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The thesis I am submitting is entirely my own work except where otherwise indicated.

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PUBLISHED WORK

The thesis contains three papers that are planned to be submitted for publication. The submission guidelines for the chosen journals are in the appendices. At the point of preparing this thesis:

The Systematic review paper is planned to be published in the *Journal of Applied Research in Intellectual Disabilities (JARID) (*see Appendix A). JARID is recognised across the world for publishing research of a high standard. It aims to publish research that can improve the quality of life of individuals with intellectual disabilities. This journal has also published other research around Intensive Interaction historically including the original findings of Hutchinson & Bodicoat, (2015).

The Service improvement project paper is planned to be submitted to the *Housing, Care and Support* (see Appendix E). The journal publishes research relating to evidence-based practice to inform improvements in the housing conditions of vulnerable and stigmatised individuals (e.g. people who are homeless). They have also recently published similar research to the SIP that looked at the implementation of PIE in homelessness hostels.

The Theory driven research project paper is planned to be submitted to the *Journal of Obsessive-Compulsive and Related Disorders (JOCRD)* (see Appendix J). This journal publishes high quality research in OCD and HD. It particularly focuses on the ways current treatment for these conditions can be advanced and outcomes can be improved.

AI Statement

I have not used AI software in writing this submission.

ABSTRACTS

Systematic Review of the Literature

The Effects of Intensive Interaction: A Systematic Review of the Literature.

Background:

Intensive Interaction (II) and Adaptive Interaction (AI) are approaches that help individuals with pre-verbal communication abilities to communicate. The evidence-base has grown since 2015 and would benefit from being systematically reviewed.

Method:

Database, specialist institutes and reference searches were completed using key-terms relating to 'Learning Disability', 'Autism', 'Dementia', 'Intensive/ Adaptive Interaction'.

Results:

Five mixed methods, six qualitative and one quantitative paper were identified exploring the effectiveness and experiences of II / AI interventions and staff training in both health and educational settings.

Conclusion: II / AI interventions and training can help individuals communicate and support staff to be more attuned and understanding. There is conflicting evidence about the impact of II on challenging behaviour, and several implementation challenges identified in the literature. Limitations of the evidence-base related to quality of evidence (e.g. Lack of RCT's), inconsistency of measurement and challenges measuring quality of the interventions.

Keywords: learning disability; intellectual disability; autism spectrum disorder; dementia; intensive interaction; adaptive interaction

Service Improvement Project

Exploring the impact of adopting a restorative practice approach in a homelessness hostel: A service improvement project

Purpose:

This service improvement project (SIP) took place at Matilda House (MH), a homeless hostel in Oxford. It aimed to explore the impact of staff training in restorative practice (RP) approaches. It also aimed to understand the experiences of those who went through RP approaches, and the challenges to their implementation.

Design / methodology / approach

This SIP used a Plan-Do-Study-Act (PDSA) cycle to explore the possible impact of Restorative Practice (RP) training and implementation. The author used service outcomes, psychometric data and survey data to achieve its aims.

Findings

This cycle identified that there were low levels of RP being utilised at MH. Therefore, it was difficult to draw conclusions about its impact. Implementation barriers included low staffing levels, environmental challenges, staff and resident ambivalence and awareness issues. Improvement recommendations were put forward and shared with the service.

Originality / Value

There is growing interest in restorative approaches in homelessness settings. Despite this the evidence-base is still small, and there is a need for further research. Therefore, this report is important as it expands this and provides insights into how to implement these approaches in similar services.

Key words: *Restorative Approaches / Practice, Homelessness, service improvement, questionnaires.*

Theory Driven Research Project

Hoarding Disorder (HD) and Object Attachment: The role of Object Importance and Object Qualities

Background and aims

Although clinical and research literature suggests that individuals with Hoarding Disorder (HD) form strong emotional attachments with their objects, research has yet to examine the role of subjective importance and how this impacts HD symptoms. The present study aimed to evaluate the role of importance in the distress caused when imagining the loss of particular objects. It also aimed to explore other object characteristics.

Method

A mixed method experimental design involving two groups: HD (n = 46) and Non Clinical Community Controls (NCCC) (n = 35), who identified two important and two unimportant objects. All groups completed measures assessing demographics, psychopathology, spontaneous imagery, attachment and the Quality of Objects Questionnaire. They also completed an imagery experimental task involving the loss of two important / two unimportant objects.

Results

The HD group scored significantly higher than NCCCs on distress linked to loss of all objects; similarly, when considering links to negative / positive emotion, link to memories and links to self these were uniformly elevated.

Discussion

Object importance influenced the distress experienced by all when considering loss of possessions, with the HD group being higher overall in these ratings. This pattern was also seen in the ratings of links to negative / positive emotions, memories and links-to-self which appear more important in HD participants objects than NCCC.

