! and network! The biggest thing we did before we started was network like anything." – Annie

Insightful tools for assessment and planning

In relation to assessments, firstly participants identified with service users whether there was an occupational need and considered whether they were interested in engaging with Recovery Through Activity (Parkinson 2014). Following this in many cases, service user interests were

identified, which then informed the planning of group sessions. There were a number of tools that participants found helpful to aid in the planning of Recovery Through Activity (Parkinson 2014) interventions. One of the commonly used tools in the planning phase was the Activity Checklist (Parkinson 2014). This tool was described as helpful when planning the group topics as it helped to highlight service users interests and provide an insight into their previous experiences. Participants explained that the tool was easy to use and that it was most beneficial when used well in advance to enable the outcomes to inform the sessions.

"The activity checklist is pretty straightforward, really. So, we use that all the time and it was more initially to just draw out what people are what interests people had, so we could set up the group." – Debbie

The OSA (Baron et al 2006) was used in the assessment phase to determine service user's self-perceived levels of confidence in occupational areas and level of importance they placed on these areas. This tool helped participants to unpick service users' needs and assisted in informing goal planning. Participants described how informal methods of assessment were carried out throughout the course of the sessions to inform ongoing planning and changing needs. According to participants, this was done through discussions with service users on a group and one-to-one level, as well as through observations and helped to inform intervention progress and insight into service user views.

Measuring change: Outcome measure tools and informal insights

The OSA (Baron et al. 2006) was also used as an outcome measure by using the tool at the beginning and the end of Recovery Through Activity (Parkinson 2014). The tool measured changes in self-perceived competence and changes in what people valued. According to the participants, in most instances the tool was effective and accurately measured change as service users had insight into their abilities. Some

participants did however report difficulties collecting post intervention OSA's (Baron et al. 2006) as Covid-19 restrictions came into place before the end of Recovery Through Activity (Parkinson 2014) sessions, halting groups, meaning that the outcome measure could not be repeated in some cases.

"Unfortunately, we couldn't do the OSA at the end because obviously there was no end [due to covid restrictions]." – Annie.

Other intervention outcome measure tools that were used by participants were the Role Checklist v.3 (Scott 2019), the 3B~S scale (Rebeiro Gruhl et al. 2018) and Goal Attainment Scaling (Kiresuk et al. 1994). Participants expressed that these were straight forward to use. The MOHOST (Parkinson et al. 2006) was also used pre and post intervention by some participants. It was expressed that these tools were helpful to outline particular areas of need, however it was felt that the tools did not capture the benefits of engaging in occupational therapy groups. Participants also created their own feedback forms in the format of a questionnaire to determine what service users enjoyed about sessions, what they would change and feedback on the general structure. Alongside using these tools, many participants also gathered informal feedback to aid in evaluation. This was described as facilitating discussion and feedback sessions at the end of interventions. Participants explained that this provided an opportunity to gain rich insight into service user views and ask questions. It was important to participants to evaluate the intervention to enable them to measure change and enhance their future interventions.

"It's really important that you've got that outcome measure, so you know if it's worked or not worked, and if you've got to do anything else." – Eve

Some participants used multiple outcome measure tools with each service user at the end of Recovery Through Activity (Parkinson 2014).

Participants felt that this could be overwhelming for some service users, and it took up a large chunk of time. Based on feedback from service users, the participants reflected that it was important to be mindful of the volume of outcome measure tools that were being used and to consider why they were being used and what information they hoped to gain from them. Another thing that was raised as a consideration in relation to this, was the time it took to review and collate information gathered from the outcome tools. Many participants explained that it took considerable time when multiple tools were being used.

"Doing all of these outcome measures at the end took up a massive chunk of the session. And people were evaluationed out basically." – Debbie

6.2.1.7 Theme 7: Adapting Recovery Though Activity to diverse settings and service user needs

The structure of Recovery Through Activity (Parkinson 2014) was valued by participants alongside its flexibility as it guided occupational therapists, while also allowing for it to be adapted to each setting and service user needs. There were commonalities across participants in the way the intervention was implemented, with the duration commonly lasting 10-12 weeks and one to two hours per session. Many settings covered all 12 activity categories, while others merged activity types or selected ones that were of interest to their service user group. Flexibility with the structure of the group was appreciated by participants to balance educational and practical elements.

Harnessing the flexibility of the Recovery Through Activity Handbook

According to the participants, the structure of Recovery Through Activity (Parkinson 2014) interventions were similar across settings. Participants reported that they appreciated the structure of the manual to use as a

framework. Additionally, participants appreciated that the manual was flexible, enabling them to tailor their interventions to service user needs and the structure of their service, based on observations and service user feedback. They expressed that if the manual was used as a standardised programme, it was difficult to implement. Whereas due to the flexibility to be able to create a tailored programme, it was effective across varying settings, with different service users with differing needs.

"We adapted and made it our own. I think if you're creative with it and implement it is more as a guide and a structure..... It's incredible, to be honest." – Eve

Tailoring duration for engagement and concentration

The length of Recovery Through Activity (Parkinson 2014) interventions varied across settings. In acute inpatient settings, groups were carried out on a weekly rolling basis. Within community settings, groups were also held weekly, however it was commonly run for a duration of 12 weeks, although some settings ran sessions for 10 weeks. Sessions in both inpatient and community settings ran for between one and two hours each, depending on service user interest and engagement. It was felt that two hours was a good length of time for sessions to enable activity participation and discussion. It was reported that service users lost motivation and concentration after around the two-hour mark. An impacting factor on the length of group (in relation to community settings) was how long a venue was available for. If the venue was only available for an hour, it limited the flexibility to extend the session if service users were engaged and interested, whereas on a ward, physical space was less of a barrier.

"I think two hours was just about right. Anything more than that they just start to lose focus." – Beth

Customising Recovery Through Activity with varied categories

Recovery Through Activity (Parkinson 2014) interventions in most settings covered each of the 12 categories of activity, with one activity per week. Other settings merged some of the activity types together, or selected ones that were of most interest to their service users. Participants described that some activity categories were favoured more by both practitioners and service users. These included leisure, self-care and creative activities. Due to the flexibility of Recovery Through Activity (Parkinson 2014), this allowed participants to focus on areas of interest. Participants found it helpful to begin Recovery Through Activity (Parkinson 2014) with a self-care, creative or leisure group as they were broad topics that everyone could relate to. During this initial session participants were able to ask service users what was important to them, build rapport and the group could get to know each other a bit better. The final session of Recovery Through Activity (Parkinson 2014), participants reported that service users enjoyed doing a community activity. Some activities participants facilitated within the community that were of interest to service users were: bowling, cinema; or going for a meal. The key factor in selecting activities were to consider service user interests, needs and functional abilities.

"It all depends on the people in the group." – Debbie

Theme 8: Shaping Recovery Through Activity for Individual Engagement and Acceptance"

Participants described how it was helpful being able to adapt the structure of the groups based on service user feedback. A common group structure comprised of an educational discussion session one week, with a practical activity the following week. Based on feedback, some participants shortened the length of time for the education session due to

concentration levels being low and some settings combined the education and practical elements into one session. Participants also found it was beneficial to facilitate one-to-one sessions alongside groups. The flexibility with Recovery Through Activity (Parkinson 2014) meant that participants could offer this via differing means based on service structure. In a ward setting, participants offered one-to-one sessions on an ad hoc basis as and when service users would like to participate. In some community setting participants booked in planned one-to-one sessions or offered one-to-one support at the end of a group.

"We changed the formats throughout them based on feedback." Eve

In relation to flexibility, one setting in particular expressed that they had adapted the name of the intervention. The service users did not like the term 'recovery' and when invited to Recovery Through Activity (Parkinson 2014) immediately declined based on the language used. This participant explained that once this group of service users had heard the term 'recovery' being used, it was difficult to re-engage them as they had pre-conceived ideas about what the intervention was about. The participant in this setting had asked advice from Sue Parkinson (the creator of Recovery Through Activity) while on training, who confirmed that the groups could be called anything they wanted. Following this the participant had discussions with service users and renamed the groups 'Discovery Through Activity' with inspiration coming from the Recovery Through Activity companion manual.

"As soon as you said Recovery Through Activity*, they would go, 'I don't need recovery'." – Georgia*

6.2.1.8 *Theme 9: The Role of Recovery Through Activity in Balancing Generic Roles and Promoting Occupational Principles*

Participants felt that Recovery Through Activity (Parkinson 2014) supported them in maintaining an occupational approach by helping them to maintain a balance between generic roles and an occupational focus, supporting the planning of groups, enabling the articulation of the value of occupation, combining theory and practice and encouraging the use of occupational therapy conceptual models of practice.

Preserving an Occupational focus

Participants described that they felt once you are an occupational therapist, you always work with an occupational therapy approach in everything you do. Sometimes, however, tasks arise within a role that are generic in nature and not occupationally focused due to the structure of services and staffing levels. Some of these tasks include generic paperwork, care co-ordinating, supporting people with benefits and risk assessing/risk management. Participants explained that at times balancing generic working could be a challenge, as it was difficult prioritising occupationally focused roles when there were pressing generic tasks that needed attending. Participants felt that Recovery Through Activity (Parkinson 2014) supported them in balancing generic roles and maintaining an occupational focus. Recovery Through Activity (Parkinson 2014) was described as feeling like protected time to focus on the core of occupational therapy.

"It kind of gave that protected time where we could actually have a proper occupational focus." – Eve

Participants described the manual as guiding them in the planning of occupationally focused groups in relation to identifying types of activities and gave them specific examples as ideas, which was reported as helpful. Participants also explained that the manual supported them in identifying what it is that interest's people and encouraged service users to reflect. The number of resources within the manual was appreciated, supporting the implementation of an occupational approach within interventions.

"There's loads of resources in there. It was my favourite printing tool." – Beth

The Role of the Recovery Through Activity Manual in Articulating and Promoting the Value of Occupation

Participants felt that the manual alongside training sessions with Sue Parkinson, better helped them articulate the value of occupation. They explained that the manual broke things down simply and defined complex principles in understandable terms. It also helped them to articulate the benefits of a balance of occupations by clearly outlining various activity types and the benefits of each. In particular, participants appreciated having the summary of evidence for each of the 12 activity types that can be included in Recovery Through Activity (Parkinson 2014) interventions. They said that the manual was helpful in drawing upon evidence to share with other professionals and both aiding discussions with services users, supporting them to implement a psychoeducational element. This enabled the wider MDT and service users to better understand the value of occupation. The handbook was also described as supportive in helping them to convey the value of occupations and an occupational approach to the wider community. They reported that community organisations engaged well with occupational therapy services, and it was beneficial for them to come into Recovery Through Activity (Parkinson 2014) sessions to understand what it was about and also then see the service users being

referred on to engage in their organisations. Participants felt that external agencies recognised and valued Recovery Through Activity (Parkinson 2014).

"I could kind of pass on that knowledge to my patients, as well as kind of try out different things with them, because I understood that having kind of a varied spectrum of occupations is really useful and can improve mental health was as well as support recovery." – Annie

Bridging Theory and Practice with Recovery Through Activity

Participants concluded that the manual helped them to marry theory and practice together. Participants who were occupational therapy support staff specifically expressed that it helped them to gain a better understanding of the value of occupations and understand the underpinnings and principles of occupational therapy. Additionally, they described how it supported them in transforming this learning into actions for practice. They explained that sometimes they can get a lost within the theories of occupational therapy, however the manual simplified the theories and focussed the meaning on what occupational therapy is. Participants also stated that the training sessions facilitated by Sue Parkinson supported them in putting the focus back on occupation.

"It just kind of marries that theory and practice together." – Flo

Participants predominantly utilised the MOHO (Kielhofner 2008) to support their practice and enhance the implementation of Recovery Through Activity (Parkinson 2014). They found that the principles of MOHO (Kielhofner 2008) aligned closely with the goals of Recovery Through Activity (Parkinson 2014), allowing for a cohesive integration of the two in therapeutic interventions. A central concept from MOHO (Kielhofner 2008) that was frequently discussed was volition, which involves understanding what motivates service users and influences their

engagement levels. This understanding is vital as it helps tailor activities to match individual motivation levels and readiness, ranging from those setting independent goals to those exploring new activities within sessions.

Participants appreciated how MOHO (Kielhofner 2008) provided a conceptual framework to assess and understand the varying motivational states and skill levels of service users during activities. This insight was instrumental in adapting interventions to meet the unique needs of each service user effectively.

While MOHO (Kielhofner 2008) was the primary conceptual model or practice referenced, one participant also highlighted the benefits of integrating the KAWA model (Teoh and Iwama 2015) into their practice. This model was particularly useful for assessing barriers and supports within a service user's occupational engagement. It facilitated a deeper understanding of the environmental and personal factors that could influence a service user's ongoing engagement in meaningful occupations after the intervention. The KAWA model provided an additional layer of analysis, helping participants identify key elements that could enhance or hinder the therapeutic process, thus enriching the overall strategy for Recovery Through Activity (Parkinson 2014).

"The MOHO….It tied in with thinking about what volitional levels somebody's at, their state of curiosity." – Debbie.

"The KAWA…you can see what the things are that support activities. If they're going to be discharged, what is important for them to have to keep them on the same river flow?" – Flo

6.2.1.9 *Theme 10: The Impact of* Recovery Through Activity *on Fostering Professional Understanding and Confidence*

Participants discussed how Recovery Through Activity (Parkinson 2014) *supported* their professional role and identity through enabling the wider MDT to gain a better understanding of the role of an occupational therapist, increasing role satisfaction and increasing confidence in their professional identity and role.

Shaping perceptions within the MDT

Participants noted that Recovery Through Activity (Parkinson 2014) played a significant role in reinforcing their professional identity within the multidisciplinary team (MDT), as it helped clarify the role of occupational therapists. In many service settings, the MDT had a good understanding of Recovery Through Activity (Parkinson 2014), which in turn enhanced their appreciation of the contributions made by occupational therapy. This understanding often led to occupational therapy being considered a valuable step before service users were discharged, as the MDT recognised the intervention as a critical component of the recovery process.

However, in some settings, participants observed that while the MDT recognised the enjoyment service users derived from Recovery Through Activity (Parkinson 2014), they lacked a deeper understanding of its underlying philosophy and purpose. These MDT members often perceived the intervention as simply a pleasant activity for service users, rather than a therapeutic intervention with specific occupational outcomes. Despite this, the positive feedback from service users to their care coordinators and other MDT staff highlighted the benefits of the intervention, even in settings where the full scope of occupational therapy was not fully understood.

"They wanted to do this group as a bit of like a step down before being discharged." – Debbie

Enhancing job satisfaction and team dynamics

Participants reported that Recovery Through Activity (Parkinson 2014) increased their job role satisfaction. They described that Recovery Through Activity (Parkinson 2014) wasn't difficult to carry out as it was similar to their usual occupation focused interventions, however it added structure and support to their practice. They described enjoying having the structure around something that was occupationally focussed within their daily/weekly practice to look forward to. Recovery Through Activity (Parkinson 2014) was seen by participants as protected time to be an occupational therapist. A common factor that increased participants role satisfaction was observing the interaction between service users and their development throughout the course of the intervention. It was also noted that the wider MDT joined in on sessions on occasion. Participants expressed that it was enjoyable for both staff members and service users to do things together which were engaging and fun. During the sessions it was felt that there was no hierarchy of power among staff members and service users, creating a feeling of togetherness.

"Myself and my colleague, we absolutely loved it……It was refreshing." – Eve

Empowering Professional Confidence and Identity through Recovery Through Activity

It was felt that by participants that Recovery Through Activity (Parkinson 2014) increased their confidence in professional identity and job role. It supported those who were entering a new job role and supported occupational therapy support workers to gain a better understanding of the theories surrounding occupational therapy and the language.

Participants felt that Recovery Through Activity (Parkinson 2014) was explained in a simplified way that linked directly to practice which gave them confidence in their role. Recovery Through Activity (Parkinson 2014) also enabled participants to have the confidence to better articulate their role in MDT meetings and helped them to describe interventions in clinical notes. It also helped to build confidence in building rapport with service users through supporting them to establish their role in a way that was engaging for service users, while making them feel valued.

"Sometimes I think we struggle with our profession in that we're seen as entertainers, sometimes. So, it's just ensuring that we're informing them. Actually, there's so much more than just what we're seem doing with an individual. There's so much more behind that, the benefits of it." – Georgia

6.2.2 Summary

Participants felt that through tailoring Recovery Through Activity (Parkinson 2014) to individual service user needs it shifted the focus from activity group to occupational therapy intervention, it helped service users identify goals and it enabled service users to re-engage in activities and the community. The most common service user need that was identified by participants was motivation. One of the challenges of tailoring Recovery Through Activity (Parkinson 2014) to service user needs was the impact of Covid-19 restrictions and available activities within the community. In order to tailor Recovery Through Activity (Parkinson 2014) to service user needs, participants used the MOHO (Kielhofner 2008) tools and asked questions surrounding interests and needs and set time aside for planning groups in advance. Participants felt that it was important when delivering Recovery Through Activity (Parkinson 2014) to balance both practical activities and the educational elements of the interventions because the practical activities helped to consolidate educational

elements, and the educational elements and practical activities combined helped to facilitate discussions. A challenge described by participants that arose when trying to balance practical activities and educational elements surrounded implementing practical activities while adhering to Covid-19 restrictions, as well as transport and restrictions accessing the community in secure ward settings. Participants described the Recovery Through Activity manual (Parkinson 2014) as a helpful tool in promoting education alongside practical activities. Participants also felt that group dynamics were important to consider when delivering Recovery Through Activity (Parkinson 2014) and some of the factors they considered important were the size of groups, service user functioning levels and needs and the physical environment. Participants felt that one-to-one interventions alongside groups maximised the benefits of Recovery Through Activity (Parkinson 2014) as it helped them to identify and build on individual skills, needs and goals as well as enabling participants to assess and evaluate the appropriateness of groups and offering opportunities to build rapport. Making connections and links with community organisations was raised as a supportive factor when implementing Recovery Through Activity (Parkinson 2014) interventions as it made sessions more engaging, gave service users an opportunity to meet people from the organisations and provided an opportunity to connect with others after Recovery Through Activity (Parkinson 2014). The importance of assessment and planning prior to running recovery through activity was emphasised by participants as a means of ensuring interventions are person centred. The importance of evaluating interventions was also emphasised as it supported participants to measure change to enhance future interventions. The structure of Recovery Through Activity (Parkinson 2014) was valued alongside its flexibility as it guided participants, while also allowing for it to be adapted to each setting and service user needs. There were commonalities cross participants in the way the intervention was implemented, with the duration typically lasting

10-12 weeks and one to two hours per session. Many participants described covering all 12 activity categories, while others merged activity types or selected ones that were of interest to their service user group. Flexibility with the structure of the group was appreciated by participants as it allowed a balance of educational and practical elements. Participants felt that Recovery Through Activity (Parkinson 2014) supported them in maintaining an occupational approach by helping them to maintain a balance between generic roles and an occupational focus, supporting the planning of groups, enabling the articulation of value of occupation, combining theory and practice and encouraging the use of occupational therapy models. Participants also felt that Recovery Through Activity (Parkinson 2014) supported their professional role and identity by enabling the wider MDT to gain a better understanding of the role of an occupational therapist, increasing role satisfaction and confidence in their professional identity and role.

6.3 Reflection on attending face-to-face Recovery Through Activity sessions

Using the Gibbs (1988) reflective cycle I carried out a reflection of my experiences of visiting Recovery Through Activity (Parkinson 2014) being delivered in community mental health services across the geographical region where this research was located.

6.3.1 Description

During my time planning the research design I visited community mental health services delivering Recovery Through Activity (Parkinson 2014) to gain an understanding of how the intervention could be used in various settings. Each session unfolded as a unique intervention within the

distinct settings. One particularly memorable session took place in a community park, where a sizable group embarked on a nature walk. With cameras in hand, we immersed ourselves in the social walk and took photos of the leaves and trees. The gathering at a nearby café following this activity added a layer of social interaction, where our captured images became a prompt to initiate conversations. In this dynamic, the simple act of observing nature evolved into a shared experience that deepened the sense of connection among group members.

Another session that I visited took place within a community centre, the group was characterised by its smaller size and an atmosphere that projected familiarity and a sense of comfort. Here, discussions among service users, occupational therapists, and a representative from a third-sector organisation took place about connecting with community groups post Recovery Through Activity (Parkinson 2014). The intimate setting encouraged an environment where the two service users that attended engaged in meaningful conversations, accompanied by teas and coffees. This session felt like a friendly gathering.

Another session was held in a church providing a relaxing social space. During this session service users engaged in conversations surrounding self-care and the benefits of meaningful occupations. Teas and coffees were on hand and service users talked about how they had found the sessions beneficial, learning transferable skills that they had subsequently used at home and in other social situations. They described how they enjoyed chatting with others without any pressure within the groups.

The final session of the Recovery Through Activity (Parkinson 2014) that I attended was at a restaurant. This was also the final session for this group of people within their Recovery Through Activity (Parkinson 2014) journey, marking both the conclusion and celebration of shared experiences. Group members reflected on their experiences and chatted

about what activity groups they would like to try, based on things they had tried within their Recovery Through Activity (Parkinson 2014) sessions. The atmosphere radiated a sense of achievement and camaraderie. Some service users had exchanged numbers and had made friendships outside of the groups.

6.3.2 Feelings

Upon entering each session, I experienced a genuine sense of welcome and relaxation. The occupational therapists facilitated introductions, promoting an environment of openness. Engaging in activities during the sessions alleviated the pressure to initiate conversations, allowing social connections to evolve naturally. Overall, the experience was enjoyable, reminiscent of attending a relaxed social event.

6.3.3 Evaluation

The atmosphere in all settings was not only welcoming but also supportive. The interactions between service users, occupational therapists and myself felt inclusive and without hierarchical structures. It resonated as a collective experience of Recovery Through Activity (Parkinson 2014). The dynamics of the sessions allowed service users to freely engage at their own pace, without any pressures to engage. The sharing of personal experiences by occupational therapist created a collaborative atmosphere, strengthening the sense of community within the groups.

6.3.4 Analysis

Reflecting on the sessions, it is evident that the flexibility of Recovery Through Activity (Parkinson 2014) was a benefiting factor as it allowed for adaptability to service user needs, service needs and environmental setting. Despite the differing group structures, environments and activities, the underlying principles of Recovery Through Activity

(Parkinson 2014) were integrated into each session. The common thread connecting all groups was the emphasis on social connection, an element that contributed to the overall effectiveness of the sessions.

6.3.5 Conclusion

The varied settings and activities across the sessions highlight the flexibility and adaptability of Recovery Through Activity (Parkinson 2014). The diverse structures didn't dilute the core principles instead, they showcased the versatility of Recovery Through Activity (Parkinson 2014). The common theme in all groups was the significant impact of social connection. This reinforces the idea that, regardless of the setting or activity, promoting meaningful social interactions is at the heart of successful Recovery Through Activity (Parkinson 2014) sessions.

6.3.6 Action Plan

Reflecting on these experiences it is evident that when planning Recovery Through Activity (Parkinson 2014) sessions it is important to prioritise the promoting of environments that encourage social connection and interaction. Additionally, Recovery Through Activity (Parkinson 2014) sessions would benefit from tailoring sessions to the unique preferences and needs of service users, ensuring a collaborative and inclusive approach.

6.4 Service user interview

Recovery Through Activity (Parkinson 2014) played a fundamental role in supporting the mental health journey of the service user (SU), a 48-year-old individual who had experienced significant isolation and mental health challenges. Recovery Through Activity's (Parkinson 2014) face-to-face implementation provided an essential foundation for SU's recovery,

offering a structured routine, social support, and various activities to foster growth and resilience.

The in-person sessions were initially held in a church, allowing SU to connect directly with therapists and other participants. This setting provided a supportive environment that helped SU rebuild confidence and reintegrate into the community, offering a consistent schedule and a range of hands-on activities.

It was hoped more than one service user would be interviewed, however due to unknown reasons, which have been speculated in reflections in chapter 10, only one service user came forward. Nonetheless, this interview provided rich valuable insights into Recovery Through Activity (Parkinson 2014) from a service user perspective.

The thematic analysis of the face-to-face implementation reveals several key themes:

Social Support and Community: The face-to-face sessions promoted a sense of community, allowing SU to build relationships with therapists and other participants. This social connection reduced feelings of isolation and created a supportive network.

Structured Routine and Engagement: The sessions provided a structured routine, helping SU establish positive habits and maintain consistency in her recovery journey. The hands-on activities engaged SU's senses and provided constructive outlets for energy.

Empowerment and Confidence: The sessions enabled SU to rediscover herself, reigniting passions and developing skills. This self-discovery created a positive feedback loop, transforming SU's perception and reinforcing her sense of identity.

Therapeutic Relationships: The in-person sessions allowed SU to build trust and rapport with therapists, offering individualised support and guidance. These relationships continued beyond Recovery Through Activity (Parkinson 2014), supporting SU's ongoing recovery journey.

Through these themes, the face-to-face implementation demonstrated its effectiveness in supporting SU's recovery, creating a foundation for sustained progress and personal growth.

6.4.1 Themes

*6.4.1.1 **Theme 1:** Social Support and Community*

The face-to-face sessions played a pivotal role in promoting a sense of community and support, enabling SU to connect intimately with other participants and therapists. This in-person interaction facilitated engagement and rapport-building, providing a supportive environment that bolstered SU's recovery journey. SU emphasised the importance of direct interactions.

"When we started off in a church, it was a different feeling to being on Teams. It was like I had to go out and see everyone, which built that social connection in person." - SU

These in-person sessions also created opportunities for SU to build social networks with therapists and other participants. This real-time interaction promoted camaraderie and integration within a supportive community, making SU feel more comfortable. The ability to share struggles, successes, and challenges face-to-face also cultivated empathy and understanding among participants, who supported each other through shared experiences. This sense of mutual understanding further strengthened the community. The face-to-face setup also provided SU with a vital step in breaking down barriers and reintegrating into a community setting. Being in a group environment helped reduce SU's

social anxiety and rebuild her confidence, which had been eroded by isolation. Furthermore, non-verbal cues such as body language, facial expressions, and gestures added layers to communication, enriching interactions and enhancing understanding. Over time, the in-person sessions deepened SU's relationships with therapists and participants. This allowed SU to establish a more profound sense of trust and reliance on the group, which in turn strengthened her recovery process. SU highlighted the importance of relationships with the Occupational therapists.

"Meeting the therapists in person, built trust and made the sessions more engaging. We worked through obstacles together." - SU

The connections formed during the face-to-face sessions also created a sense of accountability and continuity, supporting SU in maintaining her recovery journey beyond the sessions. Recovery Through Activity's (Parkinson 2014) structure played a role in breaking SU's cycle of isolation, providing a regular reason to leave the house and integrate into the community. SU reflected, emphasising the importance of overcoming isolation.

"I was looking for confidence to go back out into the community, and I did find that through the in-person sessions at the church." - SU

*6.4.1.2 **Theme 2:** Structured Routine and Engagement*

The face-to-face sessions provided a structured routine, pushing SU out of her comfort zone and enhancing her recovery process. SU highlighted the routine's impact.

"Having to go to the church got me out of the house and gave me structure, which I needed. It made a difference in how I approached my day-to-day life." - SU

This consistent and predictable schedule helped SU establish a daily routine, reducing the chaotic nature of her days and stabilising her mental health. The routine of attending sessions also helped SU break the cycle of isolation, gradually making it easier to engage with her surroundings.

"The sessions at the church got me out into the community, which was a big step after isolating myself for so long." - SU

The face-to-face sessions also helped establish positive habits, such as engaging in constructive activities and interacting with others, which supported SU's recovery journey.

"I learned to work with my hands again, making crafts and gardening, which re-engaged me in hobbies that I had neglected." - SU

This routine-building aspect provided a sense of accountability, encouraging SU to attend regularly and participate in activities.

"The sessions kept me accountable. I knew I had to go, which helped me stay on track and not backslide into old habits." - SU

Moreover, the structure of the sessions allowed SU to develop mindfulness skills, which extended beyond Recovery Through Activity (Parkinson 2014) and contributed to a balanced approach to daily life. The routine established by the sessions continued to support SU's recovery, even after Recovery Through Activity (Parkinson 2014) ended.

"The sessions gave me structure, which helped me build momentum. This routine has continued to support me." - SU

The sessions also involved various hands-on activities, such as crafting and gardening, which helped SU channel her energy constructively. These activities engaged SU's senses, allowing her to connect more deeply with her environment and tasks at hand, which diverted her mind from

negative thoughts. The activities also allowed SU to develop practical skills, such as crafting, gardening, and painting, providing immediate therapeutic benefits and long-term value.

"I rediscovered my love for arts and crafts, and the sessions helped me develop skills that I can continue to use in my daily life."- SU

The hands-on activities provided an outlet for SU to channel her energy into productive tasks, reducing self-destructive behaviours by offering alternatives for managing stress and anxiety.

"I set goals to distract myself through activities, and the sessions helped me do that. I got back into knitting, crocheting, and gardening, which took my mind off negative thoughts." - SU

The activities also encouraged SU to develop patience and problem-solving skills, helping her navigate challenges more effectively.

"We had to build a bird box, and it didn't fit together properly. Instead of throwing it away, I took it to the garden and fixed it, which taught me patience and problem-solving." - SU

These hands-on activities provided SU with tangible achievements, which boosted her confidence and reinforced her progress, creating a positive feedback loop. The skills developed extended into SU's daily life, allowing her to apply them in other contexts and support her ongoing recovery journey.

"The activities helped me build skills like mindfulness and problem-solving, which I've used in my daily life, from managing my garden to helping my friend." - SU

6.4.1.3 Theme 3: Empowerment and Confidence

The face-to-face sessions helped SU rediscover herself, renewing her confidence and interests.

"It was about finding myself again, and these sessions did help me do that. I found joy in my arts and crafts, gardening, and being able to spend hours at it." -SU

This self-discovery process reignited neglected hobbies such as arts, crafts, and gardening, contributing to SU's sense of identity and fulfilment.

"It reminded me that I have got my arts. I love arts and crafts, you know... and I CAN. And it doesn't matter if I garden and lose myself for 3 hours." - SU

The sessions also helped SU reconnect with her core values, such as kindness, patience, and mindfulness, which reinforced her sense of self and provided a guiding framework for her recovery journey. This process also gave SU a renewed sense of purpose, enabling her to focus on constructive goals and personal growth.

"It was about finding myself again, and these sessions did help me do that. It gave me a sense of purpose and direction in my recovery journey." - SU

The self-discovery process created a positive feedback loop that strengthened SU's confidence and motivation, reinforcing her recovery journey.

"The sessions helped me build momentum. Seeing my progress in arts, crafts, and gardening boosted my confidence, which further encouraged me to continue." - SU

This positive feedback loop also transformed SU's self-perception, shifting her view from isolated and struggling to capable and resilient.

"*I learned I could do things again, which changed how I saw myself. This transformation strengthened my confidence and supported my recovery."*
- SU

The combination of in-person support, routine, and hands-on activities created a positive feedback loop that reinforced SU's sense of purpose. This feedback loop encouraged SU to engage more actively in the sessions, knowing that her involvement would lead to further progress. This cycle of engagement and progress contributed to SU's empowerment.

"I've applied the skills I developed in the sessions to my daily life, from managing my garden to helping my friend, which has continued to support my recovery." - SU

The feedback loop also extended into SU's daily life, maintaining her progress beyond Recovery Through Activity (Parkinson 2014) and reinforcing her sense of self and recovery.

6.4.1.4 Theme 4: Therapeutic Relationships

The face-to-face sessions promoted closer relationships between SU and her therapists, supporting her recovery journey.

"Meeting the therapists in person, built trust and made the sessions more engaging. We worked through obstacles together." - SU

This direct interaction helped build trust and rapport, making SU feel supported and validated, which contributed to her engagement and progress. The individualised support offered by therapists helped SU navigate her challenges more effectively, promoting her recovery.

The in-person interaction with therapists also provided encouragement to SU, reinforcing her positive feedback loop and strengthening her confidence and engagement. The therapists were available to help SU navigate challenges, providing guidance and strategies to overcome obstacles.

"We had to build a bird box, and the therapists helped us work through the frustration. This taught me patience and problem-solving, which I applied in my recovery." - SU

The therapists' involvement in the sessions also allowed SU to see their support in action, reinforcing her sense of community.

The face-to-face sessions established a foundation for SU's ongoing relationship with her therapists, which continued to support her beyond Recovery Through Activity. Additionally, the face-to-face setup allowed SU to observe the progress of others, providing encouragement and validation.

"I saw the progress of another participant who initially couldn't speak. It was inspiring to see her progress, which made me feel better about my own journey." - SU

The shared progress promoted a supportive environment where SU and others could share both successes and struggles, normalising the difficulties of recovery.

"Seeing others work through challenges and share their struggles made me feel less alone." - SU

The sessions also provided opportunities to celebrate milestones collectively, reinforcing a sense of achievement and contributing to a positive atmosphere.

This shared progress helped build therapeutic relationships between participants and therapists, promoting a sense of trust and camaraderie. This therapeutic relationship created a reliable support system that sustained SU's momentum beyond the sessions, reinforcing her recovery journey.

6.4.2 Summary

The face-to-face implementation of the Recovery Through Activity (Parkinson 2014) proved to be a catalyst for SU's mental health journey, offering an effective combination of structure, community, and therapeutic relationships. The in-person sessions provided a sense of social support, helping SU build relationships with therapists and other participants, promoting a supportive network that reduced isolation. This community, combined with a structured routine, allowed SU to establish positive habits and engage in a variety of activities, from crafting to gardening, which channelled her energy constructively.

The sessions also facilitated SU's self-discovery, reigniting her passions and renewing her confidence, which created a positive feedback loop, transforming her perception of herself. Furthermore, the therapeutic relationships built during the sessions provided individualised support. This supported her to navigate challenges and continue her recovery journey beyond Recovery Through Activity (Parkinson 2014).

Overall, the face-to-face implementation laid a solid foundation for SU's recovery, creating a framework for sustained progress, personal growth, and resilience. This allowed her to integrate recovery practices into her daily life and thrive beyond Recovery Through Activity (Parkinson 2014).

6.5 Chapter conclusion

The exploration of Recovery Through Activity (Parkinson 2014) in face-to-face settings, as detailed in this chapter, highlights the multifaceted impact of occupational therapy interventions that focus on individualised engagement and community integration. The findings from occupational therapy staff interviews reveal that implementing Recovery Through Activity (Parkinson 2014) face-to-face allows for significant tailoring of interventions to meet the diverse needs of service users. This personalised approach not only enhances motivation and engagement but also facilitates the reintegration of service users into community life, thus fulfilling core objectives of occupational therapy.

The reflection of the researcher on attending Recovery Through Activity (Parkinson 2014) sessions offers valuable insights into the dynamic interactions and transformations observed within these settings. These observations highlight Recovery Through Activity's (Parkinson 2014) adaptability to various environments and its ability to promote a supportive community atmosphere, which is instrumental in enhancing participant engagement and satisfaction.

Moreover, the service user interview provides a poignant testament to the effectiveness of face-to-face Recovery Through Activity (Parkinson 2014) sessions. It presents a narrative of empowerment, connection, and recovery, illustrating how structured, and well-facilitated interactions can significantly impact an individual's journey towards mental health recovery.

In conclusion, the face-to-face implementation of Recovery Through Activity (Parkinson 2014) not only supports the professional role and identity of occupational therapists by enabling a clear articulation of the value of occupational engagement but also resounds with service users, It

provides them with a platform to rediscover their interests, establish supportive social networks, and enhance their overall quality of life. This chapter affirms that the face-to-face implementation method of Recovery Through Activity (Parkinson 2014) offers substantial benefits that are both measurable and felt as beneficial by those involved.

Chapter 7 – Virtual implementation case findings

7.1 Introduction

This chapter delves into the virtual implementation of Recovery Through Activity (Parkinson 2014), exploring its execution via Microsoft Teams. It presents a comprehensive analysis based on interviews with occupational therapy staff, including both registered occupational therapists and support workers, who have adapted Recovery Through Activity (Parkinson 2014) to a virtual format. The chapter evaluates how occupational therapy staff's perceptions and experiences shape the virtual delivery of Recovery Through Activity, focusing on their views and the thematic outcomes from these interventions.

Further, the chapter explores a rich set of intervention outcome data, including feedback questionnaires, the 3B scale (Gruhl at al 2018) and the OSA (Baron et al. 2006). These tools collectively offer insights into the efficacy and impact of virtual Recovery Through Activity (Parkinson 2014) sessions on service users' rehabilitation and recovery journeys.

Additionally, this chapter discusses findings from an interview with a service user who participated in the Recovery Through Activity (Parkinson 2014) sessions via Microsoft Teams. This interview highlights the service user's personal experiences and reflections on the virtual format, providing an understanding of how virtual interventions can support recovery and activity engagement from a service user's perspective.

Through these insights, the chapter aims to provide a thorough understanding of the challenges and opportunities presented by the virtual implementation of Recovery Through Activity (Parkinson 2014),

contributing to ongoing discussions on best practices in occupational therapy in a digitally evolving world.

7.2 Occupational therapy staff interviews.

Interviews were conducted with registered occupational therapists and occupational therapy support workers/assistants who delivered Recovery Through Activity (Parkinson 2014) virtually (as opposed to face-to-face). For anonymity, both are referred to as occupational therapy staff in this section. Interviews were carried out via Microsoft Teams. Virtual Recovery Through Activity (Parkinson 2014) interventions were implemented via Microsoft Teams, however some settings met face-to-face for their final session. Four occupational therapy staff were interviewed in total. Two being registered occupational therapy staff and two being occupational therapy support workers/assistants. All virtual Recovery Through Activity (Parkinson 2014) sessions were carried out with community dwelling service users as opposed to inpatients.

Across both cases (virtual and face to face) 7 interviews were conducted. Only occupational therapy staff Annie, Beth, Carrie and Flo had experience with virtual implementation, and thus this chapter refers to their experiences. See table 2 below.

Table 5 - Breakdown of participant interviews across implementation methods

Face to face	Virtual
Annie	Annie
Beth	Beth
/	Carrie

Debbie	/
Eve	/
Flo	Flo
Georgia	/

There were nine key themes drawn from participant interviews within the virtually implemented Recovery Through Activity (Parkinson 2014) Case:

1. Meeting Service User Needs: Participants emphasized the importance of tailoring interventions to meet individual service user needs. Tools such as the Occupational Self-Assessment (OSA), Interest Checklist, and Role Checklist were pivotal in identifying these needs, interests, and goals. Flexibility within sessions was vital to accommodate changing needs, ensuring interventions remained relevant and beneficial.

2. Innovative Approaches to Enhancing Virtual Recovery Through Activity: The shift to virtual formats during COVID-19 introduced challenges, which participants addressed through creative solutions like sending resource packs, providing informational videos, and using IT tools for interactive activities. These strategies helped maintain engagement and effectiveness despite the limitations of virtual sessions.

3. Adapting Engagement Strategies for Virtual Group Dynamics: Tailoring engagement strategies for virtual group settings revealed diverse user engagement levels. Participants found that smaller group sizes and leveraging tools like chat boxes and face filters helped maintain motivation and interaction. Virtual sessions served as social hubs, promoting connections and support among service users.

4. Support and Virtual Collaboration alongside Recovery Through Activity: One-to-one sessions were integral to delivering effective virtual Recovery Through Activity (Parkinson 2014) interventions. These sessions helped address personal struggles, build motivation, and ensure tailored support. The limitations of virtual interactions highlighted the importance of personalized engagement to optimize the effectiveness of group sessions.

5. Enriching Virtual Recovery Through Activity with Community Partnerships: Collaborations with community organisations enriched virtual sessions. These partnerships provided valuable resources, such as activity packs and guest speakers, promoting engagement and long-term community connections for service users.

6. Enhancing Virtual Recovery Through Activity through Assessment, Planning, and Evaluation Insights: Effective assessment, planning, and evaluation were vital for the success of virtual Recovery Through Activity (Parkinson 2014) sessions. Tools like the OSA and Role Checklist guided these processes, ensuring interventions were tailored to diverse service user goals and needs. Post-intervention evaluations provided insights into service user progress and experiences.

7. A Framework Not a Programme: Participants valued Recovery Through Activity (Parkinson 2014) as a flexible framework rather than a rigid programme. The adaptability of the manual allowed for customization based on service user needs and service structure. This flexibility was crucial for accommodating diverse settings and ensuring personalized, effective interventions.

8. Creative Occupational Change: Recovery Through Activity (Parkinson 2014) was praised for supporting creative occupational

change. Despite the challenges of adapting to a virtual format, the intervention proved flexible and effective. Informative leaflets and digital implementation received positive feedback, highlighting considerable progress in addressing short-term and mid-term goals.

9. Elevating occupational therapy Practice: Insights and Recognition via Recovery Through Activity: Recovery Through Activity (Parkinson 2014) helped solidify professional identity and articulate the role of occupational therapy within the multidisciplinary team (MDT). Participants noted the intervention's role in challenging preconceptions and broadening the understanding of occupational therapy contributions, enhancing professional confidence and recognition.

7.2.1 Themes

7.2.1.1 Theme 1: Meeting service user needs

Meeting service user needs was raised as important by participants to ensure that the intervention was engaging and of benefit to service users. It was felt that the OSA (Baron et al 2006) and the Interest Checklist (Heasman and Salhortra 2008) and Role Checklist (Scott 2019) were of benefit to draw out service user needs, interests and goals. Providing information on existing community organisations that related to these interests and goals helped to support service user needs. Flexibility within the sessions was seen as a facilitating factor to account for service users' changing needs. These are discussed in turn below.

Tools for Tailoring

Participants highlighted the effectiveness of specific tools in uncovering service user needs, which are essential for customising interventions. The Interest Checklist (Heasman and Salhortra 2008) and Role Checklist (Scott 2019) were instrumental in eliciting service users' interests, providing a foundational understanding of what activities might engage

and motivate them. Following this initial exploration, participants used the OSA (Baron et al. 2006) to delve deeper into identifying specific needs and setting relevant goals. These tools were not just mechanisms for gathering data but were integral in building a comprehensive profile of each service user. This process allowed participants to tailor the Recovery Through Activity (Parkinson 2014) sessions more precisely, ensuring that the interventions were closely aligned with individual aspirations and requirements. The variability in the quality and quantity of information provided on referral forms was noted as a challenge. In some cases, these forms were detailed, offering a good starting point for tailoring interventions. However, when the forms lacked detailed information, the aforementioned tools became even more critical. They enabled participants to gain a deeper understanding of service users beyond the initial referrals, ensuring that the activities planned were well-suited to each individual's unique needs and interests.

"We go through all of that [Interest checklist, Role checklist and OSA] and then hopefully come up with a goal that it most pertinent to them at the moment in time." – Carrie

Participants explained that signposting service users to existing community organisations and providing information related to their interests helped to support service user needs. Through Recovery Through Activity (Parkinson 2014) sessions, service users were able to be introduced to different activities and services. This was followed up with leaflets and website links related to these activities to enable service users to engage in their interests within the community.

"If they were interested in volunteering, we put the website down for the [geographical region] association for volunteering. If they wanted to do self-care, we put down websites for mindfulness exercises and stuff like that." – Annie

Flexible approach to meet changing needs

Participants emphasised the importance of being mindful of the changing needs of service users and incorporating flexibility within Recovery Through Activity (Parkinson 2014) interventions. They noted that while service users often entered sessions with clear goals, these goals can evolve over time. To accommodate this, participants recommended not setting too many fixed goals at the outset. Instead, they suggested tailoring the intervention to each service user's specific needs and remaining adaptable throughout the process. This approach involved regularly revisiting and adjusting goals to reflect any changes in service users' needs and preferences. Participants found that planning sessions with a general topic area and structure in mind provided a necessary framework. However, the actual focus of each session was often adjusted based on the specific individuals attending that day, ensuring that the sessions remained relevant and engaging. By staying flexible, participants could better respond to the dynamic nature of service users' needs, making the intervention more effective and personalised. This adaptability was key in maintaining the relevance and benefit of Recovery Through Activity (Parkinson 2014) for each service user.

"They are quite clear on what it they want to get out of the group…….but they can change throughout really." – Carrie

7.2.1.2 Theme 2: Innovative Approaches to Enhancing Virtual Recovery Through Activity

Innovative approaches to enhancing virtual Recovery Through Activity (Parkinson 2014) were a significant theme raised by participants, who also highlighted various challenges in implementing these interventions virtually. To overcome these challenges, participants adopted several strategies: sending out resource packs to facilitate practical activities both during virtual sessions and between sessions; providing videos and

information leaflets before sessions to explain the benefits of the activities and using virtual sessions to discuss and consolidate information from the practical activities and information videos. These approaches helped to maintain engagement and ensure the effectiveness of the interventions despite the limitations of the virtual format.

Enhancing Engagement through pre-session Activity Packs

Due to Covid-19 restrictions participants explained that it was challenging to incorporate practical activities within Recovery Through Activity (Parkinson 2014) sessions. This was partly due to there being limited activities within the community during this period, but also this was the first time participants had run the intervention virtually and so had to think of diverse ways to incorporate practical activities while conveying the educational elements of the intervention. One way in which this challenge was overcome was by sending out activity packs to service users with resources and information prior to the virtual session to increase engagement. Resources and information leaflets were provided for all 12 activity categories within the Recovery Through Activity (Parkinson 2014) manual.

"We sent them before every session, a little pack that had resources and a little leaflet of information of the occupation." – Annie

Adapting Virtually through interactive I.T. Solutions

Participants stated that they used information technology (IT) to adapt activities to be carried out online, for example carrying out an online music quiz and watching videos related to activities which occupational therapy staff found quite interactive. Sessions were facilitated focusing on how to use online map applications, encouraging service users to find things within their local community and developing the skills to source information. Participants explained that it could be challenging at times

facilitating engaging practical activities during the virtual sessions, particularly activities within the physical and outdoor categories. For the final session within the virtual course of Recovery Through Activity (Parkinson 2014), many services met up and had lunch or a get together. Participants reported that service users and staff members enjoyed meeting face-to-face and getting together.

"We ran a lot of quizzes which were quite interactive, but yeah it was quite difficult." – Beth

Balancing Practical and Educational Elements Through Autonomous Activities

Another way in which a balance was maintained between practical and educational elements was through providing and setting activities for service users to do independently within the week, in between virtual Recovery Through Activity (Parkinson 2014) sessions. For example, participants described how activity resources were provided by an local third sector organisation which enabled service users to engage in activities such as building bird houses, painting, planting flowers and making cakes in a mug. During the virtual sessions, service users could then show what they had made and discuss their experiences. Participants felt that this worked well as service users were able to share common experiences with others, have a discussion and be a part of a group, while also having a routine and activity to do in between sessions.

"We gave them practical activities to do during the week and then bring back into the session." Beth

Reinforced learning through Handouts and Pre-session Videos

Alongside the virtual delivery, participants described that handouts were given to service users to reinforce the understanding of the benefits of occupations, some of which were resources within the Recovery Through

Activity (Parkinson 2014) manual. Videos were also provided in advance of the sessions, which discussed each of the 12 activity types and the benefits to engaging in activities. Psychoeducational discussions were facilitated, where participants briefly discussed the content of the videos, explained the importance of a balance of occupations and offered advice on maintaining a routine.

"The videos took the place of quite a lot of the theory chat that we might have had if we were running it face-to-face." – Flo

7.2.1.3 Theme 3: Adapting engagement strategies for virtual group dynamics

Occupational therapy staff expressed that adapting engagement strategies for virtual group dynamics revealed a diverse spectrum of service user engagement, from chat box interactions to the use of face filters on the camera. According to participants, motivating service users in an online setting, compared to face-to-face interaction, proved challenging but highlighted intrinsic motivation as a driving force. However, participants felt that post-session community interactions offered valuable connections, especially for those overcoming agoraphobia. Participants reported that introducing videos during the sessions aimed to alleviate screen-time anxiety, promoting a comfortable environment. The virtual platform primarily served as a social hub, encouraging service users to share experiences and advice. Determining an optimal group size became vital, with a smaller group size proving more conducive to service user comfort. Lastly, entering a virtual space filled with strangers underlined unique dynamics. These insights emphasise the need for tailored virtual sessions to accommodate diverse participant needs and comfort levels.

Small groups, Big impact

Participants explained that determining the ideal group size proved essential for effective virtual sessions. While Microsoft Teams limited the visible participants to nine at one time on the screen, a smaller group setting of around six proved more comfortable for service users. Balancing the desire for a close-knit environment with technical constraints, participants described how they carefully considered group size to ensure service users felt at ease while maintaining a manageable and interactive session. Participants also explained that engagement was difficult when the group was too large.

"I think a smaller group feels more comfortable for the participants." – Carrie

Building Connections in a Virtual Space Amidst Strangers

Participants felt that entering a space filled with strangers, both staff and service users, evoked nervousness and apprehension among service users. Participants felt that unfamiliarity with the virtual environment, at that time, heightened the challenge. The unique dynamics of interacting with unknown individuals in a virtual context highlighted the need for careful consideration of service users comfort levels and anxieties during the virtual facilitation of Recovery Through Activity (Parkinson 2014).

"Going into that space full of strangers…the staff are strangers, participants are strangers. It's really, really nerve racking." – Flo

Building connections in the virtual setting presented both challenges and unique opportunities according to participants. During breaks, within the face-to-face format, service users engaged in social activities such as smoking or having a coffee with other service users, however the virtual groups did not foster the same dynamic. That said, participants felt that whilst face-to-face interactions during breaks promoted deeper connections, virtual service users also maintained contact through text,

demonstrating the ability to build social networks, albeit in a different manner. Once group service users had gotten to know each other, the participants felt the virtual group primarily served as a social platform, providing service users with an opportunity to share experiences and connect with others facing similar challenges. Participants acknowledged that whilst some topics were not discussed in any great depth, although deeper discussions were occasionally had, the group functioned as a support system. Service users exchanged insights, offering advice and building confidence in expressing personal struggles, contributing to a positive and supportive atmosphere.

"I think people really appreciated just kind of finding out that other people feel the same way they do." – Carrie

Managing intrinsic motivation to participate through facilitating diverse avenues of connection.

Participants described how motivation and engagement were key aspects of virtual group dynamics. Service users displayed various levels of engagement, with some choosing to express themselves through the chat box, while others utilised face filters during discussions, as they were conscious of being on camera. According to participants, maintaining motivation in a virtual setting proved challenging, as the absence of face-to-face interactions made it more difficult to encourage active participation. Despite these challenges, participants felt that they successfully managed the groups, leveraging the service users' intrinsic motivation to navigate the online format. To mitigate potential anxiety associated with constant screen time, videos related to Recovery Through Activity (Parkinson 2014) were incorporated into the virtual sessions. This approach aimed to offer a balanced experience, allowing service users to focus on the content without feeling compelled to maintain constant eye contact. Participants explained that the goal was to create a comfortable

environment that accommodated varying comfort levels with being on screen.

"They're were all really engaging some just wrote in the chat and some had like a filter on their face." – Annie

Participants described offering service users who attended virtual Recovery Through Activity (Parkinson 2014) sessions the opportunity to meet face-to-face for a social gathering during the final session. This unique opportunity to connect in person was beneficial, particularly for service users overcoming agoraphobia and social difficulties. However, not everyone felt comfortable attending the face-to-face gathering. The digital format presented both advantages and disadvantages, as some service users preferred the online setting due to social fears. This highlighted the need for versatility in catering to individual needs.

"I think the was really beneficial, just to be able to take that step to meet someone." – Annie

7.2.1.4 Theme 4: Support and virtual collaboration alongside Recovery Through Activity

occupational therapy staff expressed that support and virtual collaboration alongside Recovery Through Activity (Parkinson 2014) was important. The participants described how collaboration between service users and occupational therapy staff is deemed essential in order to create a supportive environment for service users. Participants explained that one-to-one sessions between occupational therapy staff and service users alongside groups were integral to delivering Recovery Through Activity (Parkinson 2014) sessions virtually. Participants described how the OSA (Baron et al. 2006) was used to guide one-to-one discussions. The benefits described by participants derived from these individualised sessions include addressing personal struggles and building motivation,

this was considered particularly important in the virtual realm, where limitations in follow-up support and the establishment of rapport become apparent. The unique difficulties of initial encounters in the virtual setting further highlight the importance of one-to-one sessions, especially when participants first appear on screen without prior face-to-face interaction. Participants felt that one-to-one sessions optimised the effectiveness of virtual group sessions while addressing individual experiences, goals and needs.

Individual empowerment through one-to-one sessions

It was felt by participants that one-to-one sessions helped service users identify and build upon individual skills, which then supported them within groups and with their transition to community involvement. The one-to-one sessions involved getting to know the service users through the use of the OSA (Baron et al. 2006) which served as a foundation for identifying personal goals and challenges. Participants described how these one-to-one interventions allow occupational therapy staff to work with service users on their individual skills, challenges and routines. They felt that one-to-one sessions played a pivotal role in understanding individuals on a deeper level, by delving into their challenges and exploring the experiences that have shaped their journey, the goal was to identify person centred goals. It was felt by participants that the one-to-one sessions allowed them to address with service users how to manage their anxiety, explore positive coping strategies and build motivation. One-to-one sessions were also felt to be particularly important if service users were new to group settings or experienced social anxiety.

"It's more kind of looking at the way a person things about themselves or what the struggles have been over the years to bring them to this point…..goals come out of that conversation." – Carrie

Challenges and strategies in establishing virtual connections

Despite the advantages of virtual groups, the limitations of one-to-one sessions in this format were acknowledged by participants. The confined time frame of virtual meetings, as opposed to face-to-face interactions, posed challenges in providing follow-up support and continuous engagement between sessions. Participants explained that building rapport became a simultaneous task during the group sessions. Some service users who were uncomfortable with the virtual setting required additional support, especially when facing anxiety in a group of strangers. Participants described how the initial encounter in virtual sessions, where service users appear on screen for the first time, introduces unique challenges. They felt that the absence of familiar faces during these sessions could intensify feelings of nervousness and impact the overall comfort level of service users. To overcome the disadvantage of not being able to offer continuous engagement between sessions as one may do in a face-to-face setting on a ward for example, some participants described how they planned structured time slots where possible to offer one-to-one support to service users and felt these were of benefit as described below.

"One lady in particular was really uncomfortable being on the screen. She said that she thought "I'm not coming back" because she was so nervous in a group of strangers." – Flo

7.2.1.5 Theme 5: Enriching virtual Recovery Through Activity with community partnerships

Participants reflected that embarking on the journey of virtual Recovery Through Activity (Parkinson 2014) groups during the Covid-19 pandemic not only connected service users during challenging times but also forged meaningful collaborations with community organisations. This collaborative and comprehensive approach extended to promoting tangible connections and future community involvement for service users.

The Role of Community Organisations in Acquiring and Distributing Activity Packs for Virtual Recovery Through Activity

One organisation that was described by participants as particularly valuable in the facilitation of virtual Recovery Through Activity (Parkinson 2014) was a local third sector organisation. They operate as a third sector organisation and have secured significant government funding to facilitate various community activities. They extend their support by distributing art packs and resources to individuals facing health challenges. Regarding virtual Recovery Through Activity (Parkinson 2014), the local third sector organisation played a paramount role by sending out weekly activity packs, consisting of thoughtful items like mindfulness books, face masks, hand creams, and gratitude journals. These activity packs not only served as tangible resources but also became discussion points within sessions, promoting engagement and exploring diverse ways of incorporating self-care practices into daily routines. The local third sector organisation consistent and dedicated effort in fulfilling these contributions had significantly enhanced the facilitation of Recovery Through Activity (Parkinson 2014) and supported the wellbeing of service users within the virtual sessions.

"We gave them a list of things to send out each week, they were brilliant and they just sent out each week without fail." Annie

Broadening horizons with virtual guest speakers

Participants felt the virtual sessions had been enriched by the presence of guest speakers from community organisations, further diversifying the experiences for service users. Local third sector organisations actively engaged with virtual groups, providing valuable insights into volunteering opportunities and other resources available in the community. This collaborative effort extends beyond virtual interactions, with the inclusion of a guest speaker specialising in bushcraft. Participants felt that these

guest speakers not only shared information but also prompted service users to establish a personal connection with the organisations. Following these sessions with guest speakers, participants referred interested service users to the organisations. Sometimes they also introduced them face-to-face, promoting potential future engagement.

"It's just a way of putting the names to face for people in the group. And then either my colleague or I will refer them, or actually take them and introduce them face-to-face if they're really interested in those organisations and what they do." - Carrie

7.2.1.6 Theme 6: Enhancing virtual Recovery Through Activity through assessment, planning and evaluation insights

Occupational therapy staff expressed that assessment, planning and evaluation insights enhanced virtual Recovery Through Activity (Parkinson 2014). Participants described tools that facilitated this process but also expressed challenges in executing this virtually. Participants used the OSA (Baron et al. 2006) and a comprehensive Role Checklist (Scott 2019) to support the assessment and planning process. The planning phase sought to support to diverse service user goals and needs. Post-intervention evaluations, encompassing the OSA (Baron et al. 2006), Role Checklist (Scott 2019)s, and informal feedback, provided insights into service user experiences and progress.

Assessment under time constraints

It was expressed by participants that the planning phase of virtual Recovery Through Activity (Parkinson 2014) groups faced considerable time constraints, leading to a rapid implementation. The virtual nature of the sessions added an extra layer of uncertainty regarding the integration of third-sector involvement beyond verbal contributions. According to

participants, this added a challenge when planning sessions tailored to service user's needs. Despite these challenges, participants implemented a screening process involving online questionnaires and email evaluations by care coordinators to assess service user backgrounds. In addition, it assessed suitability for Recovery Through Activity (Parkinson 2014) and suitable connections were made with community organisations. Another factor when considering service user suitability was the virtual implementation format. Participants explained that while some service users opted for the digital format due to comfort, others faced challenges that made face-to-face meetings preferable. This highlighted the pros and cons of both modalities, emphasising the importance of assessment and accommodating the diverse needs within this service user group.

What we did was we screened participants through a kind of like an online questionnaire …as well as we had care coordinators send us an email on why they would be appropriate." – Annie

The OSA (Baron et al. 2006) emerged as a crucial tool for gauging participants' volition and goals. Addressing aspects such as concentration, routine satisfaction and engagement in leisure, productivity and self-care, the OSA (Baron et al. 2006) became influential in tailoring interventions to individual needs. According to participants, service user willingness to change and set goals varied, ranging from returning to the gym to engaging in community groups or enhancing activities at home, highlighting the diverse aspirations within the group. Participants described how the Role Checklist (Scott 2019) complemented the OSA (Baron et al. 2006) by delving into service users' backgrounds and preferences, uncovering valuable information that might not surface during the OSA (Baron et al. 2006). Questions about volunteering or joining specific groups provided a more comprehensive understanding of each service users' interests and history, enriching participants knowledge base for tailored individualised interventions.

"It helps get that extra little knowledge about somebody that I suppose you might not ask otherwise." - Carrie

Measuring change and post intervention insights

Post-intervention, participants used different tools to capture changes and progress. Participants evaluated Recovery Through Activity (Parkinson 2014) interventions using OSA (Baron et al. 2006), Role Checklist (Scott 2019), and the CORE-10 (Barkham et al 2013) assessment post sessions to measure the difference from pre-intervention. Interestingly, participants stated that service users exhibited increased honesty during post-outcome measures, reconsidering the importance of certain aspects. The 3B Scale (Rebeiro Gruhl et al 2018) was also used to evaluate the sessions by some participants. This tool allowed participants to evaluate service users' perspectives on the group's atmosphere, reflecting on its safety and their comfort within the space. The scale prompted deeper reflections on the group's nature and what service users envisioned gaining from their involvement. It offered a valuable perspective on the interpersonal dynamics at play. Participants also had informal conversations with service users which revealed valuable insights, highlighting the need for varied assessment methods. Participants described how informal feedback from participants proved invaluable. This offered an open and positive reflection on the group's impact. This feedback provided a deeper understanding of the service users experiences, and the meaningful connections promoted within the group dynamic.

"I think what I found quite interesting so far with the people I've done outcome measures with...I felt they were a bit more honest the second time around about what it is they can and can't do." Carrie

7.2.1.7 Theme 7: A framework not a programme

In exploring the optimal duration for Recovery Through Activity (Parkinson 2014), participants engaged in insightful discussions, emphasising the use of Recovery Through Activity (Parkinson 2014) as a flexible framework and not a rigid programme. Participants from a primary care service favoured a concise six-week duration, aligning with their operational requirements. Conversely, participants in secondary care leaned towards an extended duration, spanning between 10 to 12 weeks. This longer timeframe was deemed essential for cultivating strong relationships and tailoring effective strategies to individual needs. Participants highlighted the significance of time in building rapport, expressing reservations about shorter durations in these settings. Sessions typically lasted one to one and a half hours, striking a balance between content delivery and service user engagement. The structured yet flexible framework of the Recovery Through Activity (Parkinson 2014) manual received praise from participants. Participants described how it enabled them to plan sessions around the 12 activity categories. The manuals adaptability was especially valued in accommodating the diverse needs of group service user members. There was a keen emphasis on flexibility in session content based on group dynamics and the unique interests of service users. Additionally, participants emphasised the importance of ongoing assessment and adaptability to address changing needs and overcome barriers to occupational engagement. This reflects Recovery Through Activity (Parkinson 2014)'s commitment to personalised and dynamic support.

Flexibility in intervention length

The optimal duration for Recovery Through Activity (Parkinson 2014) was discussed, with participants expressing that they appreciated the flexibility to adapt the length of interventions to the needs of their

service. Participants from primary care services felt that six weeks was an ideal length of time to implement Recovery Through Activity (Parkinson 2014) based on their service needs. In secondary care participants suggested that the ideal length could range between 10 to 12 weeks. This allowed ample time to develop strong relationships and identify effective strategies tailored to individual service user needs. Participants emphasised the importance of time to building rapport. This suggests that shorter durations might not afford sufficient time for this within these settings. The sessions typically lasted for approximately an hour to an hour and a half, providing a balanced mix of content and engagement.

"I think in that time you get to know the participants really well to identify, you know what works for them." – Annie

Flexibility in group content

Participants appreciated the structured yet flexible framework of the Recovery Through Activity (Parkinson 2014) manual, supporting them to structure sessions in planned themes covering various aspects of daily life, such as cultural, domestic and self-care activities. Participants highlighted the importance of flexibility in accommodating the diverse needs of group members. Participants appreciated the flexibility of Recovery Through Activity (Parkinson 2014) to adapt session content based on the composition of each group and the interests and priorities of the service users involved. Participants discussed the significance of adapting approaches to meet changing needs over time. The value of ongoing assessment and flexibility to adapt was emphasised, noting the importance of identifying individual service user changing needs and addressing underlying barriers impacting occupational engagement.

"Sometimes you've got to switch it up because of who you have in the group and what their most important needs are or what's of most interest to them really." – Carrie

7.2.1.8 Theme 8: Creative occupational change

Participants praised the impact of Recovery Through Activity (Parkinson 2014) on supporting creative occupational change. Despite challenges in adapting face-to-face activities to a virtual format. They appreciated the flexibility of the intervention. Informative leaflets accompanied the sessions, guiding service users and providing valuable resources. The digital implementation received positive feedback from service users, who found it valuable and effective. Participants observed significant positive changes, attesting to the intervention's efficacy. Success in addressing short-term and mid-term goals often surpassed participants' expectations, highlighting the intervention's adaptability and the meaningful progress that service users can achieve within a short timeframe.

Recovery Through Activity as a Catalyst for Creative Ideas in Virtual Settings

Participants expressed that Recovery Through Activity (Parkinson 2014) supported an occupational approach through generating ideas for potential activities that could be implemented within group sessions. The manual was described by participants as serving as a valuable tool for brainstorming and exploring various engaging activities. When adapting these activities for virtual Recovery Through Activity (Parkinson 2014) however, participants encountered challenges due to the face-to-face orientation of the manual. Despite this, due to the flexibility of Recovery Through Activity (Parkinson 2014), participants were able to use their unique skills to modify and incorporate the activities, recognising the necessity of adjustments for the virtual format. For each activity type, participants developed informative leaflets detailing the nature of the activity, instructions and additional information on where service users could explore further details. Some activities had a community focus, while others were more centred around online engagement. These

informational materials aimed to guide service users through the activities and provide resources for those interested in delving deeper into specific activities.

"We found it quite useful because obviously the book's got quite good ideas." – Annie

Achieving Occupational Goals and Positive Changes in a Virtual Setting

Participants felt that the impact of Recovery Through Activity (Parkinson 2014) on the occupational approach has been significant, with noticeable differences observed with service users over the course of Recovery Through Activity (Parkinson 2014) interventions. Witnessing positive changes within this relatively short timeframe had been encouraging for participants and highlighted for them the effectiveness of Recovery Through Activity (Parkinson 2014) in supporting an occupational approach. The overall reception of virtual Recovery Through Activity (Parkinson 2014) was positive, with participants expressing satisfaction and finding the experience to be valuable. The shift to a digital format posed challenges, but the resilience of participants and the adaptability of Recovery Through Activity (Parkinson 2014) contributed to its success. Regarding goal achievement, participants felt that Recovery Through Activity (Parkinson 2014) has been successful in addressing both short-term and midterm goals. It was reported that service users often surpassed their initial expectations, surprising themselves with the progress made during the course of interventions.

"Recovery Through Activity (Parkinson 2014) has benefitted an occupational approach and in the course of 6 weeks I have seen a difference. Which is just incredible, really encouraging." – Carrie

7.2.1.9 Theme 9: Elevating occupational therapy Practice: Insights and Recognition via Recovery Through Activity

Participants found Recovery Through Activity (Parkinson 2014) supportive in solidifying their professional identity, offering a clear framework grounded in the MOHO (Kielhofner and Burke 1980). They described how it facilitates easy articulation of their role and contributions to wellbeing, serving as a tool for recognition that allows them to articulate their capabilities beyond generic roles. There was enthusiasm among participants for offering placements to students in alternative settings to enrich learning experiences. The MDTs' initial positive but slow acknowledgment of Recovery Through Activity (Parkinson 2014) highlights its transformative impact, challenging preconceptions and broadening their understanding of occupational therapy contributions.

Recovery Through Activity Illustrating and Enhancing occupational therapy Practice

Participants highlighted the importance of maintaining a professional identity in the field and expressed that Recovery Through Activity (Parkinson 2014) has been influential in solidifying this identity. They felt that Recovery Through Activity (Parkinson 2014) offered a framework to explain and showcase the role of occupational therapy staff. Participants felt that Recovery Through Activity (Parkinson 2014), being underpinned by the MOHO (Kielhofner and Burke 1980) provides a clear illustration of occupational therapy practices, making it easier to articulate how occupational therapist’s contribute to service users’ wellbeing. Participants expressed that this has allowed them to emphasise that, while they can work generically, they are, in fact, occupational therapists with diverse capabilities. Ultimately, participants felt that Recovery Through Activity (Parkinson 2014) serves as a tool for recognition and acknowledgment of the valuable contributions occupational therapists make. In addition,

regarding the prospect of offering placements to students in alternative settings, participants expressed enthusiasm. They emphasised the significance of being able to confidently articulate what occupational therapy offers. They felt that this will help to create opportunities for students to engage with OT practices in diverse settings, further enriching their learning experiences.

"I think having the Recovery Through Activity has given us something concrete to hold on to. To say yes, this is OT and this is what we do. It's easy to explain using Recovery Through Activity." – Carrie

Shifting Perspectives and Recognition of occupational therapy through Recovery Through Activity

The MDT perspective on the implementation of Recovery Through Activity (Parkinson 2014) and understanding the role of occupational therapy was described by participants as initially positive but a slow burner. Participants explained that the teams gradually recognised the comprehensive nature of their interventions. Initially uncertain about what occupational therapists offer, the MDT observed that Recovery Through Activity (Parkinson 2014) was not just an activity group, but a therapeutic intervention tailored to service users' occupational goals. Recovery Through Activity (Parkinson 2014) has reportedly challenged preconceptions within the MDT, broadening their understanding of what occupational therapists can offer.

"I think it's helped to open people's eyes as to what else we could do." – Carrie

7.2.2 Summary

The importance of tailoring Recovery Through Activity (Parkinson 2014) to individual service user needs is emphasised. Participants found benefit in the use of tools like the OSA (Baron et al. 2006), Interest Checklist

(Heasman and Salhortra 2008), and Role Checklist (Scott 2019) to draw out specific user needs, interests and goals. Additionally, providing information on community organisations related to these aspects supports person centredness. Participants highlighted the challenge of balancing practical and educational elements, especially via virtual implementation. Overcoming this challenge involved innovative strategies like sending resource packs for practical activities, sharing informational videos and encouraging discussions during virtual sessions to consolidate information. The dynamics of virtual group engagement were explored, revealing a variety of service user interactions from chat box engagement to the use of face filters. Motivating service users in an online setting was recognised as a challenge, emphasising the role of intrinsic motivation. Participants recommended post-session community interactions, the use of videos and the determination of optimal group size for enhanced service user comfort. The collaboration between occupational therapists and service users was deemed essential by participants for creating a supportive environment. Integral to delivering Recovery Through Activity (Parkinson 2014) sessions were one-to-one sessions alongside group interactions. The OSA (Baron et al 2006) was highlighted as a guiding tool in one-to-one discussions, addressing personal struggles and building motivation. Participants promoted collaboration with community organisations and stressed the importance of assessing and planning to ensure the smooth running of virtual Recovery Through Activity (Parkinson 2014) sessions. Tools like the OSA (Baron et al. 2006) and a comprehensive Role Checklist (Scott 2019) supported this process. Post-intervention evaluations, including the OSA (Baron et al. 2006), Role Checklist (Scott 2019), and informal feedback, offered insights into service user experiences and progress. The optimal duration for the Recovery Through Activity (Parkinson 2014) is suggested by participants. Primary care services leant towards a concise six-week duration, aligning with operational requirements. In secondary care, there was a consensus

for an extended duration of 10 to 12 weeks. This longer timeframe was deemed vital for building strong relationships and tailoring effective strategies to individual needs. Participants appreciated the structured yet flexible framework of the manual. The manuals adaptability appeared valuable in session content planning based on group dynamics and service users' unique interests. The positive impact of Recovery Through Activity (Parkinson 2014) on promoting an occupational approach was acknowledged by participants. Positive feedback from service users highlights the intervention's value, with participants observing significant changes and success in addressing short-term and midterm goals. Additionally, Recovery Through Activity (Parkinson 2014) was recognised as supportive in promoting the professional identity of participants, offering a clear framework grounded in the MOHO (Kielhofner and Burke 1980), which facilitated easy articulation of their role and contributions to wellbeing. Participants felt that the MTD’s initial positive but slow acknowledgment of Recovery Through Activity (Parkinson 2014) helped to broaden their understanding of occupational therapy contributions.

7.3 Feedback Questionnaire

A feedback questionnaire was given to 12 service users by occupational therapy staff who had run Recovery Through Activity (Parkinson 2014) via Microsoft Teams. This was part of business as usual. The respondents in this section have pseudonyms. The questions on the feedback form and mode of response are listed in Table 3

Table 6 - Service user feedback questionnaire questions and mode of response

Questions	Mode of response

As you are aware, the group was run virtually on Microsoft Teams. How satisfied were you with the information you received prior to the group e.g. the Microsoft Teams information leaflet?	Rating Scale: Very unsatisfied, Unsatisfied, Neutral, Satisfied, Very Satisfied Open space for service user comments
Were there any problems with technology during any of the group sessions you attended?	Yes/No If yes, space to provide details
How satisfied were you with the virtual group you attended?	Rating Scale: Very unsatisfied, Unsatisfied, Neutral, Satisfied, Very Satisfied Open space for service user comments
How likely are you to attend a virtual group in the future?	Rating Scale: Extremely unlikely, unlikely, unsure, likely, extremely likely Open space for service user comments
Were all the things you wanted to discuss, addressed during the virtual group?	Yes/No If no, please can you tell us what you would have liked to see discussed

Were any advice and strategies provided, explained clearly during the virtual group sessions?	Yes/No
How useful were the video clips used in your experience of the group?	Rating scale: useless, unsure, moderately useful, very useful, extremely useful
How useful were the handouts used in your experience of the group?	Rating scale: useless, unsure, moderately useful, very useful, extremely useful
How useful were the resource packs used in your experience of the group?	Rating scale: useless, unsure, moderately useful, very useful, extremely useful
What elements of the group did you find MOST useful?	Open space for service user comments
What elements of the group did you find LEAST useful?	Open space for service user comments
Are there any lifestyle changes that you have or want to make as a result of attending the programme?	Open space for service user comments
What elements of the group do you think could be improved for future participants?	Open space for service user comments

“As you are aware, the group was run virtually on Microsoft Teams. How satisfied were you with the information you received prior to the group e.g. the Microsoft Teams information leaflet?”

A small number (8.3%) of respondents indicated that they were neither unsatisfied nor satisfied, 25% of respondents indicated they were satisfied, 66.7% of respondents stated that they were very satisfied.

Bert stated that they weren’t sure about the sessions to begin with, however felt better once they had gotten on screen and were attending. Liam responded that they felt the sessions were highly informative and accessible, explaining that the handouts prior to the group helped them to manage their anxiety. Charlie stated that the group was lovely and welcoming. Some service users outlined some challenges, Fred explained that they had some difficulties with internet connection and Demetri stated that there was a lot of written information which they found a challenge due to difficulties with reading.

“Were there any problems with technology during any of the group session you attended?”

In total, 66.7% of service users responded “No” and 33.3% responded “Yes”. Service users who responded yes were asked to expand. Service user’s Fred, Howard and James reported difficulties with connectivity, explaining that they often lost connection and had to disconnect and log back in. Service user’s Howard and James also reported that sound quality was an issue for them and that there was lots of feedback and echoes.

In relation to the question "How satisfied were you with the virtual group you attended?" 8.3% responded "neither satisfied not unsatisfied", 16.7% responded "Satisfied", 75% responded "Very satisfied". Bert stated that they felt satisfied once they had been able to get online and used to it. Ieuan reported that they found the other people attending the virtual group to be very honest about what was discussed during the sessions. Eddie said that they felt a key factor for them was connecting with others with similar experience:

"I've got to know other individuals who've gone through similar situations as myself & the empathy in which we've given too each other has put my faith back into society" – Eddie

Eddie also fed back that group facilitators had made a difference to how they felt, giving them hope and confidence moving forward. Kaden also fed back that the group facilitators were great, and they enjoyed speaking with people each week, however due to their anxiety and depression felt that they needed more help in person as opposed to via a virtual group.

"How likely are you to attend a virtual group in the future?"

Overall, 8.3% responded "extremely unlikely", 8.3% responded "unsure", 33.3% responded "likely", 50% responded "very likely". Bert reported that they would try it again, however they also said that when they were previously emailed about information in the group and shown leaflets during the group it was too small for them to see as they were using their phone. Two other service users (Fred and Liam) also had difficulties with the virtual implementation expressing that they were unsure if anything virtually would be of use and that they preferred in person to online. However, Eddie fed back that meeting virtually was the next best option to being in the same room, stating that it made a difference to them being able to see as well as hear about other people's experiences and journeys.

"Were all the things you wanted to discuss, addressed during the virtual group?" and "Were any advice and strategies provided, explained clearly during the virtual group sessions?"

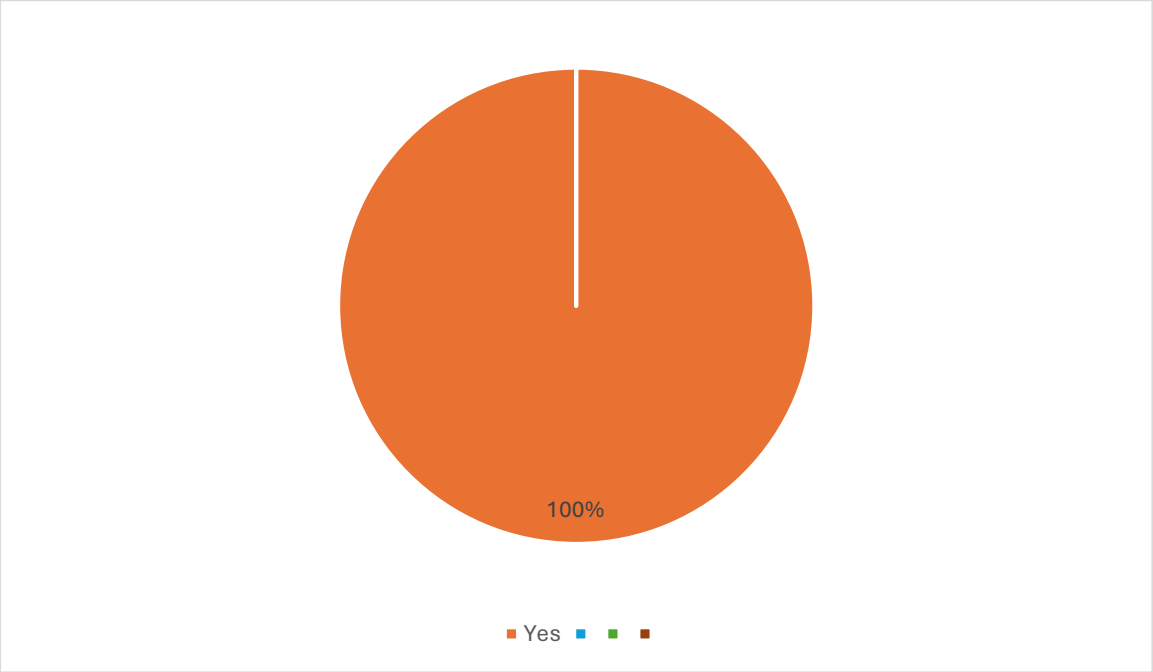


Figure 5 - Service user response to being able to discuss and receive advice during virtual group

"How useful were the video clips used in your experience of the group?"

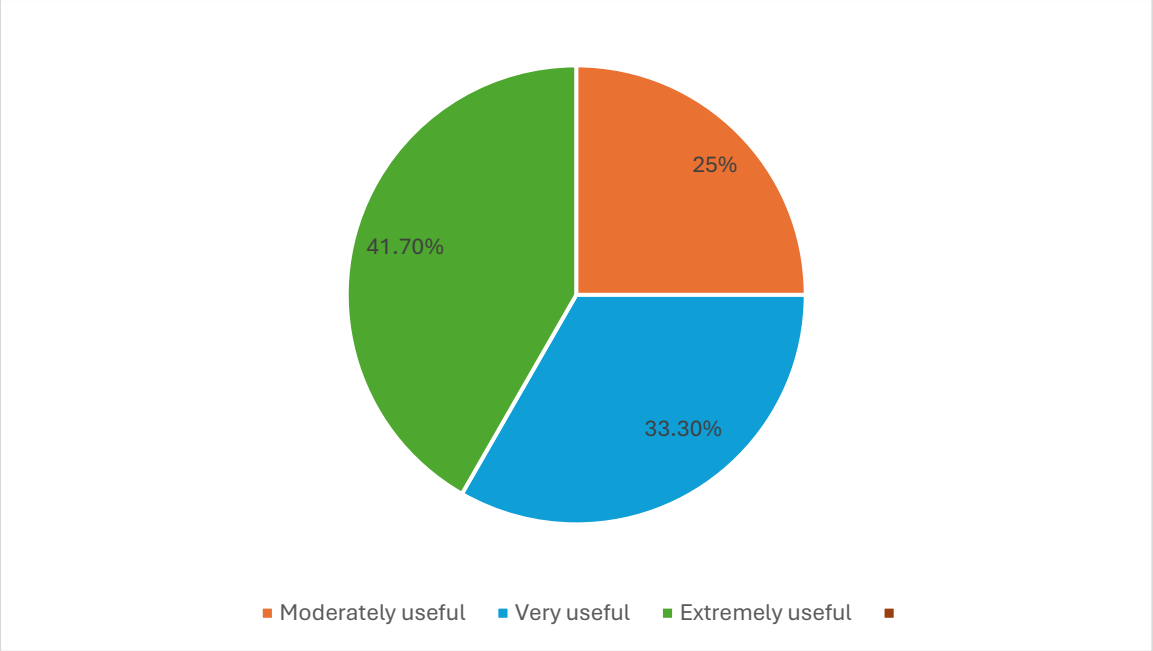


Figure 6 - Service user responses to usefulness of video clips

"How useful were the handouts used in your experience of the group?"

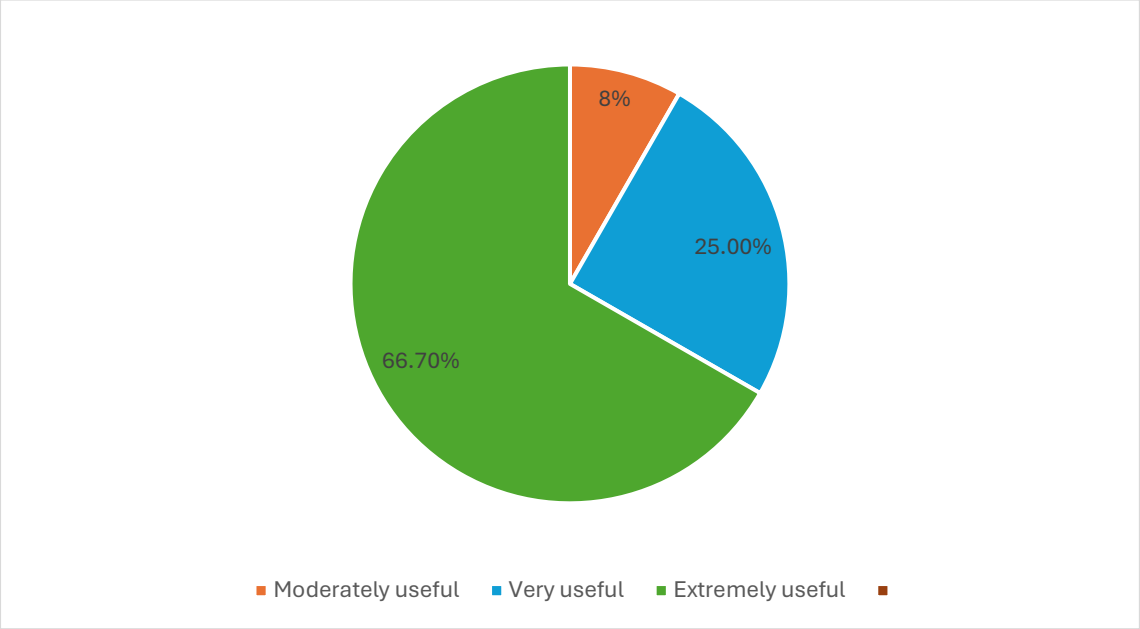


Figure 7 - Service user responses to usefulness of handouts

"How useful were the resource packs used in your experience of the group?"

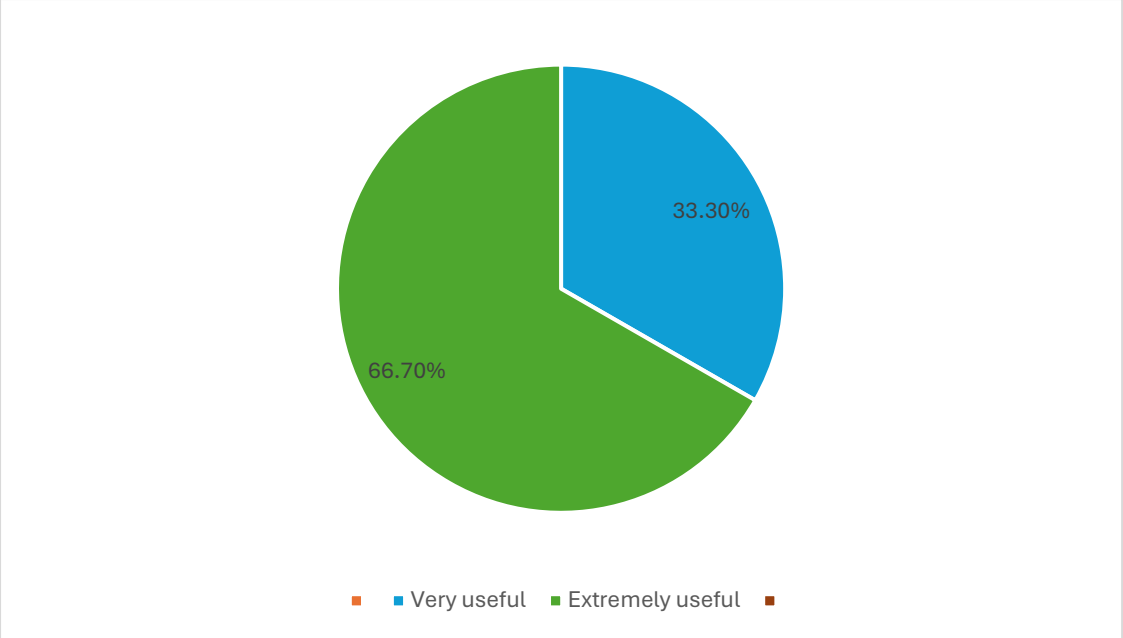


Figure 8 - Service user responses to usefulness of resource packs

"What elements of the group did you find MOST useful?"

Half (50%) of service users fed back that speaking and sharing with others as well as being able to relate to other's views was most important to them. Respondents stated that they appreciated other people's views, they felt less shame and isolation, didn't feel judged and felt that they could discuss problems with the feeling that they were among friends.

"Realising that there are other people struggling just like I was"- Liam

Kaden responded that they felt the one-to-one sessions with the occupational therapist were the best part of Recovery Through Activity (Parkinson 2014). Howard stated that they appreciated having two therapists present in the session as it encouraged discussion. They also expressed that group discussions were something that they had previously been concerned about due to a lack of confidence, however the groups supported their confidence, as they were encouraging and without pressure. Kaden also expressed enjoying guest speakers attending the groups and enjoyed engaging in different activities.

"What elements of the group did you find LEAST useful?"

In total, 41.7% of service users fed back that there was nothing that they didn't enjoy and that they found everything useful. Interestingly, 41.7% did not answer the question. The remaining two participants (Bert & Demetri) reported that not all of the sessions were relevant to them and that they were unable to see some of the things on the screen.

"Are there any lifestyle changes that you have or want to make as a result of attending the programme?"

Half (50%) of the service users responded that they had not made changes yet, but they wanted to. Bert explained that the reason they had not made changes yet was because there were no groups available to them until a later date. Some of the changes service users suggested they wanted to make in the future were to help others in the future (Eddie), to get out more and improve their routine (service users Fred, George and James). Better health and lifestyle were also described as a change service users wanted to make (service users Demetri, Howard and James).

"I'm feeling more positive and ready to start doing more by being more socially active with friends and colleagues. It's also helped me realise that I need to focus more on my self-care". – Howard

A total of 33.3% of service users stated that they had already made a change following Recovery Through activity. Charlie felt very positive that they had started to make small changes, likewise Ieuan explained that they had started going to see their friends and started exercising again following Recovery Through Activity (Parkinson 2014). Liam reported that they were able to return to work and undertake a volunteer position.

“What elements of the group do you think could be improved for future participants?”

Two service users (Eddie and George) expressed that they felt face-to-face groups as opposed to virtual would improve the groups. Specifically, Charlie felt that the groups could be improved by being longer and Demetri felt that grouping people with similar issues would improve the sessions.

7.3.1 Summary and revisiting research aim and objectives

A feedback questionnaire was given to 12 service users who participated in virtual Recovery Through Activity (Parkinson 2014) sessions via Microsoft Teams. The majority (66.7%) were very satisfied with the pre-session information, although some faced challenges with internet connectivity and sound quality. Most respondents (75%) were very satisfied with the virtual group experience, valuing the connection with others sharing similar experiences. While half of the respondents were very likely to attend future virtual sessions, some preferred in-person meetings. The sharing of experiences and one-to-one sessions with occupational therapists were deemed most useful. Suggestions for improvement included offering face-to-face sessions and longer group durations. Overall, the intervention promotes a sense of community and supported positive lifestyle changes.

The feedback questionnaire findings, completed by service users, directly support the overarching aim of the research by offering detailed insights into how service users experienced and valued Recovery Through Activity (Parkinson 2014). This data provides compelling evidence of Recovery Through Activity’s (Parkinson 2014) impact on various aspects of service users' well-being, social connections, and daily routines. For example,

75% of respondents reported feeling "very satisfied" with the virtual group experience, while 66.7% indicated they were "very satisfied" with the information provided prior to the sessions, demonstrating overall satisfaction with the intervention's accessibility and delivery. These high satisfaction ratings highlight Recovery Through Activity's (Parkinson 2014) perceived effectiveness from the participants' perspective.

In relation to specific research objectives, the feedback questionnaires directly address Objective 3, which focused on evaluating service user perceptions and experiences of Recovery Through Activity (Parkinson 2014). The responses provide qualitative data on service users' appreciation for both the structure and emotional support within the virtual groups, with 50% of participants emphasising the value of connecting with others who had similar experiences. Eddie, for example, expressed that "the empathy we've given to each other has put my faith back into society," which emphasises the intervention's impact on reducing isolation and promoting a supportive community. This aligns with key elements of mental health recovery by highlighting Recovery Through Activity's role in reducing social isolation, facilitating shared understanding, and enhancing participants' overall sense of belonging.

The feedback also offers insights relevant to Objective 2, which aimed to identify the opportunities and challenges occupational therapists face in implementing an occupationally focused approach. The questionnaires reveal specific practical challenges encountered within the virtual format, such as technological difficulties—33.3% of service users reported issues with connectivity and sound quality. These technological barriers highlight implementation challenges that occupational therapists may encounter in virtual settings. Conversely, the feedback data also highlights opportunities for enhancing virtual delivery: resources like handouts, videos, and resource packs were rated as "very useful" or "extremely useful" by 100% of participants, indicating their effectiveness in

maintaining engagement and providing accessible support remotely. This data demonstrates that, while challenges exist in virtual implementation, Recovery Through Activity's (Parkinson 2014) structure and resources offer meaningful support and engagement, even in a non-traditional setting.

For Objective 4, which involves evaluating the effectiveness of Recovery Through Activity's (Parkinson 2014) through outcome data, the feedback questionnaires provide direct evidence of the intervention's value from the service user perspective. The data reflects both immediate satisfaction and intentions for future positive change. For instance, 50% of participants reported feeling "very likely" to attend virtual groups again, indicating confidence in Recovery Through Activity as a viable intervention format. In addition, several service users noted lifestyle changes they wished to pursue following their participation, such as increasing social activity, improving routines, and focusing on self-care. Howard noted, "It's helped me realise that I need to focus more on my self-care," suggesting that Recovery Through Activity (Parkinson 2014) not only meets immediate needs but also encourages long-term positive behaviour change. The findings from the questionnaire therefore provide measurable evidence of the intervention's effectiveness in creating a supportive, engaging environment for service users, despite the inherent challenges of virtual implementation.

In summary, the feedback questionnaires substantiate the overarching aim by illustrating the positive impact of Recovery Through Activity (Parkinson 2014) on service users' well-being and social connections, confirming its effectiveness from a person-centred viewpoint. This data also directly addresses the specific objectives by capturing service user experiences, pinpointing the unique challenges and opportunities within a virtual setting, and providing concrete evidence of the intervention's

effectiveness in promoting community, satisfaction, and change among participants.

7.4 3B Scale – Being, Belonging, Becoming

Following a course of virtually implemented Recovery Through Activity (Parkinson 2014) sessions, 18 service users were asked to rate on a 5-point scale (strongly disagree, disagree, neither disagree nor agree, agree, strongly agree) 23 statements (see Table 4) on the 3B Scale (Rebeiro Gruhl et al 2018).

Table 7 - 3B Scale Statements

S1	The staff treat me in a respectful manner at all times.
S2	The staff genuinely listen to me and validate my concerns.
S3	The staff understand my issues and demonstrate empathy for my concerns.
S4	The staff provide reassurance and support to me.
S5	The staff help me to believe that I can get better, and that recovery is possible.
S6	The staff help me to be hopeful about my future.
S7	I feel comfortable to raise concerns about this program with the staff.

S8	There is a place for me and space where I am comfortable to socialise.
S9	I am comfortable to just be present in the space, without feeling pressured to participate or socialise.
S10	Since participating, I feel like I belong somewhere.
S11	I feel that I am a part of a community.
S12	I feel welcomed at the Recovery Through Activity programme.
S13	As a result of my participation, I feel that I am better able to manage my mental health.
S14	As a result of my participation, I am achieving my goals.
S15	Compared to when I began participating, my quality of life has improved.
S16	Participation has helped me to obtain employment, a volunteer position, or return to school or college.
S17	Since participating in this program, I have been less reliant on hospital services.
S18	Since participating in this program, I have been less reliant on emergency services.
S19	Since participating in this program, I have been less reliant on other mental health services.

S20	The Recovery Through Activity programme connects me with the community and has an important social purpose.
S21	Since participating in this program, I feel I am more involved in my community and contributing to it in meaningful and valued ways.
S22	Overall, I am satisfied with the services I receive at the Recovery Through Activity programme.
S23	Would you refer a friend or family member to the Recovery Through Activity programme?

Ratings were numericised as 'strongly disagree' (1), 'disagree' (2), 'neither agree nor disagree' (3), 'agree' (4), 'strongly agree' (5). Participant 11 did not rate statement 9 and participant 16 did not rate statement 19, and so results were calculated acknowledging this.

As seen in Figure 8 below, a total across statements and participants, 52% stated "strongly agree" and 25% "agree", totalling 77% in agreement in relation to the statements. A total of 21% of statements were rated as "neither disagree nor agree", 2% "disagree" and 0% "strongly disagree.

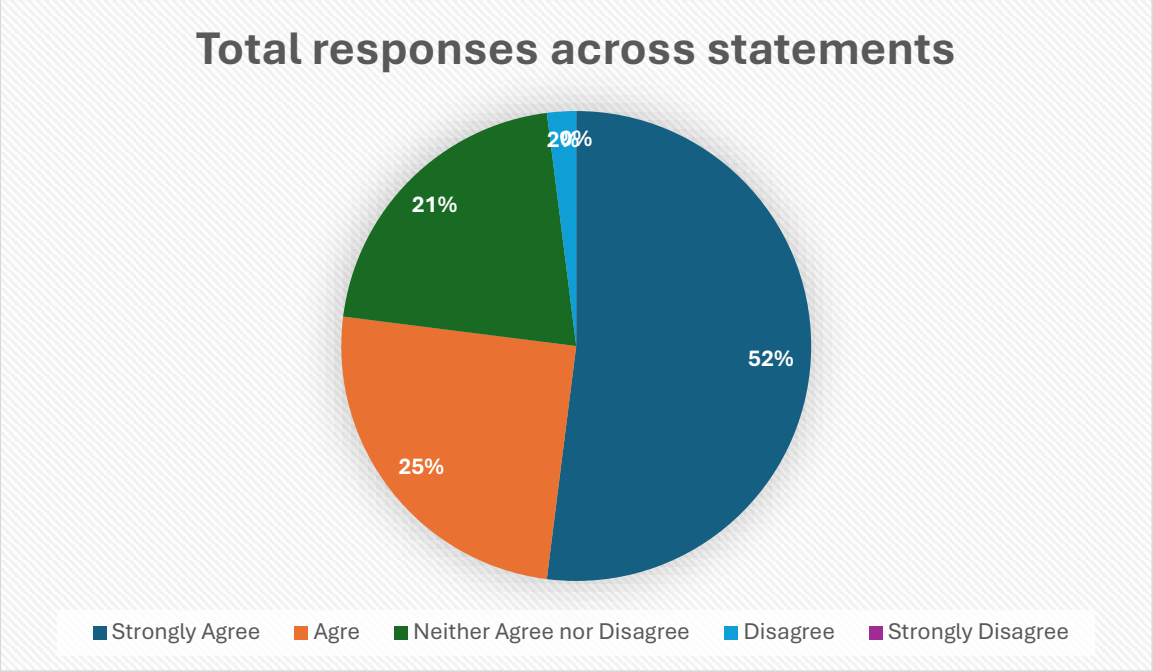


Figure 9 - 3B scale total responses across statement

The statement participants rated most frequently as "strongly agree" was S12 (I feel welcomed at the Recovery Through Activity programme) at 94%. This was followed at 89% for S1 (the staff treat me in a respectful manner at all times), S2 (the staff genuinely listen to me and validate my concerns), S4 (the staff provide reassurance and support to me) and S7 (I feel comfortable to raise concerns about this program with the staff). The third highest rated "strongly agree" statement at 83% was S5 (the staff help me to believe that I can get better, and that recovery is possible).

The most rated "agree" statements at 50% were S14 (as a result of my participation, I am achieving my goals), S15 (compared to when I began participating, my quality of life has improved) and S20 (the Recovery Through Activity programme connects me with the community and has an important social purpose). The second most rated "agree" statement at 44% was S13 (as a result of my participation, I feel that I am better able to manage my mental health). The third most rated "agree' statements at 39% were S8 (there is a place for me and space where I am comfortable

to socialise), S11 (I feel that I am a part of a community) and S21 (since participating in this program, I feel I am more involved in my community and contributing to it in meaningful and valued ways).

The most rated "neither agree nor disagree" statements at 50% were S18 (since participating in this program, I have been less reliant on emergency services) and S21 (since participating in this program, I feel I am more involved in my community and contributing to it in meaningful and valued ways). The second most rated "neither agree nor disagree" statements at 44% were S16 (participation has helped me to obtain employment, a volunteer position, or return to school or college), S17 (since participating in this program, I have been less reliant on hospital services) and S19 (since participating in this program, I have been less reliant on other mental health services).

The most rated "disagree" statements at 17% were S16 (participation has helped me to obtain employment, a volunteer position, or return to school or college) and S19 (since participating in this program, I have been less reliant on other mental health services). The second most rated "disagree statements at 6% were S13 (as a result of my participation, I feel that I am better able to manage my mental health) and S14 (as a result of my participation, I am achieving my goals).

No participants rated "strongly disagree" for any statements.

7.4.1 Summary and revisiting research aim and objectives

Following a course of virtually implemented Recovery Through Activity (Parkinson 2014) sessions, 18 service users were asked to rate 23 statements on the 3B Scale (Rebeiro Gruhl et al. 2018) using a 5-point scale (strongly disagree, disagree, neither disagree nor agree, agree, strongly agree).

The overall results indicated strong positive feedback, with 52% of responses marked as "strongly agree" and 25% as "agree," totaling 77% agreement. 21% of responses were "neither agree nor disagree," 2% were "disagree," and none were "strongly disagree."

The highest-rated statements included:

- S12 (I feel welcomed at the Recovery Through Activity (Parkinson 2014) programme) at 94%.

- S1 (the staff treat me in a respectful manner at all times), S2 (the staff genuinely listen to me and validate my concerns), S4 (the staff provide reassurance and support to me), and S7 (I feel comfortable to raise concerns about this program with the staff) at 89%.

- S5 (the staff help me to believe that I can get better, and that recovery is possible) at 83%.

The most frequent "disagree" responses were for:

- S16 (participation has helped me to obtain employment, a volunteer position, or return to school or college) and S19 (since participating in this program, I have been less reliant on other mental health services) at 17%.

- S13 (as a result of my participation, I feel that I am better able to manage my mental health) and S14 (as a result of my participation, I am achieving my goals) at 6%.

The findings from the 3B Scale (Rebeiro Gruhl et al. 2018), completed by service users following the virtual implementation of Recovery Through Activity (Parkinson 2014), provide quantitative evidence that supports the overarching research aim of evaluating both the efficacy and effectiveness of Recovery Through Activity. This scale, which assesses the dimensions

of "Being, Belonging, and Becoming" (Rebeiro Gruhl et al. 2018), allows a deeper understanding of how service users perceived and experienced the intervention in terms of personal well-being, social connection, and goal achievement, all of which are central to the research aims.

In particular, the responses to the 3B Scale (Rebeiro Gruhl et al. 2018), address Objective 3, which aimed to evaluate service user perceptions and experiences. High levels of agreement with statements such as S12 ("I feel welcomed at the Recovery Through Activity programme") at 94%, S1 ("the staff treat me in a respectful manner at all times"), S2 ("the staff genuinely listen to me and validate my concerns"), S4 ("the staff provide reassurance and support to me"), and S7 ("I feel comfortable to raise concerns about this program with the staff")—all at 89%—indicate a strong sense of support and safety in the sessions. This elevated level of agreement reflects service users' positive experiences and satisfaction with Recovery Through Activity (Parkinson 2014), highlighting the intervention's perceived value in creating an inclusive and empathetic environment.

The findings also speak to Objective 2, which focused on identifying opportunities and challenges within the occupationally focused approach of Recovery Through Activity (Parkinson 2014). Particularly, the highest-rated statement, S12 ("I feel welcomed at the Recovery Through Activity programme") at 94%, points to the success of the virtual format in creating a supportive atmosphere. However, challenges are apparent in areas where agreement was lower. For example, S16 ("participation has helped me to obtain employment, a volunteer position, or return to school or college") and S19 ("since participating in this program, I have been less reliant on other mental health services") had the highest "disagree" ratings at 17%. These findings suggest that while Recovery Through Activity (Parkinson 2014) is effective in promoting social connections and a sense of belonging, further attention may be needed to support

transitions into work or educational opportunities, as well as to reduce reliance on other services. These challenges reflect potential areas for development within the intervention's structure to maximise occupational engagement outcomes.

Furthermore, the 3B Scale (Rebeiro Gruhl et al. 2018), findings relate to Objective 4, which focused on evaluating the effectiveness of Recovery Through Activity's (Parkinson 2014) implementation by analysing outcome data. The strong agreement with statements regarding participants' perceptions of being welcomed and listened to, as well as the sense of community (e.g., S10, "Since participating, I feel like I belong somewhere" and S11, "I feel that I am a part of a community"), all indicate that Recovery Through Activity (Parkinson 2014) has effectively met service users' needs for social support in a virtual format. Statements such as S13 ("as a result of my participation, I feel that I am better able to manage my mental health") and S15 ("compared to when I began participating, my quality of life has improved") reflect positive personal impacts on mental health and quality of life, with 50% or more of respondents indicating "agree." These responses offer measurable evidence of the intervention's role in supporting mental health and quality of life, thus indicating the effectiveness of Recovery Through Activity (Parkinson 2014) from the perspective of service users.

In summary, the 3B Scale (Rebeiro Gruhl et al. 2018), findings strongly align with the overarching aim of the research by demonstrating that Recovery Through Activity (Parkinson 2014) positively impacts service users in various dimensions of well-being and social connectedness, even within the constraints of a virtual format. These insights from the 3B Scale (Rebeiro Gruhl et al. 2018), not only highlight the intervention's success in promoting a sense of belonging and support but also uncover areas for further development, particularly in relation to promoting greater occupational and community engagement outcomes.

7.5 Occupational Self-Assessment (OSA) outcomes

Service users we given the OSA (Baron et al. 2006) by occupational therapy staff as part of business as usual, to self-complete via Microsoft Forms pre and post a course of virtual Recovery Through Activity (Parkinson 2014) interventions. They were given a list of statements about things they may do in everyday life, which are listed below in Table 5. In total 16 service users completed the OSA (Baron et al. 2006) pre and post intervention.

Table 8 - OSA questions

Q1	Concentrating on my task
Q2	Physically knowing what I need to do
Q3	Taking care of the place where I live
Q4	Taking care of myself
Q5	Taking care or others for whom I'm responsible
Q6	Getting to where I need to go
Q7	Managing my finances
Q8	Managing my basic needs (food, medicine)

Q9	Expressing myself to others
Q10	Getting along with others
Q11	Identifying and solving problems
Q12	Relaxing and enjoying myself
Q13	Getting done what I need to do
Q14	Having a satisfying routine
Q15	Handling my responsibilities
Q16	Being involved as a student, worker, volunteer, and/or family member
Q17	Doing activities I like
Q18	Working towards my goals
Q19	Making decisions based on what I think is important
Q20	Accomplishing what I set out to do
Q21	Effectively using my abilities

Service users were asked to rate both their perception of competence in relation to each statement and the value they place on each statement. For the purposes of analysis, the ratings were converted to numbers. Competence ratings we scored as follows: 'I have a lot of problems doing this' (1), 'I have some difficulty doing this' (2), 'I do this well' (3), 'I do

this extremely well' (4). Value ratings were scored as follows: 'This is not so important to me' (1), 'This is important to me' (2), 'This is more important to me' (3), 'This is most important to me' (4). The tables below provide participants self-rated competence and value scores, before and after Recovery Through Activity (Parkinson 2014) interventions.

7.5.1 Shapiro-Wilk test of normality

Initially, a Shapiro-Wilk test of normality was conducted to determine whether competence before, competence after, value before, and value after scores were normally distributed. The results identified that the data was non-parametric (Competence before p = .95, Competence after p = .10, Value before p = .31, Value after p = .10). Therefore, non-parametric equivalent tests were used. The Model of Human Occupation (MOHO) (Kielhofner 1995) may offer an inference as to why the data is not evenly distributed. This could be due to individual differences such as service users' volitional impacts, the values they place on activities, self-efficacy, motor and cognitive skill differences, as well as environmental influences on perceived competence. Additionally, the sample consists of 16 service users, and the data may be less dispersed with a larger sample. Due to the sample not being normally distributed, non-parametric tests were conducted.

7.5.2 Cronbach's Alpha on OSA (Baron et al. 2006) outcomes

A Cronbach's Alpha was carried out to determine the internal consistency of the data, this identified that the findings should be interpreted with caution as reliability was weak (p = .4).

7.5.3 Wilcoxon Signed rank test on OSA (Baron et al. 2006) outcomes

The first thing that was looked at was whether there was a significant difference between the median total score for competence levels before and after Recovery Through Activity (Parkinson 2014) intervention. Following this, values were looked at to determine whether there was a significant difference in the median value scores before and after Recovery Through Activity (Parkinson 2014) intervention. The Wilcoxon signed rank test was used to determine this. This test examined the medians for each question before and after intervention. For descriptive reasons the means have also been presented. As seen blow in table 6, the mean for total competence before and total competence after intervention had increased from 43.63 (SD=5.52) to 52.44 (SD=12.97). The mean for the total values before and total values after had increased from 63.88 (SD=10.54) to 69.69 (SD=8.84).

Table 9 – Mean Competence and Values scores before and after Recovery Through Activity (Parkinson 2014)

	N	Mean	Std. Deviation	Minimum	Maximum
Competence before (Total)	16	43.63	5.52	31.00	53.00
Competence after (Total)	16	52.44	12.97	33.00	70.00
Values before (Total)	16	63.88	10.54	46.00	80.00
Values after (Total)	16	69.69	8.84	58.00	83.00

The Wilcoxon signed ranked test compared the median competence score before and after intervention and revealed a significant difference ($Z = -2.93$, $p = 0.003$). The median value score was also compared before and after and also revelated a significant difference ($Z = -2.3$, $p = 0.02$). This

means that scores for both competence and values significantly increased after intervention compared to before. Due to the significant differences before and after, each question was then analysed to determine if there were significant differences for individual questions.