PAPER ONE: SYSTEMATIC REVIEW OF THE LITERATURE

THE EFFECTS OF INTENSIVE INTERACTION: A SYSTEMATIC REVIEW OF THE LITERATURE

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External Supervisors: Dr Catherine Crane, Senior Clinical Psychologist, North Oxfordshire Community Learning Disability Team, Oxford Health NHS Foundation Trust and Jules McKim, Intensive Interaction Specialist Care Coordinator, The Intensive Interaction Service, Oxford Health NHS Foundation Trust.

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Submission Date: 22 May 2026

Published in: A version of this article is planned to be submitted to the Journal of Applied Research in Intellectual Disabilities

Acknowledgements: Thank you to Abigail O'Shea, Trainee Clinical Psychologist, for acting as the second reviewer during study selection, quality appraisal and the data extraction process.

Abstract

Background:

Intensive Interaction (II) and Adaptive Interaction (AI) are approaches that help individuals with pre-verbal communication abilities to communicate. The evidence-base has grown since 2015 and would benefit from being systematically reviewed.

Method:

Database, specialist institutes and reference searches were completed using key-terms relating to 'Learning Disability', 'Autism', 'Dementia', 'Intensive/ Adaptive Interaction'.

Results:

Five mixed methods, six qualitative and one quantitative paper were identified exploring the effectiveness and experiences of II / AI interventions and staff training in both health and educational settings.

Conclusion: II / AI interventions and training can help individuals communicate and support staff to be more attuned and understanding. There is conflicting evidence about the impact of II on challenging behaviour, and several implementation challenges identified in the literature. Limitations of the evidence-base related to quality of evidence (e.g. Lack of RCT's), inconsistency of measurement and challenges measuring quality of the interventions.

Pre-registration with PROSPERO [CRD42024587700)

Keywords: learning disability; intellectual disability; autism spectrum disorder; dementia; intensive interaction; adaptive interaction

Introduction

Learning disability, Autism and Dementia

A Learning Disability (LD) is diagnosed if a person meets three specific criteria 1) a low intellectual ability (e.g. IQ below 70), 2) impaired adaptive functioning and 3) these difficulties were present in childhood (NICE, 2015). It is estimated that approximately 1.3 million people in England would be classed as having an LD (PHE, 2023). These individuals are more likely to have comorbid diagnoses such as Autism Spectrum Disorder (ASD), which is present in around 1 in 3 people with an LD (NHS Digital, 2021). They are also more likely to develop conditions such as Dementia particularly if they have Downs Syndrome (Alzheimer's Society, 2022; Zigman et al., 2002).

Individuals with a more severe LD and some Autistic individuals have limited verbal language and communication skills (NICE, 2015; Nind & Hewett, 2001). It is also common for language production skills to become more impaired as a person's dementia progresses (Kempler et al., 1995). When individuals who struggle to communicate verbally attempt to communicate through other means, their attempts may go ignored and be seen as challenging or be incomprehensible (Keatinge et al., 2000; Kitwood, 1997; Klimova & Kuca, 2016). This results in individuals potentially experiencing a lack of social opportunities, social exclusion and lack of fulfilment with their social world (Department of Health., 2001; Lee et al., 2007; Sweeting & Gilhooly, 1997). These difficulties in communication can potentially result in increases in self-injurious behaviour (Duncan et al., 1999).

Intensive Interaction and Adaptive Interaction:

Intensive Interaction (II) is an approach that aims to help individuals who are either non-verbal or at a preverbal stage of communication. It aims to help individuals find enjoyment in expression and connection with others. It utilises pre-verbal techniques such as eye-contact,

imitation, gestures and facial expressions to build the fundamentals of communication and increase connection with others (Nind & Hewett, 1994; Nind & Hewett, 2001). The approach was originally utilised with individuals who had a severe or profound LD and / or autism, however it has also begun to be utilised with individuals who have advanced dementia (Ellis et al., 2008; Nind & Hewett, 2001). An adapted version of II called 'Adaptive Interaction' (AI) has been developed for individuals' with dementia. Practitioners who use AI argue it differs from II because there is no expectation of previous learning, and a requirement for more spontaneous responses from the practitioner as the individual interacts with their social world. (Ellis & Astell, 2017).

Theoretical underpinnings of Intensive / Adaptive Interaction

Intensive Interaction was conceptualised by David Hewett and Melanie Nind in the 1980's (Henwood & Ellis, 2015). The approach is underpinned by Geraint Ephraim's psychological theory of 'Augmented Mothering' (Firth et al., 2008). This theory proposed that babies interact with their adult caregivers from birth, and that they can quickly build the skills required to understand and interact socially with their caregiver (e.g. facial expressions, eye contact). It proposes that they build these skills by having a caregiver who joins in, imitates and responds to their baby's behaviour and feedback. Through this an environment is created where the baby feels safe to build the fundamentals of communication and motivated to understand their social world. This is the process that is utilised by those who use II and AI (Jefferies et al., 2009).