7.5.3.1 Competence

A Wilcoxon signed rank test was conducted, comparing competence ratings before and after Recovery Through Activity (Parkinson 2014) intervention, for each individual question. The questions with statistically significant differences will be reported here, however please see Table 7 for the full results. The competence means were also calculated for each question, for ease of interpretation, before and after intervention. Please see figure 9 for the mean results.

The question "concentrating on my task" had a significant increase post intervention, ($Z = -3.41$, $p = <.001$), with a mean difference of 1.69 (SD=.48). The question "getting where I need to go" had a significant increase post intervention ($Z = -2.18$. $p = .03$), with a mean difference of 1.8 (SD=1.17). The question "relaxing and enjoying myself" had significantly increased post intervention ($Z = - 2.39$, $p = 0.02$), with a mean difference of 1.81 (SD=.83). The question "having a satisfying routing" increased significantly post intervention ($Z = -2.49$, $p = .01$), with a mean difference of 1.63 (SD=.72). The question "being involved as a student, worker, volunteer, and/or family member" significantly increased post intervention ($Z = -2.19$, $p = .03$), with a mean difference of 1.88 (SD=.89). The question "working towards my goals" had a significant increase post intervention ($Z = -3.207$, $p = .001$), with a mean difference of 1.5 (SD=.73). The question "accomplishing what I set out to do" had a significant increase post intervention ($Z = -2.50$, $p = .01$), with a mean difference of 2.43 (SD=.96). Finally, the question "effectively

using my abilities" had a significant increase post intervention (Z = -1.99, *p* = .05), with a mean difference of 2.43 (SD=.63).

Table 10. Wilcoxon signed rank test on competence before and after Recovery Through Activity (Parkinson 2014)

Competence	Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Q9	Q10	Q11	Q12	Q13	Q14	Q15	Q16	Q17	Q18	Q19	Q20	Q21
Z	-3.416[b]	-.632[b]	-1.414[b]	-.707[c]	-.832[b]	-2.183[b]	-1.000[b]	-.905[b]	-1.342[b]	-.378[b]	-1.428[b]	-2.392[b]	-1.461[b]	-2.486[b]	-1.027[b]	-2.194[b]	-1.387[b]	-3.207[b]	-1.221[b]	-2.496[b]	-1.994[b]
Asymp. Sig. (2-tailed)	<.001	.527	.157	.480	.405	.029	.317	.366	.180	.705	.153	.017	.144	.013	.305	.028	.166	.001	.222	.013	.046

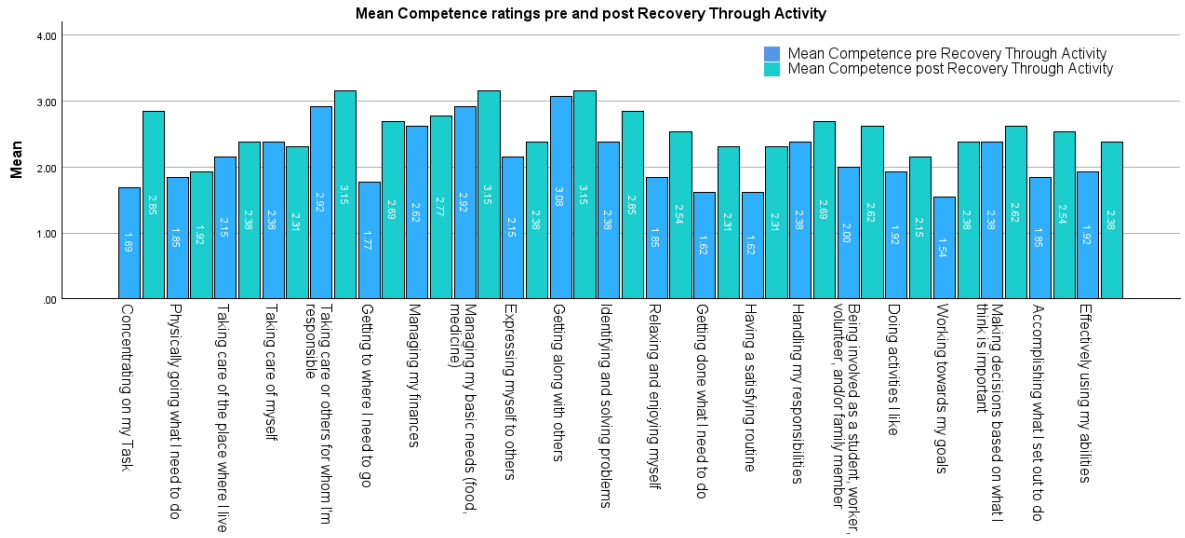


Figure 10. Question means - Competence ratings pre and post Recovery Through Activity (Parkinson 2014)

7.5.3.2 Value

A Wilcoxon signed rank test was conducted, comparing value ratings before and after Recovery Through Activity (Parkinson 2014) intervention, for each individual question. The questions with statistically significant results will be reported here, however please see Table 8 for the full results. The value means were also calculated for each question before

and after intervention for ease of interpretation. Please see Figure 10 depicting the mean results. The question "managing my basic needs (food, medicine)" significantly increased post intervention (Z = -212, *p* = .03), with a mean difference of 3.62 (SD=.81). The question "expressing myself to others" significantly increased post intervention (Z = -2.16, *p* = .03), with a mean difference of 3.38 (SD=.89). The question "getting along with others" significantly increased post intervention, (Z = -2.933, *p* = .05), with a mean difference of 2.81 (SD=1.28). The question "identifying and solving problems" significantly increased post intervention (Z = -2.53, *p* = .01), with a mean of 2.88 (SD=.96). The question "relaxing and enjoying myself" significantly increased post intervention (Z = -2.07, *p* = .38), with a mean difference of 3.5 (SD=.82). The question "handling my responsibilities" significantly increased post intervention (Z = -2.401, *p* = .012), with a mean difference of 3.25 (SD=1.00).

Table 11, Wilcoxon signed rank test on Values before and after Recovery Through Activity (Parkinson 2014)

Values	Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Q9	Q10	Q11	Q12	Q13	Q14	Q15	Q16	Q17	Q18	Q19	Q20	Q21
Z	-1.633[b]	-.966[b]	-1.000[c]	-.750[b]	-1.633[b]	-1.732[b]	-1.730[b]	-2.121[b]	-2.157[b]	-1.933[b]	-2.530[b]	-2.070[b]	-.439[c]	-.539[b]	-2.401[b]	-1.298[b]	-.319[b]	-.439[b]	-.351[c]	-.669[c]	-.866[c]
Asymp. Sig. (2-tailed)	.102	.334	.317	.453	.102	.083	.084	.034	.031	.053	.011	.038	.660	.590	.016	.194	.750	.660	.725	.503	.386

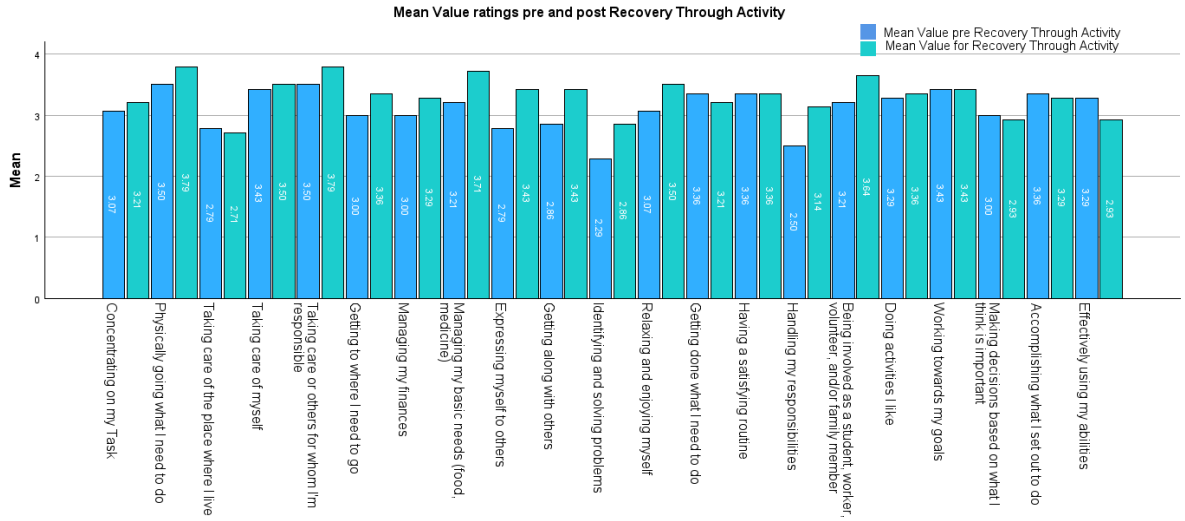


Figure 11 Question means - Value ratings pre and post Recovery Through Activity (Parkinson 2014)

7.5.4 Spearman Correlation test on OSA (Baron et al. 2006) outcomes

Correlational tests were conducted to determine if there were any relationships between competence ratings both before and after, as well as value ratings both before and after intervention. Due to the data not being normally distributed, the non-parametric Spearman Rho test was used to determine the relationship between variables. A two tailed test was conducted as the hypothesis was that there would be a relationship between variables, whether this be positive or negative. Table 9 below provides a matrix of correlations. Two variables had a positive correlation of statistical significance. The variable 'competence before' and 'competence after' had a strong positive correlation, (r_s = .78, N=16, p <.001). See scatter graph Figure 11. The variables 'values before' and 'values after' had a moderate positive correlation, (r_s = .60, (N=16), p = .13). See scatter graph figure 12.

Table 12. correlations, competence before/after, Value before/after

Correlations

			Competence before	Competence after	Value before	Value after
Spearman's rho	**Competence before**	**Correlation Coefficient**	1.000	.778**	-.024	.096
		Sig. (2-tailed)	.	<.001	.931	.723
		N	16	16	16	16
	Competence after	**Correlation Coefficient**	.778**	1.000	-.129	-.278
		Sig. (2-tailed)	<.001	.	.635	.298
		N	16	16	16	16
	Value before	**Correlation Coefficient**	-.024	-.129	1.000	.604*
		Sig. (2-tailed)	.931	.635	.	.013
		N	16	16	16	16
	Value after	**Correlation Coefficient**	.096	-.278	.604*	1.000
		Sig. (2-tailed)	.723	.298	.013	.
		N	16	16	16	16

**. Correlation is significant at the 0.01 level (2-tailed).

*. Correlation is significant at the 0.05 level (2-tailed).

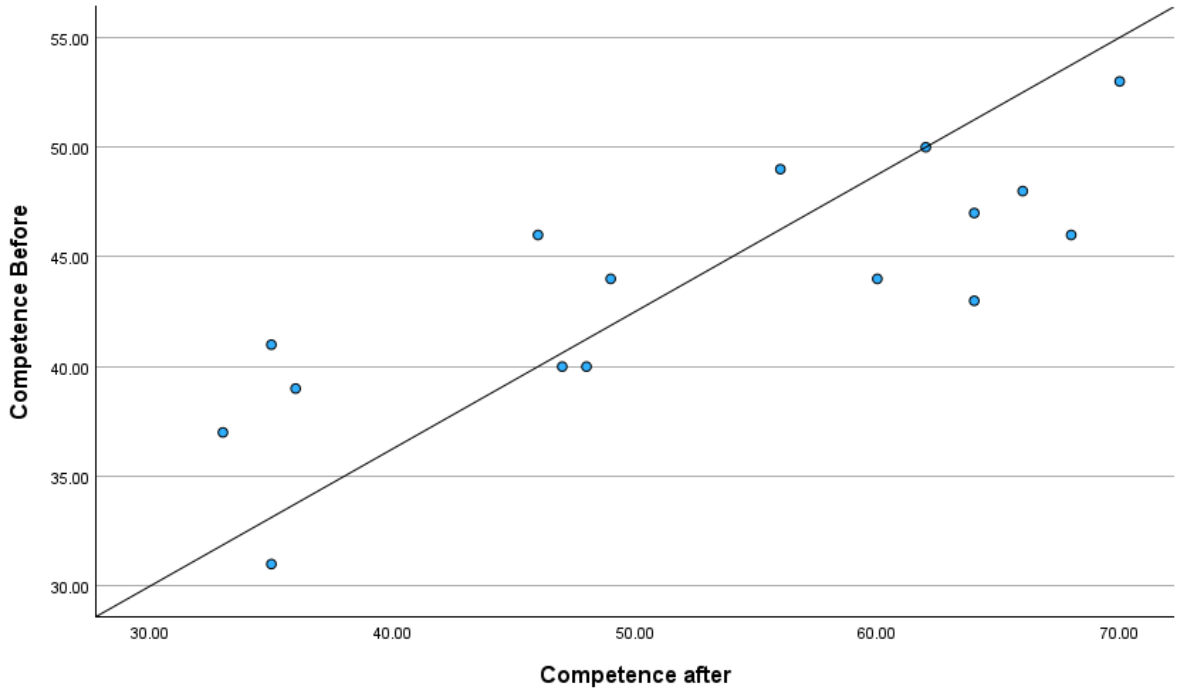


Figure 12. Competence before and Competence after

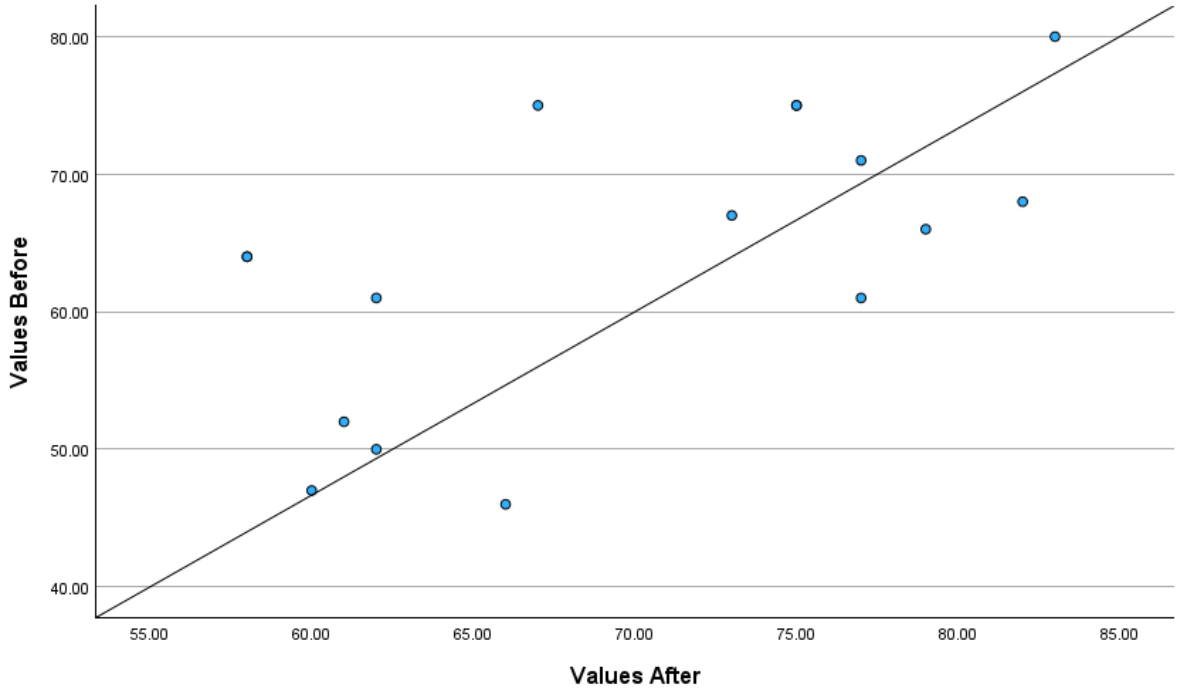


Figure 13. Value before and after correlation

7.5.5 Summary Summary and revisiting research aim and objectives

In this study, 16 service users completed the Occupational Self-Assessment (OSA) both before and after a course of virtual Recovery Through Activity (Parkinson 2014) interventions. They rated their competence and the value they placed on various everyday activities.

Normality Test: The Shapiro-Wilk test showed that the data were non-parametric. This indicated significant individual differences in perceived competence and values, influenced by personal factors and environmental conditions.

Internal Consistency: A Cronbach's Alpha test indicated weak internal consistency ($p = .4$), suggesting the results should be interpreted cautiously.

Competence Ratings: Using the Wilcoxon signed rank test, significant improvements were observed in competence ratings after the intervention. The mean competence score increased from 43.63 ($SD = 5.52$) to 52.44 ($SD = 12.97$). Key areas of improvement include concentration, getting where one needs to go, relaxing, having a satisfying routine, being involved in roles, working towards goals, accomplishing tasks, and using abilities effectively.

Value Ratings: Significant increases in value ratings were also found, with the mean value score increasing from 63.88 ($SD = 10.54$) to 69.69 ($SD = 8.84$). Significant improvements were noted in managing basic needs, expressing oneself, getting along with others, solving problems, relaxing, and handling responsibilities.

Correlational Analysis: Spearman correlation tests revealed a strong positive correlation between competence ratings before and after the

intervention (rs = .78, p < .001) and a moderate positive correlation between value ratings before and after (rs = .60, p = .13).

Overall, the study found that service users reported significant improvements in both their perceived competence and the value they placed on everyday activities following the virtual Recovery Through Activity (Parkinson 2014) interventions. These findings highlight the effectiveness of tailored occupational therapy interventions in enhancing daily functioning and perceived importance of activities among service users.

The Occupational Self-Assessment (OSA) (Baron et al. 2006) outcomes provide detailed quantitative insights into the efficacy and effectiveness of Recovery Through Activity (Parkinson 2014), directly supporting the overarching aim by showing how the intervention positively impacts service users' daily functioning and engagement. By comparing pre- and post-intervention competence and value ratings, the data highlights specific areas of improvement that align closely with the research objectives and illustrate Recovery Through Activity's (Parkinson 2014) effectiveness from the service user perspective.

In relation to Objective 3, which evaluates service user perceptions and experiences, the data captures self-reported improvements across key areas of daily life, underscoring the intervention's impact on participants' autonomy and functionality. For instance, service users demonstrated significant increases in competence scores for statements like "concentrating on my task" (Z = -3.41, p < .001), "getting where I need to go" (Z = -2.18, p = .03), and "relaxing and enjoying myself" (Z = -2.39, p = .02). These results indicate that, following the intervention, service users felt more capable in managing everyday activities that contribute to their quality of life. The improvement in perceived competence in "working towards my goals" (Z = -3.207, p = .001) and

"accomplishing what I set out to do" (Z = -2.50, p = .01) further demonstrates that Recovery Through Activity not only supports routine daily functioning but also promotes a sense of purpose and achievement, key outcomes valued by participants.

Additionally, value ratings provide evidence of service users placing greater importance on these daily activities post-intervention, reflecting a shift in how they perceive their engagement and involvement in life. For example, service users reported significant increases in the value of "managing my basic needs" (Z = -2.12, p = .03), "expressing myself to others" (Z = -2.16, p = .03), and "handling my responsibilities" (Z = -2.40, p = .012). These increased ratings suggest that participants not only gained competence in practical skills but also developed a deeper appreciation for their role in managing these tasks, indicating a holistic benefit of Recovery Through Activity (Parkinson 2014).

Objective 2, which explored the opportunities and challenges of implementing an occupationally focused approach, is also addressed through this data. The OSA (Baron et al. 2006) outcomes reveal opportunities in the virtual format's capacity to support competence across diverse areas, even under constraints such as limited physical presence. Despite the challenges posed by virtual delivery, including potential variability in individual engagement, the intervention demonstrated statistically significant growth in key areas of functioning. This indicates that the flexibility of Recovery Through Activity (Parkinson 2014), with adaptations like virtual engagement and the use of resource materials, presents feasible opportunities for occupational therapy interventions to remain effective across settings. However, the Cronbach’s Alpha test result (p = .4) suggests that capturing perceptions of improvement may have been affected by individual differences and environmental impacts, indicating that the virtual format may require tailored support strategies to maintain consistency.

Objective 4, which focused on evaluating the effectiveness of Recovery Through Activity's (Parkinson 2014) implementation through outcome data, is strongly supported by these quantitative results. The significant increases in both mean competence (from 43.63 to 52.44) and mean value scores (from 63.88 to 69.69) post-intervention provide clear evidence of the intervention's effectiveness in enhancing both service users' skills and the importance they place on daily tasks. Moreover, the strong correlation between competence scores before and after the intervention ($r_s = .78$, $p < .001$) and moderate correlation in value scores ($r_s = .60$, $p = .013$) indicate a reliable pattern of improvement, reinforcing Recovery Through Activity's (Parkinson 2014) impact in promoting meaningful daily functioning and engagement.

Overall, the OSA (Baron et al. 2006) findings reveal how Recovery Through Activity (Parkinson 2014) effectively aligns with the overarching aim by enhancing both the competence and value participants assign to everyday tasks. The quantitative evidence highlights the intervention's capacity to improve functional capabilities and influence participants' engagement with daily life, thus validating its effectiveness as a virtual occupational therapy intervention.

7.6 Service user interview

7.6.1 Introduction

Recovery Through Activity (Parkinson 2014) played a pivotal role in supporting the mental health journey of the service user (SU), a 48-year-old individual who had experienced significant isolation and mental health challenges. Initially, SU's recovery journey began with face-to-face

sessions, which were interrupted by the Covid-19 pandemic. This led to a transition to virtual sessions via Teams, allowing the recovery intervention to continue despite restrictions.

It was hoped more than one service user would be interviewed, however due to unknown reasons, which have been speculated in reflections in chapter 10, only one service user came forward. Nonetheless, this interview provided rich valuable insights into Recovery Through Activity (Parkinson 2014) from a service user perspective.

The virtual implementation provided flexibility and accessibility, making it possible for SU to maintain her recovery progress. The thematic analysis of this implementation reveals several key themes:

Flexibility and Accessibility: The virtual setup allowed Recovery Through Activity (Parkinson 2014) to continue despite Covid-19 restrictions, enabling SU to engage from the comfort of home. This reduced stress and made the sessions more accessible, helping SU establish a routine and sustain her progress.

Continued Support and Connection: The virtual sessions promoted a supportive community, connecting SU with therapists and other participants. This provided ongoing social support, maintained connections, and created a safe space for sharing experiences, struggles, and successes.

Engagement and Variety: The virtual sessions provided a variety of pre-arranged activities, including gift bags, which encouraged SU to try new things, expand her skills, and stay engaged in her recovery journey. This variety supported SU's progress and sustained her interest in Recovery Through Activity (Parkinson 2014).

Emotional Growth and Resilience: The virtual sessions provided tools and strategies, such as mindfulness techniques, problem-solving skills, and distraction techniques, helping SU navigate challenges and build resilience. These skills and practices integrated into SU's daily life, supporting her recovery journey.

Continuity and Future Growth: The virtual implementation served as a catalyst for SU's continued involvement in constructive activities, helping her explore new opportunities, expand her skill set, and build a support network. This network provided guidance and encouragement, sustaining SU's recovery journey and promoting her personal development.

7.6.2 Themes

7.6.2.1 Theme 1: Flexibility and Accessibility

The virtual implementation of the recovery intervention proved to be a crucial factor in maintaining SU's progress, particularly during Covid-19. The transition to virtual sessions ensured that Recovery Through Activity (Parkinson 2014) could continue despite restrictions, demonstrating its adaptability. SU highlighted the accessibility of the virtual setup.

"We transitioned to Teams, which I initially worried about, but it worked well. I could roll out of bed and join the session, which made it easier to stick to." - SU

The comfort of participating from home reduced the stress associated with traveling to in-person meetings, making Recovery Through Activity (Parkinson 2014) more accessible to SU and encouraging consistent participation.

"Being at home meant I could focus more on the activities, without worrying about leaving the house." -su

While SU initially had concerns about the effectiveness of virtual sessions, the design of Recovery Through Activity (Parkinson 2014) and the supportive community helped overcome these worries.

"I did worry about it being virtual because it was easy for me to just roll out of bed and switch on my device. But I had no need to worry because I made sure to shower before going online." - SU

The virtual sessions maintained social connections by providing opportunities for participants to interact with each other and therapists. This helped SU feel supported and grounded, reinforcing her recovery journey.

"We were still able to chat on Teams, share our struggles, and laugh together." - SU

The regularity of the sessions also established a routine, contributing to SU's recovery progress.

"The 12 sessions gave me something to look forward to each week, which helped me stay on track and not backslide." - SU

The flexibility and accessibility of the virtual sessions allowed SU to maintain progress beyond Recovery Through Activity (Parkinson 2014), integrating skills and connections into her daily life. This integration demonstrated the adaptability of the virtual setup, reinforcing SU's recovery journey.

7.6.2.2 Theme 2: Continued Support and Connection

The virtual sessions created a supportive environment that connected SU with other participants and therapists, providing continued social support despite the lack of in-person meetings. This virtual community helped SU

feel less isolated, creating a safe space for participants to share experiences, struggles, and successes.

"We had a space to talk about our challenges, which helped me feel understood and supported." - SU

The sessions allowed SU to continue developing relationships with therapists and participants, strengthening the therapeutic dynamic and offering guidance and encouragement. This consistency reinforced SU's sense of community, making it easier to stay engaged in Recovery Through Activity (Parkinson 2014) and maintain her progress.

"The relationships I built continued to support me, providing a network that helped me navigate my recovery journey." - SU

The virtual sessions also provided a consistent touchpoint, establishing a weekly structure that helped SU maintain momentum.

"*The 12 sessions gave me something to look forward to each week.*" - SU

This regular contact created a sense of accountability, encouraging SU to engage consistently and avoid backsliding into old habits.

"The sessions kept me accountable. I knew I had to go, which helped me stay on track and continue progressing." - SU

The regular contact also helped reinforce relationships with therapists and participants, sustaining SU's recovery journey beyond the sessions. This ongoing support provided continuity for SU's recovery, ensuring stability in her progress.

7.6.2.3 Theme 3: Engagement and Variety

The virtual sessions offered a variety of pre-arranged activities, including gift bags, which helped SU engage in various tasks and hobbies. The gift bags also provided a structured framework for the virtual sessions, including instructions and schedules for activities.

"Every three weeks, we got a gift bag with activities, which was exciting and kept me engaged. It was like a present that helped me stay focused."

- SU

This regular delivery created a sense of anticipation, sustaining SU's interest and maintaining her momentum.

"It was nice to get the bags every three weeks. It gave me something to get excited about." - SU

The virtual sessions' diverse activities ranged from crafts to mindfulness exercises, helping SU explore new interests and develop practical skills. The integration of mindfulness exercises and problem-solving tasks contributed to a balanced approach to recovery, reinforcing SU's mental health journey. The skills and practices developed during these sessions provided immediate therapeutic benefits and long-term value, sustaining SU's progress beyond Recovery Through Activity (Parkinson 2014).

"Mindfulness exercises and problem-solving tasks like the bird box helped me manage stress." - SU

7.6.2.4 Theme 4: Emotional Growth and Resilience

The virtual sessions provided tools and strategies to help SU navigate challenges and build resilience. Mindfulness techniques, such as deep breathing and present-moment awareness, helped SU manage stress and anxiety, contributing to a balanced approach to recovery. Problem-solving

strategies included activities that challenged SU's skills, teaching her to approach obstacles in a balanced manner, which helped her build resilience and cope with setbacks.

The activities in the virtual sessions also provided constructive outlets for SU's energy, diverting her mind from negative thoughts and behaviours.

"I set goals to distract myself through activities, and the sessions helped me do that. I got back into knitting, crocheting, and gardening, which took my mind off negative thoughts." - SU

The sessions also encouraged SU to reframe negative thoughts and focus on constructive activities, creating a positive feedback loop that reinforced her recovery journey. The combination of mindfulness techniques, problem-solving strategies, and distraction techniques contributed to SU's emotional resilience, helping her navigate challenges more effectively. This resilience supported SU's recovery journey and long-term wellbeing. The coping skills developed during the virtual sessions continued to support SU beyond Recovery Through Activity (Parkinson 2014), integrating recovery practices into her daily life and sustaining her recovery journey and emotional growth.

"The sessions helped me look at the bigger picture. I learned to focus on what I can fix, which shifted my mindset from negative thoughts to constructive actions." - SU

7.6.2.5 Theme 6: Continuity and Future Growth

The virtual sessions served as a catalyst for SU's continued involvement in constructive activities, helping her explore new opportunities and expand her skill set. The relationships built during the virtual sessions also provided a support network that offered guidance and encouragement, reinforcing SU's recovery journey and ensuring continuity and stability. This network introduced new opportunities, such as

community involvement and volunteer work. This continued to support SU's recovery journey and integrated her into her local community. This demonstrates how the skills and practices developed during the sessions became integrated into her daily life.

*"I've taken the skills and applied them in my life, from visiting my friend to embracing new opportunities like [*local third sector organisation*]."- SU*

The ongoing involvement allowed SU to continue developing her skills and interests, contributing to her emotional growth and resilience. This in turn supported her long-term recovery journey. The foundation established by the virtual sessions provided a base for future growth, allowing SU to explore new opportunities and directions. The support network established during the sessions also created a safe space for SU to share struggles, successes, and progress, offering consistent guidance and validation. This continuity reinforced SU's recovery journey, providing a foundation for sustained progress. The relationships built during the virtual sessions continued to support SU's mental health journey, contributing to her emotional growth and resilience.

7.6.3 Summary

The virtual implementation of Recovery Through Activity (Parkinson 2014) proved to be a crucial factor in sustaining SU's progress, offering a flexible and accessible setup that allowed her to maintain her recovery journey during Covid-19. The virtual sessions provided a supportive community that connected SU with therapists and other participants, creating a safe space for sharing experiences, struggles, and successes. This social support, combined with a variety of activities, helped SU stay engaged and motivated, expanding her skills and interests.

Recovery Through Activity (Parkinson 2014) also provided tools and strategies that helped SU navigate challenges and build resilience,

integrating these practices into her daily life. The long-term impact of the virtual implementation sustained SU's recovery journey beyond the sessions, promoting continued involvement in constructive activities, developing her skills and interests, and building a support network. This network offered guidance and encouragement, reinforcing SU's recovery journey and contributing to her emotional growth and resilience.

Overall, the virtual implementation served as a catalyst for SU's ongoing progress, providing a foundation for sustained recovery, personal growth, and future development.

7.7 Chapter Conclusion

This chapter has comprehensively explored the adaptation of Recovery Through Activity (Parkinson 2014) to a virtual environment facilitated through Microsoft Teams. The findings from occupational therapy staff interviews reveal a flexible, albeit challenging, transition from face-to-face to online settings. Staff highlighted the importance of using specific tools like the OSA (Baron et al. 2006), the Interest Checklist (Heasman and Salhortra 2008), and the Role Checklist (Scott 2019) to tailor interventions to service users' needs effectively. This adaptation not only preserved the essence of Recovery Through Activity (Parkinson 2014) but also extended its reach, accommodating service users within their community settings without the need for physical presence.

The evaluation of intervention outcomes through feedback questionnaires, the 3B~S scale, and the OSA (Baron et al. 2006) has demonstrated that virtual Recovery Through Activity (Parkinson 2014) sessions can effectively support service users' needs. These outcomes suggest that while virtual sessions pose unique challenges, particularly in engaging participants and replicating the dynamic interactions of in-person settings,

they also offer substantial benefits in terms of accessibility and continuous support.

Insights from a service user interview further highlight the value of virtual Recovery Through Activity (Parkinson 2014). The service user's experience highlighted the practical benefits of accessing therapy from home and the emotional support gained through continued engagement with therapists and peers online. This perspective is particularly valuable in understanding how virtual sessions can be optimised to enhance user satisfaction and engagement.

In conclusion, while the shift to virtual Recovery Through Activity (Parkinson 2014) sessions was initially driven by necessity due to the Covid-19 pandemic, the findings suggest that this mode of delivery has viable long-term benefits. It offers flexibility, maintains therapeutic relationships, and supports the ongoing recovery of service users. Future considerations should focus on enhancing interaction quality, personalising user experiences to increase engagement, and leveraging technology to mimic the benefits of physical group dynamics. As occupational therapy continues to adapt to digital platforms, the lessons learned from virtual Recovery Through Activity (Parkinson 2014) implementations will be vital in shaping effective, resilient, and accessible therapeutic interventions.

Chapter 8 - Cross Case analysis

8.1 Introduction

This chapter presents a comprehensive cross-case analysis within a case study research design, examining the implementation of Recovery Through Activity (Parkinson 2014) in two distinct formats: face-to-face and virtual. To ensure an in-depth understanding of each setting, the research was first conducted as individual case analyses, focusing on the unique elements of Recovery Through Activity in each modality. These separate case analyses allowed for a detailed examination of the intervention's impact within the specific contexts of traditional in-person delivery and the novel, virtual environment, necessitated by the COVID-19 pandemic.

Once each case was analysed individually, a cross-case analysis was undertaken to compare and contrast findings across both formats. This two-stage approach—individual analysis followed by cross-case comparison—enabled the study to explore themes and patterns that would not be visible in isolation, providing a holistic understanding of the intervention's adaptability and effectiveness.

To guide the cross-case analysis, Yin's (2018) methodology was applied, incorporating several critical techniques to enhance rigor and transparency. The process began with thematic comparison, where themes that had emerged from each case were systematically reviewed and evaluated for alignment or divergence across contexts. For instance, themes such as *tailoring Recovery Through Activity to individual needs* and *maintaining a balance between practical and educational elements* were re-examined to understand how each mode—face-to-face and virtual—supported or challenged these core principles. Each theme was

mapped in an evidence web, allowing for a clear visual representation of how it manifested differently or similarly in each format.

Following thematic comparison, data triangulation was used to confirm findings across multiple sources within each case. By integrating qualitative data from interviews, quantitative intervention outcomes, and reflective observations, the study ensured that the themes and sub-themes were consistently supported by diverse data points. For example, feedback from service users and occupational therapy staff was cross-referenced with intervention outcome scores to validate whether the themes were genuinely reflective of participants' experiences across both settings.

A third step involved pattern matching, which helped identify any consistent relationships between the findings and the MOHO (Kielhofner 2008). For each theme, patterns in service user and therapist experiences were compared against the propositions derived from MOHO, confirming whether each format of Recovery Through Activity met the theoretical expectations of promoting occupational engagement, volition, and performance. This stage of the analysis was iterative, with patterns revisited and refined to ensure alignment with MOHO's core concepts, while still allowing for the identification of context-specific adaptations.

In addition to pattern matching, exploring rival explanations strengthened the validity of the findings by considering alternative interpretations of the data. For instance, the analysis examined whether differences in engagement could be attributed to external factors, such as access to technology in the virtual format or transportation availability in the face-to-face format. By systematically addressing these rival explanations, the analysis provided a more robust understanding of the specific conditions under which Recovery Through Activity (Parkinson 2014) was most effective.

The final stage, synthesis and generalisation, involved comparing the inferences drawn from each case and combining them to form broader insights applicable across settings. Through this synthesis, two levels of inference were made: Level 1 inferences focused on patterns within each case, while Level 2 inferences drew connections across both cases, leading to generalisable conclusions about the implementation and impact of Recovery Through Activity (Parkinson 2014). By examining shared themes and unique challenges in each setting, this synthesis offered a comprehensive view of how Recovery Through Activity supports occupational engagement, therapeutic relationships, and community connection.

This chapter is structured around nine key themes that encapsulate the core elements of implementing Recovery Through Activity (Parkinson 2014). These themes address factors such as tailoring interventions to individual needs, balancing practical and educational activities, and integrating community resources. Each theme includes insights drawn from both face-to-face and virtual formats, supported by data from the evidence web to illustrate how Recovery Through Activity (Parkinson 2014) operates across varied therapeutic environments. Through this approach, the cross-case analysis contributes to a deeper understanding of the contextual factors that support or challenge Recovery Through Activity (Parkinson 2014) in mental health services, providing valuable insights for future implementation across diverse settings. The key themes are as follows:

Tailoring Recovery Through Activity (Parkinson 2014) to individual service user needs Examines how both modalities use tools like the OSA (Baron et al. 2006), Interest Checklist (Heasman and Salhortra 2008), and Role Checklist (Scott 2019) to customise interventions according to individual needs.

Maintaining a balance between practical activities and educational aspects of Recovery Through Activity, discusses the challenges and solutions in incorporating practical activities within the virtual format, such as distributing resource packs and utilising instructional videos to complement educational content.

One to one support alongside group sessions enhances Recovery Through Activity: Highlights the critical role of personalised support sessions in both formats, essential for addressing specific user goals and challenges, with a focus on how these are adapted for online delivery.

The Involvement of Community Organisations support Recovery Through Activity: Details the contribution of community organisations enriching the virtual format through the provision of activity packs and guest speakers, enhancing user engagement and extending Recovery Through Activity's (Parkinson 2014) reach.

Assessment, Planning, and Evaluation are key factors in implementing Recovery Through Activity: Focuses on the processes involved in ensuring that interventions are well-planned, suitably assessed, and continually evaluated to align with user goals and track progress effectively in both settings.

Recovery Through Activity supports an Occupational Approach: Explores how each format supports the occupational approach, guiding service users toward beneficial changes in routine, self-care, and overall wellbeing.

Group Dynamics a key factor to consider when implanting Recovery Through Activity: Investigates the unique dynamics of virtual groups, including managing group size, mitigating screen-time anxiety, and promoting social connections in a digital environment.

Recovery Through Activity supports occupational therapy Professional Roles: Considers how Recovery Through Activity (Parkinson 2014) reinforces the professional identity of occupational therapists, providing a framework to articulate their role and contributions to service users' wellbeing.

The Structure and Flexibility of Recovery Through Activity supports implementation across settings: Analyses the flexibility of Recovery Through Activity's (Parkinson 2014) structure, which accommodates varying durations and adapts to the needs of both primary and secondary care across both formats.

8.2 Themes

8.2.1 Theme 1: Tailoring Recovery Through Activity to individual service user needs

The theme of "Tailoring Interventions" emphasises the importance of customising therapeutic interventions to meet the unique needs of individual service users, regardless of the delivery method. In both face-to-face and virtual formats, several key aspects stand out that contribute to the effectiveness of this approach. Figure 13 below outlines what data was used to derive the theme.

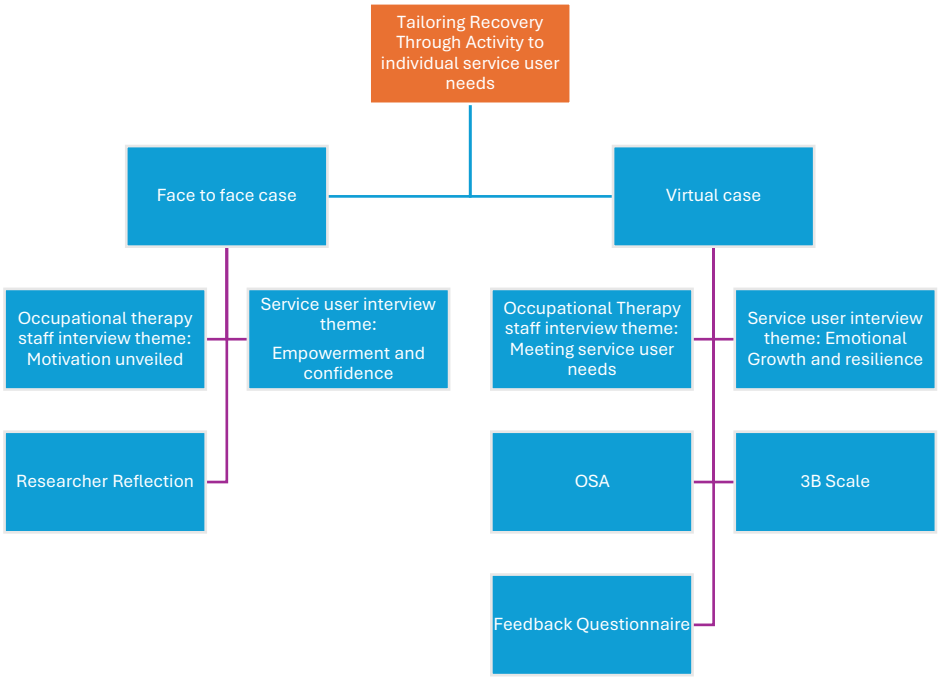


Figure 14 - Evidence web for Tailoring Recovery Through Activity (Parkinson 2014) theme

Both face-to-face and virtual formats rely on tools such as the OSA (Baron et al. 2006), Interest Checklist (Heasman and Salhortra 2008), and Role Checklist (Scott 2019) to gather information about service users' needs, interests, and goals. The OSA (Baron et al. 2006) helps assess service users' self-perceived abilities and values, enabling therapists to understand their competence in various areas and the importance they attach to different activities. Carrie reflects, *"We go through all of that [Interest Checklist, Role Checklist, and OSA] and then hopefully come up with a goal that is most pertinent to them at the moment in time."* The Interest Checklist (Heasman and Salhortra 2008) and Role Checklist (Scott 2019) further explore service users' interests and roles, providing therapists with a comprehensive understanding of each individual's preferences.

Initial referral forms provided varying levels of information about service users, ranging from comprehensive to sparse. This necessitated reliance

on the aforementioned tools, as well as initial sessions, to build a deeper understanding of each service user's needs and goals.

Both formats emphasise connecting service users to existing community resources. This involves signposting to organisations and services that relate to their interests and goals, such as volunteering opportunities or mindfulness exercises.

"If they were interested in volunteering, we put the website down for the [geographical region] Association for Volunteering. If they wanted to do self-care, we put down websites for mindfulness exercises and stuff like that." – Annie

This helps service users engage in activities outside therapy sessions, promoting long-term engagement. Both formats highlight the importance of flexibility in tailoring interventions to changing needs. Therapists recognise that service users' goals might shift over time, necessitating an adaptable approach. This flexibility extends to revisiting goals and allowing sessions to be adjusted based on the interests and needs of attendees on a given day.

"They are quite clear on what it is they want to get out of the group... but they can change throughout really." – Carrie

The virtual format introduces additional strategies to ensure interventions remain tailored to individual needs. Sending out activity packs with resources and information before virtual sessions bridges the gap between practical and educational elements.

"We sent them before every session, a little pack that had resources and a little leaflet of information of the occupation." – Annie

Handouts and videos further reinforce the educational component, providing information on various occupations and their benefits. Virtual

sessions then incorporate discussions around these materials, consolidating information and allowing therapists to tailor interventions in real-time.

"The videos took the place of quite a lot of the theory chat that we might have had if we were running it face-to-face." – Flo

Service users' feedback reflects the importance of tailoring interventions. Pre-intervention assessment tools, particularly the OSA (Baron et al. 2006), reveal diverse challenges and goals, highlighting the need for individualised approaches. The post-intervention feedback questionnaire shows appreciation for the flexibility of interventions, with some service users highlighting how they were able to connect with others and build supportive relationships.

"I've got to know other individuals who've gone through similar situations as myself, and the empathy in which we've given to each other has put my faith back into society." – Eddie

Demonstrating the value of tailored interventions in promoting meaningful connections.

Quantitative data reflects the impact of tailored interventions. A significant difference was found in the OSA (Baron et al. 2006) between pre- and post-intervention competence scores, with mean competence increasing from 43.63 (SD=5.52) to 52.44 (SD=12.97), and mean value increasing from 63.88 (SD=10.54) to 69.69 (SD=8.84). This indicates that service users perceived their competence and the value they placed on activities had increased following the interventions. The 3B Scale (Rebeiro Gruhl et al. 2018) responses indicate a high level of agreement (77%). This demonstrates the positive impact of tailored interventions on service users' occupational goals and overall wellbeing.

My reflection details several different environments and group configurations, demonstrating Recovery Through Activity (Parkinson 2014) ’s adaptability to various contexts and individual preferences. The diversity of settings (community park, community centre, church, restaurant) and activities (nature walks, social discussions, celebratory gatherings) in my reflection highlights the practical application of tools discussed by occupational therapy staff, such as the OSA (Baron et al. 2006), Interest Checklist (Heasman and Salhortra 2008), and Role Checklist (Scott 2019), to tailor Recovery Through Activity (Parkinson 2014) to enhance engagement and effectiveness.

The service user interview supports the findings identified in this theme. In face-to-face sessions, the service user appreciated the direct interaction, finding that the tailored, hands-on approach, built trust and facilitated personal growth.

"Meeting the therapists in person...built trust and made the sessions more engaging." -SU

In contrast, the virtual sessions offered a different kind of tailoring, adapting to the service user's home environment, which also provided comfort and ease, as indicated by SU.

"I could roll out of bed and join the session, which made it easier to stick to." - SU

Both environments effectively met the service user's needs but did so through different mechanisms—direct personalisation versus convenience and accessibility.

8.2.2 Theme 2: Maintaining a balance between practical activities and educational aspects of Recovery Through Activity

Balancing practical activities and educational content emerged as a crucial theme in both virtual and face-to-face formats of Recovery Through Activity (Parkinson 2014), enabling comprehensive interventions that foster meaningful progress and support occupational goals. Figure 14 below outlines the data that was used to derive the theme.

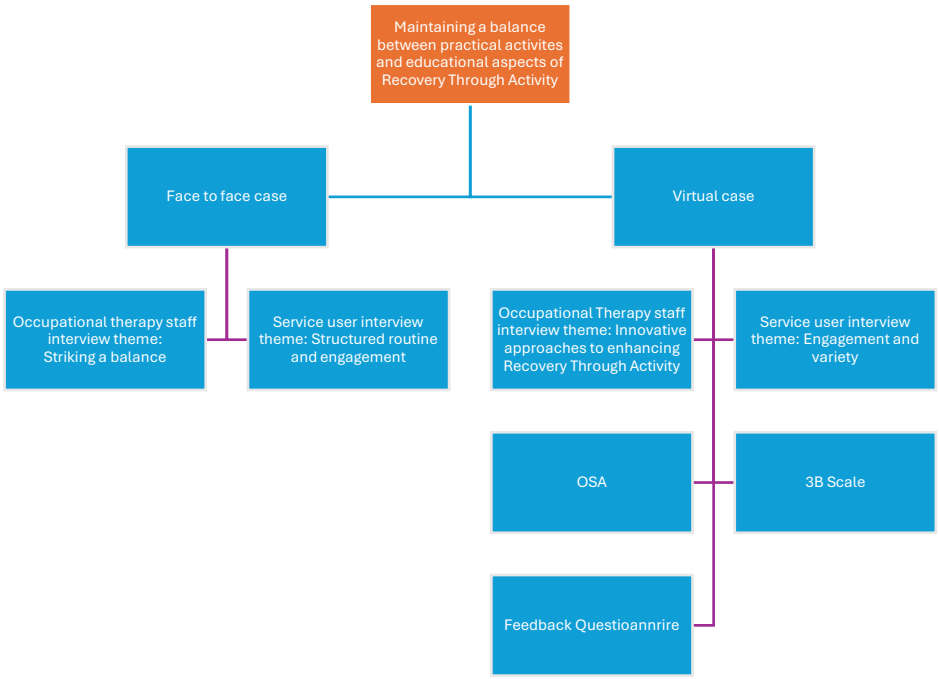


Figure 15 - Evidence web for maintaining a balance theme

The virtual delivery of Recovery Through Activity (Parkinson 2014) sessions, necessitated by Covid-19 restrictions, posed unique challenges in combining practical tasks with educational components. The pandemic limited opportunities for direct engagement in practical tasks, which had traditionally been a core component of Recovery Through Activity

(Parkinson 2014). This led to innovative solutions to ensure a balance between practical activities and educational elements.

One strategy was the distribution of resource packs to service users prior to virtual sessions. These packs contained resources and information related to all 12 categories outlined in the Recovery Through Activity (Parkinson 2014) manual, allowing service users to engage in practical tasks both within and outside the sessions.

"We sent them before every session, a little pack that had resources and a little leaflet of information of the occupation." – Annie

highlighting how these packs served as tangible aids in balancing practical and educational elements. This approach was supported by service user feedback, with 66.7% rating them as "extremely useful."

Additionally, videos and handouts reinforced the educational component of interventions. These videos covered the 12 activity types and their benefits, providing service users with a comprehensive understanding of balanced occupations.

"The videos took the place of quite a lot of the theory chat that we might have had if we were running it face-to-face." – Flo

This highlights how videos replaced in-person discussions. Handouts further supplemented this educational component, consolidating service users' understanding.

In the face-to-face Recovery Through Activity (Parkinson 2014) format, therapists employed direct engagement strategies, allowing service users to participate immediately in practical activities. This was followed by in-depth discussions, promoting an understanding of the relationship between practical tasks and educational content, reinforcing an occupational approach.

"It was more beneficial to be involved in the actual doing." – Debbie

This highlights the importance of practical engagement to consolidate educational elements. This direct involvement allowed occupational therapy staff to explore interventions dynamically, integrating practical tasks and educational components seamlessly. Immediate feedback from service users allowed therapists to adapt the intervention in real time, sustaining engagement and balancing both elements effectively.

The virtual and face-to-face formats each faced challenges in balancing educational and practical elements. In the virtual format, autonomous activities encouraged by third-sector organisations offered resources for activities such as building birdhouses, painting, planting flowers, and making cakes in a mug. Service users shared their experiences during virtual sessions, promoting discussions and a sense of routine.

"*We gave them practical activities to do during the week and then bring back into the session." – Beth*

This highlights the importance of balancing practical tasks with educational content.

In the face-to-face format, managing session length was crucial to maintaining engagement. Therapists found that integrating both elements within each session, and inviting guest speakers or community organisations, offered diverse opportunities for engagement and discussion, avoiding service user fatigue.

"Incorporating discussion into general conversation during activity and combining both. That was the other thing I made sure to embody." – Georgia

This reflects how integration of practical and educational elements enhanced group sessions.

Service user feedback and quantitative data highlighted the effectiveness of both formats. In the feedback questionnaire, 75% of service users in the virtual sessions indicated they were "very satisfied," appreciating engagement strategies and opportunities to connect with others.

"I've got to know other individuals who've gone through similar situations as myself & the empathy in which we've given to each other has put my faith back into society"- Eddie

This highlights the importance of balancing practical and educational elements to foster meaningful connections. Resource packs in the virtual sessions were rated as "very useful" or "extremely useful" by 100% of service users, demonstrating their value in balancing practical activities with educational content.

OSA (Baron et al. 2006) outcomes further showed significant increases in both competence and value scores after intervention, with mean competence rising from 43.63 to 52.44, and mean value increasing from 63.88 to 69.69. This suggests that interventions effectively balanced practical and educational elements, contributing to service users' perceived competence and the value they placed on activities.

The 3B Scale (Rebeiro Gruhl et al. 2018) indicated that 83% of participants agreed that "participation has helped me to obtain employment, a volunteer position, or return to school or college," and 50% agreed that Recovery Through Activity (Parkinson 2014) "connects me with the community and has an important social purpose," reflecting the impact of practical activities alongside educational content.

In my reflection, I describe sessions that combine practical activities such as photography during nature walks with educational components like discussions on connecting with community groups post-Recovery Through Activity (Parkinson 2014). This practical application mirrors strategies

used in virtual formats, where balancing these elements was challenged by the inability to conduct face-to-face activities, leading to the use of resource packs and instructional videos. Both approaches aim to integrate practical and educational elements.

The service user interview supports maintaining a balance between practical activities and education, with an emphasis on the practical activities. The face-to-face format allowed the service user to engage actively with physical tasks, which was vital for re-engaging with hobbies and crafting new skills.

"I learned to work with my hands again, making crafts and gardening." - SU

Conversely, the virtual format, maintained engagement through structured activities delivered to the service user's home, ensuring continuity of practical engagement.

"Every three weeks, we got a gift bag with activities...It was like a present that helped me stay focused." - SU

Both formats succeeded in balancing educational content with practical application, though the nature of activities varied between physical presence and remote delivery.

8.2.3 Theme 3: One to one support alongside group sessions enhances Recovery Through Activity

The theme of one-to-one support highlights its critical role in Recovery Through Activity (Parkinson 2014) interventions, particularly in both virtual and face-to-face formats. These sessions play a vital role in complementing group interventions, providing tailored support to service users, and addressing their unique goals and struggles. Figure 15 below outlines the data that was used to derive the theme.

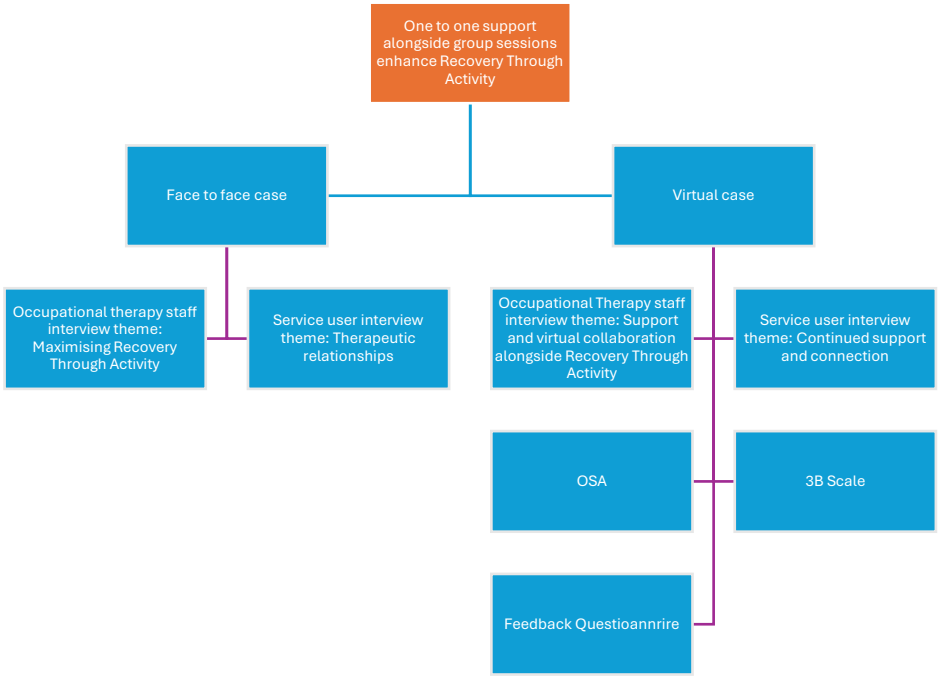


Figure 16 - Evidence web for one-to-one support theme

In both virtual and face-to-face formats, one-to-one sessions were considered essential in understanding and addressing personal goals and challenges. The digital nature of the virtual format posed unique challenges in building rapport and maintaining individualised support.

"It's more kind of looking at the way a person thinks about themselves or what the struggles have been over the years to bring them to this point… goals come out of that conversation." – Carrie

This highlights how these sessions provide opportunities for personalised support.

In the face-to-face setting, many occupational therapy staff did not have the time to run formalised one-to-one sessions but recognised their value.

"Doing one-to-ones helped us to check the appropriateness [of groups] from kind of a goal perspective and risk perspective." – Eve

This demonstrates the importance of individualised sessions in tailoring interventions effectively.

One-to-one sessions were also integral to supporting the success of group interventions in both formats. These sessions allowed occupational therapy staff to work closely with service users, addressing individual skills, challenges, and routines, helping service users feel more confident within group settings.

"The one-to-one sessions allow us to address how to manage their anxiety, explore positive coping strategies, and build motivation." – Carrie

This emphasises how individualised sessions contribute to overall progress and engagement.

In the face-to-face format, therapists incorporated one-to-one sessions through various methods, including informal discussions at the end of group sessions.

"There's a lot of one-to-one that goes along with it and that's another benefit I guess of being on the wards." – Flo

In the virtual format, maintaining rapport and providing follow-up support was challenging. Service users initially struggled to feel comfortable in a digital setting, making one-to-one sessions vital for overcoming initial apprehensions.

"One lady in particular was really uncomfortable being on the screen. She said that she thought 'I'm not coming back' because she was so nervous in a group of strangers." – Flo

Therapists addressed these limitations by planning structured time slots for one-to-one sessions where possible, providing additional support and addressing personal experiences, goals, and needs.

In the face-to-face setting, time constraints were a challenge. Therapists found it easier to have one-to-one contact in ward settings, where service users were easily accessible.

"I think it's always handy to have extra staff. Two people's ideal with an extra person as well just as a backup is always good." – Debbie

Feedback from service users in the feedback questionnaire reinforced the importance of individual support sessions in both formats.

"I felt the 1:1 sessions with the occupational therapy staff were the best part of Recovery Through Activity." Kaden

In the face-to-face format, therapists found that one-to-one sessions helped service users set goals and evaluate progress.

"There was a kind of push each week for people to reflect on something that they could do or add into their lives." – Debbie

Quantitative data further supports the significance of individual support sessions in both formats. The OSA (Baron et al. 2006) revealed a significant increase in competence and value scores post-intervention, with competence rising from 43.63 to 52.44, and value increasing from 63.88 to 69.69. This suggests that one-to-one sessions contributed to boosting both perceived competence and the value placed on activities.

The 3B Scale (Rebeiro Gruhl et al. 2018) further indicated a strong positive impact of Recovery Through Activity (Parkinson 2014) on participants' sense of comfort and support, with 89% "strongly agreeing" that "staff treat me in a respectful manner at all times," and 89% also "strongly agreeing" that "staff provide reassurance and support to me," reflecting the individualised attention provided by one-to-one support.

While my reflection mainly focuses on group settings, the intimate nature of some sessions—like those involving deep discussions within a smaller,

familiar group at a community centre—suggests an element of individualised attention and support.

The service user's experiences expressed in their interview support the findings in this theme. Although the service user did not explicitly engage in structured one to one sessions, they expressed that in the face-to-face setting, the immediacy and personal connection enhanced trust and engagement.

"Meeting the therapists in person built trust." - SU

In the virtual setting, although physical presence was missing, consistent digital interactions still provided essential support and connection.

"We were still able to chat on Teams, share our struggles, and laugh together." - SU

Each format provided the necessary support, using the advantages of its medium to maintain a therapeutic relationship.

8.2.4 Theme 4: The Involvement of Community Organisations support Recovery Through Activity

The "Involvement of Community Organisations" theme highlights the pivotal role that community organisations play in enhancing Recovery Through Activity (Parkinson 2014) interventions, particularly in a virtual format. The involvement of such organisations significantly contributes to Recovery Through Activity (Parkinson 2014) 's delivery, engagement, and overall success. Figure 16 below outlines the data that was merged to derive the theme.

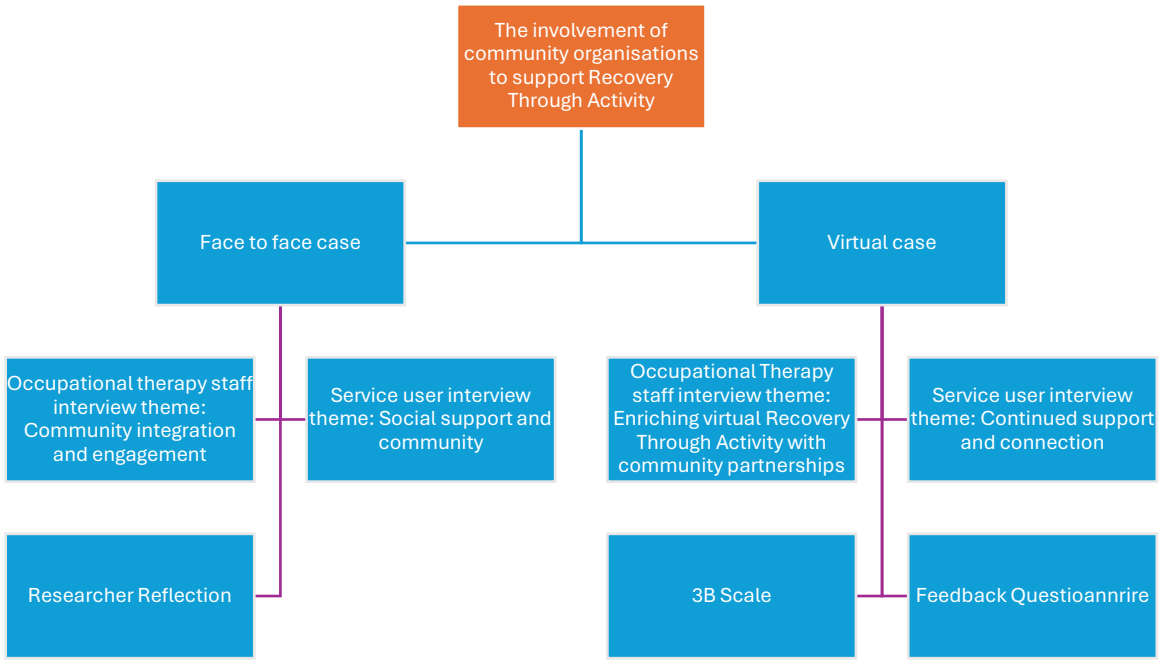


Figure 17 - Evidence web for involvement of community organisations theme

In the virtual case study, community organisations played a vital role in enriching Recovery Through Activity (Parkinson 2014)'s delivery.

"We gave them a list of things to send out each week, they were brilliant, and they just sent out each week without fail." – Annie

A local third sector organisation also distributed weekly activity packs, containing resources such as mindfulness books, face masks, hand creams, and gratitude journals. These packs served as tangible resources and discussion points, promoting engagement and promoting self-care practices.

"They curated weekly activity packs, each containing thoughtful items that not only promote self-care but also serve as engaging discussion points within virtual sessions." – Carrie

This dual function of the packs helped maintain a balance between practical and educational elements, enhancing the overall experience of Recovery Through Activity (Parkinson 2014).

Similarly, in the face-to-face format, community organisations offered resources and hands-on activities that enriched sessions. These interactions facilitated a balance between practical and educational content, reinforcing Recovery Through Activity (Parkinson 2014)'s comprehensive nature. The involvement of organisations such as Hafal, the Exercise Referral Scheme, and local third sector organisations in face-to-face sessions provided immediate opportunities for engagement, as well as avenues for service users to explore long-term support options.

"The third sector was so key, that without them, it would have meant nothing. That time networking to start off with was invaluable, to be honest." – Eve

Furthermore, community organisations enriched the virtual sessions by providing guest speakers. Speakers from third sector organisations, providing insights into volunteering opportunities and community resources.

"It's just a way of putting the names to face for people in the group. And then either my colleague or I will refer them, or actually take them and introduce them face-to-face if they're really interested in those organizations and what they do." – Carrie

This integration deepened the connection between service users and broader societal support networks.

In face-to-face sessions, guest speakers and organisations played a similar role.

"They were able to give firsthand insight into what they offer." – Annie

This demonstrates how direct engagement helped participants form connections and make informed decisions about their future support networks.

The involvement of community organisations also contributed to the overall social engagement and connectivity of Recovery Through Activity (Parkinson 2014). In the virtual format, this engagement promoted meaningful discussions and interactions. In the feedback questionnaire Kaden's feedback emphasised the benefits of connecting with others, stating they enjoyed speaking with people each week and engaging in different activities. This sentiment reflects the positive influence of community organisations on promoting connections, an essential element for Recovery Through Activity (Parkinson 2014) interventions.

Quantitative data further reinforced the impact of community organisations, particularly through the 3B Scale (Rebeiro Gruhl et al. 2018). The scale showed significant agreement on statements highlighting community connection and involvement, indicating broader societal impact. Fifty percent of participants agreed that "the Recovery Through Activity (Parkinson 2014) program connects me with the community and has an important social purpose," while 39% agreed that "I feel that I am a part of a community," illustrating the societal impact facilitated by community organisations.

In my reflection I discuss the involvement of a representative from a third-sector organisation in one of the sessions which illustrates the collaborative approach to Recovery Through Activity (Parkinson 2014). This supports findings discussed above regarding the use of community organisations to enrich Recovery Through Activity (Parkinson 2014), such as by distributing activity packs or providing guest speakers, highlighting the value of external partnerships in extending the reach and impact of recovery activities.

The views expressed in the service user interview support this theme. Community involvement, particularly in the virtual setting was highlighted by the distribution of activity packs and collaboration with organisations.

*"I've embraced new opportunities like [*local third sector organisation*]."- SU*

8.2.5 Theme 5: Assessment, Planning, and Evaluation are key factors in implementing Recovery Through Activity

The "Assessment, Planning, and Evaluation" theme highlights the essential role of these processes in both the face-to-face and virtual case studies of Recovery Through Activity (Parkinson 2014) interventions. Ensuring that interventions align with individual goals and measure progress was a focal point in both formats, and this theme delves into the various aspects that contributed to its success. Figure 17 below shows the data that was converged to identify the theme.

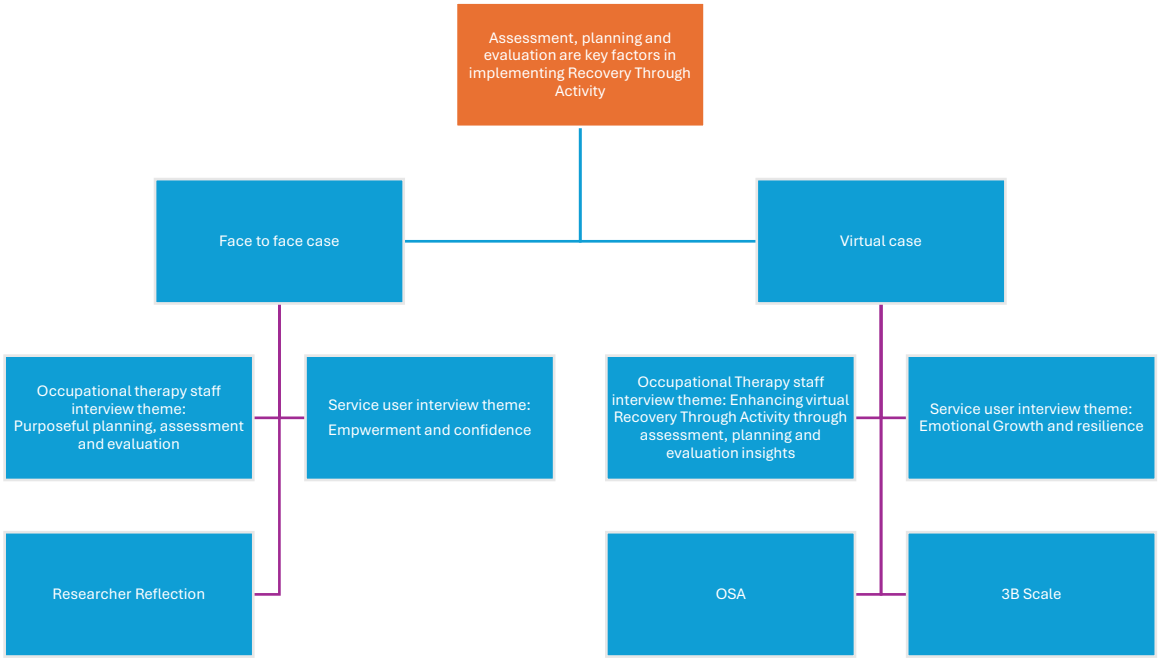


Figure 18 - Evidence web for assessment, planning and evaluation theme

Comprehensive assessments were integral to both formats, allowing therapists to identify service user goals and needs effectively. Tools such as the OSA (Baron et al. 2006) and the Role Checklist (Scott 2019) played a pivotal role in this process, providing a detailed understanding of individual service users' motivations, challenges, and aspirations. This enabled tailored interventions that reflect the specific needs of each individual.

"We go through all of that [Interest Checklist, Role Checklist, and OSA] and then hopefully come up with a goal that is most pertinent to them at the moment in time." – Carrie

This statement highlights the importance of these assessment tools in guiding interventions that are both relevant and meaningful to service users.

However, the virtual case highlighted unique challenges, particularly regarding assessment and planning. Time constraints necessitated rapid implementation, especially in terms of integrating third-sector involvement.

In the face-to-face format, planning and assessment similarly guided tailored interventions. Participants emphasised the importance of assessments and planning prior to running Recovery Through Activity (Parkinson 2014) groups.

"Plan! plan plan plan! and network! The biggest thing we did before we started was network like anything." – Annie

Evaluation was another critical component in both case studies, measuring the progress of interventions and allowing for ongoing

adjustments. The OSA (Baron et al. 2006), Role Checklist (Scott 2019), and informal feedback were employed to evaluate progress.

"What I found interesting so far with the people I've done outcome measures with... I felt they were a bit more honest the second time around about what they can and can't do." - Carrie

This feedback reveals how post-intervention assessments can provide valuable insights into service users' progress and reflections. The OSA (Baron et al. 2006) data supported this perspective, showing significant differences in median competence and value scores before and after interventions, indicating positive outcomes for service users in areas such as confidence, occupational goals, and overall wellbeing.

Another aspect of evaluation involved balancing structured assessments with flexibility. This flexibility was particularly highlighted in the virtual case, where interventions needed to account for varied service user experiences and the digital format's unique dynamics. The 3B Scale (Rebeiro Gruhl et al 2018) results highlights the importance of this balance. Statements such as "I feel welcomed at the Recovery Through Activity programme" (94% agreement) and "I feel that I am a part of a community" (39% agreement) demonstrated the value of creating an adaptable yet structured environment.

In face-to-face interventions, assessments and evaluations were similarly balanced with flexibility.

"Doing all of these outcome measures at the end took up a massive chunk of the session. And people were evaluationed out basically." - occupational therapy staff

My reflection indicates continuous adaptation to meet the needs of the group, such as selecting accessible and relevant settings for activities. This ongoing assessment and planning process is crucial as outlined in

both studies, emphasising the need to evaluate and align interventions with evolving individual goals and measure progress, ensuring the interventions remain responsive and effective.

From a service user perspective, in the interview it was found that both formats included structured assessments and adjustments based on the service user's feedback and progress. The face-to-face interactions allowed for immediate adjustments and responsive support.

"The sessions gave me structure, which helped me build momentum." - SU

In the virtual sessions, the structured and regular feedback helped maintain progress.

8.2.6 Theme 6: Recovery Through Activity supports an Occupational Approach

The "Occupational Approach" theme highlights how Recovery Through Activity (Parkinson 2014) effectively supports an occupational approach, guiding service users toward positive changes in routine, self-care, and overall wellbeing. This theme is evident in both the face-to-face and virtual case studies, showcasing Recovery Through Activity (Parkinson 2014)'s adaptability and impact across diverse formats. Figure 18 below outlines the data from which this converged theme emerged.

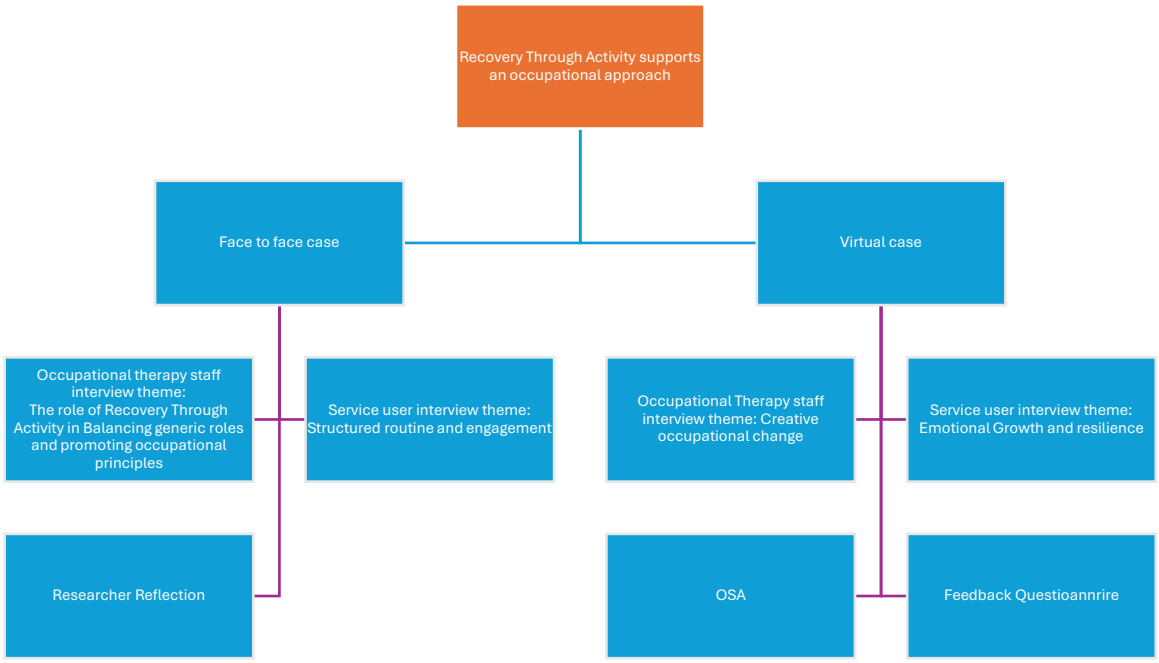


Figure 19 - Evidence web for supporting an occupational approach theme

In both cases, Recovery Through Activity (Parkinson 2014) promotes positive changes for service users by providing an occupational framework that guides their progress. In the virtual case, Recovery Through Activity (Parkinson 2014) played a key role in facilitating meaningful changes across various occupational domains.

> *"Recovery Through Activity (Parkinson 2014) has benefitted an occupational approach, and in the course of 6 weeks, I have seen a difference. Which is just incredible, really encouraging." - Charlie*

This highlights how Recovery Through Activity (Parkinson 2014) supports an occupational approach by influencing service users' routines, goals, and overall wellbeing.

However, the digital format presented unique challenges in adapting the occupational approach. The flexibility of the Recovery Through Activity (Parkinson 2014) framework allowed for adaptation, utilising informative leaflets, videos, and interactive sessions to guide service users through various occupational activities.

"The group was great, and I enjoyed speaking with people each week, but I felt I needed more help in person." – Kaden

This feedback illustrates both the positive aspects of the virtual format and the need for personalised support, emphasising the importance of balancing digital interventions with individual needs.

In contrast, face-to-face Recovery Through Activity (Parkinson 2014) interventions had the benefit of direct interaction, allowing therapists to engage service users in hands-on activities that reinforce an occupational approach.

Quantitative data from the OSA (Baron et al. 2006) outcomes provided further insights into how Recovery Through Activity (Parkinson 2014) supports an occupational approach. The competence scores showed significant improvements post-intervention, indicating progress in areas such as concentration, routine satisfaction, and accomplishing goals. The Wilcoxon signed rank test revealed a significant increase in median competence scores ($Z = -2.93$, $p = .003$), indicating positive changes in service users' occupational abilities and routines.

The occupational approach supported by Recovery Through Activity (Parkinson 2014) extended beyond practical activities to include holistic support, addressing self-care, lifestyle changes, and overall wellbeing. Both face-to-face and virtual formats encouraged service users to make meaningful changes to their daily routines and overall lifestyles.

"I've started going to see my friends and started exercising again following Recovery Through Activity." – Liam

Community involvement also played a vital role in the occupational approach, promoting connections to local organisations and activities.

"I've got to know other individuals who've gone through similar situations as myself & the empathy we've given each other has put my faith back into society." – Eddie

In the face-to-face format, community organisations such as MIND and Hafal further contributed to Recovery Through Activity (Parkinson 2014) interventions, providing pathways for service users to engage with local resources.

"It's reassuring. It's by making that first connection with those third sectors. Letting them see who it is and having it all explained to them." - Annie

The sessions I describe in my reflection are rooted in everyday activities that promote self-care, routine, and wellbeing. This directly supports the occupational approach discussed above, where engaging in meaningful activities leads to positive changes in routines and overall wellbeing. My reflection on the effective use of different settings and activities demonstrates how face-to-face and virtual interventions can successfully incorporate this approach.

The service user interview highlighted the benefits of an occupational approach. Engaging in meaningful activities was central in both settings. In face-to-face sessions, immediate engagement with materials and tasks provided therapeutic benefits.

"I rediscovered my love for arts and crafts." - SU

Virtually, the provision of materials through gift bags allowed the service user to maintain this engagement. Both approaches ensured that the service user remained actively involved in meaningful occupations and activities.

8.2.7 Theme 7: Group Dynamics a key factor to consider when implementing Recovery Through Activity

The "Group Dynamics" theme sheds light on unique aspects of group interactions in both virtual and face-to-face settings, highlighting the importance of managing group size, overcoming screen-time anxiety, and promoting social connections. Figure 19 below highlights the data across cases which informed this theme.

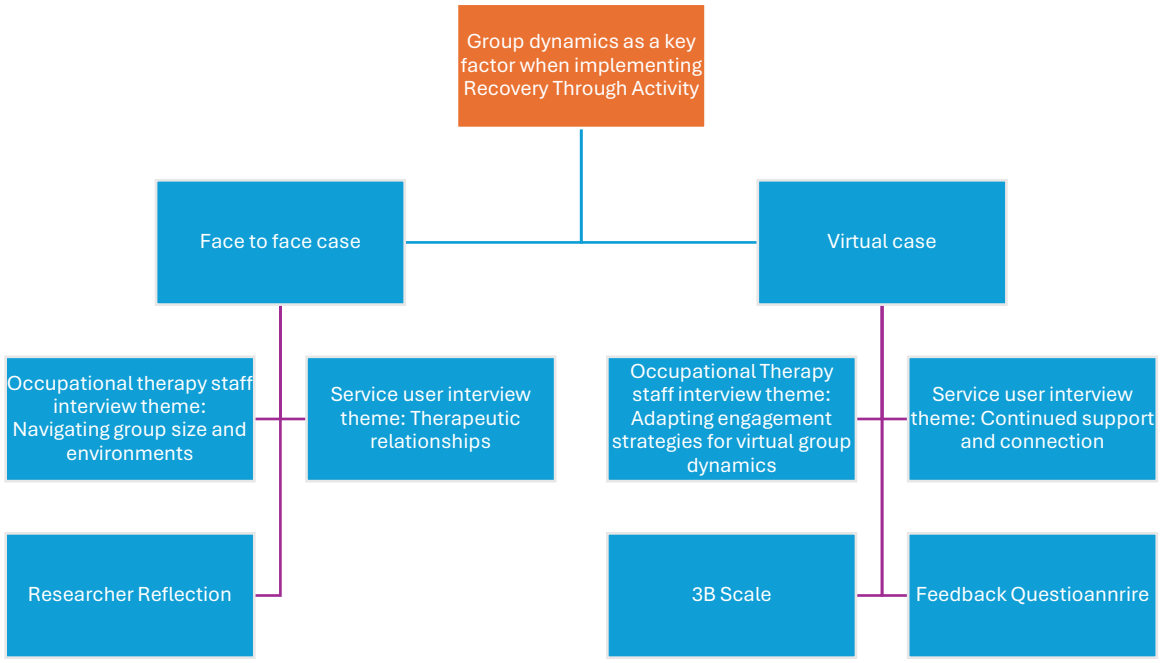


Figure 20 - Evidence web for group dynamics theme

Managing group size proved to be a crucial factor in both case studies for creating a conducive environment. In the virtual format, smaller groups were found to be more comfortable for service users, allowing for greater engagement and interaction. This was particularly essential due to limited visibility on digital platforms like Microsoft Teams.

"I think a smaller group feels more comfortable for the participants." - Carrie

This reflects how managing group size in the virtual format helped maintain an inclusive and interactive session. In the face-to-face format, managing group size was also vital, but the focus was on ensuring balanced dynamics and group cohesion rather than overcoming technical constraints.

The virtual format also introduced unique challenges related to screen-time anxiety. Participants employed strategies such as incorporating videos during sessions to alleviate constant screen-time pressure.

"The videos took the place of quite a lot of the theory chat that we might have had if we were running it face-to-face." - Flo

This highlights how multimedia content helped alleviate screen-time anxiety and maintain engagement. In the face-to-face setting, the challenge was different, focusing on balancing practical and educational elements during sessions without relying on digital aids.

Despite these differences, both formats successfully promoted social connections among service users. In the virtual setting, sessions provided a platform for service users to share experiences, advice, and build a supportive network.

"I've got to know other individuals who've gone through similar situations as myself & the empathy in which we've given each other has put my faith back into society." – Eddie (Feedback Questionnaire)

This highlights the importance of social connections in the recovery journey. In the face-to-face case, social connections were further facilitated by in-person interactions, breaks, and casual conversations, allowing for deeper, spontaneous bonds.

Quantitative feedback from the 3B Scale (Rebeiro Gruhl et al 2018) offers further insights into group dynamics. Statements regarding the social aspects of Recovery Through Activity (Parkinson 2014), such as S10 ("Since participating, I feel like I belong somewhere") and S11 ("I feel that I am a part of a community"), received positive ratings, indicating the success of the virtual sessions in promoting a sense of belonging and community involvement. S10 received a total of 72% agreement ("agree" or "strongly agree") in the virtual case, while S11 received 67%, demonstrating Recovery Through Activity (Parkinson 2014) 's ability to cultivate meaningful social connections despite the digital format.

The group dynamics also promoted a supportive environment in both formats, allowing service users to raise concerns and share struggles.

"I think people really appreciated just kind of finding out that other people feel the same way they do." - Carrie

The varied group dynamics I observed and reflected upon—ranging from larger, more informal groups in a park to smaller, intimate settings in a church or café—illustrate the importance of managing group size and interaction to foster meaningful connections. This is particularly relevant when compared to the virtual study, where managing group dynamics and promoting social connections digitally presented unique challenges, such as overcoming screen-time anxiety.

During the interview the service user expressed their views on group dynamics across both face-to-face and virtual implementation methods. Face-to-face sessions offered more dynamic social interactions, helping reduce feelings of isolation and building a community.

"It was like I had to go out and see everyone, which built that social connection in person." - SU

Virtual sessions, while less immediate, still promoted a sense of community through regular digital meetings.

"We were still able to chat on Teams...which kept me connected and grounded." - SU

Each format offered a different path to promoting group cohesion and support, adapting to the limitations and strengths of their respective environments.

8.2.8 Theme 8: Recovery Through Activity supports occupational therapy Professional Roles

The "Professional Role" theme highlights how Recovery Through Activity played a significant role in solidifying the identity of occupational therapy staff in both the virtual and face-to-face case studies, providing a clear framework to articulate their role in supporting service users' wellbeing. Figure 20 below outlines the data that was drawn upon to unveil this theme.

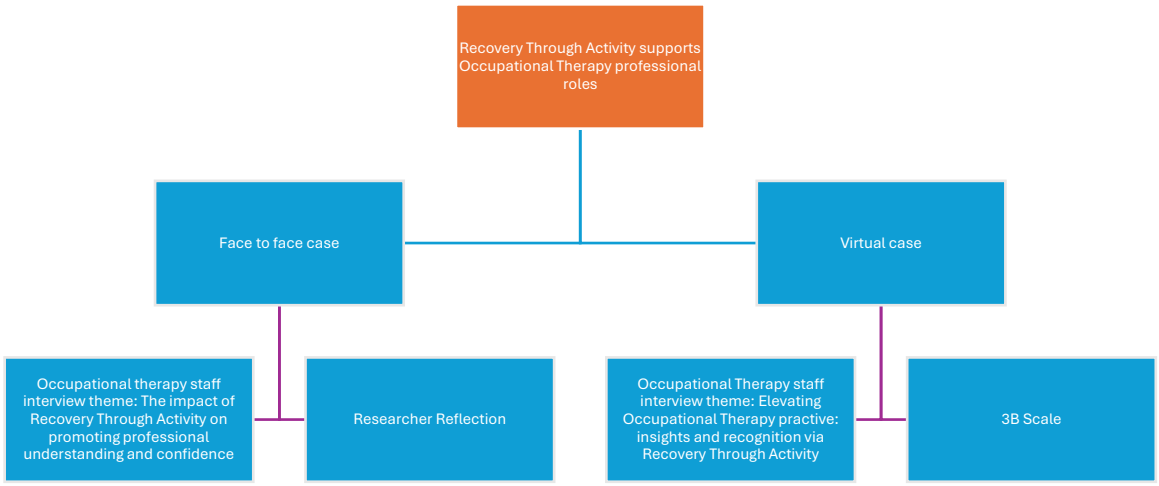


Figure 21 - Evidence web for supporting professional role's theme

One key aspect emphasised was how Recovery Through Activity (Parkinson 2014) helped articulate the role of occupational therapy staff in both formats. Recovery Through Activity (Parkinson 2014)'s structure, grounded in the MOHO (Kielhofner 2008), allowed for an easy explanation and recognition of the diverse capabilities of occupational therapists.

"I think having Recovery Through Activity has given us something concrete to hold on to. To say yes, this is OT, and this is what we do. It's easy to explain using Recovery Through Activity" - Carrie

This highlights how Recovery Through Activity (Parkinson 2014) served as a clear framework for articulating the occupational therapy role. In both formats, Recovery Through Activity (Parkinson 2014) also facilitated an understanding of the multifaceted nature of occupational therapy, showcasing its contributions beyond generic roles.

Another aspect emphasised was how Recovery Through Activity (Parkinson 2014) supported student placements in alternative settings, enriching their learning experiences.

"The program helps us to confidently articulate what occupational therapy offers, creating opportunities for students to engage with OT practices in diverse settings." - Carrie

Furthermore, Recovery Through Activity (Parkinson 2014) played a key role in shifting perspectives within the multidisciplinary team (MDT) in both case studies. Initially viewed as an activity group, Recovery Through Activity (Parkinson 2014)'s comprehensive nature gradually challenged preconceptions, broadening the understanding of occupational therapy's contributions.

"I think it's helped to open people's eyes as to what else we could do." - Carrie

This demonstrates how Recovery Through Activity (Parkinson 2014) promoted recognition and appreciation for the occupational therapy role in supporting service users' wellbeing. In both the virtual and face-to-face formats, Recovery Through Activity (Parkinson 2014)'s transformative impact on MDT perspectives emphasised the depth of occupational therapy interventions.

Quantitative feedback from the 3B Scale (Rebeiro Gruhl et al 2018) further highlighted the impact of Recovery Through Activity (Parkinson 2014) on service users' wellbeing and the professional role of occupational therapists. Statements such as S13 ("As a result of my participation, I feel that I am better able to manage my mental health") and S15 ("Compared to when I began participating, my quality of life has improved") received positive ratings, reflecting the success of occupational therapy interventions. S13 received a total of 61% agreement ("agree" or "strongly agree") in the virtual case, while S15 received 78%, demonstrating the positive impact of Recovery Through Activity (Parkinson 2014) on service users' mental health and quality of life. In the face-to-face study, these aspects were similarly recognised, reinforcing the role of occupational therapists in supporting service users' recovery.

In the face-to-face format, Recovery Through Activity (Parkinson 2014)'s structure also allowed for a more immediate impact on MDT perspectives and practical application. By facilitating discussions and interventions directly with service users and other team members, the face-to-face format contributed to an integrative approach that broadened recognition of the occupational therapy role.

In my reflection I discuss how Occupational therapists played a key facilitative role in the sessions I attended, introducing activities and promoting an inclusive environment. This reflects their defined role in both face-to-face and virtual formats as outlined in the cases, emphasising their professional identity and their importance in guiding service users toward wellbeing.

During the service user interview, it was found that in both contexts, the role of occupational therapists was foundational. Face-to-face sessions allowed therapists to directly guide and adjust activities, enhancing the therapeutic impact. In virtual sessions, therapists provided support and guidance digitally, adapting their methods to the online format.

"The relationships I built continued to support me."- SU

In both cases, therapists adapted their roles to best support the user within the constraints of the environment.

8.2.9 Theme 9: The Structure and Flexibility of Recovery Through Activity supports implementation across settings

The flexibility of Recovery Through Activity (Parkinson 2014) allowed it to adapt to varying needs in both primary and secondary care settings, across both face-to-face and virtual formats. Figure 21 below demonstrates the range of data across cases that were drawn upon to identify this converged theme.

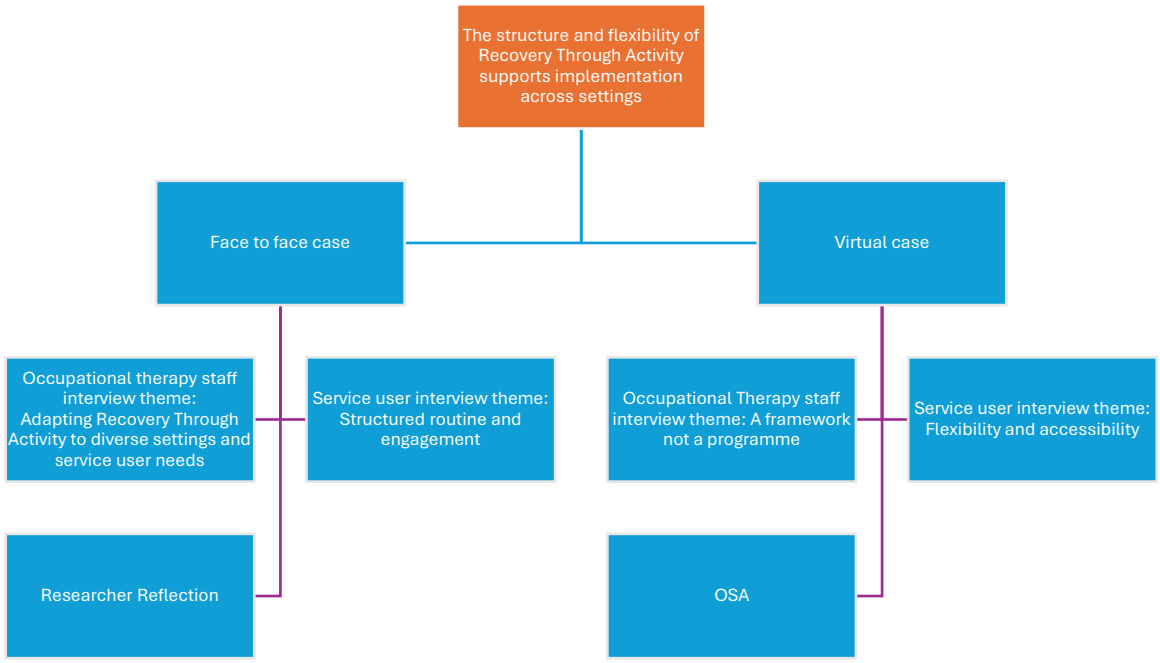


Figure 22 - Evidence web for structure and flexibility theme

In the virtual format, primary care services opted for a concise six-week duration to align with operational needs. This shorter timeframe allowed for an immediate impact, providing tangible support and progress within a limited period.

"I think in that time, you get to know the participants really well to identify, you know, what works for them" - Annie

In secondary care, Recovery Through Activity (Parkinson 2014) extended to a 10 to 12-week timeframe, allowing more time to build relationships and tailor strategies to individual needs. This was crucial for promoting strong rapport between therapists and service users, creating a supportive environment conducive to recovery and engagement.

"We felt that with the extended duration, we had ample time to build on individual service users' needs." - Carrie

In contrast, the face-to-face format offered a similar structure, with durations tailored to meet individual needs. This format allowed for more immediate follow-up support and continuous engagement, particularly in a ward setting. However, it faced challenges in providing flexibility, particularly in secondary care settings, where longer durations were necessary to achieve desired outcomes.

"In secondary care, the longer sessions allowed us to build on each person's goals and needs" - Debbie

In both formats, the Recovery Through Activity (Parkinson 2014) manual served as a valuable resource, guiding sessions across 12 activity categories. This structured yet flexible framework helped therapists plan sessions while adapting to service user needs.

"switching it up depending on who you have in the group" - Beth

Quantitative data further supports these findings, with both formats achieving significant increases in service user competence and values post-intervention, as measured by the OSA (Baron et al. 2006). The virtual format, in particular, demonstrated an increase in median competence scores from 43.63 (SD=5.52) to 52.44 (SD=12.97), and median value scores from 63.88 (SD=10.54) to 69.69 (SD=8.84). The Wilcoxon signed rank test confirmed significant differences in both competence ($Z = -2.93$, $p = 0.003$) and values ($Z = -2.3$, $p = 0.02$) scores before and after intervention.

My reflection highlights the structured yet flexible approach of the Recovery Through Activity (Parkinson 2014) sessions I attended, where activities were carefully chosen to suit the specific contexts and needs of different groups. For example, nature walks in a community park and discussions in a community centre each provided unique, context-sensitive engagement opportunities. This echoes the findings from both

face-to-face and virtual formats discussed in the studies, which emphasised the need for a flexible structure to cater to varied settings and participant needs. The ability to adjust the structure of the sessions, from more active and communal outdoor activities to more intimate and conversational settings, demonstrates Recovery Through Activity (Parkinson 2014)'s adaptability.

The service user interview findings support the flexibility of Recovery Through Activity (Parkinson 2014) during the changing times of Covid-19. The structure and flexibility were crucial in both settings. Face-to-face sessions provided a structured yet adaptable routine that supported daily living.

"Having to go to the church got me out of the house and gave me structure." - SU

Virtually, the flexibility to participate from home was essential during the pandemic, offering stability and continuity.

"We transitioned to Teams...which made it easier to stick to." - SU

Both environments demonstrated flexibility in structure, vital for accommodating the service user's changing needs and circumstances.

8.3 Revisiting Propositions

Proposition 1: Service dynamics and processes will impact on occupational therapy staff experiences of Recovery Through Activity.

The cross-case analysis highlights how service dynamics and processes, such as available resources, community links, and staff capacity, significantly impact occupational therapy staff experiences with Recovery Through Activity (Parkinson 2014). The flexibility and structured

framework of Recovery Through Activity (Parkinson 2014) enable therapists to tailor interventions to individual needs, whether in primary or secondary care settings. This adaptability is central for managing varying service demands, client groups, and local policies.

Proposition 2: The implementation method of Recovery Through Activity will impact on occupational therapy staff and service user experiences.

The findings illustrate that the method of implementing Recovery Through Activity (Parkinson 2014), whether through one-to-one sessions or group settings, significantly impacts both staff and service user experiences. Tailoring interventions to individual needs using assessment tool to support, ensures relevance and effectiveness. One-to-one support sessions, highlighted as central in both face-to-face and virtual formats, allow for personalised goal setting and progress evaluation, enhancing engagement and outcomes. The balance between practical activities and educational components, as well as the integration of community resources, further refines the intervention approach, making it adaptable and beneficial for diverse service user needs and preferences.

Proposition 3: Access to community resources will impact on the effectiveness and the benefits of the use of Recovery Through Activity.

The involvement of community organisations plays a pivotal role in the effectiveness and benefits of Recovery Through Activity (Parkinson 2014). Access to community resources such as mindfulness books, volunteering opportunities, and hands-on activities provided by third sector organisations enriches the therapeutic experience. These resources help bridge the gap between structured sessions and practical, real-world applications, promoting long-term engagement and community integration. The support from these organisations not only enhances the

delivery of Recovery Through Activity (Parkinson 2014) but also facilitates smoother transitions for service users to community-based activities, thereby promoting sustained recovery and engagement.

Proposition 4: Individual differences will impact on the effectiveness and the benefits of Recovery Through Activity.

Individual differences such as readiness for change, volition, habituation, and performance capacity significantly influence the effectiveness of Recovery Through Activity (Parkinson 2014). The tailored approach, facilitated by comprehensive assessments and ongoing evaluations, ensures that interventions are aligned with each service user's unique needs and goals. This personalisation is central in addressing varying levels of motivation, expectations, and perceptions of recovery. Service user feedback highlights the importance of meeting individual needs, with both face-to-face and virtual formats providing the necessary flexibility to adapt interventions in real-time. This personalised attention promotes trust, engagement, and meaningful progress in recovery.

Proposition 5: Recovery Through Activity will have an impact on service users' occupational participation and engagement.

Recovery Through Activity (Parkinson 2014) has a profound impact on service users' occupational participation and engagement. The structure, combining practical activities with educational elements, enhances motivation, communication, interaction skills, and overall occupational performance. Quantitative data demonstrates significant improvements in competence, value placed on activities, and quality of life. Service users report increased engagement in meaningful occupations, improved social connections, and greater confidence in managing their mental health. The holistic approach of Recovery Through Activity (Parkinson 2014), supported by community involvement and tailored interventions, effectively promotes sustained occupational engagement and recovery.

8.4 Revisiting Rival explanations

Direct Rivals

The cross-case findings highlight that while other interventions such as psychology input, medication, or alternative therapies could contribute to service user outcomes, the unique structure and flexibility of Recovery Through Activity (Parkinson 2014) specifically address occupational participation and engagement. The tailored approach, emphasizing individual needs and community integration, provides a distinctive therapeutic benefit that complements but is not wholly replicated by other interventions.

Commingled Rival

The data suggests that Recovery Through Activity (Parkinson 2014) works synergistically with other interventions. For instance, on inpatient wards, it was reported as vital that medication is balanced before service users can fully benefit from the occupational engagement strategies provided by Recovery Through Activity (Parkinson 2014). This commingling highlights the necessity of a holistic approach where Recovery Through Activity (Parkinson 2014) complements other therapeutic inputs to enhance overall recovery.

Implementation Rival

The success of Recovery Through Activity (Parkinson 2014) is heavily influenced by its implementation. The person-centred approach and the ongoing assessment and planning processes are critical for its effectiveness. The findings show that when interventions are carefully tailored to meet individual goals and when the implementation is flexible to adapt to changing needs, the benefits for service users are significantly

enhanced, suggesting that both the process and the program itself are central for positive outcomes.

Rival Theory

Alternative theories such as group theory, community psychology theory, and organizational theory might also explain the positive outcomes observed. However, Recovery Through Activity (Parkinson 2014) incorporates elements from these theories by promoting social connections through group dynamics, integrating community resources, and promoting an organisational culture that supports recovery. Therefore, while rival theories offer valuable insights, the multifaceted approach of Recovery Through Activity (Parkinson 2014) effectively encapsulates and applies these broader theoretical frameworks.

8.5 Chapter conclusion

This cross-case analysis has provided a thorough examination of the implementation of Recovery Through Activity in both traditional face-to-face and innovative virtual settings, exploring how therapeutic interventions adapt to maintain efficacy across diverse operational challenges. The research has highlighted the importance of tailoring interventions to individual needs using assessment tools such as the OSA (Baron et al. 2006), Interest Checklist (Heasman and Salhortra 2008), and Role Checklist (Scott 2019), which are instrumental in customising the therapeutic approach in both formats.

Despite challenges posed by virtual delivery, such as the integration of practical activities, both formats have developed effective strategies to balance educational content with engaging practical tasks. This ensures that service users remain actively involved and benefit tangibly from their

participation. The analysis also highlights the critical role of personalised one-to-one support sessions, which are pivotal in addressing personal goals and enhancing the therapeutic experience across both delivery methods.

Community organisations significantly enhance the connectivity and reach of Recovery Through Activity (Parkinson 2014), especially in the virtual format, by providing essential resources and guest speakers. This involvement helps to extend Recovery Through Activity (Parkinson 2014)’s impact beyond traditional therapeutic settings. Furthermore, the foundation of effective interventions in both face-to-face and virtual settings is built on rigorous assessment, meticulous planning, and continuous evaluation. These processes ensure that each intervention is aligned with service user goals and facilitates measurable progress.

Both formats uphold a strong occupational approach, guiding service users toward positive changes in routine, self-care, and overall wellbeing, showcasing Recovery Through Activity (Parkinson 2014)’s ability to adapt foundational therapeutic principles to different operational contexts. The research also revealed unique dynamics in virtual groups, such as managing group sizes and overcoming screen-time anxiety, which, while distinct from face-to-face interactions, are equally vital in promoting effective social connections.

Recovery Through Activity (Parkinson 2014) has reinforced the professional identity of occupational therapists, providing a clear framework to articulate their role in promoting service users' wellbeing across diverse environments. The flexibility to adapt the structure of Recovery Through Activity (Parkinson 2014) to meet varying needs across primary and secondary care settings highlights Recovery Through Activity (Parkinson 2014)’s capacity to accommodate diverse service delivery demands.

In conclusion, this analysis highlights the resilience and adaptability of Recovery Through Activity (Parkinson 2014) as a model for mental health recovery across different settings. The findings demonstrate that the core principles of effective, tailored, and responsive care are consistent across delivery methods. This research lays a foundation for future initiatives to further refine and adapt therapeutic practices to meet the evolving needs of service users, ensuring that Recovery Through Activity (Parkinson 2014) continues to be a valuable asset in mental health services, irrespective of the delivery format.

Chapter 9 - Discussion

9.1 Introduction

The Model of Human Occupation (MOHO) (Kielhofner 2008) provides a comprehensive theoretical framework for understanding and addressing the complex factors influencing occupational engagement and therapy outcomes. This chapter examines how Recovery Through Activity (Parkinson 2014) aligns with various MOHO (Kielhofner 2008) domains—volition, habituation, performance capacity, environment, and occupational adaptation—to enhance occupational therapy and support both therapists and service users within a mental health context. By exploring each MOHO (Kielhofner 2008) domain within Recovery Through Activity (Parkinson 2014), this analysis directly contributes to the overarching aim of evaluating the intervention's efficacy and effectiveness from both occupational therapist and service user perspectives. Unlike a model alone, Recovery Through Activity (Parkinson 2014) translates theory into structured, actionable steps, enhancing its practical application for occupational therapists and engaging service users directly.

Volition, encompassing personal causation, values, and interests, is central to individuals' occupational choices and experiences (Kielhofner 2008). Findings in this area address Objective 3, showing that aligning therapeutic activities with service users' personal motivations and values enhances the meaningfulness and engagement of interventions. This supports the overarching aim by demonstrating how meaningful engagement can increase intervention effectiveness. For service users, a tailored approach builds competence through promoting a strong personal connection to activities, while for occupational therapists, it clarifies how each activity directly supports the user's unique motivational patterns.

Habituation, involving the formation of routines, is vital in both face-to-face and virtual Recovery Through Activity (Parkinson 2014) formats, as establishing regular routines supports continuity and stability in occupational engagement. The findings relate to Objective 2 by addressing the challenges and opportunities that occupational therapists encounter when implementing a structured yet adaptable, occupation-focused approach, especially in virtual settings.

Performance Capacity, which includes the physical and mental abilities needed to engage in occupations, is another core focus of Recovery Through Activity (Parkinson 2014). The findings address Objective 4, as the intervention outcome measure analysis evaluates its effectiveness in improving service users' functional abilities. This performance capacity domain directly addresses the overarching research aim by providing evidence of Recovery Through Activity's (Parkinson 2014) impact on service users' competence and daily functioning.

The Environment is a critical MOHO (Kielhofner 2008) domain that shapes occupational behaviour through cultural, social, and physical factors. This study explores how Recovery Through Activity (Parkinson 2014) effectively integrates both the immediate therapy setting and wider community resources to facilitate service user engagement and connection. This element addresses Objective 1 by examining how occupational therapists utilise these environments to maximise therapeutic impact and engagement, thereby clarifying therapists' roles and experiences within Recovery Through Activity (Parkinson 2014). Additionally, by assessing environmental supports, the study contributes to the overarching aim by evaluating the intervention's broader reach and contextual adaptability.

Occupational Adaptation, an essential focus within MOHO (Kielhofner 2008), involves enabling individuals to achieve a balanced and fulfilling

occupational life. Recovery Through Activity (Parkinson 2014) supports occupational adaptation by equipping service users with the skills, confidence, and opportunities to participate in meaningful activities that align with their evolving goals and circumstances. The findings in this domain address Objective 4, as intervention outcome data highlights its role in promoting adaptability and growth in service users.

Tools such as the OSA (Baron et al. 2006) were used to understand service users' values and perceived abilities, allowing occupational therapists to tailor interventions that enhance engagement and satisfaction. This personalised approach is a key facilitator in creating sustainable routines that align with service users' individual contexts, promoting a sense of competence and self-efficacy.

Recovery Through Activity (Parkinson 2014) also promotes performance-focused one-to-one sessions alongside group activities, providing insights into how individualised support enhances competence and engagement, contributing to both the effectiveness and adaptability of the intervention. Finally, Recovery Through Activity (Parkinson 2014) supports occupational adaptation by encouraging service users to pursue activities that reinforce their identity and personal development. By focusing on practical skills and community involvement,

This chapter will discuss each MOHO (Kielhofner 2008) domain in detail, highlighting how Recovery Through Activity (Parkinson 2014), guided by MOHO (Kielhofner 2008), supports diverse aspects of occupational therapy within mental health settings. In doing so, it addresses the research aim and objectives and demonstrates how the intervention can enhance both professional practice and the therapeutic journey of service users.

9.2 Volition

According to MOHO, volition refers to the patterns of thoughts and feelings about oneself as an actor in one's world, which motivate occupational behaviour. This includes personal causation, or the sense of capacity and effectiveness; values, or beliefs and commitments about what is good, right, and important; and interests, or attention and preference towards certain activities (Kielhofner 2008). These elements of volition are essential in understanding how and why individuals engage in specific occupations, underscoring the importance of aligning occupational therapy interventions with individual volitional narratives. Rather than relying solely on theoretical frameworks, Recovery Through Activity (Parkinson 2014) provides specific tools and structured sessions that apply MOHO (Kielhofner 2008) principles, making it accessible and practical for occupational therapists. The theme of tailoring Recovery Through Activity (Parkinson 2014) to individual service user needs is linked to volition (figure 22).

Figure 23 - Theme link to Volition

Argentzell et al. (2020) emphasise that individualised support and client-centred approaches are crucial in enhancing personal meaning and motivation, which are key components of volition. They found that interventions aligned with an individual's intrinsic values lead to stronger engagement and higher satisfaction with therapeutic activities, reinforcing the idea that volitional aspects in occupational therapy promote self-efficacy and sustained participation. This study highlights the importance of personalised interventions like Recovery Through Activity, which directly address clients' volitional needs by aligning activities with their personal motivations and life contexts, thereby enhancing engagement. Newport and Clarke (2020) highlight the role of personal narratives and identity expression in occupational engagement, noting that connecting with authentic self-values enhances therapeutic motivation and fulfilment. Rebeiro Gruhl et al. (2021) further support this by emphasising the role of 'being' and self-acceptance in promoting a stable identity and sense of purpose. They suggest that supportive staff interactions that validate self-worth and identity can deepen users' personal causation and motivation,

a factor that aligns with the approach of Recovery Through Activity (Rebeiro Gruhl et al. 2021). Additionally, Eklund et al. (2017) support this view by observing that client-centred approaches in the BEL program promote volitional engagement through a balanced approach to activities, helping users feel a greater sense of mastery and purpose. This directly aligns with Recovery Through Activity's focus on personalised, motivationally relevant interventions.

Implementing tailored therapeutic interventions specific to each service user’s needs is a foundation of effective occupational therapy, especially within mental health services. Findings directly support Objective 1, illuminating how Recovery Through Activity (Parkinson 2014) aligns with therapists' roles in supporting service users' volitional needs, such as personal causation, values, and interests. This approach not only deepens engagement but also demonstrates the effectiveness of personalised approaches, which brings us back to the research’s overarching aim to evaluate the intervention's success. For service users, tailored interventions provide a sense of purpose, promoting competence in managing daily activities. For practitioners, this personalised approach offers a practical way to translate volitional concepts into measurable outcomes. This research emphasises the importance of such personalisation in Recovery Through Activity (Parkinson 2014), drawing on principles from the Model of Human Occupation (MOHO), which highlights volition as a fundamental aspect influencing occupational engagement (Kielhofner 2008). Addressing Objective 3, findings further reveal how service users' feedback highlights the positive impact of tailored interventions on their competence and well-being, affirming the intervention's value from a user perspective. This emphasis on volitional alignment is corroborated by Eklund et al. (2017), who found that BEL's structured approach supports users in enhancing daily life satisfaction and achieving personal goals, reinforcing the idea that interventions like

Recovery Through Activity (Parkinson 2014) should prioritise user-defined values and interests to maximize engagement and satisfaction.

Rose and Smith (2018) highlight the importance of setting clear, achievable, and relevant goals in the mental health recovery process. These goals should connect closely with the service user's personal occupations, needs, and wants, ensuring they are not only relevant but also imbued with personal significance. Likewise, this research identified tools such as the OSA (Baron et al. 2006), Interest Checklist (Heasman and Salhotra 2008), and Role Checklist (Scott 2019) to effectively map out each service user's personal causation, values, and interests. These tools provided a detailed understanding of individual goals, which is critical in crafting interventions that are both effective and personally resonant.

The evolving nature of mental health conditions means that service users' needs and goals can shift over time. This research highlights the importance of flexibility in intervention plans, allowing for adjustments as service users' interests and goals change. Addressing Objective 2, findings indicate that occupational therapists face both opportunities and challenges when implementing tailored, flexible approaches to volition in face-to-face and virtual settings. This adaptability is particularly relevant in contexts where therapists must continually reshape intervention strategies to meet changing needs, ensuring that therapy remains relevant and engaging. The ability to modify intervention strategies based on ongoing assessments, using tools like the OSA (Baron et al. 2006), is essential in maintaining engagement and ensuring therapy’s relevance to the user's current state.

Building on this, Argentzell et al. (2020) found that the perception of control over one’s environment and activities correlates directly with higher levels of engagement and well-being in occupational settings. This

is in line with the approach of Recovery Through Activity, where volitional elements are closely integrated to help service users feel autonomous and competent, thereby enhancing their motivation and participation in the therapeutic process.

Echoing Hammell (2009), this research challenges traditional categorisation of occupations and advocates for a more personalised, client-centred approach that transcends conventional categories like self-care, productivity, and leisure. The findings reveal that such an approach, which considers each service user's cultural, personal, and situational contexts, enhances the effectiveness of interventions. This aligns with the idea that occupational therapy should not only address functional abilities but also resonate with the personal and cultural narratives of individuals, thereby promoting deeper and more meaningful engagement in therapeutic activities.

Tan et al. (2020) suggest that interventions need to be graded to build competence and address cognitive distortions related to depressive symptoms, such as overestimating task difficulty or underestimating personal competence. These research findings support this by demonstrating the importance of bridging the gap between perceived and actual competence, reinforcing Objective 4's focus on evaluating effectiveness. By integrating assessments that gauge not only functional abilities but also psychological elements like hope and self-efficacy, occupational therapists can help bridge the gap between perceived and actual competence, thus supporting service users in developing a more realistic and empowered occupational identity.

Expanding on Tan et al. (2020), this research also emphasises the role of hope and empowerment in the therapeutic process. These psychological elements are important for motivating service users toward recovery and enabling them to envision a future actively engaged in meaningful

occupations. Such tailored interventions promote empowerment, aligning with the overarching aim to support both functional and psychological elements of recovery. Consequently, these interventions must focus not only on functional recovery but also promote a sense of hope and efficacy, making the therapy process more holistic and aligned with the users' aspirations and capabilities.

The impact of tailored interventions is evident in significant improvements in service users' competence and value scores, as shown by pre- and post-intervention assessments using the OSA (Baron et al. 2006). Additionally, service user feedback highlights the importance of these tailored interventions in building supportive relationships, promoting a sense of community, and belonging, which are essential for sustained mental health recovery and long-term engagement.

In summary, tailoring Recovery Through Activity (Parkinson 2014) to individual needs within the framework of MOHO (Kielhofner 2008) enhances the engagement, efficacy, and satisfaction of occupational therapy interventions. By focusing on the volitional components of personal causation, values, and interests, occupational therapists can effectively address the unique and dynamic needs of service users. Findings highlight the value of a flexible, culturally sensitive, and client-centred approach that considers everyone’s evolving goals and contexts, thereby enhancing engagement and mental health outcomes.

This research highlights the role of occupational therapists in facilitating not just functional recovery but also personal empowerment and resilience through meaningful, tailored interventions. By integrating the principles of volition into goal setting and intervention planning, Occupational therapists can more effectively support service users on their journey toward recovery and well-being, ensuring interventions are

not only effective but also deeply aligned with each individual's personal narrative and aspirations.

9.3 Habituation

According to the Model of Human Occupation (MOHO) (Kielhofner 2008) habituation focuses on patterns of behaviour that are routinely performed, developing into habits and structured roles. This process is essential in helping individuals organize their daily lives and maintain consistent engagement in occupations. The themes “Maintaining a balance between practical activities and educational aspects of Recovery Through Activity (Parkinson 2014)” and “The structure and flexibility of Recovery Through Activity (Parkinson 2014) supports implementation across settings” are linked to habituation (Figure 23).

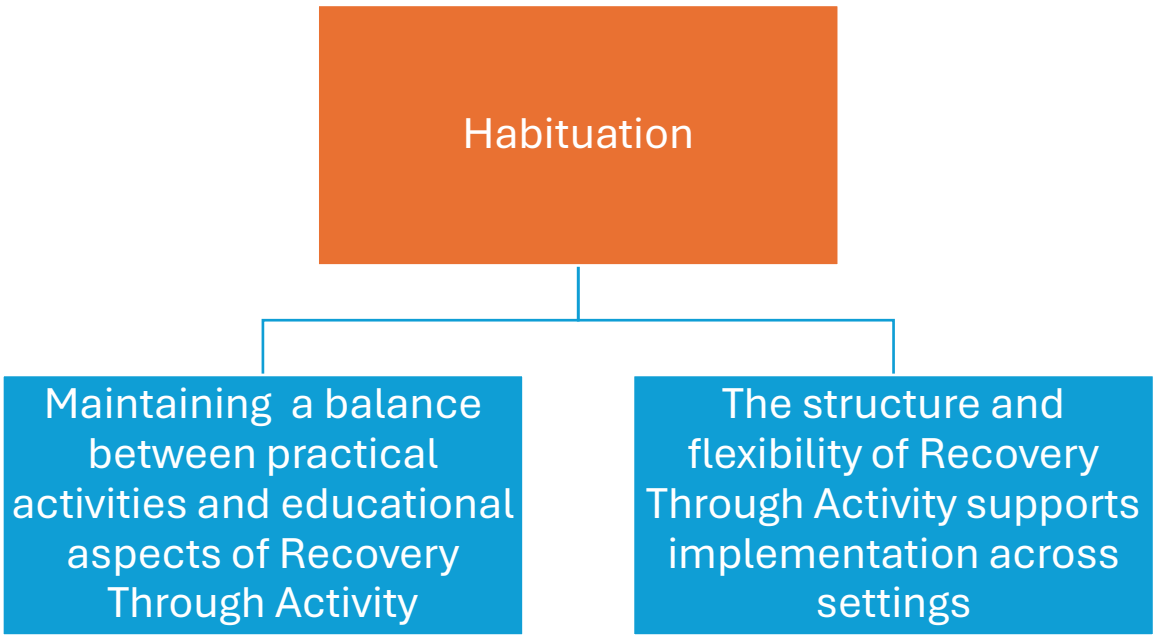


Figure 24 - Theme links to Habituation

According to the Model of Human Occupation (MOHO) (Kielhofner 2008) habituation focuses on patterns of behaviour that are routinely performed, developing into habits and structured roles. This process is essential in helping individuals organize their daily lives and maintain consistent engagement in occupations. The themes "Maintaining a balance between practical activities and educational aspects of Recovery Through Activity (Parkinson 2014)" and "The structure and flexibility of Recovery Through Activity (Parkinson 2014) supports implementation across settings" are linked to habituation (Figure 23).

This research found that Recovery Through Activity (Parkinson 2014), adapted for virtual delivery due to Covid-19, effectively integrates practical and educational components in therapeutic sessions. Eklund et al. (2017) observed a similar outcome in the BEL program, where combining practical and educational components helped participants establish regular routines and a stronger sense of structure in their lives. Such structure and consistent routines promote stability and enhance the effectiveness of interventions focused on habituation. Argentzell et al.

(2020) also emphasise the importance of combining structured activities with educational content to promote stability and predictability in daily routines. Similarly, Woolley et al. (2020) noted that occupational therapy groups offering a normalising and supportive social environment were essential for clients in developing new, stable habits and routines. This reinforces the role of Recovery Through Activity in promoting structured environments that support habit formation through group participation. Newport and Clarke (2020) found that the Occupation Matters Program enabled participants to transition from isolation to a sense of belonging by establishing routine engagement. Rebeiro Gruhl et al. (2021) further highlight the value of regular, occupation-based activities, noting that structured engagement promotes stability, reinforces positive habits, and aids community integration. Their findings in the NISA program show that structured activities support habit formation and improve participants' ability to manage daily routines effectively, providing both practical and social benefits (Rebeiro Gruhl et al. 2021). This aligns with the MOHO (Kielhofner 2008) concept of habituation, which promotes resilience and a sense of control through routine activities. This integration is essential for maintaining engagement and reinforcing the application of learned skills in practical settings.

Recovery Through Activity is set apart from purely theoretical models by actively guiding service users to apply learned habits in daily life, promoting consistent routines. Further, Argentzell et al. (2020) found that habituation activities tailored to individual needs are more likely to support long-term habit formation, suggesting that Recovery Through Activity's (Parkinson 2014) approach aligns well with effective habit development in occupational therapy. For occupational therapists, this structured yet adaptable approach offers clear guidance for developing personalised routines that align with service user goals. The distribution of resource packs prior to sessions exemplifies a strategic method of

combining practical tasks with educational materials, supporting Objective 1 by highlighting the roles of occupational therapists in structuring sessions and Objective 2 by demonstrating the adaptation process.

Cultural factors significantly influence habituation, as individual routines are often shaped by cultural norms and expectations (Duncan 2006; Giddens 2001). Recovery Through Activity (Parkinson 2014) adapts to cultural diversity by allowing flexibility in how activities are presented and engaged with, which is essential for Recovery Through Activity's (Parkinson 2014) effectiveness across diverse cultural contexts. Eklund et al. (2017) similarly observed that BEL's adaptability to individual cultural and social norms made it effective across diverse client populations. This supports a personalised approach to habituation that aligns with Recovery Through Activity's alignment of culturally responsive therapy. Argentzell et al. (2020) also note that culturally sensitive interventions encourage higher engagement by allowing service users to incorporate therapeutic activities into established cultural and social patterns, further underscoring the importance of flexible, personalised routines in habituation. This aligns with Hatch's (2013) discussion on how cultural beliefs shape habits and routines, emphasising the need for occupational therapy to adapt to be relevant and resonant for diverse populations.

Flexibility in therapeutic practice is essential for addressing individual needs effectively. Wimpenny et al. (2010) highlight that therapists often need to adapt theoretical models to fit specific practice contexts. Likewise, Recovery Through Activity (Parkinson 2014) provides a flexible structure that occupational therapists can adapt to meet changing service user needs, whether in virtual or face-to-face formats. This flexibility is integral to habituation, as it ensures that new routines are introduced in ways that are both sustainable and meaningful to service users. This addresses Objective 3, focusing on service user experiences by adapting

interventions to fit their daily lives, as demonstrated by service user feedback.

Engaging service users in meaningful activities is known to enhance their sense of purpose and motivation, which is vital for mental health recovery (Argentzell et al. 2020). This alights with the overarching research aim of evaluating the effectiveness of Recovery Through Activity (Parkinson 2014) by highlighting its relevance and adaptability to individual needs, thereby promoting wellbeing and sustained engagement. It was found in this research that occupational therapists utilised educational videos and handouts with practical tasks within Recovery Through Activity (Parkinson 2014), ensuring that service users understand the value and purpose of the activities they engage in. This educational component was found to be of benefit in reinforcing the practical application of skills, which supports the development of new, health-promoting habits.

This research found that the structured yet flexible approach of Recovery Through Activity (Parkinson 2014) allows for the personalisation of interventions to fit individual recovery timelines and needs. Doroud et al. (2015) found that meaningful occupation supports recovery by promoting elements such as connectedness and empowerment, which are promoted by Recovery Through Activity's (Parkinson 2014) balanced approach. By providing structured activities that service users find meaningful, Recovery Through Activity (Parkinson 2014) supports the establishment of routines that are crucial for long-term recovery and habituation. This finding links to Objective 4, demonstrating the impact of implementation on overall competence and adaptive capacity, as shown by positive service user feedback and outcome data.

This research found that integrating practical tasks with educational content is a core component of Recovery Through Activity (Parkinson 2014), as it enables service users to apply learned concepts directly. This

approach is reflected in Recovery Through Activity's (Parkinson 2014) use of resource packs and educational materials, ensuring service users can practice skills in real-world settings while understanding their therapeutic benefits. This method is supported by Sutton et al. (2012), who emphasise the importance of understanding how activity engagement impacts recovery.

This research also highlighted that maintaining flexibility within structured routines is essential for adapting to service users' evolving needs. Recovery Through Activity (Parkinson 2014) illustrates this by allowing for the adjusting of session content and duration based on immediate service user feedback and changing circumstances, a practice. This aligns with findings from Lund et al. (2019b), who discuss the importance of adjusting daily occupations to better align with personal values and recovery goals.

The flexibility of Recovery Through Activity (Parkinson 2014) enables it to adapt to varying needs in both primary and secondary care settings, across both face-to-face and virtual formats. In primary care services, a concise six-week duration aligned with operational needs, providing immediate impact and support. occupational therapist A noted: "I think in that time, you get to know the participants really well to identify, you know, what works for them." In secondary care, a 10 -12-week duration allowed for building stronger relationships and tailored strategies, essential for promoting rapport and recovery.

Quantitative data further supports these findings. The OSA (Baron et al. 2006) outcomes showed significant increases in competence and value scores after intervention, with mean competence rising from 43.63 to 52.44, and mean value increasing from 63.88 to 69.69. The Wilcoxon signed rank test confirmed significant differences in both competence ($Z = -2.93$, $p = 0.003$) and value ($Z = -2.3$, $p = 0.02$) scores before and

after intervention. The 3B Scale (Rebeiro Gruhl et al. 2018) indicated that 83% of participants agreed that "participation has helped me to obtain employment, a volunteer position, or return to school or college," and 50% agreed that Recovery Through Activity "connects me with the community and has an important social purpose," highlighting the impact of practical activities alongside educational content.

Comparing these study findings with broader research as above reveals that Recovery Through Activity (Parkinson 2014) aligns well with best practices in occupational therapy, particularly in promoting sustained engagement and supporting long-term habituation in service users. This analysis highlights not only the effectiveness of Recovery Through Activity (Parkinson 2014) but also points to areas for further enhancement to better support service users' occupational engagement and recovery.

9.4 Performance Capacity

Performance capacity, which involves the physical and mental capabilities enabling skilled occupational engagement, is a central theme in enhancing Recovery Through Activity (Parkinson 2014). The findings illustrate how tailored one-to-one sessions complement group activities by providing customised support that enhances service users' ability to engage meaningfully in occupations. Figure 24 demonstrates which themes link to performance capacity.

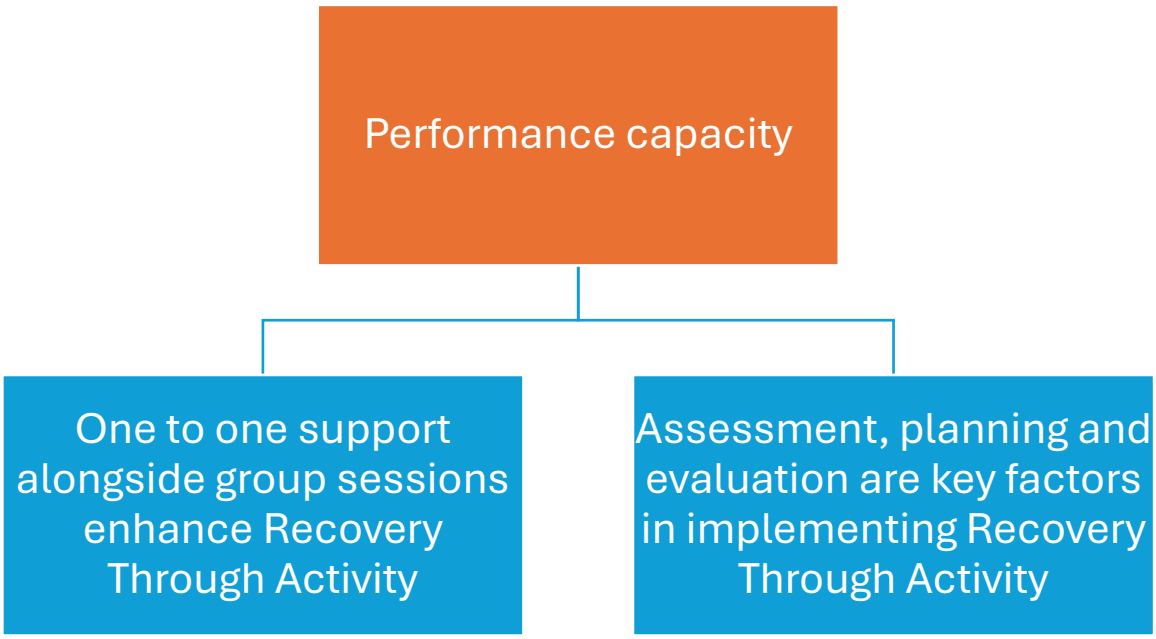


Figure 25 - Theme links to performance capacity

The findings address Objective 1 by exploring how occupational therapists can support user engagement through targeted, capacity-building approaches. Eklund et al. (2017) emphasise that BEL's focus on manageable, individualised support builds service users' confidence and functional abilities over time, reflecting the tailored approach of Recovery Through Activity (Parkinson 2014). Petersen et al. (2019) further support this by highlighting the need for a balanced combination of structured tasks and supportive feedback to promote functional capacity and self-efficacy, demonstrating how consistent, individualised support promotes resilience among mental health service users. Recovery Through Activity's (Parkinson 2014) balance of structured tasks with personalised feedback aligns closely with these findings, affirming its success in building confidence and functional abilities. Eklund et al. (2017) found that client-centred performance support promotes a sense of self-efficacy, enhancing users' resilience in managing daily activities.

Unlike a model that provides theoretical insights without concrete steps for application, Recovery Through Activity (Parkinson 2014) includes

structured, yet flexible sessions that build tangible skills in a practical, supportive setting. This approach enables service users to develop confidence and competence in specific tasks, directly enhancing functional capacities. Argentzell et al. (2020) found that one-to-one sessions addressing specific skill areas promote greater confidence and self-efficacy in managing physical and cognitive challenges, thereby enhancing overall performance capacity. Newport and Clarke (2020) similarly observed that tailored support within the Occupation Matters Programme helped participants develop functional skills and reinforced their confidence in managing daily activities, highlighting the importance of personalisation in occupational interventions. Such individualized support is key to building resilience and promoting long-term engagement in occupations.

Lund et al. (2019b) provide compelling evidence that one-to-one interactions, when combined with group sessions, catalyse significant personal and lifestyle changes. This supports the observation that individualised support sessions allow for a deeper understanding of service users' personal narratives, which is essential for setting relevant and achievable goals. This research suggests that such tailored interactions are instrumental in breaking larger goals into manageable tasks, enhancing motivation and engagement—key aspects of performance capacity. This addresses Objective 2, highlighting the challenges occupational therapists face in ensuring personalised, occupation-focused support, particularly in varied formats like virtual or face-to-face settings.

Fletcher-Wood (2018) reinforces this by noting that breaking tasks into smaller steps reduces the overwhelm of larger goals, providing immediate, attainable targets that offer positive reinforcement and enhance motivation. This aligns with findings from this research, indicating that personalised one-to-one sessions delve into an individual's

personal context to refine goals that resonate with their specific challenges and aspirations. This also links back to Objective 1, highlighting occupational therapists' roles in addressing unique barriers to activity engagement.

This research highlights that one-to-one support not only benefits users individually but also enhance group intervention efficacy. Argentzell et al. (2020) emphasise the importance of adapting therapy to suit the varying cognitive and physical capacities among service users, which aligns with this research's observation that tailored support maximises each individual's ability to engage in meaningful activities. This approach ensures that personal attention is maintained within group settings, thus enhancing individual engagement. This is particularly essential in virtual formats, where establishing rapport and continuous engagement can be challenging. Structured one-to-one sessions in the virtual environment address these challenges by providing focused, individualised support, thus reinforcing the service user's performance capacity in a digital setting.

The positive changes in Occupational Self-Assessment (OSA) scores post-intervention, as noted in this research, validate the effectiveness of integrating one-to-one support within Recovery Through Activity (Parkinson 2014). This quantitative evidence addresses Objective 4, evaluating Recovery Through Activity's (Parkinson 2014) implementation effectiveness. Similarly, Eklund et al. (2017) observed significant improvements in performance measures, validating the importance of personalised, capacity-building interventions to sustain occupational engagement. Supporting this, Argentzell et al. (2020) found similar positive changes in occupational self-assessment among participants who received tailored interventions, noting that these improvements in self-perception and competency are key to sustaining engagement and promoting functional growth. Quantitative data from OSA outcomes

indicated significant improvements in competence, with scores rising from 43.63 to 52.44, further supported by high agreement rates on the 3B Scale (Rebeiro Gruhl et al. 2018) regarding respectful, supportive interactions. This data highlights that personalisation in therapy significantly boosts perceived and actual performance capacities, reinforcing the overarching aim of evaluating the intervention's efficacy from the perspectives of service users and therapists.

In conclusion, evidence from Lund et al. (2019a) and Fletcher-Wood (2018) strongly supports this research, indicating that one-to-one sessions are critical in enhancing the performance capacity of service users. These sessions not only provide essential personalisation but also address individual goals and challenges, significantly enhancing motivation and engagement. This tailored approach supports both direct engagement in activities and the overall therapeutic experience and outcomes within both group and individual settings. Rebeiro Gruhl et al. (2021) add that resilience-building through one-to-one interactions enhance task engagement capacity and positively impacts participants' well-being and adaptability, a finding consistent with the impact of Recovery Through Activity's (Parkinson 2014) tailored support structure. The integration of performance capacity through one-to-one support thereby emerges as a key strategy in optimising Recovery Through Activity (Parkinson 2014), ensuring both individual attention and collective participation are effectively balanced to achieve optimal therapeutic benefits. This aligns with the overarching aim by demonstrating the intervention's effectiveness in promoting meaningful, individualised engagement and promoting functional improvement.

This research emphasises the role of assessment tools like the OSA (Baron et al. 2006) and the Role Checklist (Scott 2019) in identifying service users' needs and goals. These tools provide a foundational understanding that guides the therapeutic process, ensuring interventions

are both relevant and personalised to enhance competency and engagement. The OSA (Baron et al. 2006), as mentioned, is critical in measuring service users' perceptions of their occupational competence and identity, central to the MOHO (Kielhofner 2008). Tan et al. (2020) highlight this by demonstrating how the OSA (Baron et al. 2006) prioritises occupations that service users value most, often including performance, habituation, and volition items. Evaluation in occupational therapy encompasses not only outcome measurement but also adapting interventions to meet evolving needs. This research utilises structured assessments, and informal feedback to continuously refine therapeutic approaches, ensuring relevance and user-centred focus in changing contexts, such as virtual delivery formats. Supporting evidence from Lund et al. (2019a) discusses how evaluations recognising small steps and accomplishments can promote progress and self-compassion among participants. In both virtual and face-to-face settings, adapting evaluations based on service user feedback ensures interventions remain service user centred. Observations on service users feeling ‘evaluated out’ highlight the need for balancing thorough assessment with the experiential quality of sessions, ensuring that enough data is gathered to guide interventions while keeping the process engaging and manageable.

Finally, the quantitative data from this study, demonstrating significant improvements in OSA scores alongside qualitative feedback, highlights the effectiveness of integrating assessment, planning, and evaluation processes. These outcomes show notable improvements in individual competencies and satisfaction, supporting the structured yet flexible approach of Recovery Through Activity (Parkinson 2014).

Supported by the literature, this research shows that assessment, planning, and evaluation are central to Recovery Through Activity’s (Parkinson 2014) implementation. These processes ensure interventions tailored to service user needs, effectively measured, and adapted over

time. This approach aligns with MOHO’s emphasis on performance capacity (Kielhofner 2008), enhancing competence and satisfaction among service users in occupational therapy.

9.5 Environment

In examining the "Group Dynamics" theme, the research on Recovery Through Activity (Parkinson 2014) provides a comprehensive look at how group interactions significantly affect therapeutic outcomes in both virtual and face-to-face contexts. Effective management of group size is central to facilitating an environment conducive to recovery, as smaller groups typically allow for deeper engagement and more personalised interaction. This aspect is particularly vital in virtual settings where the physical cues and direct human contacts of face-to-face interactions are absent. Figure 25 demonstrates which themes link with environment.

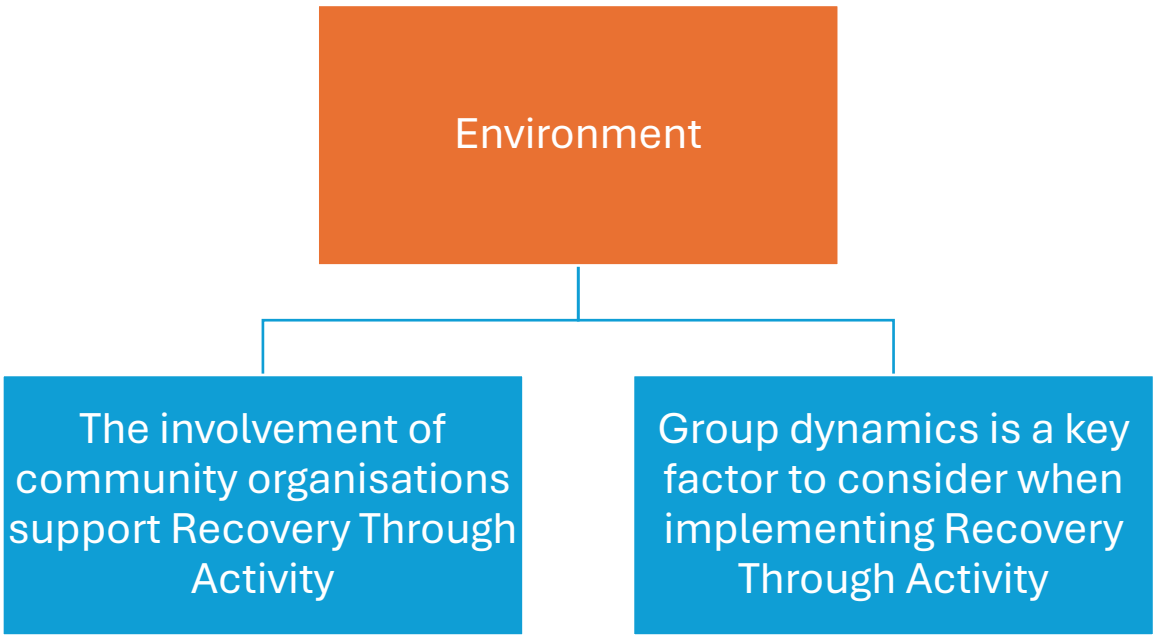


Figure 26 - Theme links to environment

Argentzell et al. (2020) highlight that positive social environments and well-managed group dynamics in therapeutic settings can promote a strong sense of community, trust, and belonging among service users, which in turn encourages greater openness and mutual support throughout their recovery journey. Chang et al. (2020) found that cultural and social dynamics heavily shape group interactions in occupational therapy settings. For example, in Taiwan, modifications to recovery programs were needed to respect cultural values of group harmony, which sometimes created challenges in prioritising individual autonomy within therapy (Chang et al. 2020). This cultural context presents potential challenges to Recovery Through Activity's focus on autonomy and suggests a need for adaptation when introducing group-centred approaches in certain settings.

Effective management of group size is central to creating an environment that supports recovery, as smaller groups typically allow for deeper engagement and more personalised interactions. Eklund et al. (2017) support this by noting that group settings in BEL enhanced social support

and promote a sense of community among participants, mirroring the impact of Recovery Through Activity (Parkinson 2014) on service user perceptions. Similarly, Newport and Clarke (2020) emphasise the importance of building a therapeutic community within group settings, finding that group cohesion promotes a strong sense of belonging, which is vital for mental health recovery. Rebeiro Gruhl et al. (2021) found that creating inclusive group environments strengthens a sense of belonging and mutual support. In the NISA program, small group settings helped to reinforce social connections, build confidence, and promote a supportive recovery-focused environment. These findings align with Recovery Through Activity's (Parkinson 2014) emphasis on supportive group dynamics.

Unlike some theoretical models that highlight the importance of social context without providing practical guidance, Recovery Through Activity (Parkinson 2014) offers specific strategies for managing group dynamics to create a structured social environment where service users can develop supportive connections. This aspect is especially critical in virtual settings where physical cues and direct human contact are limited. This analysis links to Objective 3, demonstrating how structured group dynamics support service user perceptions and experiences of therapy by promoting meaningful social connections and therapeutic engagement. The findings on group dynamics align with those of Waygood et al. (2012) and Walker and Thistlewood (2012), who emphasise the diversity in practitioners' experiences and the influence of cultural norms within different organisational contexts. These norms shape group dynamics and dictate how occupational therapists and service users interact within therapeutic settings (Waygood et al. 2020; Thistlewood 2020). As Martin (2003) notes, understanding the cognitive, affective, and behavioural traits shaped by these norms can aid therapists in designing interventions suited to the dynamics of each group. This insight supports Objective 2 by

acknowledging the organisational and cultural challenges occupational therapists may face when implementing Recovery Through Activity (Parkinson 2014), particularly when adapting group dynamics for diverse settings.

The use of videos and multimedia tools to reduce screen-time fatigue in virtual Recovery Through Activity (Parkinson 2014) settings illustrates an innovative approach to adapting therapy for digital constraints. This strategy diversifies engagement methods to cater to different preferences and learning styles, helping to maintain interest and alleviate fatigue. This adaptation mirrors the flexibility needed in face-to-face sessions, where balancing educational and practical elements requires dynamic adjustment.

Tuckman’s (1965) stages of group development—from forming and storming to norming and performing—demonstrate how groups progress towards cooperative and goal-oriented interactions, creating a therapeutic environment where all members feel valued and understood. The emphasis on planning and networking in this research is essential for tailoring interventions that extend beyond individual sessions and integrate community resources. Pro-active networking before interventions highlights the importance of linking therapy with community assets, broadening Recovery Through Activity’s (Parkinson 2014) impact. This is supported by findings from Lund et al. (2019a), which highlighted that feeling supported and connected to a community significantly bolsters an individual's motivation to pursue balanced life changes. Networking ensures service users have access to a wide array of resources and support systems, making therapeutic interventions more comprehensive and grounded in community support.

Social connections emerge as a key component of Recovery Through Activity (Parkinson 2014), with positive feedback on social interaction

measures like the 3B Scale (Rebeiro Gruhl et al. 2018). In virtual settings, despite the lack of physical presence, structured opportunities for sharing experiences and mutual support help build a virtual community, highlighting the potential of digital implementation methods to promote meaningful social connections. Argentzell et al. (2020) further observed that peer support environments encourage service users to see their progress mirrored in others, which promotes engagement and strengthens the therapeutic environment. Rebeiro Gruhl et al. (2021) note that peer support significantly boosts motivation and reinforces group cohesion, especially in virtual or community-based group settings where individuals might otherwise feel isolated. These findings highlight the importance of structured social support, a fundamental component in both Recovery Through Activity (Parkinson 2014) and NISA interventions (Rebeiro Gruhl et al. 2021). These findings are consistent with Lund et al. (2019a), where the BEL intervention highlighted the importance of group dynamics in promoting a sense of belonging and self-value through collective engagement. This connects to Objective 3 by illustrating how Recovery Through Activity (Parkinson 2014) supports service user experiences through its focus on social support and belonging, enhancing perceptions of therapy.

Insights from the Welsh Government (2020a) report on virtual interventions. These insights stress the importance of a balanced approach to technology use in therapeutic settings, acknowledging both the accessibility benefits and the potential risks of isolation or anxiety. This also relates to Objective 2 by identifying potential challenges in virtual implementation and the adjustments required by occupational therapists to address these in practice.

In conclusion, this research integrates theoretical and empirical insights to highlight how effective management of group dynamics can enhance the therapeutic process in Recovery Through Activity (Parkinson 2014)

interventions. Both virtual and face-to-face formats, despite inherent challenges, utilise group dynamics to promote a supportive therapeutic environment. This approach not only aids individual recovery but also encourages collective support and community integration, aligning with MOHO (Kielhofner 2008) principles where the environment is crucial.

In examining the 'Involvement of Community Organisations' theme, this research explores how external partnerships enhance Recovery Through Activity (Parkinson 2014) interventions, highlighting their importance in both virtual and face-to-face formats. Community organisations, enrich the delivery and engagement of Recovery Through Activity (Parkinson 2014) by providing resources that promote self-management and health, aligning with Health and Social Care Alliance Scotland's (2021) view that signposting should be part of a holistic, long-term approach to health care. Support from community organisations in the virtual format was versatile, including the distribution of weekly activity packs. These packs, which included mindfulness books, hand creams, and other self-care items, served a dual purpose: they offered practical resources and facilitated engagement within sessions. This aligns with Objective 4 by demonstrating how community support in virtual sessions contributes to the overall effectiveness of Recovery Through Activity (Parkinson 2014), supporting service users' engagement and recovery goals. The provision of tangible items by community organisations exemplifies the effective use of external resources to reinforce the Recovery Through Activity's (Parkinson 2014) educational and practical aspects.

Guest speakers from community organisations, provided service users with information about local resources and volunteering opportunities. This connection promotes deeper links between service users and their communities, enriching the social aspect of recovery. This reflects the findings of Doroud et al. (2015), who noted the connection between activity engagement and recovery, emphasising that personal recovery

often involves accessing community resources to build a supportive network. In face-to-face sessions, community organisations had a similarly significant impact. Insights from representatives helped service users establish direct connections with community resources, enhancing their understanding and engagement. Quantitative feedback from the 3B Scale (Rebeiro Gruhl et al. 2018) further highlights the importance of community involvement in Recovery Through Activity (Parkinson 2014) interventions. High agreement levels on statements about community connection and involvement demonstrate that these interventions effectively link service users with broader societal networks, thus fulfilling an essential social purpose. This connection to Objective 3 highlights the value of Recovery Through Activity (Parkinson 2014) in enhancing service user experiences by integrating them within a supportive community.

Reflecting on the integration of community resources, it's evident that these partnerships are not just supplementary but foundational to the success of Recovery Through Activity (Parkinson 2014). They provide essential links between service users and the broader community, enabling a more comprehensive approach to recovery that extends beyond individual sessions. This integration ensures that Recovery Through Activity (Parkinson 2014) is not isolated from the community but is embedded in a cohesive system that supports recovery and wellbeing.

In summary, the involvement of community organisations in Recovery Through Activity (Parkinson 2014) demonstrates an effective application of external resources in therapeutic settings. By bridging the gap between individual needs and community resources within the use of Recovery Through Activity (Parkinson 2014), it ensures that recovery is supported by a network that enhances health and social integration. These findings link with the overarching aim of evaluating the intervention's efficacy and effectiveness, demonstrating how it serves both service users and therapists by promoting an integrated, community-supported recovery.

9.6 Occupational adaptation

The "Occupational Approach" theme in this research showcases how Recovery Through Activity (Parkinson 2014) supports an occupational approach by guiding service users toward positive changes in routine, self-care, and overall wellbeing. The application of the MOHO (Kielhofner 2008) within Recovery Through Activity (Parkinson 2014) emphasises the domain of occupational adaptation, particularly focusing on occupational competence. Occupational adaptation, as explained by Taylor (2017), involves the development of occupational competence and occupational identity, which are essential for engaging in life roles effectively and satisfyingly. Figure 26 demonstrates which themes link with occupational adaptation.

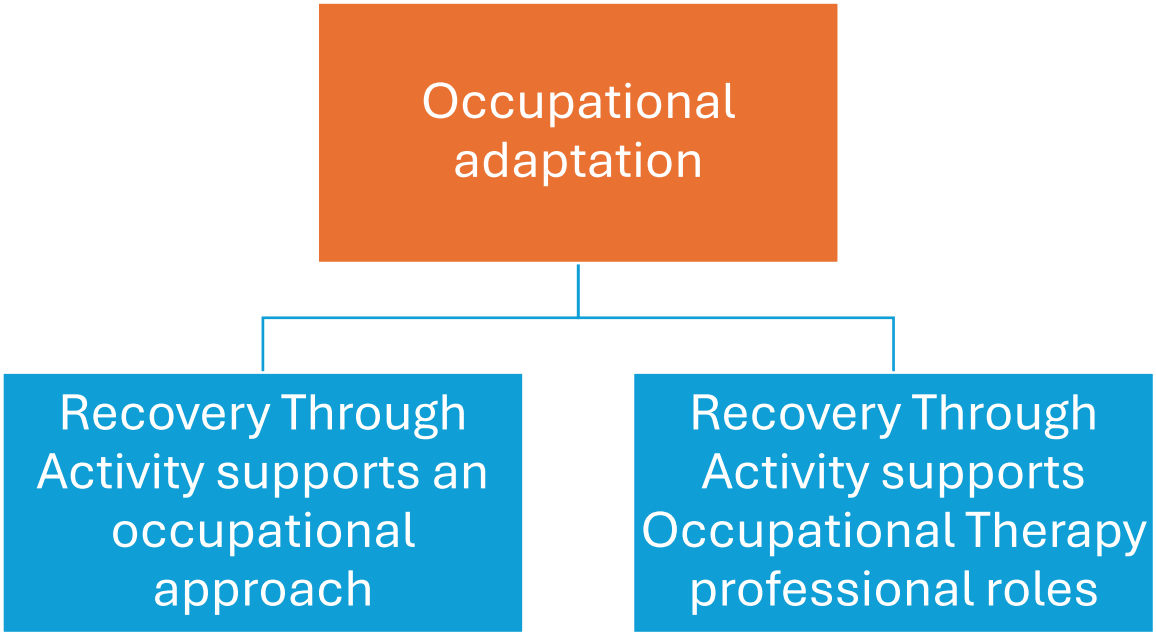


Figure 27 - Theme links to Occupational adaptation

The ‘Occupational Approach’ theme in this research demonstrates how Recovery Through Activity (Parkinson 2014) supports an occupational approach by guiding service users toward positive changes in routine, self-care, and overall well-being. This research has found Recovery Through Activity (Parkinson 2014) emphasises the domain of occupational adaptation, focusing on achieving occupational competence and adaptation. This finding addresses the overarching aim of evaluating its efficacy and effectiveness. Woolley et al. (2020) found that opportunities for community integration outside therapeutic groups played a crucial role in promoting long-term occupational adaptation, reinforcing social roles and helping participants develop and maintain meaningful routines. This supports Recovery Through Activity’s (Parkinson 2014) focus on community-based practices, showing how engagement in real-world contexts can strengthen occupational identity and establish lasting routines. Eklund et al. (2017) found similar outcomes with BEL participants, where occupational adaptation was evident through improvements in daily routines, social engagement, and goal setting. Rebeiro Gruhl et al. (2021) support this perspective, noting that structured, adaptable interventions like NISA help participants develop meaningful routines, increase autonomy, and improve their ability to manage daily challenges—key components of occupational adaptation. These findings highlight how interventions that support autonomy and role adaptation support service users in developing sustained, meaningful routines (Rebeiro Gruhl et al. 2021). They align with Recovery Through Activity (Parkinson 2014) by demonstrating that a structured, adaptive intervention can promote greater occupational competence, supporting both functional and social adaptation among service users.

Recovery Through Activity (Parkinson 2014) extends the theoretical focus of MOHO (Kielhofner 2008) by providing tangible tools and strategies for occupational therapists to actively support occupational adaptation and

change in service users. Occupational adaptation, as explained by Taylor (2017), involves the development of occupational competence and identity, which are essential for effective and satisfying engagement in life roles. Figure 26 illustrates which themes link with occupational adaptation.

Occupational competence is vital for service users as it involves the ability to meet the demands of valued roles and maintain a productive and satisfying engagement in various occupations. Argentzell et al. (2020) found that promoting occupational competence requires a blend of skill development and confidence-building, and they emphasise that structured activities aligned with service users' evolving roles support this adaptive process. Recovery Through Activity (Parkinson 2014) aligns well with these findings by promoting both competence and adaptive skills, which are critical for service users' sustained engagement and well-being. Schwammle (1996) suggests that occupational competence results from the dynamic interaction among individual characteristics, the environment, and the occupations themselves. This interplay is evident in Recovery Through Activity (Parkinson 2014), where service users engage in activities that not only meet their personal and therapeutic needs but also enhance their competence across various domains. These findings support Objective 3 by highlighting service user experiences and perceptions of increased competence and self-efficacy.

In both virtual and face-to-face formats, Recovery Through Activity (Parkinson 2014) promotes significant improvements in service users' routines and goals, aligning with Tan's (2020) assertion that occupational competence reflects a personal state of self-efficacy in fulfilling valued occupations. This is distinct from mere functional ability, pointing to a deeper, more personal accomplishment that Recovery Through Activity (Parkinson 2014) aims to promote. These outcomes support the overarching aim by providing evidence of Recovery Through Activity's

(Parkinson 2014) effectiveness in enhancing both functional and perceived personal competence. The OSA (Baron et al. 2006) outcomes from this research reveal significant improvements in competence scores, indicating not only enhanced ability but also an increased sense of personal efficacy and achievement among service users.

The integration of activities such as self-care, cleaning, music, creative activities, and physical activities is central to promoting occupational competence. Argentzell et al. (2020) highlight the importance of meaningful activities in enhancing users' occupational identities and personal satisfaction, noting that engaging in a range of personalised activities supports adaptive change by allowing service users to experience mastery and self-efficacy across diverse contexts.

Community involvement and the inclusion of various activity types within Recovery Through Activity (Parkinson 2014) also play significant roles in reinforcing occupational competence. The involvement of organisations like MIND and Hafal in providing resources and support exemplifies the practical application of community resources to enhance occupational engagement and competence. This aligns with Objective 2, highlighting the opportunities and challenges of integrating community partnerships within therapy to support occupationally focused approaches. These organisations not only provide immediate resources but also help in building long-term support networks for service users, further facilitating their occupational adaptation.

Quantitative and qualitative feedback from service users, such as improved competence scores and personal reflections on the benefits of Recovery Through Activity (Parkinson 2014), highlight the efficacy of Recovery Through Activity (Parkinson 2014) in promoting occupational competence. Eklund et al. (2017) also emphasise the critical role of qualitative feedback in evaluating occupational interventions, with positive

changes in daily routine adaptation and community engagement further supporting Recovery Through Activity's (Parkinson 2014) benefits for occupational competence and adaptation. These improvements in routine and goal management highlight the intervention's impact on long-term adaptation, addressing Objective 4 by evidencing its effectiveness in enhancing service user outcomes. Argentzell et al. (2020) similarly found that enhanced competence and personal narratives tied to occupational identity contribute to adaptation, further supporting that structured yet personalised approaches, like those in Recovery Through Activity (Parkinson 2014), effectively support sustained engagement and recovery. Service users report enhanced routines, better management of personal goals, and a renewed engagement with community and social activities, all of which are indicative of successful occupational adaptation.

Furthermore, the use of theory and practice is exemplified through Recovery Through Activity's (Parkinson 2014) alignment with MOHO (Kielhofner 2008), helping to articulate the purpose of Recovery Through Activity (Parkinson 2014) and the value of occupations. This theoretical foundation ensures that the interventions are grounded in occupational therapy principles, providing a framework for understanding and addressing the occupational needs of service users.

In conclusion, Recovery Through Activity (Parkinson 2014) supports effective occupational adaptation by promoting occupational competence through a well-rounded approach that integrates theory with practical activities. By engaging service users in a variety of meaningful occupations and supporting them with a strong theoretical framework, Recovery Through Activity (Parkinson 2014) contributes to their ability to fulfil valued roles and achieve a satisfying pattern of occupational behaviour. This integration of occupational adaptation principles supports both the professional practice of occupational therapists and the recovery journey of service users. This finding relates to the research overarching

aim of evaluating the intervention's comprehensive efficacy and effectiveness.

9.7 Summary

This chapter has explored how the MOHO (Kielhofner 2008) aligns with the more structured and practical approach of Recovery Through Activity (Parkinson 2014), especially in the context of mental health. Unlike theoretical models that remain abstract, Recovery Through Activity turns theory into actionable steps, providing occupational therapists with practical tools that can directly enhance service user engagement.

Starting with volition, this research emphasises the importance of aligning therapeutic activities with what service users value, what interests them, and what gives them a sense of control over their lives (Kielhofner 2008). Findings related to Objective 3 demonstrate that tailoring activities to fit individual motivations leads to deeper engagement and higher levels of satisfaction. Unlike models that only outline principles, Recovery Through Activity (Parkinson 2014) takes those principles and turns them into client-centred interventions, making them accessible and effective in practice. Research by Argentzell et al. (2020) supports this, showing that aligning interventions with service users' personal values significantly enhances both engagement and self-efficacy.

In terms of habituation, which involves building structured routines, this study highlights how Recovery Through Activity (Parkinson 2014) balances the need for structure with the flexibility required in mental health settings (Kielhofner 2008). This aligns with Objective 2, focusing on how occupational therapists navigate the complexities of delivering structured interventions in both virtual and in-person formats. Findings reveal that maintaining regular routines, even through virtual adaptations during COVID-19, helps service users establish stability, which is crucial for their recovery journey. This is consistent with the work of Eklund et al.

(2017) and Rebeiro Gruhl et al. (2021), who found that structured routines promote consistency and engagement.

When it comes to performance capacity, the focus is on enhancing service users' physical and cognitive abilities needed for everyday tasks (Kielhofner 2008). This ties into Objective 4, where findings indicate that combining one-to-one support with group activities strengthens service users’ competence and confidence. Recovery Through Activity (Parkinson 2014) differentiates itself by providing structured, yet flexible sessions tailored to each individual's needs, which directly supports the improvement of functional abilities. Tools like the OSA (Baron et al. 2006) were used to measure progress, showing a marked improvement in competence. Studies by Argentzell et al. (2020) and Eklund et al. (2017) further validate that personalised interventions can significantly enhance self-efficacy and resilience.

The environment is another crucial domain, influencing how service users engage in therapy through cultural, social, and physical contexts (Kielhofner 2008). Recovery Through Activity (Parkinson 2014) effectively leverages both the immediate therapeutic environment and broader community resources to support service user engagement. This directly addresses Objective 1, which explored how occupational therapists utilise environmental factors to maximise therapeutic impact. The results from the 3B Scale (Rebeiro Gruhl et al. 2018) highlighted the importance of promoting social connections, especially in virtual formats, which continue to support engagement despite physical distance.

Occupational adaptation is concerned with enabling individuals to achieve a balanced and fulfilling life (Kielhofner 2008). Recovery Through Activity (Parkinson 2014) excels in promoting this by developing service users' skills, confidence, and routines, aligning with Objective 4. Structured, yet adaptable interventions provide long-term support for service users, helping them adjust to changing circumstances. Argentzell et al. (2020)

and Eklund et al. (2017) emphasise that promoting occupational competence through structured activities leads to sustained engagement and a sense of accomplishment.

What sets Recovery Through Activity (Parkinson 2014) apart from theoretical models like MOHO (Kielhofner 2008) is its emphasis on practical application. While MOHO provides the theoretical foundation, Recovery Through Activity transforms these principles into concrete actions that therapists can easily implement. This practical approach not only makes the theory more accessible but also enhances its impact on service user outcomes, providing a bridge between theory and real-world practice.

Addressing the research objectives, this study shows how Recovery Through Activity enables occupational therapists to make effective use of the therapeutic environment (Objective 1), adapt interventions across both face-to-face and virtual formats (Objective 2), align therapy with service users' motivations (Objective 3), and improve their overall performance capacity and adaptability (Objective 4). The improvements seen in OSA scores (Baron et al. 2006) further substantiate the effectiveness of Recovery Through Activity in enhancing both competence and satisfaction among service users.

In summary, integrating MOHO principles (Kielhofner 2008) with the practical framework of Recovery Through Activity (Parkinson 2014) has proven effective in enhancing occupational therapy practice. This approach not only supports therapists but also empowers service users to achieve meaningful, sustainable engagement, ultimately supporting their recovery journey.

Chapter 10 - Conclusion

10.1 Introduction

The primary objective of this research was to evaluate the efficacy and effectiveness of Recovery Through Activity (Parkinson 2014) (Parkinson 2014) as employed by occupational therapists in adult mental health services within an NHS Health Board. Specifically, the research aimed to assess how this intervention, grounded in the MOHO (Kielhofner 2008) supports occupational therapists in their practice and enhances the therapeutic experience of service users.

The study objectives were to:

1. Explore occupational therapists' Experiences: To delve into the roles and experiences of occupational therapists using Recovery Through Activity (Parkinson 2014), providing insights into how they implement and perceive the intervention.

2. Identify Challenges and Opportunities: To uncover the challenges and opportunities faced by therapists in employing an occupationally focused approach within different service delivery formats.

3. Evaluate Service User Perceptions: To assess service user perceptions and experiences, particularly focusing on how Recovery Through Activity (Parkinson 2014) impacts their engagement and recovery process.

4. Analyse Intervention Outcomes: To evaluate the effectiveness of Recovery Through Activity (Parkinson 2014) by analysing existing

anonymised intervention outcome data to ascertain measurable impacts on service user wellbeing.

The study's cross case findings are structured around nine key themes that illuminate both the core aspects and the challenges of implementing Recovery Through Activity (Parkinson 2014):

1. Tailoring to Individual Needs: Emphasises the customisation of interventions using tools such as the OSA (Baron et al. 2006), Interest Checklist, and Role Checklist (Scott 2019).

2. Balancing Practical and Educational Aspects: Discusses the integration of practical activities with educational content, particularly within the virtual delivery format.

3. Enhancing Recovery Through One-to-One Support: Highlights the importance of personalised support sessions in complementing group interventions.

4. Community Organisation Involvement: Outlines how partnerships with community organisations enrich Recovery Through Activity (Parkinson 2014) and extend its reach and impact.

5. Importance of Assessment, Planning, and Evaluation: Focuses on the critical role of structured assessment and ongoing evaluation in aligning interventions with user needs.

6. Supporting an Occupational Approach: Explores how Recovery Through Activity (Parkinson 2014) facilitates positive changes in routine, self-care, and wellbeing.

7. Group Dynamics: Investigates the management of group dynamics to enhance therapeutic outcomes in both face-to-face and virtual settings.
8. Reinforcing Professional Roles: Considers how Recovery Through Activity (Parkinson 2014) strengthens the professional identity of occupational therapists.

9. Structural Flexibility: Analyses the adaptability of Recovery Through Activity (Parkinson 2014) ’s structure to meet diverse needs across various care settings.

This research comprehensively applies the MOHO (Kielhofner 2008), highlighting it’s domains—volition, habituation, performance capacity, environment, and occupational adaptation—to guide and enhance therapeutic interventions. Recovery Through Activity (Parkinson 2014) is shown to effectively incorporate these domains, tailoring interventions that not only address functional improvements but also foster a deeper, personal engagement in meaningful occupations. This alignment with MOHO principles ensures that therapeutic activities are both relevant and impactful, promoting enhanced engagement and wellbeing among service users.

This chapter will synthesise the insights gained from the cross-case analysis and the application of the MOHO (Kielhofner), reflecting on how Recovery Through Activity (Parkinson 2014) has been instrumental in advancing occupational therapy practice within mental health services. The chapter highlights how the research can inform practice and further research, draws upon the research limitations areas for further research.

10.2 Reflection on Case Study research Design

The case study research design, guided by Yin's methodology, proved to be instrumental in the conduct of this study, which aimed to examine the multifaceted implementation of Recovery Through Activity (Parkinson 2014) within adult mental health services. This approach allowed for a structured exploration of the complex interrelationships between occupational therapy perspectives, service user views, intervention outcome data, and my observational reflections. The strength of this methodology lies in its systematic focus on the contextual dynamics influencing practice, particularly how the MOHO (Kielhofner 2008) informs both the use of Recovery Through Activity (Parkinson 2014) and the research design itself.

Utilising a case study framework enhanced the depth of understanding regarding contextual influences on occupational therapy. It illuminated the reasons behind pivotal shifts in practice, such as the transition of Recovery Through Activity (Parkinson 2014) to a virtual format in response to the Covid-19 pandemic. This shift was not merely a procedural change but also a significant contextual factor that influenced the experiences of both service users and occupational therapy staff. The study also delved into the effects of accessing, or the inability to access, community services during the pandemic, highlighting how these external conditions impacted the implementation and reception of Recovery Through Activity (Parkinson 2014).

The flexibility of the case study design was particularly beneficial under the uncertain circumstances brought about by the pandemic. It accommodated an examination of Recovery Through Activity (Parkinson 2014) across various real-world environments and through differing

implementation methods, such as face-to-face versus virtual delivery. This adaptability was central in gathering data during a period marked by frequent changes in public health guidelines and operational protocols within the NHS Health Board.

In occupational therapy, where the focus is on understanding the whole person within their environment, the case study approach is especially pertinent. It enabled an in-depth exploration of the environments surrounding both the participants and Recovery Through Activity (Parkinson 2014) itself. The use of MOHO to structure the case studies was particularly effective. It informed data collection methods, shaped the discussion, and grounded the Recovery Through Activity (Parkinson 2014) intervention itself, allowing for a comprehensive exploration of all MOHO domains within each case study.

Despite its strengths, the case study methodology presented certain challenges. The dynamic nature of the environments under study, exacerbated by the pandemic, required constant adaptation of the research process. Significant changes in the setting and the nature of the cases necessitated ongoing reassessment and alignment with the original research objectives. Collaboration with the local health board was essential to maintain focus and adapt to the evolving circumstances, ensuring that the research remained relevant and grounded in the current realities of healthcare delivery.

Overall, the use of a case study research design in this thesis not only enriched the investigation of Recovery Through Activity (Parkinson 2014) within occupational therapy but also highlights the importance of flexibility and contextual awareness in research. It highlighted the intricate relationship between theory and practice in occupational therapy, providing valuable insights that could guide future interventions and research in the field.

10.3 Reflection on carrying out research during the Covid-19 pandemic

Reflecting on the implementation of this study during the Covid-19 pandemic, it is clear that the timing and context significantly influenced every aspect of the research, from data collection methods to personal experiences. The pandemic dramatically reshaped the operational landscape of the NHS Health Board, affecting staff, service users, and my own role as a researcher.

As the pandemic unfolded, the NHS Health Board faced immense pressure. Many staff members, including occupational therapists, were redeployed to support critical services, contending with the dual challenges of increased workload and heightened health risks. The necessity for remote working and the cessation of many routine activities, such as home visits, disrupted standard care procedures. Particularly impactful was the temporary suspension of the Recovery Through Activity (Parkinson 2014) sessions, a central component of this study, which over time shifted to an online format as part of a broader adaptation across health services.

For occupational therapists, these changes meant a significant disruption in how they delivered care. Transitioning to virtual sessions presented numerous challenges, from technological barriers to the difficulty of engaging service users through a screen. The sense of isolation from working remotely, compounded by screen fatigue, was a recurrent theme in discussions with colleagues, reflecting a broader impact on professional wellbeing and efficacy.

Service users, too, experienced profound disruptions. The shift from in-person to virtual sessions marked a significant change in how support was received. The absence of face-to-face contact led to feelings of isolation

among many service users, compounded by reduced access to community resources. Although virtual sessions provided a continuity of contact, they lacked the immediacy and intimacy of in-person interactions, which are often central for building trust and rapport in therapeutic settings.

Initially, my plan was to explore Recovery Through Activity (Parkinson 2014) across four distinct settings, encompassing both community and inpatient environments for adult and older adult mental health services. However, the pandemic's impact forced a significant narrowing of this scope, with the suspension of activities in older adult services due to intense service demands and stringent Covid-19 restrictions. This required a flexible adaptation of the case study design, focusing on the available and viable settings.

My experience as a researcher during this period was particularly challenging. The shift to a virtual environment hindered my ability to observe interactions directly and build rapport with participants, which is central for qualitative research. Recruiting participants became increasingly difficult, as the visibility and informal interactions that often aid in recruitment were starkly limited.

I also faced personal and professional setbacks; the remote work environment was isolating, and the lack of physical presence in health settings limited my opportunities for clinical observation and interaction—key components of my research methodology. The pandemic significantly impacted my professional development as a newly qualified occupational therapist; it restricted my clinical experience at a time when I was eager to integrate research insights with practical skills.

Reflecting on these experiences, I recognise the irony in studying occupational engagement while personally experiencing occupational restrictions. Writing about the importance of meaningful occupations and their impact on mental health, while being unable to engage in my own

meaningful activities like dance and swimming, highlighting the profound effects of occupational disruption. The transition back to some normalcy highlighted the stark difference between merely 'existing' and truly 'living'—a distinction that became a poignant part of my reflections on both personal and professional levels.

This complex backdrop not only tested the resilience and adaptability of health services and their clients but also shaped my growth as a researcher and practitioner, highlighting the necessity for flexibility in research approaches and the critical importance of personal and professional support during unprecedented times.

10.4 Reflection on research collaboration with NHS Health Board

Reflecting on the collaborative efforts undertaken with the local NHS Health Board during my research, I appreciated the initial support provided by the Research and Development team. Being able to attend Recovery Through Activity (Parkinson 2014) sessions and interact directly with occupational therapists and occupational therapy support workers was invaluable. This firsthand experience, prior to the Covid-19 restrictions, greatly enriched my understanding of the context surrounding the cases and was instrumental in shaping my research methods.

However, I encountered several challenges, particularly with recruitment. The primary issue seemed to stem from a lack of awareness about the research project. Despite the efforts of local collaborators who sent emails and letters, the busy workload of occupational therapists might have caused them to overlook these messages. I believe recruitment could have been more successful if I had been able to have a more visible presence within the health board. Similarly, direct engagement with

service users might have facilitated better recruitment outcomes. Reflecting on this, I made an effort to attend a few Recovery Through Activity (Parkinson 2014) sessions that resumed in-person towards the end of my research. Although service users showed interest, there was no subsequent participation.

Utilising a gatekeeper for recruitment was both a strength and a limitation. While this approach ensured ethical standards and impartiality, it also limited my direct interaction with potential participants, which might have impacted the recruitment rate. For example, an issue arose with the handling of paper consent forms, which were supposed to be returned to an office at the NHS Health Board. Due to a miscommunication, one consent form was left at the postal sorting office within the health board for weeks and was only discovered after the ethics approval had expired, preventing any follow-up with the potential participant.

Another significant challenge was the collection of intervention outcome data. The Health Board were unable to share face-to-face case data as the service users had not consented for this information to be shared. For the virtual Recovery Through Activity (Parkinson 2014) sessions, while data was eventually shared after considerable negotiation, the process was fraught with delays and misunderstandings about data sharing permissions. The data received was also limited, which affected the depth of analysis possible.

Attending the All Wales Drivers meetings for Recovery Through Activity (Parkinson 2014) was a highlight. These meetings provided vital insights into how Recovery Through Activity (Parkinson 2014) was being adapted for virtual delivery during the pandemic. Discussions around assessment and evaluation tools, and strategies for implementation were particularly enlightening. However, my plan to use the minutes from these meetings

for documentary analysis was prevented by confidentiality restrictions imposed by the Health Board, leading to the exclusion of this component from my research.

Overall, the collaboration with the NHS Health Board offered a profound learning experience, highlighting both the complexities of conducting real-world research and the importance of adaptive strategies in the face of unforeseen challenges. This experience has not only shaped my research approach and experience but has also provided a deeper appreciation for the operational dynamics within healthcare settings.

10.5 Personal reflection

Reflecting on my journey through this PhD during such a tumultuous period has been both challenging and profoundly enriching. Undertaking this research amidst a global pandemic introduced an array of unexpected hurdles, particularly adapting to the sudden shift to working from home, the inability to engage in normal social activities, and navigating through significant changes in my living situation. These changes tested my resilience and adaptability in ways I had not anticipated.

The isolation brought on by the pandemic was one of the toughest challenges. Being cut off from friends and family and unable to participate in activities that I enjoy added layers of difficulty to an already demanding research process. However, throughout this period, my motivation was continually fuelled by my passion for occupational therapy and, more specifically, for Recovery Through Activity (Parkinson 2014). My prior experience working as an OT technician in older adult mental health services had shown me the profound impact occupational therapy can have. I often recalled witnessing individuals with Dementia who hadn’t spoken for months begin to engage during activity sessions, and those

who typically sat passively were enlivened and smiling. These memories served as powerful reminders of why I embarked on this research path: to make a difference in people's lives through the power of therapeutic engagement.

Balancing work-life became another significant hurdle during the pandemic. The blurred lines between home and work often led me to spend excessive hours in front of the laptop, which wasn't always productive. It was a poignant irony that, while writing about the benefits of engaging in meaningful activities for mental health, I found myself struggling with the same issues. Upon discussing these challenges with my supervisor, I began to consciously schedule time for social interactions and leisure activities. This approach not only improved my mental wellbeing but surprisingly enhanced my productivity. When I returned to my research, I found myself more focused and effective.

The relationship with my research was complex, marked by highs and lows that resembled a love-hate dynamic. It was daunting to navigate the intricacies of a PhD compounded by the pressures of life and unprecedented global events. Yet, despite these challenges, I feel incredibly privileged to have had the opportunity to conduct this research. It allowed me to delve into the experiences and perspectives of others within the field of occupational therapy, contributing to the body of knowledge and hopefully paving the way for future advancements.

In conclusion, this journey has not only shaped my professional capabilities but also taught me invaluable life lessons about resilience, adaptation, and the importance of maintaining a balanced life. It reaffirmed my commitment to occupational therapy and highlighted the significant impact that thoughtful, well-implemented therapeutic activities can have on enhancing the quality of life for those we serve.

10.6 Contribution to knowledge

This thesis represents a pioneering exploration into the implementation of activity-focused interventions in occupational therapy through virtual platforms during the Covid-19 pandemic. Prior to this research, previous research had not comprehensively addressed the dual perspectives of occupational therapy staff and service users regarding Recovery Through Activity (Parkinson 2014), nor the specific challenges and innovations of virtual activity-focused occupational therapy. This work not only extends the body of knowledge in occupational therapy but also establishes foundational principles for future research and practice in virtual therapeutic settings.

Unprecedented Exploration of Virtual Therapy Dynamics

This research is the first to document and analyse how occupational therapy can be effectively transitioned to and implemented in a virtual format during a global health crisis. By focusing on Recovery Through Activity (Parkinson 2014), adapted for virtual delivery, this thesis provides a detailed account of the modifications necessary to maintain therapeutic efficacy remotely. It explores the technological, interpersonal, and procedural adaptations that therapists undertake, offering a comprehensive guide on managing therapeutic integrity in the absence of physical presence. This contribution is vital for the development of guidelines and standards for virtual occupational therapy.

Comprehensive Application of the MOHO Framework

Employing the MOHO (Kielhofner 2008) as a guiding framework, this study delves into each domain—volition, habituation, performance capacity, environment, and occupational adaptation. For example, the thesis examined how volition, or the personal motivation of service users,

is assessed and integrated into virtual sessions using tools like the Occupational Self-Assessment. Such detailed exploration enhances our understanding of how theoretical constructs can be operationalised in practice, particularly in non-traditional settings, enriching the theoretical and practical applications of MOHO in modern therapy contexts.

Service User-Centric Methodological Innovations

This study pioneers the use of specific, user-centric data collection tools to gauge the effectiveness of virtual interventions. By incorporating quantitative measures like the Occupational Self-Assessment and qualitative feedback directly from participants, the research ensures a holistic view of the therapeutic impact. This approach not only validates the effectiveness of the interventions but also highlights the needs and experiences of users, thereby promoting a more empathetic and responsive therapeutic practice.

Evaluation of Therapeutic Outcomes in Virtual Settings

The findings from this research are vital in establishing the therapeutic outcomes achievable through virtual platforms. It documents specific benefits such as increased accessibility, flexibility in scheduling, and enhanced user engagement due to the convenience and comfort of receiving therapy in one's own home environment. These outcomes contribute significantly to the discourse on digital health interventions, suggesting that virtual platforms can not only match but in some aspects, enhance the delivery of occupational therapy.

Practical Guidelines and Policy Recommendations

The practical implications of this research extend beyond academic circles into clinical practice and policy formulation. By demonstrating the feasibility and effectiveness of virtual occupational therapy, this research

provides a template for practitioners and healthcare administrators to develop resilient, adaptive therapeutic services that can withstand disruptions like a pandemic. Moreover, the policy recommendations derived from this study advocate for broader acceptance and integration of virtual therapy modalities within public health strategies, potentially influencing national and international health policies.

Enrichment of occupational therapy Education and Training

This thesis contributes to the educational foundations of occupational therapy by detailing the processes, challenges, and adaptations required for effective virtual therapy. This knowledge is invaluable for curriculum developers and educators aiming to prepare future therapists for a digitally integrated healthcare landscape. By incorporating these findings into educational programmes, occupational therapy training can produce practitioners who are adept not only at traditional therapy but also skilled in utilising digital tools for therapeutic engagement.

Long-Term Implications for occupational therapy Practice

This research has long-term implications for the field of occupational therapy by illustrating how virtual interventions can be seamlessly integrated into regular practice, ensuring continuity and resilience of therapeutic services. The insights gained regarding user engagement, satisfaction, and outcome efficacy can guide ongoing improvements in therapy practices, ensuring that they remain relevant and effective in the face of evolving technology and societal needs.

In summary, this thesis significantly advanced our understanding of virtual occupational therapy, contributing comprehensive insights into the application of Recovery Through Activity (Parkinson 2014) in a virtual context, enhancing practical guidelines, and influencing policy recommendations. It not only fills existing gaps in the literature but also

lays a robust foundation for future research, potentially leading to a paradigm shift in how occupational therapy is perceived and practiced in digital age.

10.7 Study limitations

The limitations of this study are several and stem largely from its scope and the external circumstances under which it was conducted. Conducted within a single Health Board, the research did not explore Recovery Through Activity (Parkinson 2014) across diverse geographic or organisational contexts, which may limit the applicability of the findings to other settings. Additionally, the study faced significant recruitment challenges that were exacerbated by the Covid-19 pandemic. The temporary cessation of Recovery Through Activity (Parkinson 2014) during the pandemic reduced the potential pool of participants, and my inability to make myself visible within the Health Board likely further hindered recruitment efforts.

The participant demographic within the study also posed limitations. The small sample size of occupational therapy staff did not fully represent the diversity of views that might exist across the profession. Moreover, the composition of the participant group—comprising only white women—does not reflect broader demographic diversity, either in terms of gender or ethnicity. While this does mirror the predominant demographic within the occupational therapy workforce of the Health Board, it does limit the diversity of perspectives and experiences captured in the study.

The inclusion of only one service user's perspective is another significant limitation. Despite the alignment of this service user's views with the

themes identified by occupational therapists, relying on a single individual's experiences does not provide a comprehensive view of the service user population. This limitation is vital as it restricts the research's ability to fully represent the service user experience.

Conducted over an extended period marked by considerable organisational change due to the pandemic, the study's timing may also affect the relevance and applicability of its findings. The unique circumstances of the pandemic meant that the study captured a specific moment in time, which may not necessarily extrapolate to more stable or typical periods of healthcare delivery.

Furthermore, a critical reflection on the methodology reveals the inherent limitations of case study research, particularly regarding generalisability. While case studies provide in-depth insights into specific contexts or situations, the findings from a single case study, such as this, are not intended to be generalisable to all settings or situations. This research aimed to provide a detailed account of how Recovery Through Activity (Parkinson 2014) is implemented in varying formats and to explore the experiences of staff and service users within these specific contexts. While it offers valuable insights, it does not claim that the findings are universally applicable to all occupational therapy practices. However, it does enhance our understanding of the factors that influence the use of Recovery Through Activity (Parkinson 2014) in specific contexts, thereby contributing valuable perspectives to the field.

10.8 Further areas of research

This research examined Recovery Through Activity (Parkinson 2014) within adult mental health services from the perspectives of occupational therapy staff and service users, alongside intervention outcome data. The

findings highlight the importance of continuing research in several areas to deepen our understanding and contribute to theory development within occupational therapy practice.

1. **Expanding Contextual Research**: There is a need to explore how Recovery Through Activity (Parkinson 2014) can be adapted and utilised across different settings and implementation methods. Investigating the intervention in various contexts will help enhance our understanding of its adaptability and effectiveness, providing valuable insights for its broader application in occupational therapy.

2. **occupational therapy Models in Research Design:** Further research into the use of occupational therapy models to inform and design research is vital. Such research would enhance the evidence base for occupational therapy as a profession and validate the theoretical frameworks that guide practice, thereby strengthening the academic and practical facets of the field.

3. **Service User Perspectives:** It is essential to conduct comprehensive research focusing on the experiences of service users with Recovery Through Activity (Parkinson 2014). Understanding service users' perspectives can provide deeper insights into the benefits and limitations of the intervention, potentially leading to improved practices and more client-centred care.

4. **Case Study Research Design:** Exploring the use of case study research design within occupational therapy could significantly benefit the profession. This method allows for an in-depth examination of interventions in real-world contexts, offering detailed insights that can inform clinical practice and policy decisions.

By pursuing these areas of research, we can build upon the initial findings of this research to develop a richer, more comprehensive understanding of Recovery Through Activity (Parkinson 2014). Such efforts will support the ongoing development of occupational therapy practices and enhance the quality of care provided to service users.

10.9 Implications and recommendations

Implications for occupational therapy Practice

The findings from this thesis suggest notable implications for occupational therapy practice, particularly in virtual intervention contexts. The successful adaptation and implementation of Recovery Through Activity (Parkinson 2014) in a virtual setting indicate that remote delivery could potentially be as effective as traditional face-to-face interactions. This shift holds implications for accessibility and inclusivity, as it may allow therapists to reach a broader demographic, including individuals in remote or underserved areas, as well as those with mobility or transportation challenges. Furthermore, the virtual format appears beneficial in responding to client needs during public health crises, such as pandemics, where traditional therapeutic settings might not be feasible.

The detailed exploration of the MOHO (Kielhofner 2008) within virtual therapy offers occupational therapists a structured approach to understanding and addressing complex client needs remotely. By focusing on volition, habituation, performance capacity, environment, and occupational adaptation, therapists might be better equipped to develop intervention plans tailored to the unique context of each client. This structured approach has the potential to enhance client engagement and satisfaction. Additionally, the increasing reliance on digital tools and platforms points to a need for occupational therapists to develop new skills and competencies, suggesting that training and ongoing professional

development should include digital literacy and strategies for remote client engagement.

Tailoring interventions to meet the unique needs of service users is suggested to be essential for optimising therapeutic outcomes across both face-to-face and virtual formats. To support practice, it is recommended that occupational therapists consistently utilise comprehensive assessment tools, such as the Occupational Self-Assessment (OSA), Interest Checklist, and Role Checklist, to collect detailed information on service users' needs, interests, and goals. This information could inform the creation of personalised and flexible intervention plans that adapt to changing needs over time.

The observed outcomes, including improvements in service users' competence and perceived value of activities, underscore the importance of individualised approaches. Practitioners are encouraged to leverage these tools and strategies to foster environments that support personal growth, improved mental health management, and a higher quality of life for service users.

It is suggested that occupational therapists using Recovery Through Activity (Parkinson 2014) continue to balance practical activities with educational content. Data indicates that this approach has been effective in both virtual and face-to-face settings. Elements such as resource packs, videos, handouts, and direct engagement strategies may help maintain this balance, potentially enhancing occupational goals and facilitating the application of learned skills in real-world settings. This balanced approach could support immediate therapeutic needs while also contributing to long-term recovery and wellbeing.

Incorporating one-to-one support sessions in both virtual and face-to-face Recovery Through Activity (Parkinson 2014) interventions appears to be beneficial for personalised care. These sessions could provide tailored

support, clarify individual goals and challenges, and ensure client-specific care. In virtual formats, structured one-to-one sessions might assist in building rapport and providing follow-up support, addressing the unique challenges of digital interactions. In face-to-face settings, informal discussions and planned one-to-one interactions could allow therapists to effectively tailor interventions and monitor individual progress. Adequate staffing is likely essential to facilitate these sessions. One-to-one support has the potential to complement group interventions, boosting service users' confidence, engagement, and overall therapeutic outcomes.

occupational therapists are encouraged to involve community organisations in Recovery Through Activity (Parkinson 2014) interventions to enhance delivery and engagement. Data indicates that partnerships with community organisations could support delivery in both virtual and face-to-face formats. For example, local third sector organisation can distribute weekly activity packs in virtual settings, promoting self-care and facilitating discussion, while guest speakers could introduce additional community resources and volunteer opportunities. In face-to-face settings, community organisations may offer hands-on activities, providing immediate engagement and reinforcing the holistic nature of Recovery Through Activity (Parkinson 2014). Community involvement is shown to enhance social engagement, foster meaningful connections, and support long-term recovery.

Integrating Recovery Through Activity (Parkinson 2014) into practice appears to support an occupational approach by providing a structured yet adaptable framework for promoting positive changes in routine, self-care, and overall wellbeing. This intervention can foster meaningful engagement through hands-on activities in face-to-face settings and innovative digital strategies in virtual settings. Such an approach could help service users to develop and sustain new, healthy routines while

promoting a sense of community and connection with local resources, thereby enhancing therapeutic outcomes.

Lastly, occupational therapists should consider group dynamics when implementing Recovery Through Activity (Parkinson 2014) to enhance intervention efficacy. Data suggests that both virtual and face-to-face settings benefit from attention to group size, management of screen-time anxiety, and encouragement of social connections. In virtual settings, smaller groups may facilitate engagement and comfort, while the use of multimedia content could reduce screen-time pressure. Face-to-face settings benefit from balanced group sizes that maintain cohesion and allow for spontaneous interactions. Across all settings, a sense of community and social support is vital, as these connections can significantly contribute to recovery. Tailoring group dynamics to the specific needs of the setting can support more inclusive, supportive, and effective therapeutic environments.

Integrating Recovery Through Activity (Parkinson 2014) could enhance and support occupational therapists' roles. It provides a way for therapists to communicate their diverse capabilities and contributions, while showcasing the multifaceted nature of occupational therapy, especially within multidisciplinary teams. By adopting Recovery Through Activity (Parkinson 2014), occupational therapists can highlight their role in promoting mental health, improving quality of life, and guiding service users toward meaningful, sustained recovery.

The flexible nature of Recovery Through Activity (Parkinson 2014) suggests it can be adapted to diverse settings and individual needs. occupational therapists should use this adaptability to create meaningful and responsive interventions that meet the evolving needs of service users.

Implications for Research

The implications of this thesis for future research could be substantial and multifaceted. This study addresses a gap in the literature on virtual occupational therapy and may set a foundation for further studies to explore additional dimensions of digital interventions. Expanding research into different types of therapeutic activities that might be adapted for virtual delivery could help in assessing their potential effectiveness across varied demographic and diagnostic groups. Such an approach may contribute to understanding the scalability and adaptability of virtual occupational therapy across broader clinical contexts and cultural settings.

The integration of the MOHO (Kielhofner 2008) a virtual setting also suggests an opportunity for investigating how other theoretical models might be applied in remote therapy contexts. Future research could examine comparative studies to understand the relative effectiveness of different occupational therapy models when applied in virtual versus in-person settings. These studies have the potential to deepen insight into theoretical frameworks in practice and may assist in refining and optimizing remote therapy methods in response to emerging evidence.

Additionally, longitudinal research might benefit the field by exploring long-term impacts of virtual occupational therapy on client outcomes, particularly in terms of sustained engagement, satisfaction, and quality of life improvements.

These research directions could support the academic discourse within occupational therapy while enhancing the evidence base. Such findings may ultimately advocate for policy adjustments that encourage the use of digital tools within healthcare practices.

10.10 Conclusion

This thesis has provided meaningful findings regarding the implementation of Recovery Through Activity (Parkinson 2014) within an NHS Health Board, offering insights into its potential efficacy and effectiveness when applied through the MOHO. The initial objectives of this study—to explore occupational therapists' experiences, identify challenges and opportunities, evaluate service user perceptions, and examine intervention outcomes—have been rigorously investigated. This exploration has led to an understanding of how Recovery Through Activity may support occupational therapists and enhance the therapeutic experience of service users.

The cross-case findings from this study reveal nine key themes that capture both the strengths and challenges of implementing Recovery Through Activity (Parkinson 2014). These themes, which span the importance of tailoring interventions to individual needs, balancing practical and educational aspects, and reinforcing professional roles, offer valuable insights into the varied aspects of occupational therapy practice within adult mental health services.

By applying the MOHO (Kielhofner 2008), this research illustrates how Recovery Through Activity (Parkinson 2014) may incorporate its domains effectively, facilitating interventions that are not only functionally beneficial but also engaging for service users. This approach can help ensure that therapeutic activities are relevant and impactful, potentially enhancing user engagement and supporting overall wellbeing.

The findings from this research suggest important implications for both occupational therapy practice and future research: For Practice: The virtual implementation of Recovery Through Activity (Parkinson 2014) suggests that remote delivery of occupational therapy has the potential to

be as effective as traditional methods. This adaptability is valuable for maintaining service continuity during events such as pandemics and for increasing access to mental health services. Furthermore, applying the MOHO (Kielhofner 2008) in this way may provide a structured method for addressing complex client needs across settings, enhancing personalised care and client satisfaction.

For Research: This study lays a foundation for future research to further explore digital interventions within occupational therapy. There is potential for future studies to explore other therapeutic activities adapted for virtual delivery and to assess their effectiveness across diverse populations and contexts. Additionally, longitudinal studies could help evaluate the long-term impacts of virtual occupational therapy, contributing to an enhanced understanding of its benefits and limitations.

Reflecting on the case study research design, this approach has proven useful in exploring the dynamics involved in implementing Recovery Through Activity (Parkinson 2014) during a pandemic. The flexibility and depth of this method have facilitated a comprehensive analysis of the intervention in real-world settings, though the dynamic nature of these environments has also presented some challenges.

In summary, this thesis contributes to the field of occupational therapy by offering a detailed exploration of a virtual adaptation of Recovery Through Activity (Parkinson 2014) within the MOHO (Kielhofner 2008). It not only addresses a gap in existing research but also offers practical considerations for implementing digital tools in therapeutic settings. The insights gained underscore the adaptability and resilience of occupational therapy practices, supporting the potential for future advancements that align with evolving technological and societal needs.

References

Adams, K. B., Leibbrandt, S., & Moon, H. 2011. A critical review of the literature on social and leisure activity and wellbeing in later life. *Ageing & Society*, 31(4), 683–712. https://doi.org/10.1017/S0144686X10001091

American Occupational Therapy Association, 2010. *Occupational Therapy's Role in Mental Health Recovery*. [online] Available at: https://www.cptopr.org/Documents/Mental%20Health%20Recovery.pdf [Accessed 8 January 2024].

Argentzell, E., et al. 2020. Exploring mediators of the recovery process over time among mental health service users, using a mixed model regression analysis based on cluster RCT data. *BMC psychiatry* 20(1), p.520.

Arksey, H., & O'Malley, L. 2005. Scoping studies: Towards a methodological framework. International Journal of Social Research Methodology, 8(1), pp.19-32.

Backman, C.L. 2010. 'Occupational balance and well-being', in Christiansen, C.H. and Townsend, E.A. (eds.) *Introduction to occupation: The art and science of living*. 2nd edn. Upper Saddle River, NJ: Pearson, pp. 231-249.

Barkham, M. et al. 2013. The CORE-10: A short measure of psychological distress for routine use in the psychological therapies. *Counselling and Psychotherapy Research*, 13(1), pp.3–13.

Baron, K., et al. 2006. *The Occupational Self Assessment (OSA) (Version 2.2).* Chicago: Model of Human Occupation Clearinghouse, Department of

occupational therapy, College of Applied Health Sciences, University of Illinois at Chicago.

BBC News. 2022. COVID-19 Coverage in Wales. Available at: https://www.bbc.com/news [Accessed: 21 October 2023].

Becker, H. S., 1998. *Tricks of the trade: How to think about your research while you're doing it*. Chicago: University of Chicago Press.

Bejerholm, U. 2010. Occupational Balance in People With Schizophrenia. *occupational therapy in Mental Health,* 26, pp.1-17. doi: 10.1080/016421208026420197.

BMA. 2024. Mental health pressures in England. Available at: www.bma.org.uk [Accessed 21 October 2024].

Boniface, G. 2012. Defining occupational therapy theory. In: G. Boniface and A. Seymour, eds. 2012*. Using occupational therapy Theory in Practice.* West Sussex: Wiley-Blackwell. pp.21-37.

Braun, V. and Clarke, V. 2013. *Successful Qualitative Research: A Practical Guide for Beginners.* London: SAGE.

Braun, V., et al. 2023a. *Thematic analysis: A practical guide*. Sage.

Braun, V., et al. 2023b. *Doing reflexive thematic analysis. In: Supporting research in counselling and psychotherapy: Qualitative, quantitative, and mixed methods research.* Cham: Springer International Publishing, pp.19-38.

Bruner, J., 1986. *Actual Minds, Possible Worlds*. Cambridge, MA: Harvard University Press.

Bryman, A. 2008. *Social Research Methods.* 3rd ed. Oxford: Oxford University Press

Cardiff University. 2020. New survey reveals toll of COVID-19 on mental health in Wales. Available at: https://www.cardiff.ac.uk/ [Accessed: 21 October 2024].

Centre for Mental Health. 2024. The economic and social costs of mental ill health. Available at: www.centreformentalhealth.org.uk [Accessed 21 October 2024]

Chang, Y. C., et al. 2020. Recovery Programs for People with Mental Illness in Taiwan: a Feasibility Study. The American journal of occupational therapy: *official publication of the American occupational therapy Association*, 74(4), pp.7404205110p1–7404205110p11.

Christiansen, C. H., 1999. Defining Lives: Occupation as Identity: An Essay on Competence, Coherence, and the Creation of Meaning*. American Journal of occupational therapy,* 53, pp.547-558.

College of Occupational Therapists. 2017. *Occupational therapy: the heart of rehabilitation*. London: College of Occupational Therapists.

Creek, J. 2003. *occupational therapy Defined as a Complex Intervention*. London: COT.

Creek, J. 2010. *The Core Concepts of Occupational Therapy: A Dynamic Framework for Practice*. Jessica Kingsley Publishers, London.

Creswell, J. W. 2009. *Research Design: Qualitative, Quantitative, and Mixed Methods Approaches.* 3rd ed. Thousand Oaks, CA: SAGE Publications.

Critical Appraisal Skills Programme (CASP) 2024. *CASP Checklists*. [online] Available at: https://casp-uk.net/casp-tools-checklists/ [Accessed 7 December 2024].

Crotty, M., 1998. *The Foundations of Social Research: Meaning and Perspective in the Research Process.* London: Sage Publications.

Crowe, A., & Deane, F.P. 2018a. Barriers to recovery-oriented mental health services. Community Mental Health Journal, 54(1), pp.31-40.

Crowe, S. and Deane, F. 2018b. Characteristics of mental health recovery model implementation and managers' and clinicians' risk aversion. *Journal of Mental Health Training, Education and Practice,* 13(1), pp.22-33.

Data Protection Act, 1998. c.29.

Denzin, N. K. and Lincoln, Y. S., 1994. *Handbook of Qualitative Research*. Sage.

Department of Health and Social Care. 2021. Mental Health and Wellbeing Plan for England. Available at: www.gov.uk

Doroud, N., et al. 2015. Recovery as an occupational journey: A scoping review exploring the links between occupational engagement and recovery for people with enduring mental health issues. Australian occupational therapy Journal, 62(6), pp.378–392.

Duncan, E. 2006. *An introduction to conceptual models of practice and frames of reference. In: E. Duncan, ed. 2006. Foundations for Practice in occupational therapy.* pp.59-66.

Eckstein, H., 1975. Case studies and theory in political science. In: F.I. Greenstein and N.W. Polsby, eds. *Handbook of Political Science: Strategies of Inquiry.* Reading, MA: Addison-Wesley, pp.79-138.

Eklund M, Leufstadius C, Bejerholm U. 2009. Time use among people with psychiatric disabilities: Implications for practice. Psychiatric Rehabilitation Journal, 32(3), 177–191.

Eklund, M. and Argentzell, E. 2016. *Perception of occupational balance by people with mental illness: A new methodology*. Scandinavian Journal of Occupational Therapy, 23(4), pp. 304-313.

Eklund, M., et al. 2017. Effectiveness of Balancing Everyday Life (BEL) versus standard occupational therapy for activity engagement and functioning among people with mental illness - a cluster RCT study. *BMC psychiatry,* 17(1).

Ellison, M. L., et al. 2018. *Explication and Definition of Mental Health Recovery: A Systematic Review. Administration and Policy in Mental Health and Mental Health Services Research*, 45(1), pp.91-102. doi: 10.1007/s10488-016-0767-9.

Elmontsri, M., et al. 2018. Improving patient safety in developing countries – moving towards an integrated approach. *JRSM Open*, 9(11). doi: 10.1177/2054270418786112.

Equality Act. 2010. C.15.

Evely, A. C., et al. 2008. High levels of participation in conservation research and practice. *Conservation Biology,* 22(5), pp. 1167–1174.

Farnworth, L. 2003. Time use, tempo and temporality: occupational therapy's core business or someone else's business? *Australian occupational therapy Journa*l, 50(3), pp.116-126.

Finlay, L. 2006. 'Rigour, ethical integrity or artistry? Reflexively reviewing criteria for evaluating qualitative research'. British Journal of occupational therapy, 69(7), pp. 319–326.

Finlay, L. 2008. 'Reflecting on reflective practice', *Practice-based Professional Learning Centre*, pp. 1-27.

Fletcher-Wood, H. 2018. Step by step: breaking learning down using behavioural psychology. Available at: https://improvingteaching.co.uk/2018/04/22/step-by-step-using-behavioural-psychology-to-break-tasks-down/ [Accessed: 28 November 2021].

Flyvbjerg, B. 2006. Five Misunderstandings About Case-Study Research. *Qualitative Inquiry*, 12(2), pp.219-245.

Foden, M., et al. 2014. *The health legacy of coal mining: Analysis of mortality rates over time in England and Wales (1981–2019)*. [online] Available at: https://research.wu.ac.at/en/publications/the-health-legacy-of-coal-mining-analysis-of-mortality-rates-over [Accessed 8 January 2024].

Foley, R., 1987. *The Theory of Epistemic Rationality.* Cambridge, MA: Harvard University Press.

Forsyth, K. and Kielhofner, G. 2008. 'Therapeutic Reasoning: Planning, Implementing and Evaluating the Outcomes of Therapy', in G. Kielhofner (ed.) *Model of Human Occupation: Theory and Application*. 4th ed. Baltimore: Lippincott Williams & Wilkins, pp. 161-170.

Forsyth, K., et al. 2005. Scholarship of Practice: Making Occupation-Focused, Theory-Driven, Evidence-Based Practice a Reality. *The British Journal of occupational therapy*, 68(6), pp.260-268.

Fox, V. 2013. Professional roles in community mental health practice: generalist versus specialist. *Occupational Therapy in Mental Health,* 29(1), pp.3–9.

Gerring, J. 2017. *Case Study Research: Principles and Practices*. 2nd ed. Cambridge: Cambridge University Press.

Gibbs, G., 1988. *Learning by doing: A guide to teaching and learning methods*. Further Education Unit.

Giddens, A., 1991*. Modernity and Self-Identity: Self and Society in the Late Modern Age*. Cambridge: Polity Press.

Glynn, A.N. and Ichino, N. 2016. Using causal models to improve case study inference: Methodology for case studies. *Political Analysis*, 24(4), pp.344–362.

Guba, E. and Lincoln, Y., 1994. *Competing paradigms in qualitative research. In: N. Denzin and Y. Lincoln, eds. Handbook of Qualitative Research.* Thousand Oaks, CA: Sage, pp.105-177.

Guba, E. G., 1990. *The Paradigm Dialog.* Newbury Park, CA: Sage Publications.

Hammell, K.W. 2009. Self-care, productivity and leisure, or dimensions of occupational experience? Rethinking occupational "categories". *Canadian Journal of Occupational Therapy*, 76(2), pp.107-114.

Hasselkus, B. R. 2002. *The meaning of everyday occupation*. Thorofare, NJ: Slack.

Hatch, J.A. 2013. Cultivating daily routines: The influence of cultural beliefs on habits and implications for occupational therapy. *Journal of Occupational Science*, 20(2), pp.123–137.

Health and Care Professions Council (HCPC) 2024. *Standards of Conduct, Performance and Ethics: Service User and Carer Consultation*. Retrieved from: HCPC Standards of Conduct, Performance and Ethics.

Health and Social Care Act 2001. c.15.

Health and Social Care Alliance Scotland (the ALLIANCE) 2021. The ALLIANCE Digital Health and Care Programme 2021 Review. [online] Available at: https://www.alliance-scotland.org.uk/blog/news/the-alliance-digital-health-and-care-programme-2021-review/ [Accessed 6 December 2024].

Health Research Authority 2017. UK policy framework for health and social care research. Available at: https://www.hra.nhs.uk/planning-and-improving-research/policies-standards-legislation/uk-policy-framework-health-social-care-research/ [Accessed: 27 May 2024].

Heasman, D. and Salhortra, G. 2008. UK modified interest checklist. Model of Human Occupation Clearinghouse (MOHO Web): University of Illinois. Retrieved from: http://www.cade.uic.edu/moho/productDetails.aspx?aid=39.

Hitch, D., et al. 2014. In the footsteps of Wilcock, part one: The evolution of doing, being, becoming, and belonging. *Occupational Therapy in Health Care*, 28(3), pp.231–246.

Hoffman, S. G. and Hay, A. C. 2018. Rethinking Avoidance: Toward a Balanced Approach to Avoidance in Treating Anxiety Disorders. *Journal of Anxiety Disorders,* 55, pp.14-21.

Hurst, H. 2017. *Using the Canadian Model of Occupational Performance in Occupational Therapy Practice: A Case Study Enquiry*. Ph.D. Thesis, University of the West of England. Available at: https://uwe-repository.worktribe.com/output/884522 [Accessed Day Month Year].

Institute for Health Metrics and Evaluation. 2020. Global prevalence and burden of depressive and anxiety disorders in 204 countries and territories in 2020 due to the COVID-19 pandemic. Available at: www.healthdata.org. [Accessed 21 October 2024]

Jasper, M. 2013. *Beginning Reflective Practice*. 2nd edn. Andover: Cengage Learning.

Jenkins, R. et al. 2008. Debt, income and mental disorder in the general population. *Psychological Medicine*, 38(10), pp.1485–1493.

Johnson, R. B. and Onwuegbuzie, A. J. 2004. Mixed Methods Research: A Research Paradigm Whose Time Has Come. *Educational Researcher,* 33(7), pp.14-26. doi: 10.3102/0013189X033007014.

Kaye, C. and Howlett, M. 2008*. Mental Health Services Today and Tomorrow*. London: CRC Press.

Kielhofner, G. 1995. *A Model of Human Occupation: Theory and Application*. 2nd ed. Baltimore: Williams & Wilkins.

Kielhofner, G. 2002. *A Model of Human Occupation: Theory and Application*. 3rd ed. Baltimore: Lippincott Williams & Wilkins.

Kielhofner, G. 2008. Model of Human Occupation: Theory and Application (4th ed.). Baltimore, MD: Lippincott Williams & Wilkins.

Kielhofner, G. and Burke, J., 1980. *A Model of Human Occupation: Theory and Application*. Baltimore: Williams & Wilkins.

King, N. and Horrocks, C. 2010. *Interviews in Qualitative Research.* London: SAGE.

Law, M. & Baum, C. 2005. *Measuring occupational performance: Supporting best practice in occupational therapy*. 2nd ed. Thorofare, NJ: Slack Incorporated.

Law, M. et al. 2016. *Client-centred occupational therapy*. 2nd ed. Thorofare, NJ: Slack Incorporated.

Leamy, M. et al. 2011. A conceptual framework for personal recovery in mental health: Systematic review and narrative synthesis. *The British Journal of Psychiatry*, 199(6), pp.445–452.

Leufstadius, C. and Eklund, M. 2008. Time use among individuals with persistent mental illness: identifying risk factors for imbalance in daily activities. *Scandinavian Journal of Occupational Therapy*, 15(1), pp.23–33.

Levac, D., et al. 2010. Scoping studies: advancing the methodology. Implementation Science, 5(1), p.69.

Lincoln, Y. S. and Guba, E. G., 1985. Naturalistic Inquiry. Newbury Park, CA: SAGE Publications.

Lloyd, C. et al. 2002. Generic versus specialist clinical work roles of occupational therapists and social workers in mental health. *Australian and New Zealand Journal of Psychiatry*, 38(3), pp.119–124.

Lockie, S. 2003. Situated environmental risks: A bounded relativist perspective on the nature of environmental risks. *Risk Analysis*, 23(6), pp.879–888.

Lund, K., et al. 2019a. Group leader and participant perceptions of Balancing Everyday Life, a group-based lifestyle intervention for mental health service users. Scandinavian Journal of occupational therapy, 27(4), pp.307–316.

Lund, K., et al. 2019b. Breaking a cycle of perceived failure: The process of making changes toward a more balanced lifestyle*. Australian occupational therapy Journal*, 66(5), pp.627-636.

Lund, K., et al. 2020. Group leader and participant perceptions of Balancing Everyday Life, a group-based lifestyle intervention for mental

health service users. *Scandinavian Journal of occupational therapy,* 27(6), pp.462-473.

Macpherson, R. et al. 2016. The relationship between clinical and recovery dimensions of outcome in mental health. *Schizophrenia Research*, 175(1-3), pp.142-147.

Marmot, M., et al. 2020. *Health equity in England: The Marmot Review 10 years on*. Institute of Health Equity. Available at: https://www.health.org.uk [Accessed 1 December 2024].

Martin, V. 2003. *Leading Change in Health and Social Care.* London: Routledge.

Mental Capacity Act 2005. c.10.

Mental Health Foundation 2020. *The COVID-19 pandemic, financial inequality, and mental health*. [online] Available at: https://www.mentalhealth.org.uk [Accessed 5 December 2024].

Mental Health Foundation. 2016. Mental Health in Wales: Fundamental Facts. Available at: https://www.mentalhealth.org.uk/sites/default/files/FF16%20Wales.pdf [Accessed: 1 September 2022].

Mental Health Foundation. 2024. Mental health at work: 2024 statistics. Available at: www.mentalhealth.org.uk [Accessed 24 October 2024]

Meyer, A. 1922. The philosophy of occupation therapy. *Archives of Occupational Therapy*, 1(1), pp.1–10.

Mind Cymru. 2020. The mental health emergency: Wales summary report. Available at: https://www.mind.org.uk/ [Accessed 21st October 2024]

Mind Cymru. 2021. Mental Health Impact of COVID-19 in Wales. Available at: https://mind.org.uk [Accessed 21st October 2024]

Mo, P. K., et al. 2016. Physical Activity in People With Mental Illness in Hong Kong: Application of the Health Belief Model. *Journal of Sport and Exercise Psychology*, 38(2), pp.203-208.

Molineux, M. 2004. *Occupation for Occupational Therapists*. Oxford: Blackwell Publishing.

Moon, K. and Blackman, D. 2014. A guide to ontology, epistemology, and philosophical perspectives for interdisciplinary researchers. *Ecological Economics,* 105, pp.10-19.

Morgan, D. L. 2007. Paradigms lost and pragmatism regained: Methodological implications of combining qualitative and quantitative methods. *Journal of Mixed Methods Research,* 1(1), pp.48-76.

Morgan, K. and Rees, G., 2016. *The State and Post-Industrial Urban Regeneration: The Reinvention of South Cardiff*. *Urban History*, 43(4), pp.578-596. [online] Available at: https://www.cambridge.org/core/journals/urban-history/article/abs/state-and-postindustrial-urban-regeneration-the-reinvention-of-south-cardiff/397EA4BE2961F2E90FED8FA59225DD01 [Accessed 8 January 2024].

Moses, J. W., and Knutsen, T. L. 2012. *Ways of Knowing: Competing Methodologies in Social and Political Research.* 2nd ed. London: Palgrave Macmillan.

Moule, P. and Hek, G. 2011. *Making sense of research: An introduction for health and social care practitioners*. 4th ed. London: SAGE Publications.

Munn, Z., et al. 2018. Systematic review or scoping review? Guidance for authors when choosing between a systematic or scoping review approach. *BMC Medical Research Methodology,* 18(1), pp.1-7.

National Assembly for Wales. 2010. *Mental Health (Wales) Measure 2010*. Available at: https://www.legislation.gov.uk/mwa/2010/7/contents [Accessed: 6 December 2024].

National Research Council 2003. *Protecting participants and facilitating social and behavioral sciences research.* Washington, DC: National Academies Press.

National Survey for Wales. 2023. Mental well-being and life satisfaction results for 2022-23. Available at: www.gov.wales. [Accessed 21st October 2024]

Newing, H. 2010. *Conducting Research in Conservation: Social Science Methods and Practice*. London: Routledge.

Newport, A. and Clarke, C. 2020. The experiences of people with severe mental health conditions participating in the Occupation Matters Programme: An interpretative phenomenological analysis. *British Journal of occupational therapy*, 83(10), pp.620-630.

NHS Digital. 2024. Mental Health Services Monthly Statistics. Available at: digital.nhs.uk. [Accessed October 2024]

NHS Wales. 2021. Adult Community Mental Health Services in Wales: Our Vision for the Future. Available at: https://executive.nhs.wales/ [Accessed 21st October 2024]

Office for National Statistics. 2020a. COVID-19 impact on mental health in Wales. Available at: https://www.ons.gov.uk/ [Accessed 21st October 2024]

Office for National Statistics. 2021. Coronavirus and depression in adults, Great Britain: January to March 2021. Available at: www.ons.gov.uk [Accessed 21st October 2024]

O'Toole, G. 2011. What is occupation analysis? In: L. Mackenzie and G. O'Toole, eds. *Occupation Analysis in Practice*. Chichester: Wiley-Blackwell, pp.3–24.

Page, M.J., et al. 2021. The PRISMA 2020 statement: an updated guideline for reporting systematic reviews. *BMJ*, 372, p.n71. Available at: https://www.bmj.com/content/372/bmj.n71 [Accessed 7 December 2024].

Parkinson, S. 2014. *Recovery Through Activity: Increasing Participation in Everyday Life.* New York: Routledge.

Parkinson, S., et al. 2006*. User's Manual for the Model of Human Occupation Screening Tool (MOHOST) (version 2.0).* Available at: http://moho.uic.edu/pdf/MohostManual.pdf [Accessed: 27 May 2024].

Patton, M. Q. 2002. *Qualitative Research and Evaluation Methods.* 3rd ed. Thousand Oaks, CA: Sage Publications.

Pentland, D. et al. 2018. *Occupational Therapy and Complexity: Defining and Describing Practice*. London: Royal College of Occupational Therapists.

Pentland, W. et al. 2008. Occupational integrity: another perspective on "life balance". *Canadian Journal of Occupational Therapy*, 75(3), pp.135–138.

Peterson, C., et al. 2019. Occupational therapy interventions in mental health: A scoping review of recent evidence. *Australian occupational therapy Journal,* 66(1), pp. 75-83.

Pettican, A. and Bryant, W. 2007. Sustaining a Focus on Occupation in Community Mental Health Practice. *The British Journal of occupational therapy*, 70. doi: 10.1177/030802260707000402.

Pham, M. T., et al. 2014. A scoping review of scoping reviews: advancing the approach and enhancing the consistency. *Research synthesis methods*, 5(4), pp.371-385. doi: 10.1002/jrsm.1123.

Polatajko, H. J., et al. 2007. Specifying the domain of concern: Occupation as core. In: E. A. Townsend and H. A. Polatajko, eds. *Enabling Occupation II: Advancing an occupational therapy Vision for Health, Well-being, & Justice through Occupation*. Ottawa: CAOT Publications, pp.13-36.

Powell, R. A. 2001. *Qualitative research in health: An introduction.* London: SAGE Publications.

Pratt, M. G., 1998. To be or not to be? Central questions in organizational identity. *Academy of Management Review,* 23(1), pp.171-193.

Public Health England. 2022. COVID-19 Updates in England. Available at: https://www.gov.uk. [Accessed October 2024]

Public Health Wales. 2021. COVID-19 Response in Wales: Lessons Learned. Available at: https://phw.nhs.wales/. [Accessed 21st October 2024]

Public Health Wales. 2022. COVID-19 Death Statistics. Available at: https://phw.nhs.wales [Accessed 21st October 2024]

Public Health Wales. 2024. Wellbeing of Wales 2023: A Healthier Wales. Available at: www.gov.wales [Accessed 21st October 2024]

Reagon, C. 2012. Evidence-based practice in occupational therapy: Integrating research, client feedback, and values. *Journal of occupational therapy Practice*, 18(3), pp.145–153.

Rebeiro Gruhl, K., et al. 2018. Being, belonging and becoming: Development of the 3B Scale. *Aust Occup Ther J*, 65, pp.354-362. doi: 10.1111/1440-1630.12468.

Rebeiro Gruhl, K.L., et al. 2021. Evaluation of an occupation-based, mental-health program: Meeting being, belonging and becoming needs. Mental Health and Social Inclusion, 21(2), pp. 91-101.

Reed, K. L. and Sanderson, S. N., 1999. *Concepts of occupational therapy.* 4th ed. Philadelphia: Lippincott Williams & Wilkins.

Reilly, M., 1961. Occupational therapy Can Be One of the Great Ideas of 20th-Century Medicine. *American Journal of occupational therapy*, 16(1), pp.1-9.

Ritchie, J. and Lewis, J. 2003. *Qualitative research practice: A guide for social science students and researchers*. London: SAGE Publications.

Roberts, G. and Boardman, J. 2014. Becoming a recovery-oriented practitioner. *Advances in Psychiatric Treatment* 20, pp.37-47. doi: 10.1192/apt.bp.112.010652.

Robinson, D.G. et al. 2004. Symptomatic and functional recovery from a first episode of schizophrenia or schizoaffective disorder. *American Journal of Psychiatry*, 161(3), pp.473–479.

Robson, C. 2002. *Real World Research: A Resource for Social Scientists and Practitioner-Researchers*. 2nd ed. Oxford: Blackwell.

Rohlfing, I. 2012. *Case Studies and Causal Inference: An Integrative Framework*. Basingstoke: Palgrave Macmillan.

Rose, G. and Smith, L. 2018. Mental health recovery, goal setting and working alliance in an Australian community-managed organisation. *Health Psychol Open*, 5(1).

Royal College of occupational therapists. 2020. Occupational therapy in a pandemic. Available at: https://www.rcot.co.uk/ (Accessed: 21 October 2024).

Royal College of occupational therapists. 2021a. Roots of recovery: Occupational therapy at the heart of health equity. Available at: www.rcot.co.uk. [Accessed 21st October 2024]

Royal College of occupational therapists. 2021b. Social prescribing and occupational therapy. Available at: www.rcot.co.uk. [Accessed 21st October 2024]

Royal College of occupational therapists. 2023. Workforce survey report 2023. Available at: www.rcot.co.uk. [Accessed 21st October 2024]

Rubin, H. J. and Rubin, I. S. 2012. *Qualitative Interviewing: The Art of Hearing Data.* London: SAGE.

Rubin, H.J. & Rubin, I.S. 2005. *Qualitative Interviewing: The Art of Hearing Data*. 2nd ed. Thousand Oaks, CA: Sage Publications.

Ruse, M., 1998. *Mystery of Mysteries: Is Evolution a Social Construction?* Cambridge, MA: Harvard University Press.

Samaritans. 2016. *Suicide Statistics Report 2016*. Available at: https://www.samaritans.org/about-samaritans/research-policy/suicide-facts-and-figures/ [Accessed: 20 May 2024]

Scholz, R.W. & Tietje, O. 2002. *Embedded Case Study Methods: Integrating Quantitative and Qualitative Knowledge*. Thousand Oaks, CA: Sage Publications.

Scholz, R.W. and Tietje, O. 2002. *Embedded case study methods: Integrating quantitative and qualitative knowledge*. Thousand Oaks, CA: Sage Publications.

Schwammle, D., 1996. Occupational competence explored. *Canadian Journal of occupational therapy,* 63, pp.323-330. doi: 10.1177/000841749606300508.

Schwandt, T. A., 1994. Constructivist, interpretivist approaches to human inquiry. In: N. K. Denzin and Y. S. Lincoln, eds. *Handbook of Qualitative Research.* Thousand Oaks, CA: Sage Publications, pp. 118–137.

Scott, P. 2019. *Role Checklist Version 3: Participation and satisfaction* (RCv3). Chicago, IL: Model of Human Occupation Clearinghouse, Department of occupational therapy, University of Illinois Chicago.

Shanks, V., et al. 2013. Measures of personal recovery: A systematic review*. Psychiatric Services*, 64, pp.974-980. doi: 10.1176/appi.ps.005012012.

Shimitras, L., et al. 2006. Time Use of People Living with Schizophrenia in a North London Catchment Area*. The British Journal of occupational therapy*, 66, pp.46-54. doi: 10.1177/030802260306600202.

Singh, B., et al. 2023. Effectiveness of physical activity interventions for improving depression, anxiety and distress: an overview of systematic reviews. *British Journal of Sports Medicine*, bjsports-2022-106195. DOI: 10.1136/bjsports-2022-106195

Skocpol, T. and Somers, M., 1980. The uses of comparative history in macrosocial inquiry. *Comparative Studies in Society and History,* 22(2), pp.174-197.

Slade, M. 2008. The contribution of mental health services to recovery. *Journal of Mental Health*, 18(5), pp.367-371.

Slife, B. D., and Williams, R. N., 1995. *What's Behind the Research? Discovering Hidden Assumptions in the Behavioral Sciences.* Thousand Oaks, CA: SAGE Publications.

Social Exclusion Unit 2004. Mental Health and Social Exclusion: Social Exclusion Unit Report. London: Publications.

Spirkin, A. G., 1983. *Dialectical Materialism*. Moscow: Progress Publishers.

Stake, R. E. (1995) *The Art of Case Study Research*. Thousand Oaks: Sage.

Stickley, A. and Hall, K. 2017. Social enterprise: A model of recovery and social inclusion for occupational therapy practice in the UK. *Mental Health and Social Inclusion,* 21(2), pp.91-101.

Tan, B.-L., et al. 2020. Defining Occupational Competence and Occupational Identity in the Context of Recovery in Schizophrenia. *American Journal of occupational therapy,* 74(4), 7404205120p1-7404205120p11. doi: 10.5014/ajot.2020.034843.

Taylor, R. R. 2017. *Kielhofner's Model of Human Occupation: Theory and Application.* 5th ed. Philadelphia, PA: Lippincott Williams & Wilkins.

Teoh, J. Y. and Iwama, M. K. 2015. *The Kawa Model Made Easy: a guide to applying the Kawa Model in occupational therapy practice*. 2nd ed. Available at: www.kawamodel.com. [Accessed: 20 May 2024].

Townsend, E., & Wilcock, A.A. 2004. Occupational justice and client-centred practice: A dialogue in progress. *Canadian Journal of Occupational Therapy*, 71(2), pp.75–87.

Townsend, E., et al. 2002. *Enabling Occupation: An occupational therapy Perspective. Rev. ed.* Ottawa: Canadian Association of occupational therapists.

Townsend, E., et al., 1997. *Enabling Occupation: An occupational therapy Perspective*. Ottawa: Canadian Association of occupational therapists.

Tremblay, M.M. & Brousseau, M. 2011. Theoretical perspectives in health education and record keeping dossiers. *Canadian Journal of Occupational Therapy*, 78(1), pp.6–12.

Tuckman, B. W., 1965. Developmental sequences in small groups. *Psychological Bulletin*, 6396, pp.384-399.

Turpin, M. and Iwama, M. K. 2011. *Using occupational therapy Models in Practice: A Field Guide.* Edinburgh: Churchill Livingstone Elsevier.

Wales Centre for Public Policy, 2021. *Challenges and Priorities for Health and Social Care in Wales*. [online] Available at: https://www.wcpp.org.uk/wp-content/uploads/2021/12/Challenges-and-Priorities-for-Health-and-Social-Care-Wales-Briefing-Note-.pdf [Accessed 9 January 2024].

Wales Online. 2022. Pandemic Reporting in South Wales. Available at: https://www.walesonline.co.uk [Accessed 21st October 2024]

Walker, J. and Thistelwood, G. 2012. Dealing with barriers to change whilst implementing the Canadian Model of Occupational Performance. In: Boniface, G. and Seymour, A., eds., 2012. *Using Occupational Therapy Theory in Practice*. Chichester: Wiley-Blackwell, pp.106-119.

Waygood, E.O.D. et al. 2012. Active Travel by Built Environment and Lifecycle Stage: Case Study of Osaka Metropolitan Area, Japan. *International Journal of Environmental Research and Public Health*, 12(12), pp.15027–15048.

Weber, M. 1978. *Economy and Society: An Outline of Interpretive Sociology*. Berkeley: University of California Press.

Welsh Government, 2010. *Mental Health (Wales) Measure 2010*. [online] Available at: https://www.legislation.gov.uk/mwa/2010/7 [Accessed 18 January 2024].

Welsh Government, 2012. *Together for Mental Health: A Strategy for Mental Health and Wellbeing in Wales*. [online] Available at: https://www.gov.wales/together-mental-health-our-mental-health-strategy [Accessed 8 January 2024].

Welsh Government, 2020d. *Summary Statistics for Welsh Regions 2020*. [online] Available at: https://www.gov.wales/sites/default/files/statistics-and-research/2020-05/summary-statistics-regions-wales-2020-629.pdf [Accessed 8 December 2024].

Welsh Government, 2021. *Impact assessment: Health and social Care COVID-19 looking forward*. [online] Available at: https://www.gov.wales/impact-assessment-health-and-social-care-covid-19-looking-forward-html [Accessed 10 January 2024].

Welsh Government. 2015. *Wellbeing of Future Generations (Wales) Act 2015*. Available at: https://www.legislation.gov.uk/anaw/2015/2/contents/enacted [Accessed Day Month Year].

Welsh Government. 2019a. Statistical First Release: NHS Expenditure Programme Budgets 2017-18. Available at: https://gov.wales/sites/default/files/statistics-and-research/2019-04/nhs-expenditure-programme-budgets-april-2017-to-march-2018-168.pdf [Accessed: 1 September 2020].

Welsh Government. 2019b. Together for Mental Health Delivery Plan 2019-22. Available at: https://gov.wales/together-mental-health-delivery-plan-2019-2022 (Accessed: 21 October 2024).

Welsh Government. 2020a. Virtual group clinics to be rolled out across NHS Wales. Available at: https://gov.wales/virtual-group-clinics-be-rolled-out-across-nhs-wales [Accessed: 13 December 2021].

Welsh Government. 2020b. Mental Health Delivery Plan 2020-23. Available at: https://gov.wales/mental-health-delivery-plan (Accessed: 21 October 2024).

Welsh Government. 2020c. Written Statement: Review of Lockdown Measures and The Health Protection (Coronavirus Restrictions) (Wales) Regulations 2020. Available at: https://www.gov.wales/ (Accessed: 21 October 2024).

Welsh Government. 2022. NHS and Public Health Responses to COVID-19 in Wales. Available at: https://gov.wales (Accessed: 21 October 2023).

Wilcock, A. 2005. Occupational Science: Bridging Occupation and Health. Canadian Journal of occupational therapy. *Revue canadienne d'ergothérapie,* 72, pp.5-12. doi: 10.1177/000841740507200105.

Wilcock, A.A. & Hocking, C. 2015. *An Occupational Perspective of Health*. 3rd ed. Thorofare, NJ: SLACK Incorporated.

Wilcock, A.A. 1999. Reflections on doing, being and becoming. *Australian Occupational Therapy Journal*, 46(1), pp.1–11.

Wilcock, A.A. 2006. *An Occupational Perspective of Health*. 2nd ed. Thorofare, NJ: SLACK Incorporated.

Wimpenny, K., et al. 2010. Implementing the Model of Human Occupation across a Mental Health occupational therapy Service: Communities of Practice and a Participatory Change Process. *The British Journal of occupational therapy*, 73(11), pp.507-516.

Woolley, H., et al. 2020. “I’m not alone”: Women’s experiences of recovery oriented occupational therapy groups following depression. *Canadian Journal of occupational therapy,* 87(1), pp.73-82.

World Health Organization. 2022. World mental health report: Transforming mental health for all. Available at: www.who.int [Accessed 21st October 2024]

Yamada, T., et al. 2010. A randomised clinical trial of a wellness programme for healthy older people. *British Journal of Occupational Therapy*, 73(11), pp. 540–548.

Yerxa, E.J. 1998. Health and the human spirit for occupation. *American Journal of Occupational Therapy*, 52(6), pp.412–418.

Yin, R. K. 2009. *Case Study Research: Design and Methods. 4th ed.* Los Angeles, Calif; London: SAGE.

Yin, R. K. 2016. Qualitative Research from Start to Finish. 2nd ed. New York: The Guilford Press.

Yin, R. K. 2018*. Case Study Research and Applications: Design and Methods. 6th ed*. Los Angeles: SAGE.

Yin, R. K., 1993. Applications of Case Study Research. Thousand Oaks, CA: Sage Publications.

Yu, G., et al. 2022. Mental health services in response to the COVID-19 pandemic in high-income countries: protocol for a rapid review. *BMJ Open*, 12(6), p.e062078. Available at: https://bmjopen.bmj.com/content/12/6/e062078 [Accessed 5 December 2024].

Appendices

Appendix 1 - Scoping review Protocol

Question

The Scoping review question is: What are occupational therapist's and Service user's experiences of activity-based interventions within adult mental health?

Participants/population

The population that will be included in the search will be occupational therapy staff (including registered occupational therapists and unregistered support staff), who have had experience with activity based interventions within adult mental health services. As well as occupational therapy staff, the review will also include service users within the adult age range (18-64), who have had experience of activity based interventions within mental health services.

Intervention(s), exposure(s)

The review will include the use of any activity based framework, approach, programme tool, intervention or frame of reference, that has been used within occupational therapy to support mental wellbeing. The types of activity areas may include: leisure, physical, creative, outdoor, technological, faith, self care, domestic, vocational, social, community or caring activities. This review will include all types of exposures to activity based interventions; whether the intervention has been implemented via a group or on a one to one basis; or whether the intervention formed a singular event or a series of events.

Context

Our health and wellbeing is improved through engagement in meaningful activities; also known as occupations (Wilcock 2005). People living with

poor mental health are often under occupied or passively engage in activities that are not meaningful to them (Shimitras et al. 2006; Bejerholm 2010).

The role of an occupational therapist is to enable people to engage in the things that they want or need to do. The literature however has found that occupational therapists are often fulfilling generic roles (Lloyd et al. 2002), and are offering interventions that focus on symptom reduction as opposed to reinforcing the value of occupations themselves (Meeson 1998). This scoping review will therefore synthesise and critique the research base for activity based interventions, drawing on literature that has evaluated the effectiveness of activity based interventions, as well as literature that explores occupational therapy staff and service user experiences.

Outcome

The aims of this scoping review are to explore: (1)occupational therapy staff's experiences of using activity based interventions; (2) the opportunities and challenges in implementing an occupationally focused approach; (3) service user's perceptions and experiences with activity based interventions and (4) the effectiveness of activity based interventions.

Types of study to be included

This review will include qualitative, quantitative and mixed methods literature. Literature will not be excluded following critical appraisal, all literature will be included and the strengths and limitations discussed.

Search strategy

Databases

The databases that will be used to conduct the searches include:

Cochrane Database of Systematic Reviews (CDSR)

OT Seeker

CINAHL via EBSCO

Scopus

Web of Science

Medline via Ovid

PsycINFO

Embase

The reference lists for the articles will also screened to identify additional articles that may be relevant to the scoping review; in-keeping with the inclusion and exclusion criteria for this study.

Parameters

The studies included will be restricted to those published between 2014 and 2021 (present). The search will also be restricted to those that are available in English. International research will be included.

Concept table

The searches will be conducted by searching each of the following term columns individually using 'OR'; for example: activity* OR leisure OR physical. Following this the search lists for each column will be combined using 'AND'. This will then provide an extensive search, while keeping the articles relevant to the study.

Occupation	OT	Manual	MH
Activit*	"Occupational Therap*"	Framework	"Well#being"
Leisure		Approach	Wellness
Physical		Programme	"Mental#health"
Creativ*		Tool	
Outdoor		intervention	
Technolog*		Frame of reference	
Faith			
Self#care			
Domestic			
Vocation*			
Social*			

Communit*			
Caring			
Occupation*			

Inclusion/exclusion criteria

Inclusion criteria: Adult age range (18 – 64). Mental health. Activity focused occupational therapy interventions. Occupational therapist's experiences. Service user experiences. Evaluations of activity based interventions.

Exclusion Criteria: Child and young adult range (0-18). Older adult age range 65+. Articles not in the English language. Not within mental health. Non-activity focused occupational therapy interventions.

Study selection

In the initial phase the study titles and abstracts will be screened; those that appear to fit the review aims and inclusion criteria will be short-listed. Following this the articles will be read in full; they will be excluded if they do not meet the aims of the review. The articles will then be critically appraised. All relevant articles will be included irrespective of critical appraisal outcome, however the strengths and limitations of the study will be considered.

Quality/Risk of bias

The CASP critical appraisal tools will be used to critique the articles. These tools have been selected as they will provide structure and depth to the

critique. There are a range of CASP tools available to suit different research methodologies.

Data extraction and synthesis

The data will be extracted manually via deductive thematic analysis techniques.

The data will be synthesised through grouping the themes within the study aims to explore: (1) occupational therapy staff's experiences of using activity based interventions; (2) the opportunities and challenges in implementing an occupationally focused approach; (3) service user's perceptions and experiences with activity based interventions and (4) the effectiveness of activity based interventions.

Appendix 2 - Interview data analysis and theme flow chart

Examples of raw data	Coding the raw data
We used activities like art as an icebreaker… it distracted them and also prompted conversation and interaction. It was very hands-on and that helped people feel comfortable sharing." – Beth	Hands-On Benefits
"It was more beneficial to be involved in the actual doing. The hands-on part helped them absorb the lessons better." – Beth	Doing Reinforces Learning
We might have a third sector come in from a local third sector organisation and do an art session. And then the next session,	Practical Over Theory Experiential Learning

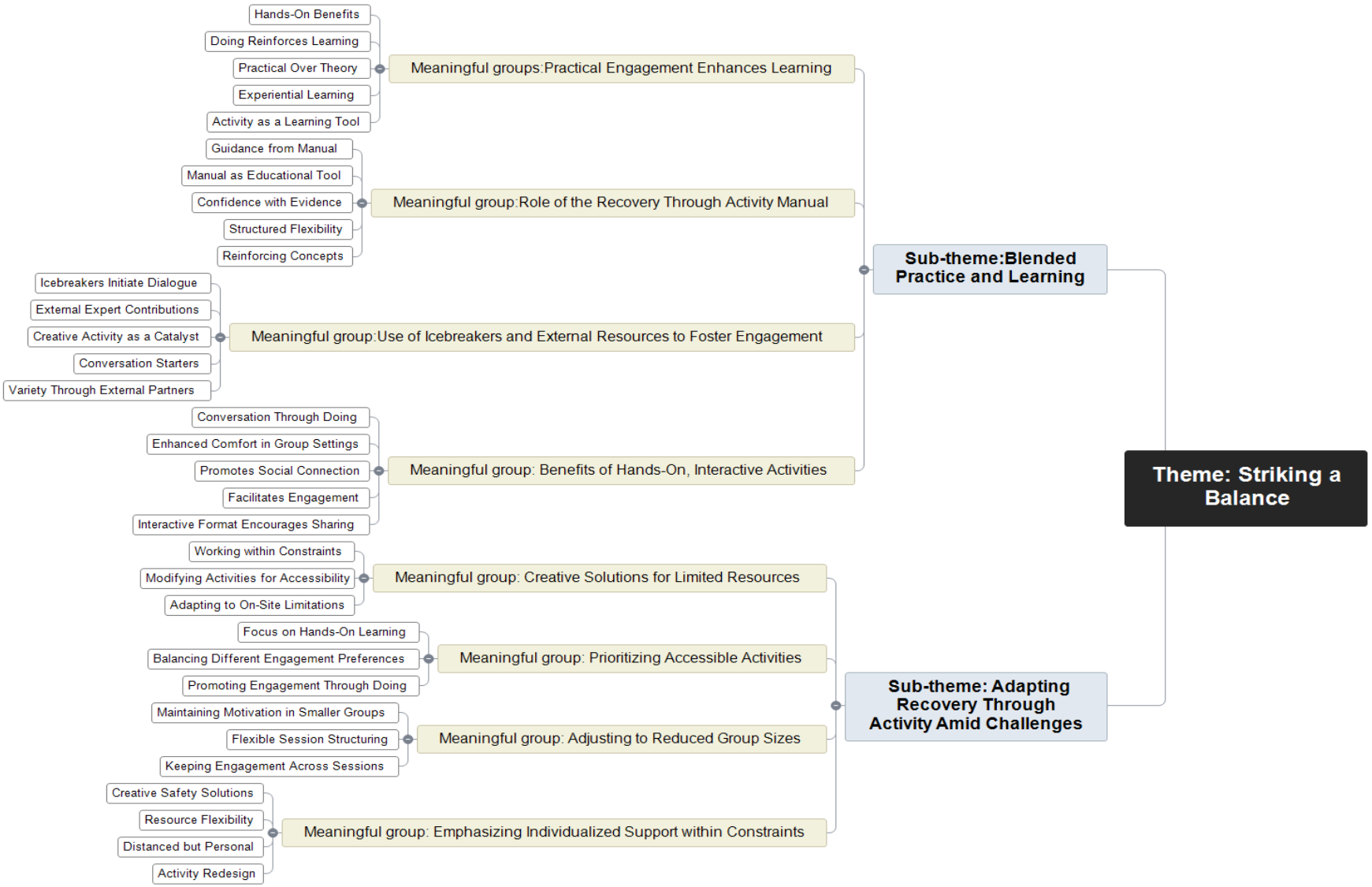
we might talk about the benefits of relaxation and creativity and things like that to then try and enhance it.” – Eve	Activity as a Learning Tool
The manual was really helpful, it laid out the rationale behind what we were doing, so I felt confident discussing why each activity was meaningful." – Beth	Guidance from Manual Manual as Educational Tool
"Having the evidence in the book gave us a structure to ensure we covered the educational part along with the activity." – Georgia	Confidence with Evidence Structured Flexibility
"Covid restrictions made it hard. We used to do things like group bus rides, but suddenly we couldn’t. We had to get creative on how to keep it practical without those options." –Georgia	Reinforcing Concepts

	Icebreakers Initiate
The nature of recovery through activity… we had to change a lot due to restrictions, and it really limited what we could do." – Georgia	Dialogue
	External Expert Contributions
"We learned from previous groups to try and make something that's pretty hands-on where they're distracted with what they're doing, but it also prompts conversation and interaction." – Beth	Creative Activity as a Catalyst
	Conversation Starters
I think just having it laid out with the evidence for the discussion really meant that I'm making sure that I'm covering psychoeducation part, like the rationale alongside." – Flo	Variety Through External Partners
	Working within Constraints

Combining practical and dialogue together worked because it wasn’t just sitting with worksheets; it encouraged participation and a natural flow in conversation." – Annie	Modifying Activities for Accessibility
	Adapting to On-Site Limitations
We used the Recovery Through Activity manual to guide our sessions, which was especially useful in explaining benefits and rationale to service users." - Annie	Focus on Hands-On Learning
	Balancing Different
The manual is really helpful because it’s structured but flexible. We can dip in and out, adapt, and still convey the educational purpose." – Annie	Engagement Preferences
	Promoting Engagement Through Doing

COVID had such an impact; we couldn't do anything community-based, and transporting service users was also restricted. We had to work within those limits on the ward." – Flo	Maintaining Motivation in Smaller Groups
I tried splitting the sessions. We'd have a chat one day, then the practical activity the next, but the challenge was keeping everyone engaged across both parts." – Flo	Flexible Session Structuring Keeping Engagement Across Sessions
Some people came for the chat with coffee, and others preferred the practical sessions. The trick was balancing both without losing participants." – Flo	Conversation Through Doing Enhanced Comfort in Group Settings Promotes Social Connection

	Facilitates Engagement Interactive Format Encourages Sharing Creative Safety Solutions Resource Flexibility Distanced but Personal Activity Redesign


Theme: Striking a Balance
Sub-theme:Blended Practice and Learning
Meaningful groups:Practical Engagement Enhances Learning
Hands-On Benefits
Doing Reinforces Learning
Practical Over Theory
Experiential Learning
Activity as a Learning Tool
Meaningful group:Role of the Recovery Through Activity Manual
Guidance from Manual
Manual as Educational Tool
Confidence with Evidence
Structured Flexibility
Reinforcing Concepts
Meaningful group:Use of Icebreakers and External Resources to Foster Engagement
Icebreakers Initiate Dialogue
External Expert Contributions
Creative Activity as a Catalyst
Conversation Starters
Variety Through External Partners
Meaningful group: Benefits of Hands-On, Interactive Activities
Conversation Through Doing
Enhanced Comfort in Group Settings
Promotes Social Connection
Facilitates Engagement
Interactive Format Encourages Sharing
Sub-theme: Adapting Recovery Through Activity Amid Challenges
Meaningful group: Creative Solutions for Limited Resources
Working within Constraints
Modifying Activities for Accessibility
Adapting to On-Site Limitations
Meaningful group: Prioritizing Accessible Activities
Focus on Hands-On Learning
Balancing Different Engagement Preferences
Promoting Engagement Through Doing
Meaningful group: Adjusting to Reduced Group Sizes
Maintaining Motivation in Smaller Groups
Flexible Session Structuring
Keeping Engagement Across Sessions
Meaningful group: Emphasizing Individualized Support within Constraints
Creative Safety Solutions
Resource Flexibility
Distanced but Personal
Activity Redesign

Appendix 3 - Research Protocol

Part A: Overview of the case study

Literature review and evidence

Academic challenge

Mental ill health has far reaching consequences, not only for the individual experiencing mental ill health, but also their families, this can include: altered family relationships (Kaye and Howlett 2008) poor physical health (Mo et al. 2016) and loss of income (Elmontsri et al. 2018). As well as the personal consequences of mental ill health, there are societal and wider economic implications. In Wales, it has been estimated by the Mental Health Foundation (2016), that the social and economic cost of mental ill health is £7.2 billion per annum. Furthermore, the Welsh Government (2019a) estimated that in 2017-18, the NHS spent 11.4% of its ~£6.5 million budget on mental ill health. It is somewhat surprising therefore, that in the UK, only 5.5% of health research funding goes towards mental health (Mental Health Foundation 2016).

In response to the impact that mental ill health has on individuals, their families and the wider economy and society, a paradigm shift has seen a move away from a medical model of treatment and cure (Ellison et al. 2018) towards a recovery oriented approach. This recovery oriented approach is now guiding services and views recovery as a journey, with the aim (with or without the presence of mental health issues) of living a meaning life, which contributes to society (Slade 2008). This approach is supported by government guidance, such as the 'Together for Mental Health Delivery Plan 2016-2019', which identifies that in mental health services, there is a need

for the availability of recovery oriented practices to be increased (Welsh Government 2019b).

Despite this push to increase recovery oriented practices, research has shown that there are several barriers to implementing this approach. One such barrier is that people have been hindered in their recovery due to the effects of traditional clinical management methods of assessing risk (Roberts and Boardman 2014) whereby, the commitment to implement the recovery oriented approach has been negatively impacted upon as a consequence of practitioners risk aversion (Crowe and Deane 2018a). That said, the congruence between recovery oriented principles and occupational science, means that in order to shift towards recovery oriented practice, occupational therapists are ideally placed to facilitate the implementation of this approach in practice (Stickley and Hall 2017).

Widely used in practice by occupational therapists is the 'Recovery Through Activity' manual (Parkinson 2014), which consists of a framework, based on the Model of Human Occupation (Kielhofner 2008), that promotes recovery oriented practice. As well as evidencing the value of meaningful activity on physical, as well as mental health and well-being, the Recovery Through Activity manual also offers a wealth of resources to support occupationally focused, activity-based interventions.

Partnership with NHS Health Board

This research project is being undertaken in partnership with an NHS Health Board. Occupational therapy in mental health services within the NHS Health Board are striving to provide efficient and effective interventions to their service users through promoting the use of evidence-based practice. The increasing human and economic impact caused by mental ill health, as previously discussed, is driving the increasing need to consistently demonstrate a strong evidence-base in practice.

Through this collaboration with the NHS Health Board, there will be a range of benefits that will impact positively on the organisation, including identifying the perceived facilitators and benefits to implementing Recovery Through Activity, and identifying if it is working effectively for occupational therapists within their mental health services. Additionally, through gathering information on service user perceptions and intervention outcome data, measurements of impact and change using Recovery Through Activity can be qualified and quantified to demonstrate its effectiveness and efficiency.

Consequentially, this collaboration will not only benefit the NHS Health Board mental health services but may have broader benefits for both the wider community and the economy. Furthermore, given that mental health is often neglected in terms of research funding, having a dedicated person to oversee and conduct this research will benefit the NHS Health Board and enhance the research capacity within occupational therapy mental health services. In addition, by involving occupational therapy staff in the research it is envisaged that it will increase staff confidence in actively engaging in research and its promotion in the future.

Description of proposed study

This study will evaluate Recovery Through Activity as used by occupational therapists in mental health services within an NHS Health Board. The aim of Recovery Through Activity is to assist occupational therapists in enabling service users to identify the long-term benefits of engaging in a range of meaningful activities. Recovery Through Activity provides a wealth of resources and an evidence base for activity-based interventions, encompassing the occupational areas of: leisure; creativity; technology;

physical; outdoor; faith; self-care; domestic; caring; vocational; social and community.

The study will explore occupational therapists' experiences and their use of Recovery Through Activity, as well as the challenges and opportunities they face in implementing an occupationally focused approach, including exploring the use of a range of outcome measure tools. Service users' experiences resulting from their engagement with Recovery Through Activity will be explored, along with their perceptions of the term 'recovery' and expectations of the intervention. An exploration of suitable outcome measure tools will be undertaken via interviews with staff, and finally the effectiveness of Recovery Through Activity will be evaluated by analysing existing anonymised intervention outcome data.

A case study research design will be used to gain an in depth understanding of how impacting factors can influence staff and service users' experience of engaging with Recovery Through Activity. This design will allow the researcher to take into consideration geographical areas, community resources, service design, local policies, and the method in which Recovery Through Activity is applied across an NHS Health Boards' mental health settings. The cases will be defined as adult inpatient mental health and adult community mental health.

Description of the population

The population that will be explored include: occupational therapy staff across an NHS Health Board mental health services. occupational therapy staff will include qualified occupational therapists, occupational therapy Assistants and Technicians, and support staff that assist the occupational therapy service in the implementation of Recovery Through Activity.

Case study rationale, aim, objectives and proposed outcomes.

Rationale

According to research, occupational therapists are finding it difficult to retain their professional identities (Farnworth 2003); fulfilling generic roles (Lloyd et al. 2008) and offering interventions that focus on symptom reduction as opposed to reinforcing the value of occupations themselves (Meeson 1998). The Recovery Through Activity manual aims to function as a tool for occupational therapists to support their core skills, evidence the value of activity, and provide resources for occupationally focused interventions (Parkinson 2014). The use of this manual is particularly important in the mental health field, as there are few occupational therapy manuals in practice (Pettican and Bryant 2007). However, there is no previous research specifically exploring the experiences of occupational therapists using Recovery Through Activity in mental health services. This research project will therefore identify the barriers and facilitators experienced by occupational therapists in an NHS Health Board's mental health services, to successfully implementing this Framework effectively and efficiently.

Previous research has demonstrated that people living with mental ill health often engage in passive leisure activities, as opposed to actively engaging in meaningful activities, and are often under-occupied (Shimitras et al. 2006; Bejerholm 2010). In addition to this, people with mental ill health are one of the most socially excluded groups in the UK (Social Exclusion Unit 2004). The use of Recovery Through Activity aims to encourage people with mental ill health to reflect and practice lifestyle choices that impact on their occupational lives as well as their health (Parkinson 2014). Thus, this research project will evidence the effectiveness of Recovery Through Activity, from a service user's perspective and experience, as well as

measuring change over time via the use of existing intervention outcome data.

Research question/ aims

Overarching aim

The overarching aim of this research project is to evaluate the efficacy and the effectiveness of the use of Recovery Through Activity, from an occupational therapist's perspective and service user perspective.

Objectives

The objectives are to:

1. Explore occupational therapy staff's role and experiences of using Recovery Through Activity.
2. Identify the opportunities and challenges faced by occupational therapy staff in implementing an occupationally focused approach.
3. Evaluate service user perceptions and experiences, resulting from the use of Recovery Through Activity.
4. Evaluate the effectiveness of the implementation of Recovery Through Activity by analysing existing anonymised intervention outcome data.

Outcome

It is expected, that from this research, recommendations will be developed on how to best implement Recovery Through Activity in practice, including: who is best suited to facilitate the use of Recovery Through Activity; the role of community links; how to evaluate service user outcomes; and how to tailor Recovery Through Activity to clients and services. It is expected following this study there will be a range of potential methods of implementation for Recovery Through Activity, for example, to guide

activity facilitation, to evidence the value of occupations, and to guide an occupationally focused approach.

Theoretical framework

relativist perspective

This research will take a relativist perspective. A relativist perspective is most appropriate as the research distinctively aims to capture the perception and experiences of occupational therapy staff and service users (Yin 2018) and assumes no absolute truth. The relativist perspective has been taken into consideration when planning the data collection methods and data analysis methods, through ensuring that the methods capture individual perspectives. The relativist perspective has also been taken into consideration when planning the study design. This case study research design complements the relativist perspective, as it acknowledges that there will be differences in perspectives across cases and contexts. The design aims to capture these complexities.

Occupational science

This research also uses occupational science theory to guide the case definitions, inform propositions, guidelines of inquiry, and guide the data analysis. Occupational science suggests that humans are occupational beings, and that engagement in meaningful occupations promotes health and wellbeing (Wilcock 2005), which are a requirement for leading a purposeful life (Hasselkus 2002). The Model of Human Occupation (Kielhofner 2008) will be used to articulate and maintain focus on the factors that surround occupational participation, engagement and meaning. The MOHO as opposed to other models was chosen as it emphasises the reality of individual patterns of performance, and highlights the influence of environmental factors, as well as the volitional powers that impact on occupational performance (Taylor 2017).

Role of the protocol

This protocol serves as the agenda to guide the researcher's line of inquiry. The protocol contains general rules and procedures to be followed when conducting the research (Yin 2018). The protocol will be important in keeping the research on topic, and will aid in anticipating problems and rival explanations for the findings, which are discussed in part B of this protocol, along with an outline of the case study design, theoretical propositions, and methods of data collection and analysis, including ethical considerations. Section C discusses protocol questions, and Section D provides a tentative outline for the case study report.

Part B: Design and Methods

Case study design

A case study research design will be used to guide this project. The case study research design has been deemed as most appropriate as it will aid in evaluating the interaction between the Recovery Through Activity manual and its implementation in practice within the contextual environment of the real world (Yin 2018). Through using a case study design to evaluate the use of Recovery Through Activity, it will allow the complexity of the cases to be encapsulated and an exploration of the contextual conditions and how they may interact with the use of Recovery Through Activity (Yin 2018). In addition to exploring the efficiency and effectiveness of Recovery Through Activity, the case study design gives a unique advantage, in that it allows for the 'process' to be examined (Yin 2018).

Propositions

A proposition guides the researcher to areas that need to be examined within the scope of the study; reflecting important theoretical issues and pointing towards the direction to look for relevant evidence (Yin 2018). The propositions are based on principles from occupational science theory. The following propositions have been used to assist in defining the 'cases' and data collection methods.

Proposition 1: Service dynamics and processes will impact on occupational therapy staff experiences of Recovery Through Activity e.g.:

- Training and support

- Staff capacity

- Perceptions of other professionals

- Available resources and community links

- Client groups

- Patient/setting dynamics e.g. ward or community

- Local policies and legislations

- Service demands and organisational objectives

Proposition 2: The implementation method of Recovery Through Activity will impact on occupational therapy staff and service user experiences, e.g.:

- 1:1 vs. groups

- Goal setting and intervention planning

- The use of a model

- Assessment and outcome measure tools used, and how this informs structure

- In service vs. community links

- The use of Recovery Through Activity as a programme/framework/tool

- The referral process for Recovery through activity

Proposition 3: Access to community resources will impact on the effectiveness and the benefits of the use of Recovery Through Activity, e.g.;

- Transitioning from Recovery Through Activity to community and community links

- Availability of community resources

- Transport

- Financial implications

- Impact of legislation such as the *Mental Capacity Act* (*2005*)and the *Equality Act* (2010).

Proposition 4: Individual differences will impact on the effectiveness and the benefits of Recovery Through Activity, e.g.:

- Readiness for change

- Volition

- Habituation

- Performance capacity

- Client expectations and perceptions of recovery

- Client expectations and perceptions of recovery through activity

- Client expectations and perceptions of occupational therapy

Proposition 5: Recovery Through Activity will have an impact on service users' occupational participation and engagement.

- Motivation for occupation
- Pattern of occupation
- Communication and interaction skills
- Process skills
- Motor skills

- Engagement environmental factors

Potential Rival explanations

Addressing 'rival' explanations is a core part of addressing case study research findings (Yin 2018). Although there could be a number of contributing factors to explain a phenomena, Yin (2018) suggests that the most plausible rivals should be addressed, rather than every possible rival. Awareness of the rivals will be incorporated in the data collection, as addressing rival explanations within case study research adds to the strength of the findings (Yin 2018). The identified rivals will not be examined to determine cause and effect; however they will be used to check for alternative explanations.

- Direct Rivals – an intervention other than Recovery Through Activity accounts for the result e.g. Psychology input, medication, alternative therapies.
- Commingled rival – other interventions and Recovery Through Activity account for the results – e.g. on inpatient wards, it may be important for medication to be balanced before Recovery Through Activity is effective.
- Implementation rival – the implementation process not Recovery Through Activity itself account for the results – e.g. is the implementation person centred? are goals being addressed? Both or either of these could impact on the benefits seen by service users and occupational therapy staff' experiences of its use.
- Rival theory – A different theory from the original theory explains the results – e.g. group theory, community psychology theory, organisational theory.

Cases

The cases can be defined as theoretical replications as they have been purposely chosen to address the research propositions, rival explanations and the theories surrounding this. The cases have been carefully selected to explore predicted contrasting results and the anticipated reasons behind these (Yin 2018).

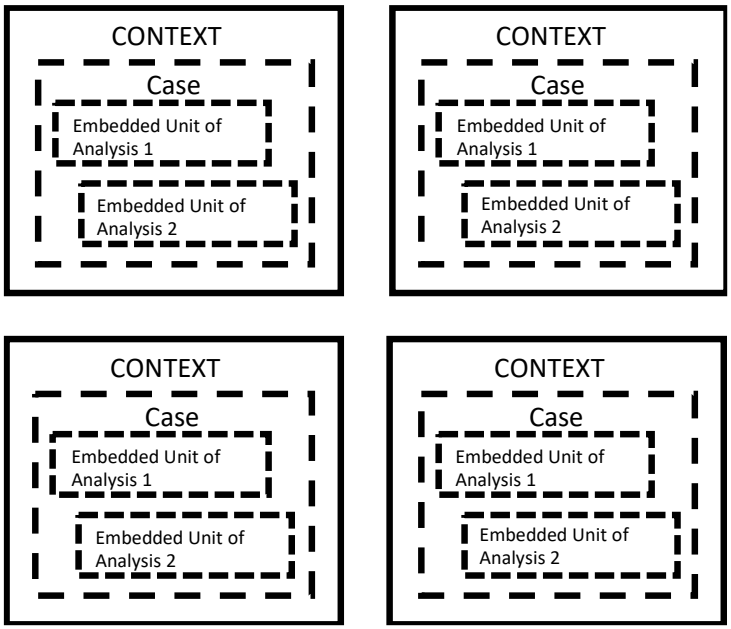


Figure 1. Multiple case embedded design

The defined cases are as follows:

- Adult community mental health services
- Adult inpatient mental health services

Within each case, attention will be directed towards embedded units of analysis: occupational therapy staff's experiences; service user experiences; anonymised outcome data and documents. Thus, this design can be described as a multiple-case, embedded design (Yin 2018). With regards to choosing the number of cases, a power analysis would be irrelevant. Instead, the number of cases have been based on what is the most appropriate to address the research objectives, propositions and rivals.

Data collection and data analysis

A mixed methods approach will be taken, combining qualitative and quantitative techniques within the study (Johnson and Onwuegbuzie 2004). This will allow for more complex research questions to be addressed, and a stronger, richer array of evidence to be collected, as opposed to a single method alone (Yin 2018).

In order to recognise the complexity of the cases, multiple sources of evidence will be used and triangulated to corroborate and confirm the findings (Yin 2018). This study will take a sequential approach, initially conducting interviews, leading into questionnaires, data from outcome measure tools used in practice and documentation.

Interviews

Interview Data collection

Interviews will be conducted online with occupational therapy staff to gather rich data regarding their experiences of the use of Recovery Through Activity and implementing an occupationally focused approach (objectives 1 and 2). Interviews will also be conducted online with service users to gather rich data regarding their perceptions and experiences of Recovery Through Activity (objective 3). These online interviews will provide insight into personal views, attitudes, meanings, and perceptions of Recovery Through Activity (Yin 2018).

The platform that will be used to conduct the online interviews will be Microsoft Teams. This platform has been chosen as it has been approved by the NHS Health Board as the most secure platform to use within the service.

There are three types of case study interviews: prolonged interviews; shorter interviews and survey interviews (Yin 2018). This research will

conduct shorter case study interviews, which will take around 1 hour to conduct (Yin 2018). The interviews will be semi-structured and as a case study interview, will resemble guided conversations as opposed to using structured questions (Yin 2018), this will ensure fluidity rather than rigidity (Rubin and Rubin 2012).

Two levels of inquiry will occur during the interviews. Level 1 inquiries will relate to questions outlined in section C of this protocol. Two separate interview schedules have been devised for occupational therapy staff (see appendix. i) and Service users (see appendix ii), which are based on these protocol questions in section C. Level 2 inquiries will occur simultaneously and consist of conversational questions that serve the needs of the line of inquiry, such as asking "why?" in relation to a level 1 answer (Yin 2018). When asking "why" questions, the term "how" will be used in conversation, as recommended by Becker (1998, pp. 58-60), as the term is more likely to generate a less defensive response from interviewees. It is important that when these questions are asked, they are worded in a non-biased way (Yin 2018). This will be facilitated by taking a relativist perspective, these interviews will be directly interested in the personal views and perspectives of the interviewees; their verbal reports and meanings will form the main body of evidence (Yin 2018).

Interview Analysis

The online interviews will be recorded on an encrypted device, speech to text software (Otter) will be used to aid transcription. Following this the audio recordings will be played back to check the accuracy of the transcription and to correct any errors, as well as anonymising the data.

An inductive approach to thematic analysis will be used to analyse data collected from occupational therapy staff and service users. This will provide structure to the analysis, which is one of the critiques of case study research (Yin 2018). There is currently no research exploring occupational

therapy staff experiences of using Recovery Through Activity, thus an inductive approach was deemed the most appropriate. This approach will allow the data to determine the themes.

Questionnaires

Questionnaire data collection

Quantitative questionnaires will be distributed across the service to occupational therapy staff and a separate questionnaire to service users. The questionnaires will be devised as part of the sequential design. Following the completion of the interviews with occupational therapy staff and service users, the data will be analysed, and the key themes that emerge will be used to inform each questionnaire. The occupational therapy staff questionnaire will reflect the key themes drawn from the occupational therapy staff interviews. The service user questionnaire will reflect the key themes drawn from the service user interviews.

The questionnaires will be used to identify whether the key themes are representative of views across the service and this will be compared with the research propositions. Each questionnaire will be divided into two sections. The first section will collect demographical information, through asking participants to respond to categorical questions which relate to the research propositions.

For the occupational therapy staff questionnaire the demographic questions will include: years practicing in occupational therapy (qualified and unregistered); setting (community mental health service or inpatient service); banding; implementation method (such as 1:1 sessions or group sessions, as well as face to face or online sessions); Recovery Through Activity training attended; assessment tools used; outcome measure tools used; model of occupational therapy used and whether community

resources and links were used in the implementation of sessions. (see appendix iii).

Demographic information to be requested from service users will include: age range; setting (community mental health service or inpatient service) and sessions attended (1:1 or groups, face to face or online). (See appendix iv)

Analysis of the interview data, (which will be conducted prior to the questionnaire as part of a sequential design) will be used to inform the categories of the demographic questions, to confirm the appropriateness of each category and to ensure that any categories that may not have been considered previously can be included if appropriate. It is proposed that there will be an impact between these demographic factors and occupational therapy staff and service user's experiences of Recovery Through Activity.

The second part of the questionnaire will ask participants to rate the themes identified from the interviews on a Likert scale in relation to two aspects. The first aspect will allow participants to rate the relevance of the theme in relation to their Recovery Through Activity experience. The second aspect will allow participants to rate the importance they place on each theme in relation to their Recovery Through Activity experience.

Questionnaire data Analysis

Statistical analysis software (SPSS) will be used to analyse the questionnaire data within each case. The use of SPSS will allow the comparison of variables and a means of visually representing participant demographics, the relevance of themes, and the importance participants rated for each theme. A multivariate Analysis of Variance (MANOVA) will be conducted to compare dependent variables (the relevance and importance ratings participants place on each theme from section 2) across

independent variables (demographic questions from section one). The demographic questions, have been identified as the independent variables, as they will be compared to identify the impact they have on Occupational therapy staff and service user experiences of Recovery Through Activity (which will be reflected in the importance and relevance placed on each theme).

Intervention outcome data

Intervention outcome data - data collection

For service users who provide consent to access their existing anonymised intervention outcome data, this will be analysed to evaluate the effectiveness and benefits of the use of Recovery Through Activity and measure change (objective 4). Across the NHS Health Board's mental health services at present, there are a range of outcome measure tools being used. Through gathering and analysing this data, not only will it provide data on the effectiveness of Recovery Through Activity, but it will also provide insight into what outcome measure tools are being used and how they inform us, and how occupational therapists measure change (Yin 2018). It is important when analysing this data to consider the conditions in which the intervention outcome data was produced (Yin 2018), for example are the outcomes based on service user or occupational therapy staff perspectives. In addition, it is important to consider the accuracy of the outcome measure tools (Yin 2018) e.g. are the tools evidence based, and are they the appropriate tools to measure what needs to be measured.

Intervention outcome data - data Analysis

The analysis will be determined following the collection of the outcome data. The reasoning for this is that different outcome measure tools are used across the service, and thus different methods of data analysis may be required for each tool used. Some tools may collect qualitative data, and others quantitative data. Some tools may take a snapshot in time, whereas

others may be conducted over a period of time. It is also important to note that some intervention outcome data tools may link back to the initial assessment tools that were used, and thus these may need to be analysed simultaneously. The intervention outcome data will be translated and framed within the domains of the Model of Human Occupation (Kielhofner 2008). Recovery Through Activity is based on the MOHO and the research propositions are based on occupational science, and thus justifies its use to guide analysis, through providing structure, ensuring that an area of occupational analysis is not overlooked, and providing guidance on which outcome measure tools capture occupational change.

Documentation

The case study design will benefit from including documentation within the data collection as it will provide contextual information of both the setting and wider literature. The documentation to be included in the data collection will be: literature; reports and evaluations relating to each case within the study. This use of documentation will be important to corroborate and augment findings from the other data collection methods used, as well as broadening the research across time, settings and events (Yin 2018). Prior to the data fieldwork, collecting documentary evidence will provide preparatory and orienting information (Yin 2018). However, this method can be conducted at convenience and reviewed repeatedly, as this evidence is not created as a result of the study (Yin 2018).

A scoping review will be conducted for each individual case: adult inpatient and adult community. This type of review was chosen as the case study areas have not been extensively reviewed, and they are complex and heterogeneous in nature (Mays et al. 2001). A scoping review will allow an examination of the nature, range, and extent of research surrounding the cases (Pham et al. 2014).

Case study analysis

In the initial stage, the cases will be analysed separately and thesis chapters then written up. This will inform the final case study report (thesis chapter), which will represent the cross case conclusions and reflect related theory to allow for policy recommendations to be developed.

Specifically, each case will be analysed independently, through triangulating the evidence gathered from the interviews, questionnaires, intervention outcome data and the documentation. A thesis chapter will be written for each case, 2 chapters in total.

The thesis chapters that are produced for each individual case, will be collated and compared to identify common themes and differences and level 1 inferences will be made (see Figure 3). Following this, the data will be compared with the case study theory, such as the propositions, and the rivals, and level 2 inferences will be made (see Figure 3). Following this the final case report/thesis chapter will be drawn.

Recruitment

In relation to recruiting service users as participants, multiple stages will be used to ensure ethical issues are taken into consideration. All service users that have been engaged in Recovery Through Activity based interventions will be eligible to participate in the research, unless there is an issue surrounding risk, lack of capacity to consent, or if the occupational therapists feel that participation would be detrimental to their care. The occupational therapists will 'screen' service users and exclude anyone that falls into the criteria outlined above. Following the screening, the occupational therapist will provide a list of names and contact details to the

gatekeeper, who will distribute permission to contact forms and an information sheet to service users.

The gatekeeper will also send out permission to contact forms and an information sheet to occupational therapy staff who have been involved with Recovery Through Activity within an NHS Health Board's mental health services either presently or in the past.

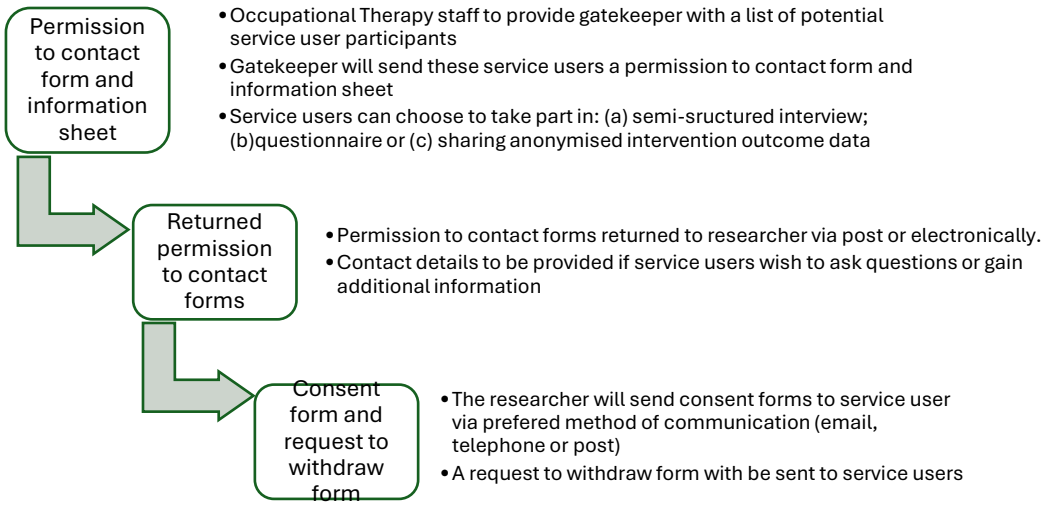
These permission to contact forms include an expression of interest section, where potential participants (both staff and service users) can indicate their interest in receiving more information about participating in one or multiple elements of the research including: interviews; questionnaires and the use of anonymised intervention outcome data. Potential participants will be asked to return the permission to contact forms electronically or post to the researcher. Potential participants will be asked their preferred mode of communication (email, telephone or post), and the researcher will contact them accordingly.

Those who have expressed an interest in participating in the interviews will be added to the database for sampling. Those who are drawn from the sample (sampling method described below) will be contacted by the researcher to discuss and answer any questions they may have. If the participant wishes to continue, an informed consent form specific to interviews will be sent to the potential participant.

The information sheet and permission to contact form explains that only a sample of respondents will be chosen at random to participate, and that expressing an interest will not necessarily mean that they will be chosen to participate. Participants will be reassured that if they are not chosen to participate in an interview, they will still have an opportunity for their voice to be heard through the second stage questionnaire.

Respondents who express an interest in participating in the questionnaires will be sent a consent form. Those who express an interest for their anonymous intervention outcome data to be used, will be sent a consent form via post/electronically and will be provided contact details for the researcher to gain more information and have any questions they may have answered.

A consent withdrawal form will also be included to enable participants to withdraw their consent to participate if they so wish, which can be returned via post/electronically at any stage during the research, up until the point where data has been coded and anonymised. After this point, should participants wish to withdraw consent, previously anonymised and analysed



data may still be used, however, any personal/identifiable information will be deleted. I will delete/destroy the consent withdrawal from (as it has identifiable information) and will keep a file note stating "participant (ID number) withdrew consent on X date".

Figure 4a. Flow diagram detailing the process for service user involvement

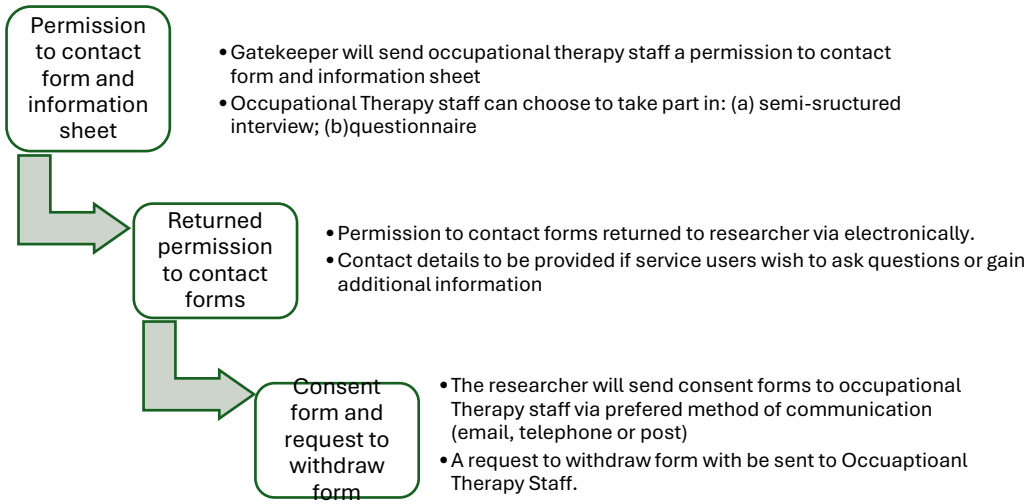


Figure 4b. Flow diagram detailing the process for occupational therapy staff involvement.

Sample

Regarding the sample selection for interviews with occupational therapy staff, a stratified sampling method will be used, to gain a broad representation of occupational therapy staff across banding levels. Following the collection of the permission to contact forms, potential participant names who have expressed an interest will be grouped in order of the following strata within each case:

- band 7
- band 6
- band 5
- band 3 and 4 combined

Within each case a simple randomised sampling technique will be used to select 1 participant from each strata, to ensure that all potential participants have an equal chance of being chosen. In order to ensure that within each case the sample is representative of the entire service, if (within a case) a participant is drawn from a team that is already, the selection will be void, and the simple randomised sample will be conducted again. This will allow for representation across banding's and teams across the service, within each case. This will result in a total of 4 participants within each case, totalling 8 occupational therapy staff member participants across cases.

With regards to the occupational therapy staff the sample for the questionnaires, will consist of all those who have consented. No further sampling method is required.

A stratified sampling technique will also be used to select participants for the service user interviews. Following the collection of the permission to contact forms, potential participant names who have expressed an interest will be grouped within the strata of the service areas.

For each case (inpatient and community), a simple randomised sampling technique will be used to determine which 4 strata’s (geographical areas) will be included. Following this a simple randomised sampling technique will be used to select 1 participant from each strata. There will be 4 service user participants per case, totalling 8 service user participants in total. The number of participants to represent service user perspectives has been chosen to reflect the number required for the occupational therapy staff sample. This allows for a balanced representation between service user and staff perspectives within the research.

With regards to service users the sample for the questionnaires and intervention outcome data, will consist of those who have consented. No further sampling method is required.

Ethical and regulatory considerations

In line with the National Research Council (2003 pp.23-28), the research will adhere to the following:

- Gaining *informed consent* from all persons who may be part of the case study, by alerting them to the nature of the case study and formally soliciting their volunteerism in participating in the study;
- Protecting those who participate in the study from any *harm*, including avoiding the use of any *deception* in the study;
- Protecting the *privacy and confidentiality* of those who participate so that, as a result of their participation, they will not be unwittingly put in any undesirable position, such as being placed on a list to receive requests to participate in some future study, whether conducted by the current researcher or anyone else;
- Taking special precautions that might be needed to protect *especially vulnerable groups*; and
- Selecting participants *equitably*, so that no groups of people are unfairly included or excluded from the research.

(Yin 2018, pp. 88-89)

Assessment and management of risk

A risk management plan has been included. It identifies any potential risks and the procedure that would be undertaken in the event of its occurrence.

Research Ethics Committee (REC) and other Regulatory review & reports

Prior to the commencement of the research, a favourable opinion will be sought from NHS REC for the study protocol, and appended documents. Annual progress reports will be produced and submitted to REC within 30 days of the anniversary date from which REC approval was granted, until the study has been declared completed by the chief investigator. Within one year of the end of the study, a final report and any publications will be submitted to the REC by the chief investigator. All correspondence with the REC will be retained.

Amendments

Any amendments to the research will need to be in agreement with the sponsor (Cardiff University) and partner organisation (NHS Health Board). The amendments will then be submitted to NHS REC for approval before the amendment is made. Information will be submitted to the appropriate body in order for them to issue approval for the amendment. Some amendments will be considered non-substantial to REC, however the NHS Health Board's R&D will still be notified.

Protocol compliance

Frequent deviations from the protocol that are reoccurring will require immediate action and would be classified as a breach. However, there are instances where accidental protocol deviations can happen. If this occurs, deviations will be adequately documented on the relevant forms and reported to the sponsor immediately.

Data protection and patient confidentiality

The research will comply with the requirements of the Data Protection Act (1998) with regards to the collection, storage, processing and disclosure of

personal information. Personal information will be temporarily accessed on a secure on an encrypted laptop before being transferred to an encrypted external hard drive. Any paper documents will be filed and stored in a locked case, in a secure room.

Participant identifiable information will be replaced by the creation of coding, using an unrelated sequence of characters. The information linking the data and the code will be kept in separate locations using encrypted digital files within encrypted folders and encrypted devices.

Expected preparation prior to fieldwork

The pilot study

A pilot study will be conducted. This pilot will be used as a formative study as opposed to a *pretest*, to assist in clarifying relevant lines of questions, provide conceptual clarification for the research design (Yin 2018), and to trial the data collection methods.

The pilot study will consist of: interviews and questionnaires with occupational therapy staff; as well as piloting the service user interview schedule and questionnaire with the PPI group.. This will provide insight into the implementation of the methods and whether the methods allow for the questions to be answered.

A report will be written following the pilot study, based on the findings, explicitly capturing the lessons learned regarding the research design and field procedures (Yin 2018). This will indicate whether alterations need to be made to the protocol.

Part C: Protocol questions

This section includes questions that will reflect the line of inquiry when collecting data. These questions are posed to the researcher, as opposed to the participant, to keep the research on track throughout the data collection process. They are categorised as 'level 2' questions and relate to each individual case (Yin 2018). Due to the nature of this research, each case will individually follow the same line of enquiry, thus the 'level 2' questions to be explored will be the same for each case, and so within this protocol only one set of questions are required. The questions below are grouped within their unit of analysis and linked to the research propositions. Below each grouping, the unit of data collection that relates to each unit of analysis is noted.

Unit of Analysis: Service users' experiences

Units of data collection: Service user interviews and questionnaire.

- How has Recovery Through Activity impacted on service users' occupational participation and engagement? [proposition 5]
  - Motivation for occupation
  - Pattern of occupation
  - Communication and interaction skills
  - Process skills
  - Motor skills
  - Engagement with environmental factors

- How has the implementation method impacted on service users' experiences of Recovery Through Activity? [proposition 2]
  - 1:1 vs Group intervention
  - Service user engagement in goal planning and intervention planning

- In service sessions vs. sessions with community links

- How has access to community resources impacted on the service users' perceptions of the effectiveness and benefits of Recovery Through Activity? [proposition 3]
  - Transitioning from Recovery Through Activity to community services
  - Availability of community resources
  - Transport
  - Financial implications

- How have individual differences impacted on service users' perceptions on the effectiveness and benefits of Recovery Through Activity? [proposition 4]
  - Gender and age
  - Readiness for change
  - Volition, Habituation and performance capacity
  - Culture and religion
  - Goals and interests
  - Expectations and perceptions of recovery, occupational therapy and Recovery Though Activity

Unit of analysis: occupational therapy Practitioner experiences

Units of data collection: OT staff' interviews and questionnaire

- What are occupational therapy staff' experiences of implementing an occupationally focussed approach? [contextual]

- What are occupational therapy staff' experiences of using Recovery Through Activity to inform practice? [contextual]

- How do service dynamics and demographics impact on occupational therapy staff' experiences of Recovery Through Activity? [linked to proposition 1]
  - Staff training and support
  - Staff capacity
  - Other professionals' perceptions of Recovery Through Activity
  - Availability of resources and community links
  - Client groups
  - Setting dynamics such as ward or community
  - Local policies and legislations
  - Service demands and organisational objectives

- How does the implementation method of Recovery Through Activity impact on occupational therapy staff' experiences? [linked to proposition 2]
  - 1:1 vs. groups
  - Goal setting and intervention planning
  - The use of a model
  - Assessment and outcome measure tools, and how this informs the structure
  - In service vs community link implementation
  - The use of Recovery Through Activity as a programme/framework/tool?
  - The referral process for Recovery Through Activity

- How does access to community resources impact on the effectiveness and the benefits of the use of Recovery Through Activity from an occupational therapy staff' perspective? [linked to proposition 3]
  - The transition form Recovery Through Activity to community and

community links
- Availability of community resources
- Transport links
- Financial implications
- Impact of legislation on accessing community resources

Unit of analysis: Existing assessment and intervention outcome data

Unit of data collection: Anonymised service user intervention outcome data

- What assessment and outcome measure tools were/are used for Recovery Through Activity? [contextual]

- Do the assessment tools and outcome measure tools inform OT staff on an individual's occupational areas of volition, habituation, performance capacity and environment? [contextual]

- Based on intervention outcome data, how has Recovery Through Activity impacted on service users' occupational participation and engagement. [linked to proposition 5]
  - Motivation for occupation
  - Pattern of occupation
  - Communication and interaction skills
  - Process skills
  - Motor skills
  - Engagement environmental factors

Unit of analysis: Documents [contextual]

Units of data collection: document analysis, OT staff' interviews and questionnaire, service user interviews and questionnaire.

- What Recovery Through Activity training and support is available?
- What resources and community links are available in the context of Recovery Through Activity?
- What are the demographics of the service users engaging in Recovery Through Activity?
- What local policies and legislations inform Recovery Through Activity practice?
- What are the service demands and objectives in the context of Recovery Through Activity?
- What are the demographics of occupational therapy staff delivering Recovery Through Activity?

Part D – outline for report

This section includes an initial outline for the case study report/thesis. It outlines the potential audiences, structural format to be used, the illustrative structure, as well as how and when composing will begin, decisions around anonymity, and the validation procedure.

Potential Audiences

The potential audience for the case study report will be diverse. The research is being conducted in partnership with an NHS Health Board and so naturally, research and professional colleagues within this organisation will form part of the audience. Additionally, research and professional colleagues within Cardiff university will form part of the audience.

On a wider scale the audience for this report could include; occupational therapy staff, Researchers, Academics, Mental Health Services, wider services using Recovery Through Activity, and policy makers.

The report will also form the basis for thesis chapters to be examined through a PhD Viva.

Due to the diversities in the audiences, there may be a need to adapt the report to the audience needs. For example, for the PhD Viva the examiners may be more interested in the methodology and theoretical issues, whereas staff may be more interested in practice implications (Yin 2018).

Compositional format

The compositional format for this study will initially report each individual case as separate reports, which will form the basis for thesis chapters. There will be a report/chapter for each of the individual cases: adult inpatient and adult community. Following this there will be a report/chapter covering the full multiple case composition, covering the cross-case analysis and results.

Illustrative structure

A linear-analytic structure will be used, adapted to the multiple-case design to structure sub-topics. This structure will comprise of; the issue being studied and the review of literature, methods used, data collected, analysis and findings, conclusion, and implications (Yin 2018). This structure was chosen as it easily translated to the structure of most journal articles and thesis chapters (Yin 2018)

When to start composing

As recommended by Yin (2018) sections of the report will begin at an early stage, including; literature review and case descriptions. As Yin (2018) notes, due to the nature of the design, the methods section will not be able

to be completed until near the end of the analysis phase, however following approval from the IRB, a partial draft methods section will be written up.

Anonymity

The service users, occupational therapy staff and service locations will remain anonymous throughout the report, to protect participants, other service users, other occupational therapy staff, and the service. The case context however, will be disclosed.

Appendix 4- occupational therapy staff interview schedule

Colour key – links to objectives and propositions.	Questions for participants
What are occupational therapy staff' experiences of implementing an occupationally focussed approach? [linked to objectives] What are occupational therapy staff' experiences of using Recovery Through Activity to inform practice? [linked to objectives] How does the implementation method of Recovery Through Activity impact on occupational therapy staff' experiences? [linked to proposition 2] • 1:1 vs. groups • Goal setting and intervention planning	Introduction • Job role, Service, Geographical Area. • Tell me a bit about yourself and your role An occupationally focussed approach and Recovery Through Activity • What are your experiences of implementing an occupationally focussed approach? • What challenges have you found in implementing an occupationally focussed approach? [how have you overcome these challenges? • What are your experiences of using Recovery Through activity? • How Recovery Through Activity changed your experiences of implementing an occupationally focussed approach? [if so how?] • Has RtA helped you meet your client goals? [If so how? If not, what challenges did you face?] Implementation method • Tell me a bit about how you've used Recovery Through activity [programme, framework or tool? 1:1, groups or frame of reference? Face to face or online?]

• The use of a model • Assessment and outcome measure tools, and how this informs the structure • In service vs community link implementation • The use of Recovery Through Activity as a programme/framework/tool? • The referral process for Recovery Through Activity How do service dynamics and demographics impact on occupational therapy staff' experiences of Recovery Through Activity? [linked to proposition 1] • Staff training and support • Staff capacity • Other professionals' perceptions of Recovery Through Activity • Availability of resources and community links • Client groups • Setting dynamics such as	• How has your staffing levels and practice capacity impacted on your ability to use RtA as an intervention? • Who do you use RtA with? [do your patients have any similar characteristics, goals or needs?] • How do you plan your interventions using recovery through activity? [goal setting with patients? Patients involved in planning?] • Which models of practice to you refer to in your practice? [Has this had an impact on how you implement Recovery Through Activity?] • Do you run your RtA sessions within the service or do you involve community links? • What is the current pathway for RtA in your service? [Referral, intervention, transition to discharge] Service dynamics • Have you had any training on how to implement RtA? [in service or external? How has this impacted how you implement RtA?] • How have you found other professionals' perceptions of RtA? [Has it changed their view of the OT role? In what way?] • How has availability of resources and community links impacted how you implement RtA? [have you found this has had an affect on it's effectiveness? How has this impacted on the transitioning post intervention?] • Have any policies or legislations had an impact on how you implement RtA? [the mental health act? Being detained on a ward and s17 leave? Risk management policies?] • How has the service demands, and organisational objectives impacted your use of RtA? [In which way does RtA help or hinder you to these demands and objectives?]

ward or community • Local policies and legislations • Service demands and organisational objectives How does access to community resources impact on the effectiveness and the benefits of the use of Recovery Through Activity from an occupational therapy staff' perspective? [linked to proposition 3] • The transition form Recovery Through Activity to community and community links • Availability of community resources • Transport links • Financial implications • Impact of legislation on accessing community resources	Community Resources • What community resources are available in your area of service? • How do access to community resources impact your implementation of RtA? • How have transport and financial implications impacted your implementation of RtA? • Has legislation had an impact on your ability to access community resources in relation to RtA? [e.g. equality act, mental health act] Is there anything we haven't spoken about that you would like mention? Do you have any questions for me? Debrief and Thank you!

Appendix 5 – Service user interview Schedule

Colour key – links to objectives and propositions.	Questions for participants
How have individual differences impacted on service users' perceptions on the effectiveness and efficacy of Recovery Through Activity? [proposition 4] • Gender and age • Readiness for change • Volition, Habituation and performance capacity • Culture and religion • Goals and interests • Expectations and perceptions of recovery, occupational therapy and Recovery Though Activity How has Recovery Through Activity impacted on service users' occupational participation	Introduction • age, geographical area, ethnicity and religion. • where they got involved in Recovery Through Activity. [service area] • Tell me a bit about yourself why you got involved in Recovery Through Activity. Expectations • What were your expectations for Recovery through Activity? Implementation method • Tell me a bit about your engagement in Recovery Through activity • Did you attend any group sessions or 1:1 sessions? Virtual or face to face [Tell me a bit about those, what were most/least beneficial to you? What part did you most/least enjoy and why?] • Did you have sessions within the service or did you engage with outside services in the community? • Were you involved in the planning of the Recovery Through Activity sessions? • [goal planning addressed below]

and engagement? [proposition 5] • Motivation for occupation • Pattern of occupation • Communication and interaction skills • Process skills • Motor skills • Engagement with environmental factors How has the implementation method impacted on service users' experiences of Recovery Through Activity? [proposition 2] • 1:1 vs Group intervention • Service user engagement in goal planning and intervention planning • In service sessions vs. sessions with community links How has access to community resources impacted on the	Volition • Prior to Recovery Through Activity, how would describe your confidence in your ability engage in your activities? • How would you describe your confidence in your ability now? • Did you set any goals for Recovery Through Activity? If so would you like to share? • Did Recovery Through Activity help you to achieve these goals? [If so, what about it do you think helped you? If not, what do you think would have helped?] • Did you have any hobbies or interests prior to Recovery Through Activity? [If so would you like to tell me about them? Did you engage in them?] • Have your hobbies and interests changed? Has your engagement with them changed? Habituation • Prior to Recovery through Activity how did you spend your time? [Work? Volunteering? A part of any social groups?] • How do you spend your time now? [Work, volunteering? Social groups?] • How would've you describe your level of satisfaction with your daily routine? • How would you describe your level of satisfaction with your daily routine now? [If any changes, why do you think that is?] Performance capacity • Prior to Recovery Through Activity were you able to do the things you wanted to do? [what types of things did you want to do? what obstacles were in the way?] • Did recovery through activity help you to do the things that you want to do? [what types of things did you want to do? In what ways did RtA help? In what ways could RtA be done

service users' perceptions of the effectiveness and benefits of Recovery Through Activity? [proposition 3] • Transitioning from Recovery Through Activity to community services • Availability of community resources • Transport • Financial implications	differently? Access to community resources [related to question above] • What were your experiences when Recovery Through Activity ended? [Did you have a plan on what do to next? Were you able to continue with your activities/ take up new actives? • Do you have access to a range of activities that you want to do where you are currently living? [whether this be community or ward] • What is available in your local area? Does any of this interest you? • How does transport have an impact your ability to engage in your activities? • How do finances have an impact on your ability to engage in your activities? Is there anything we haven't spoken about that you would like mention? Do you have any questions for me? Debrief and Thank you!

Appendix 6 - occupational therapy staff gatekeeper cover letter

IRAS ID: 276168

Name of Researcher: Savanna Cole

Cover Letter **8/7/2021**

To whom this may concern, I am writing to you on behalf of Savanna Cole, a PhD student at Cardiff University, who would like to invite you to take part in her research study.

The research project is being undertaken through Cardiff University in partnership with [redacted] *University Health Board and is being funded by a Knowledge Economy Skills Scholarship (KESS2).*

You are receiving this letter as you may have been involved with Recovery Through Activity. This research project is exploring your experiences of Recovery Through Activity. If you are interested in participating, or would like more information, please read the information sheet (attached), and complete and return the permission to contact form and Savanna will then get

in touch to answer any questions you may have. Please feel free to talk to others about the study if you wish. Permission to contact form: https://forms.office.com/r/SLs7rwM8Qv

Best wishes,

Appendix 7 - Service user gatekeeper cover letter

IRAS ID: 276168

Name of Researcher: Savanna Cole

Cover Letter **8/7/2021**

To whom this may concern, I am writing to you on behalf of Savanna Cole, a PhD student at Cardiff University, who would like to invite you to take part in her research study.

The research project is being undertaken through Cardiff University in partnership with [redacted] *University Health Board and is being funded by a Knowledge Economy Skills Scholarship (KESS2).*

You are receiving this letter as you may have been involved with Recovery Through Activity. This research project is exploring your experiences of Recovery Through Activity. If you are interested in participating, or would like more information, please read, complete and return the permission to contact form (attached) and Savanna will then get in touch to answer any questions you may have. Please feel free to talk to others about the study if you wish.

Best wishes,

Appendix 8 - occupational therapy staff information sheet

IRAS ID: 276168

Name of Researcher: Savanna Cole

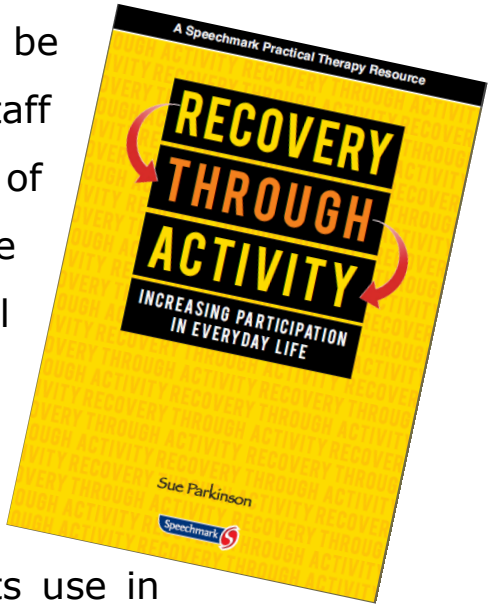
occupational therapy Staff Information Sheet

Key Information

Title of Project

Evaluating Recovery Through Activity in Mental Health Services V.1

Brief Summary



Through this research project I will be exploring both occupational therapy staff and service user experiences of Recovery Through Activity. I would like to gain insight into your personal experiences, including how you've used to it to inform interventions, maintaining an occupational focus, and the benefits and limitations of its use in your practice. This research project will help us to uncover how the theory of Recovery Through Activity relates to practice, how it can be adapted in different services and for different needs, and what benefits and limitations there when implementing or

using Recovery Through Activity. There are two ways in which you can participate: (1) through an online interview and/or (2) by completing a questionnaire. Service users have the additional option to consent to have their anonymised intervention outcome data shared with me for the purposes of this project. To be eligible to participate, you need to be currently, or previously, working in [redacted] Adult Mental Health Services and have had some experience using Recovery Through Activity (this could include its use for group sessions, 1:1 sessions, or it's use as a point of reference). I wish to gain a broad spectrum of how it is used. My research project is being carried out across [redacted] Mental Health Adult Mental Health services; however, all contact will be through phone calls, online video calls or post due to COVID. Upon completion of the study the results will be reported in the PhD thesis. In addition the results may be disseminated through publishing journal articles, or presenting at conferences.

Explanation

Through this research project I plan to explore occupational therapy staff's role and experiences of using Recovery Through Activity, as well as identifying the opportunities and challenges faced in implementing an occupationally focussed approach. In addition, I will explore service user perceptions and experiences resulting from the use of Recovery Through Activity, as well as evaluating its effectiveness though analysing anonymised

occupational therapy intervention outcome data.

Previous research has suggested that occupational therapists in mental health teams struggle with balancing their occupationally focused roles and generic roles. The Recovery Through Activity manual aims to function as a tool for occupational therapists to support their core skills, evidence the value of activity, and provide resources for occupationally focused intervention. However, there is no previous research specifically exploring the experiences of occupational therapists using Recovery Through Activity in practice in mental health services.

What taking part would involve

If you are interested in participating in this research project or gaining more information, simply complete the electronic permission to contact form attached or contact me via email at [redacted] and I can send you a paper copy. This will not mean you have committed to participating, it is just to enable me to contact you, give you more information and answer any questions you may have, to help you decide if you want to be involved or not. People that do not need to know who you are, will not be able to see your name or contact details. Your data will have a code number instead. We will keep all information about you safe and secure.

There are two ways that you can get involved in this research. I have gone into more detail below; you can decide to take part in

both or one element of the project – this is entirely up to you.

Interviews

There will be a maximum of 16 interviews conducted in total for this research project. 8 of these interviews will be with occupational therapy staff, and 8 will be with service users.

The interviews will be done online through Microsoft Teams. Help can be provided if you're not sure on how to use this platform. I can also arrange for you to borrow a computer device such as a tablet if you do not have access. Support can be provided around using the tablet if required. The interview will be relaxed and informal, the purpose is to gain your views and opinions. I will ask you some questions about your experiences of Recovery Through Activity and any benefits and challenges you faced with this. The video call will be audio recorded on my computer which is password protected and encrypted. I will type up our interview "word for word" in a word document, anonymise it(by deleting your personal information and replacing your name with a participant number), and then delete the audio recording. I will send you the typed up interview so you can check that its accurate before I then look across all of the interviews and draw out the common themes. Each interview should last around 1 hour.

I can only interview 16 people in total, I will add your name to a database if you return your permission to contact form and draw 16 names at random. If your name is chosen, I will send you a consent form in the post or email. I will give you a week to have a think. If you decide you want to participate, you will be asked to return the consent form via email or in a envelope provided, by the date on the form. If your name does not get drawn, I will send you a thank you letter for your time and let you know.

Questionnaire

I have divided the questionnaire into two sections. The first section will ask you demographic information such as; age range; setting (community mental health service or acute inpatient service); banding; implementation method (such as 1:1 sessions or group sessions, as well as face to face or online sessions); Recovery Through Activity training attended; assessment tools used; outcome measure tools used; model of occupational therapy used and whether community resources and links were used in the implementation of sessions.

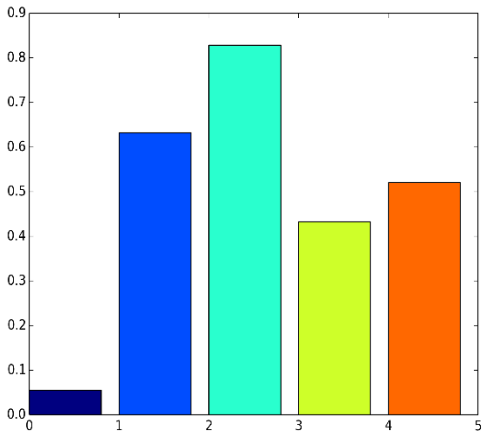
Following the interviews, I will have drawn out key themes. These themes will be used in the second part of the questionnaire. I will ask you to rate the themes in relation to

how relevant they are to you and how important they are to you.

The purpose of this is so that I can gain broad understanding of staff views across the service. I will analyse whether these views are similar or different, and if there are any patterns between for example, settings or demographic information.

If you choose to return your permission to contact form I will send you a consent form in the post/email along with the questionnaire. I'll give you 3 weeks to have a think and complete the questionnaire if you decide that you do want to participate. If you decide that you want to participate, you will be asked to return the consent form and completed questionnaire in a prepaid envelope or by email by the date on the form.

Anonymised Intervention Outcome data



Service users have an additional option regarding participating in this research project. If they wish they can consent for their intervention outcome data to be shared where Recovery Through Activity has been used as part of the intervention. You may be contacted regarding this if your client consents for this to be shared. You will be provided with a copy of the consent form and asked to anonymise their existing outcome data before sending

it on to me. The purpose of this is to evaluate the effectiveness and efficacy of Recovery Through Activity, as well as exploring the range of outcome measure tools that can be used to measure this in practice.

Additional Information

Withdrawal of consent

You can withdraw your consent at any stage throughout the research project, without giving a reason, up until the point that your data is anonymised and analysed. After this point, should you wish to withdraw consent, previously anonymised and analysed data may still be used, however, any personal/identifiable information will be deleted. You can withdraw consent by completing the "consent withdrawal" form that I will send to you when I send out the consent forms. You can return this via post or email. If you misplace the form, you can contact me at any time and I will send you another consent withdrawal form. Upon receival, following relevant action, I will delete/destroy the consent withdrawal from (as it has identifiable information) and will keep a file note stating "participant (ID number) withdrew consent on X date".

The potential benefits of taking part

There are likely to be no benefits to yourself for taking part. However, one potential benefit of taking part is that you will have the opportunity to have your views and experiences of Recovery Through Activity heard. Your participation may help to inform the evidence base for practice. As evidence based practice is a requirement in Health and Care Professions, this research project could potentially inform; policy recommendations, inform mental health services, shape occupational therapy practice, and provide future recommendations on how to best utilise Recovery Through Activity as an intervention.

The potential disadvantages and risks of taking part

There are no direct risks associated with taking part in this research project, however I will provide you with a list of useful resources if any concerns are raised during our conversations and you would like some support.

It is also important to note that although this research project will serve as an evidence base and may provide recommendations for practice and policies, it will not directly change practice or policies in itself.

Data protection

Your rights

You have a number of rights under data protection law and can find out more about these on our website: https://www.cardiff.ac.uk/public-information/policies-and-procedures/data-protection.

Lawful basis for processing personal data

Under data protection law we have to specify the legal basis that we are relying on to process your personal data. In providing your personal data for this research we will process it on the basis that doing so is necessary for our public task for scientific and historical research purposes in accordance with the necessary safeguards, and is in the public interest. The University is a public research institution established by royal charter to advance knowledge and education through its teaching and research activities. Our charter can be found on the Cardiff University website: https://www.cardiff.ac.uk/about/organisation/governance/charter-statutes-ordinances.

Time period for keeping personal information

After 7 days your personal data will be anonymised meaning that I will remove any identifiers that can identify you from the data you have provided. This anonymous information may be kept indefinitely or published in support of the research. Personal data we may have collected, such as your consent to participate in the study will be kept for 15 years following the completion of the research project.

Personal data, complaints and queries

If you have a concern or query about any aspect of this study, you can contact myself if you wish and I will do my best to answer your questions: xxxxxxxxxxxxxxxxxxxxxxxxxx

If you have any queries you can also contact my lead supervisor, and project chief investigator[redacted]who is a reader in the School of Healthcare Sciences and lead for Research and Development in occupational therapy within Cardiff University: xxxxxxxxxxxxxxxxxxxxxxxxxx

If you have a complaints and wish to speak to someone independent to the study, you can contact Kate Button, who is a reader within the school of healthcare sciences: xxxxxxxxxxxxxxxxxxxxxxx

If you remain unhappy and wish to complain formally, you can do through emailing your concern to the Health Research Authority: complaints@hra.nhs.uk who aim to investigate and respond to your concern within 25 days. Details can be obtained from: https://www.hra.nhs.uk/about-us/governance/feedback-raising-concerns/

Appendix 9 - Service user information sheet

IRAS ID: 276168

Name of Researcher: Savanna Cole

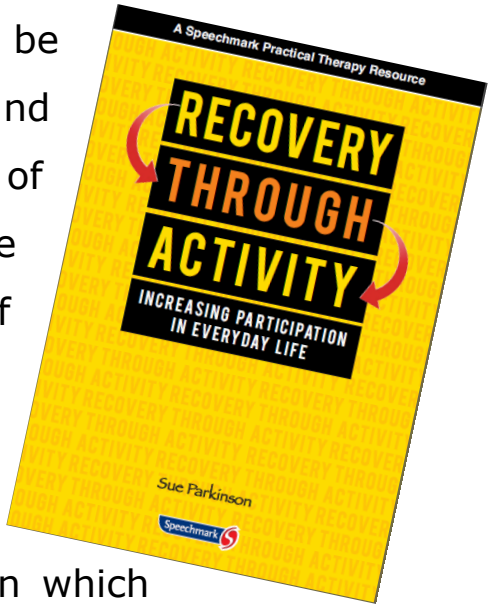
Service User Information Sheet

Key information

Title of Project

Evaluating Recovery Through Activity in Mental Health Services V.1

Brief Summary



Through this research project I will be exploring both service user and occupational therapy staff experiences of Recovery Through Activity. I would like to hear your personal experiences of Recovery Through Activity, including what your expectations were and the benefits and limitations you experienced. There are three ways in which you can get involved: (1) through an online interview; (2) by completing a questionnaire, and (3) by providing permission for your occupational therapist to share your intervention outcome data with me. To be eligible to take part, you need to (either

currently or previously) have been involved with Adult Mental Health Services and have had some involvement with Recovery Through Activity (this might have included attending group sessions or one to one sessions). This project is being carried out across [redacted]ntal Health services; however, all contact will be through phone calls, online video calls or post due to COVID. Upon completion of the study the results will be reported in the PhD thesis. In addition the results may be disseminated through publishing journal articles, or presenting at conferences.

What am I doing and why?

Through this research project I plan to explore services user perceptions and experiences of Recovery Through Activity, including any benefits and challenges you experienced. As well as this I will evaluate the effectiveness of Recovery Through Activity by looking at anonymised intervention outcome data. I will also explore occupational therapy staff's role and experiences of using Recovery Through Activity.

Previous research has found that people living with mental ill health often don't do activities that are meaningful to them and are often under-occupied. Research has also found that people with mental ill health are one of the most socially excluded groups in the UK. Recovery Through Activity aims to help people with mental ill health to do activities that are meaningful to them and improve their health.

What would taking part involve?

If you are interested in being involved in this research or finding out more information, simply complete the permission to contact form attached and send it back in the pre-paid envelope or email myself at [redacted] and I can send you an electronic version. This will not mean you have committed to anything, it's just so that I can contact you, give you more information and answer any questions you may have, to help you decide if you want to be involved or not. People that do not need to know who you are, will not be able to see your name or contact details. Your data will have a code number instead. We will keep all information about you safe and secure.

There are three ways that you can get involved in this research. I have gone into more detail below, you can decide to take part in all of the below or one or more element of the project – this is entirely up to you.

Interviews

There will be a maximum of 16 interviews conducted in total for this research project. 8 of these interviews will be with service users, and 8 will be with occupational therapy staff.

The interviews will be done online through Microsoft Teams. Help can be provided if you're not sure on how to use this platform. I can also arrange for you to borrow a computer device such as a tablet if you do not have access. Support can be provided around using the tablet if required. The interview will be relaxed and informal, the purpose is to gain your views and opinions. I will ask you some questions about your experiences of Recovery Through Activity and any benefits and challenges you faced with this. The video call will be audio recorded on my computer which is password protected and encrypted. I will type up our interview "word for word" in a word document, anonymise the document (by deleting your personal information and replacing your name with a participant number), and then delete the audio recording. I will send you the typed-up interview so you can check that its accurate before I then look across all of the interviews and draw out the common themes. Each interview should last around 1 hour.

I can only interview 16 people in total. If you return your permission to contact form, I will add your name to a database and draw 16 names at random. If your name is chosen, I will send you a consent form in the post or email. I'll give you a week to have a think. If you decide that you want to participate, return the consent form to me by email or in a prepaid envelope provided by, the date on the form. If your name does not get drawn, I will send you a thank you letter for your time and let you know.

Questionnaires

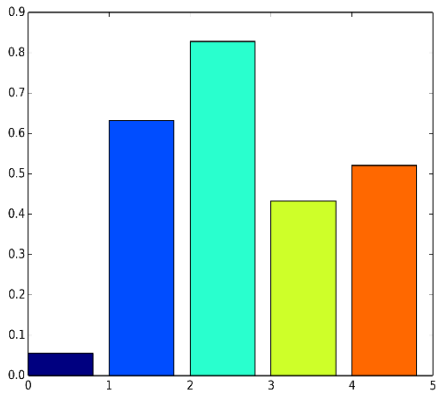
I have split the questionnaire into two sections. The first section will ask you demographic information such as; age, the service setting you attended (inpatient or community), and the type of Recovery Through Activity sessions you attended (1:1 or groups, face to face or online sessions).

Following the interviews, I will have drawn out key themes. These themes will be used in the second part of the questionnaire. I will ask you to rate the themes in relation to how relevant they are to you and how important they are to you.

The purpose of this is so that I can see service user views across the whole service. I will look at whether your views are similar or different across settings, and if there are any patterns in this.

If you choose to return your permission to contact form I will send you a consent form in the post/email along with the questionnaire. I'll give you 3 weeks to have a think and complete the questionnaire if you decide that you do want to participate. If you decide that you want to participate, you will be asked to return the consent form and completed questionnaire in a prepaid envelope or by email by the date on the form.

Anonymised Intervention outcome data



Following completion of your Recovery Though Activity intervention, your occupational therapist would have completed an outcome measure. This is to measure whether the intervention was of benefit. There are many different outcome measures, some measure how an intervention improved your skills, whereas others measure how the intervention helped you meet your goals. Your occupational therapist would have chosen one that best suits you and their service.

I would like to use anonymised intervention outcome data to explore the effectiveness of Recovery Through Activity. This data will help me to identify whether Recovery Through Activity is effective and the areas where Recovery Through Activity had the most benefit.

If choose to return your consent to contact form I will send you a consent form in the post/email and give you a week to think about whether you wish for your anonymised outcome data to be shared. You will be asked to return the consent form to me by the date stated on the consent form in the prepaid envelope/ via email. Your occupational therapist will then be contacted. They will anonymise your outcome data before sending it to me

for use in the research.

Additional information

What if I don't want to carry on with the study?

You can withdraw your consent at any stage throughout the research project, without giving a reason, up until the point that your data is anonymised and analysed. After this point, should you wish to withdraw consent, previously anonymised and analysed data may still be used, however, any personal/identifiable information will be deleted. You can withdraw consent by completing the "consent withdrawal" form that I will send to you when I send out the consent forms. You can return this via post or email. If you misplace the form, you can contact me at any time and I will send you another consent withdrawal form. Upon receival, following relevant action, I will delete/destroy the consent withdrawal from (as it has identifiable information) and will keep a file note stating "participant (ID number) withdrew consent on X date".

What are the possible benefits of taking part?

There are likely to be no benefits to yourself for taking part. However, one potential benefit of taking part is that you will have the opportunity to have your views and experiences of Recovery Through Activity heard. Your participation may help to inform the evidence base for practice. As evidence based practice is a requirement in Health and Care Professions, this research project could potentially inform; policy recommendations, inform mental health services, shape occupational therapy practice, and provide future recommendations on how to best utilise Recovery Through Activity as an intervention.

What are the possible disadvantages and risks of taking part?

There are no direct risks associated with taking part in this research project, however I will provide you with a list of useful resources if any concerns are raised during our conversations and you would like some support.

Please note that this research will not affect your care or access to services, whether you wish to participate or not.

It is also important to note that although this research project will serve as an evidence base and may provide

recommendations for practice and policies, it will not directly change practice or policies in itself.

Data protection

What are my rights?

You have a number of rights under data protection law and can find out more about these on our website: https://www.cardiff.ac.uk/public-information/policies-and-procedures/data-protection.

What is the lawful process for processing my personal information?

Under data protection law we have to specify the legal basis that we are relying on to process your personal data. In providing your personal data for this research we will process it on the basis that doing so is necessary for our public task for scientific and historical research purposes in accordance with the necessary safeguards, and is in the public interest. The University is a public research institution established by royal charter to advance knowledge and education through its teaching and research activities. Our charter can be found on the Cardiff University website: https://www.cardiff.ac.uk/about/organisation/governance/chart

er-statutes-ordinances

How long will my personal information be kept?

After 7 days your personal data will be anonymised meaning that I will remove any identifiers that can identify you from the data you have provided. This anonymous information may be kept indefinitely or published in support of the research. Personal data we may have collected, such as your consent to participate in the study will be kept for 15 years following the completion of the research project.

What if I want to make a complaint or raise a query?

If you have a concern or query about any aspect of this study, you can contact myself if you wish and I will do my best to answer your questions: xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx

If you have any queries you can also contact my lead supervisor, and project chief investigator [redacted] who is a reader in the School of Healthcare Sciences and lead for Research and Development in occupational therapy within Cardiff University: xxxxxxxxxxxxxxxxxxxxxxxxxxxx

If you have a complaints and wish to speak to someone independent to the study, you can contact [redacted] who is a reader within the school of healthcare sciences: xxxxxxxxxxxxxxxxxxxxxxxxxxxxxx

If you remain unhappy and wish to complain formally, you can do through emailing your concern to the Health Research Authority: complaints@hra.nhs.uk who aim to investigate and respond to your concern within 25 days. Details can be obtained from: https://www.hra.nhs.uk/about-us/governance/feedback

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Appendix 10 - occupational therapy staff permission to contact form

Title of Project: Evaluating Recovery Through Activity in Mental Health Services V.1

What is the purpose of this permission to contact form? Savanna Cole, a PhD student at Cardiff University is doing some research to evaluate the use of Recovery Through Activity in mental health services across [redacted] University Health Board. You should have received an information sheet which provides detailed information about the project with this form. If you are interested in participating or finding out more information about the project, please complete this form and return it to the address below in the prepaid envelope. The purpose of this form is to allow Savanna to contact you directly. Completing and returning this form does not mean that you need to participate in the project.

What happens if I sign this form? If you sign this form, you are giving consent for Savanna to contact you in relation to the research project. This is simply to discuss the research project with you and answer any questions you may have. This does not mean that you have given consent to participate in the project.

What happens if I don't sign this form? If you don't sign this form, Savanna will not contact you about this project. Your workplace will not be notified whether you sign or do not sign this form.

What do I do to consent to be contacted? If you agree to be contacted, please indicate the area of the project that you are interested in, by putting your initials next to the statement that you consent to be contacted about. Please initial that you consent to be contacted, indicate whether you would prefer to be contacted via post, email or telephone and provide contact details. Lastly, please sign and date.

I am interested in finding out more information about:

	Please
The online interviews	☐
The questionnaires	☐

	Please
I consent for Savanna to contact me in relation to the above study	☐

I would prefer to be contacted via Post ☐ Email ☐ Telephone ☐

Postal/ Email address/ Telephone_____

Name: _____ Band: _____

Service where Recovery Through Activity was used: _____

_____ _____

Signature Date

Appendix 11 - Service user permission to contact form

IRAS ID: 276168

Name of Researcher: Savanna Cole

Service user Permission to Contact Form

Title of Project: Evaluating Recovery Through Activity in Mental Health Services V.1

What is the purpose of this permission to contact form? Savanna Cole, a PhD student at Cardiff University is doing some research to evaluate the use of Recovery Through Activity in mental health services across [redacted] University Health Board. You should have received an information sheet which provides detailed information about the project with this form. If you are interested in participating or finding out more about the project, please complete this form and return it to the address below in the prepaid envelope. The purpose of this form is to allow Savanna to contact you directly. Completing and returning this form does not mean that you need to participate in the project.

What happens if I sign this form? If you sign this form, you are giving consent for Savanna to contact you in relation to the research project. This is simply to discuss the research project with you and answer any questions you may have. This does not mean you have given consent to participate in the project.

What happens if I don't sign this form? If you do not sign this form, Savanna will not contact you. Your care/access to services will not be affected whether you do/do not sign this form.

What do I do to consent to be contacted? If you agree to be contacted, please indicate the area of the project that you are interested in, by putting your initials next to the statement that you consent to be contacted about. Please initial that you consent to be contacted, indicate whether you would prefer to be contacted via post, email or telephone and provide contact details. Lastly, please sign and date.

I am interested in finding out more information about:

Please tick

The online interviews ☐

The questionnaires ☐

Sharing intervention outcome data ☐

Please initial

I consent for Savanna to contact me in relation to the above study ☐

I would prefer to be contacted via Post ☐ Email ☐ Telephone ☐

Postal/ Email address/ Telephone_____

Name : _____

Service where Recovery Through Activity was attended: _____

_____ _____

Signature Date

Appendix 12 – occupational therapy staff interview consent form

IRAS ID: 276168

Participant Identification Number for this study:

Name of Researcher: Savanna Cole

OCCUPATIONAL THERAPY STAFF CONSENT FORM

Title of Project: Evaluating Recovery Through Activity in Mental Health Services V.1

	Please initial box
I confirm that I have read and understand the information sheet dated 30/1/2021 (version 1.2) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.	☐
I understand that my participation is voluntary and that I am free to withdraw at any stage, up until the point where the data has been coded and anonymised, without giving any reason, without my legal rights being affected.	☐
I understand that data collected during the research project may be looked at by individuals from Cardiff University or from regulatory authorities, where it is relevant to my taking part in the research project. I give permission for these individuals to have access to my data.	☐
I understand that the information collected about me will be used to support other research in the future and may be shared anonymously with other researchers.	☐

I understand how the findings and results of the research project will be written up and published. ☐

I understand who will have access to my data, how the data will be stored and what will happen to the data at the end of the research project. ☐

I consent to the processing of my personal information [name, age, associated service, signature] for the purposes explained to me. I understand that such information will be held in accordance with all applicable data protection legislation and in strict confidence, unless disclosure is required by law or professional obligation. ☐

I consent to being audio recorded for the purposes of the research project and I understand how it will be used in the research. ☐

I understand that anonymised excerpts and/or verbatim quotes from my interview may be used as part of the research publication. ☐

I agree to take part in an online interview for the above study and consent for this video call to be recorded for the purposes of the research project. ☐

Name of Participant	Date	Signature
Name of Person taking consent	Date	Signature

Appendix 13 - Service user interview consent form

IRAS ID: 276168

Participant Identification Number for this study:

Name of Researcher: Savanna Cole

SERVICE USER INTERVIEW CONSENT FORM

Title of Project: Evaluating Recovery Through Activity in Mental Health Services V.1

	Please initial box
I confirm that I have read and understand the information sheet dated 30/1/2021 (version 1.2) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.	☐
I understand that my participation is voluntary and that I am free to withdraw at any stage, up until the point where the data has been coded and anonymised, without giving any reason, without my medical care or legal rights being affected.	☐
I understand that data collected during the research project may be looked at by individuals from Cardiff University or from regulatory authorities, where it is relevant to my taking part in the research project. I give permission for these individuals to have access to my data.	☐
I understand that the information collected about me will be used to support other research in the future and may be shared anonymously with other researchers.	☐
I understand how the findings and results of the research project will be written up and published.	☐

I understand who will have access to my data, how the data will be stored and what will happen to the data at the end of the research project. ☐

I consent to the processing of my personal information [name, age, associated service, signature] for the purposes explained to me. I understand that such information will be held in accordance with all applicable data protection legislation and in strict confidence, unless disclosure is required by law or professional obligation. ☐

I consent to being audio recorded for the purposes of the research project and I understand how it will be used in the research. ☐

I understand that anonymised excerpts and/or verbatim quotes from my interview may be used as part of the research publication. ☐

I agree to take part in an online interview for the above study and consent for this video call to be recorded for the purposes of the research project. ☐

Name of Participant	Date	Signature
Name of Person taking consent.	Date	Signature

Appendix 14 - Consent withdrawal form

IRAS ID: 276168

Name of Researcher: Savanna Cole

Consent withdrawal form

Title of Project: Evaluating Recovery Through Activity in Mental Health Services V.1

Please initial the boxes that apply:

I confirm that I wish to withdraw all my data regarding **interviews** from the study before the data has been anonymised. ☐

I confirm that I wish to withdraw all my data regarding **questionnaires** from the study before the data has been anonymised. ☐

I confirm that I wish to withdraw all my data regarding **intervention outcome data** from the study before the data has been anonymised. ☐

Name of Participant	Date	Signature
Name of Person taking withdrawal of consent	Date	Signature

Appendix 15 - Risk management plan

Risk Management Plan		
Person	Risk	Intervention
Service user participant	Low risk Coercion into participating Medium risks Emotional distress, but with no risk of harm to oneself or others. Unexpected disclosures	Gatekeeper will make first contact. Participant will be fully informed prior to consenting and will be informed on consent withdrawal process. Signpost to: GP Mental Health Services Confidential Advice from trained Volunteers: Samaritans

	High Risks Emotional distress, risk of harm to oneself or others.	Call [redacted] to talk or email: [redacted] for a reply within 24 hours [redacted] [redacted] Dial 999
occupational therapy Staff participant	Low risk Coercion into participating Medium risks Emotional distress Concerns regarding workplace	Gatekeeper will make first contact. Participant will be fully informed prior to consenting and will be informed on consent withdrawal Signpost to: Health Board Wellbeing Service Tel: xxxxxxxxxxx

	Unexpected disclosures	Health Board Support and advice for workplace bullying confidential wellbeing service Tel: xxxxxxxxxxx Health Board Self-referral counselling service Tel: xxxxxxxxxxx
Researcher	Low Risk Researcher fatigue Maintaining separation between researcher role and occupational therapist identity. Medium risks Emotional Distress	Consult with supervisor to debrief Researcher will keep a reflective diary. Health Board Wellbeing Service Tel: xxxxxxxxxx Health Board Self-referral counselling service

		Tel: xxxxxxxxxx Student Support and Wellbeing • xxxxxxxxxxxxxxx

Appendix 16 - REC letter

North of Scotland Research Ethics Committee (1)
Summerfield House
2 Eday Road
Aberdeen
AB15 6RE

Telephone: 01224 558458
Email: gram.nosres@nhs.scot

NHS Grampian

Please note: This is an acknowledgement letter from the REC only and does not allow you to start your study at NHS sites in England until you receive HRA Approval

11 March 2021

[redacted]

Dear [redacted]

Study title:	**Evaluating the Recovery Through Activity framework used by Occupational Therapy in Mental Health Services in** [redacted]
REC reference:	**21/NS/0010**
Protocol number:	**SPON1834-20**
IRAS project ID:	**276168**

Thank you for Miss Cole's e-submission of 10 March 2021. I can confirm the REC has received the documents listed below and that these comply with the approval conditions detailed in our letter dated 22 January 2021.

Documents received

The documents received were as follows:

Document	Version	Date
IRAS Application Form	276168/1480472/37/139	11 January 2021
IRAS Checklist XML [Checklist 10032021]		10 March 2021
Letters of invitation to participant [Cover letter - Invitation from Medical Staff]	1.1	27 January 2021
Other [Risk Management Plan]	1.2	30 January 2021

1

Other [Table of response to REC conditions]	*date received	10 March 2021
Other [Confirmation of questionnaire amendment]		27 January 2021
Participant consent form [Service user interview consent form]	1.1	30 January 2021
Participant consent form [Service user permission to contact form]	1.1	27 January 2021
Participant consent form [OT staff questionnaire consent form]	1.1	30 January 2021
Participant consent form [OT staff interview consent form]	1.1	30 January 2021
Participant consent form [Service user questionnaire consent form]	1.1	30 January 2021
Participant consent form [Intervention outcome data consent form]	1.1	30 January 2021
Participant consent form [Consent withdrawal form]	1.1	30 January 2021
Participant consent form [Occupational Therapy staff permission to contact form]	1.1	27 January 2021
Participant information sheet (PIS) [Service user PIS]	1.2	30 January 2021
Participant information sheet (PIS) [Occupational Therapy staff PIS]	1.2	30 January 2021
Research protocol or project proposal [Protocol]	1.2	30 January 2021
Summary CV for Chief Investigator (CI) [Chief Investigator CV - Dr [redacted]		07 December 2020

Approved documents

The final list of approved documentation for the study is therefore as follows:

Document	Version	Date
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [Indemnity certificate]	1	01 August 2020
Interview schedules or topic guides for participants [Occupational Therapy staff Interview schedule]	1.1	29 November 2020
Interview schedules or topic guides for participants [Service user interview schedule]	1.1	29 November 2020
IRAS Application Form	276168/148 0472/37/13 9	11 January 2021
IRAS Checklist XML [Checklist 10032021]		10 March 2021
Letters of invitation to participant [Cover letter - Invitation from Medical Staff]	1.1	27 January 2021
Non-validated questionnaire [Service user questionnaire template for reference]	1.1	14 December 2020
Non-validated questionnaire [Occupational Therapy Staff Questionnaire template for reference]	1.1	14 December 2020
Other [Risk Management Plan]	1.2	30 January 2021
Other [Table of response to REC conditions]		10 March 2021*
Other [Confirmation of questionnaire amendment]		27 January 2021

Participant consent form [Service user interview consent form]	1.1	30 January 2021
Participant consent form [OT staff questionnaire consent form]	1.1	30 January 2021
Participant consent form [OT staff interview consent form]	1.1	30 January 2021
Participant consent form [Service user questionnaire consent form]	1.1	30 January 2021
Participant consent form [Intervention outcome data consent form]	1.1	30 January 2021
Participant consent form [Consent withdrawal form]	1.1	30 January 2021
Participant consent form [Service user permission to contact form]	1.1	27 January 2021
Participant consent form [Occupational Therapy staff permission to contact form]	1.1	27 January 2021
Participant information sheet (PIS) [Service user PIS]	1.2	30 January 2021
Participant information sheet (PIS) [Occupational Therapy staff PIS]	1.2	30 January 2021
Referee's report or other scientific critique report [Sponsor letter stating scientific review has been obtained]		15 December 2020
Referee's report or other scientific critique report [Proof of KESS award]		01 October 2019
Research protocol or project proposal [Protocol]	1.2	30 January 2021
Summary CV for Student [Student CV - Miss Savanna Cole]		14 January 2021
Summary CV for Chief Investigator (CI) [Chief Investigator CV - [redacted]		07 December 2020
Summary CV for supervisor (student research) [Lead Supervisor CV - [redacted]		07 December 2020
Summary CV for supervisor (student research) [Second Supervisor CV - [redacted]		15 January 2021*
Summary CV for supervisor (student research) [Third Supervisor CV [redacted]		14 January 2021
Summary, synopsis or diagram (flowchart) of protocol in non technical language [Research process flowchart]	1	09 December 2020

*date received

You should ensure that the sponsor has a copy of the final documentation for the study. It is the sponsor's responsibility to ensure that the documentation is made available to R&D offices at all participating sites.

IRAS Project ID: 276168	**Please quote this number on all correspondence**

Yours sincerely

[redacted]

Assistant Ethics Co-ordinator

Appendix 17 - HRA approval

Ymchwil Iechyd a Gofal Cymru
Health and Care Research Wales

NHS
Health Research Authority

[redacted]

Email: approvals@hra.nhs.uk
HCRW.approvals@wales.nhs.uk

11 March 2021

Dear [redacted]

HRA and Health and Care Research Wales (HCRW) Approval Letter

Study title:	**Evaluating the Recovery Through Activity framework used by Occupational Therapy in Mental Health Services in [redacted] Health Board**
IRAS project ID:	**276168**
Protocol number:	**SPON1834-20**
REC reference:	**21/NS/0010**
Sponsor	**Cardiff University**

I am pleased to confirm that HRA and Health and Care Research Wales (HCRW) Approval has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications received. You should not expect to receive anything further relating to this application.

Please now work with participating NHS organisations to confirm capacity and capability, in line with the instructions provided in the "Information to support study set up" section towards the end of this letter.

How should I work with participating NHS/HSC organisations in Northern Ireland and Scotland?
HRA and HCRW Approval does not apply to NHS/HSC organisations within Northern Ireland and Scotland.

If you indicated in your IRAS form that you do have participating organisations in either of these devolved administrations, the final document set and the study wide governance report (including this letter) have been sent to the coordinating centre of each participating nation. The relevant national coordinating function/s will contact you as appropriate.

Please see IRAS Help for information on working with NHS/HSC organisations in Northern Ireland and Scotland.

How should I work with participating non-NHS organisations?
HRA and HCRW Approval does not apply to non-NHS organisations. You should work with your non-NHS organisations to obtain local agreement in accordance with their procedures.

What are my notification responsibilities during the study?

The standard conditions document "*After Ethical Review – guidance for sponsors and investigators*", issued with your REC favourable opinion, gives detailed guidance on reporting expectations for studies, including:

- Registration of research
- Notifying amendments
- Notifying the end of the study

The HRA website also provides guidance on these topics, and is updated in the light of changes in reporting expectations or procedures.

Who should I contact for further information?
Please do not hesitate to contact me for assistance with this application. My contact details are below.

Your IRAS project ID is **276168**. Please quote this on all correspondence.

Yours sincerely,

[redacted]
Approvals Manager

Email [redacted]

Copy to: [redacted]

List of Documents

The final document set assessed and approved by HRA and HCRW Approval is listed below.

Document	*Version*	*Date*
Contract/Study Agreement template [Model Agreement for Non-Commercial Research]	1	18 December 2020
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [Indemnity certificate]	1	01 August 2020
Interview schedules or topic guides for participants [Occupational Therapy staff Interview schedule]	1.1	29 November 2020
Interview schedules or topic guides for participants [Service user interview schedule]	1.1	29 November 2020
IRAS Application Form	276168/1480472/37/139	11 January 2021
Letters of invitation to participant [Cover letter - Invitation from Medical Staff]	1.1	27 January 2021
Non-validated questionnaire [Service user questionnaire template for reference]	1.1	14 December 2020
Non-validated questionnaire [Occupational Therapy Staff Questionnaire template for reference]	1.1	14 December 2020
Other [Risk Management Plan]	1.2	30 January 2021
Other [Table of response to REC conditions]	*date received	10 March 2021
Other [Confirmation of questionnaire amendment]		27 January 2021
Participant consent form [Service user interview consent form]	1.1	30 January 2021
Participant consent form [OT staff questionnaire consent form]	1.1	30 January 2021
Participant consent form [OT staff interview consent form]	1.1	30 January 2021
Participant consent form [Service user questionnaire consent form]	1.1	30 January 2021
Participant consent form [Intervention outcome data consent form]	1.1	30 January 2021
Participant consent form [Consent withdrawal form]	1.1	30 January 2021
Participant consent form [Service user permission to contact form]	1.1	27 January 2021
Participant consent form [Occupational Therapy staff permission to contact form]	1.1	27 January 2021
Participant information sheet (PIS) [Service user PIS]	1.2	30 January 2021
Participant information sheet (PIS) [Occupational Therapy staff PIS]	1.2	30 January 2021
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Summary CV for Chief Investigator (CI) [Chief Investigator CV - Dr [redacted]		07 December 2020
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Summary CV for supervisor (student research) [Second Supervisor CV [redacted]	*date received	15 January 2021
Summary CV for supervisor (student research) [Third Supervisor CV - [redacted]		14 January 2021
Summary, synopsis or diagram (flowchart) of protocol in non technical language [Research process flowchart]	1	09 December 2020

IRAS project ID	276168

Information to support study set up

The below provides all parties with information to support the arranging and confirming of capacity and capability with participating NHS organisations in England and Wales. This is intended to be an accurate reflection of the study at the time of issue of this letter.

Types of participating NHS organisation	Expectations related to confirmation of capacity and capability	Agreement to be used	Funding arrangements	Oversight expectations	HR Good Practice Resource Pack expectations
There is only one participating NHS organisation therefore there is only one site type.	Research activities should not commence at participating NHS organisations in England or Wales prior to their formal confirmation of capacity and capability to deliver the study.	An Organisation Information Document has been submitted and the sponsor is intending to use a model non-commercial agreement with sites.	No study funding will be provided to sites as per the Organisational Information Document	A Local Collaborator should be appointed at the study site	No Honorary Research Contracts, Letters of Access or pre-engagement checks are expected for local staff employed by the participating NHS organisations. Where arrangements are not already in place, research staff not employed by the NHS host organisation undertaking any of the research activities listed in the research application would be expected to obtaina Letter of Access based on standard DBS checks and occupational health clearance.

Other information to aid study set-up and delivery

This details any other information that may be helpful to sponsors and participating NHS organisations in England and Wales in study set-up.
No additional information