Research into Intensive Interaction and Adaptive Interaction

II has become increasingly used amongst individuals who work in healthcare, education and care systems (Hutchinson & Bodicoat, 2015). Increasingly literature indicates that staff can find II a rewarding approach and believe it benefits those they support (Berridge & Hutchinson, 2021). It also indicates that individuals with LD and Autism can experience enhanced levels of

social engagement, improved wellbeing and a reduction in levels of distress in response to II (Argyropoulou & Papoudi, 2012; Elgie & Maguire, 2001; Leaning & Watson, 2006; Nind, 1996).

AI was developed by Ellis and colleagues for individuals with advanced Dementia. Their research found that II / AI resulted in an increase in non-verbal communicative behaviours, enabled repertoires of communicative behaviours to be identified and enabled the person to take a more active role in their relationships (e.g. responding and taking turns) (Ellis & Astell, 2011; Ellis et al., 2008). This highlighted the usefulness of AI in helping these individuals maintain their social world (Ellis et al., 2008).

II / AI are both complex interventions that over time researchers have been working to implement in a range of real-life settings. The Consolidated Framework for Implementation Science (CFIR) highlights that implementation of complex initiatives should consider the influence of five domains "intervention characteristics, outer settings, inner setting, characteristics of individuals involved in the intervention, and the process used" (Khalil, 2023, p. 348) Elements of these have been considered in the II literature including characteristics of individuals involved in intervention (e.g. staff perceptions of time / support / effectiveness) and inner settings (e.g. collaborative communication between staff and team work) (Bodicoat, 2013; Jones & Howley, 2010; Zeedyk, Caldwell, et al., 2009; Zeedyk, Davies, et al., 2009). Other areas such as societal perspectives have received less attention.

Relevance of Current Review

Hutchinson & Bodicoat conducted a review exploring the effectiveness of II in 2015. They highlighted issues with the literature in terms of its quality and recommended that further research was needed in the area in order to draw conclusions about the effectiveness of II. We

wanted to review research over the past 10 years since Hutchinson and Bodicoat's review and broaden our review to incorporate research exploring the use of II in people with Profound Multiple Learning Disabilities (PMLD), ASD and Dementia. Uniquely we have also included AI as this is an adapted form of II for advanced dementia. Considerations will be given to facilitators and barriers to implementing II / AI.

The following key questions will be addressed in the review:

1. What are the effects of using II / AI on individuals who have LD, Autism or Dementia.
2. What are the effects of II / AI on the staff, carers and services in implementing the approach?
3. What are the facilitators and barriers of implementing II / AI.

Method

An integrative review was conducted to explore the above aims. This type of review allows for studies with diverse methodologies (e.g. experimental and non-experimental) to be pulled together to reach a comprehensive understanding of the area. It can be utilised to comprehensively understand key concepts, theories, literature and methodological problems in a particular topic area (Souza et al., 2010). This was chosen due to it being anticipated that the review would identify studies with a range of methodologies, wanting to gain an in-depth understanding of the literature in this area and also because similar studies had also utilised this approach. Additionally the review utilised and followed Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA), and PROSPERO registration [CRD42024587700] was completed prior to the study beginning (Page, McKenzie, et al., 2021; Page, Moher, et al., 2021).

Search Strategy

The systematic literature review was completed using seven electronic databases: SCOPUS, PsychInfo, Medline, CINAHL, ERIC, Psychology & Behavioural Collection and PubMed. The Institute of Intensive Interaction website was also searched. The reference lists of included studies and books identified during initial scoping were hand-reviewed to ensure a broad search was completed. The initial searches took place in December 2024 and were then updated in January 2026.

Search Terms: Search terms were utilised to identify LD, ASD, dementia and II or AI studies (see Appendix B)

*Eligibility Criteria***.**

Inclusion criteria:

- Studies that were either Qualitative, Quantitative or Mixed methods that evaluated the effect of II or AI in people with LD, ASD, Dementia, and their carers, parents or service providers.
    - II or AI based interventions: any individual / group-based intervention that explicitly uses II or AI.
    - II or AI Training: Participants with some knowledge of II / AI acquired through training, professional information given or observation of other.
- Participants of all ages, who have either completed / been the recipient of an II / AI intervention or completed II / AI training and are working with people who have either LD, ASD or Dementia.
- Research conducted in any setting including education, health and social care.
- Publications between 2015 to present.

Exclusion Criteria:

- No primary research reported
- Non-English Language
- Papers reporting duplicate participant samples and data.

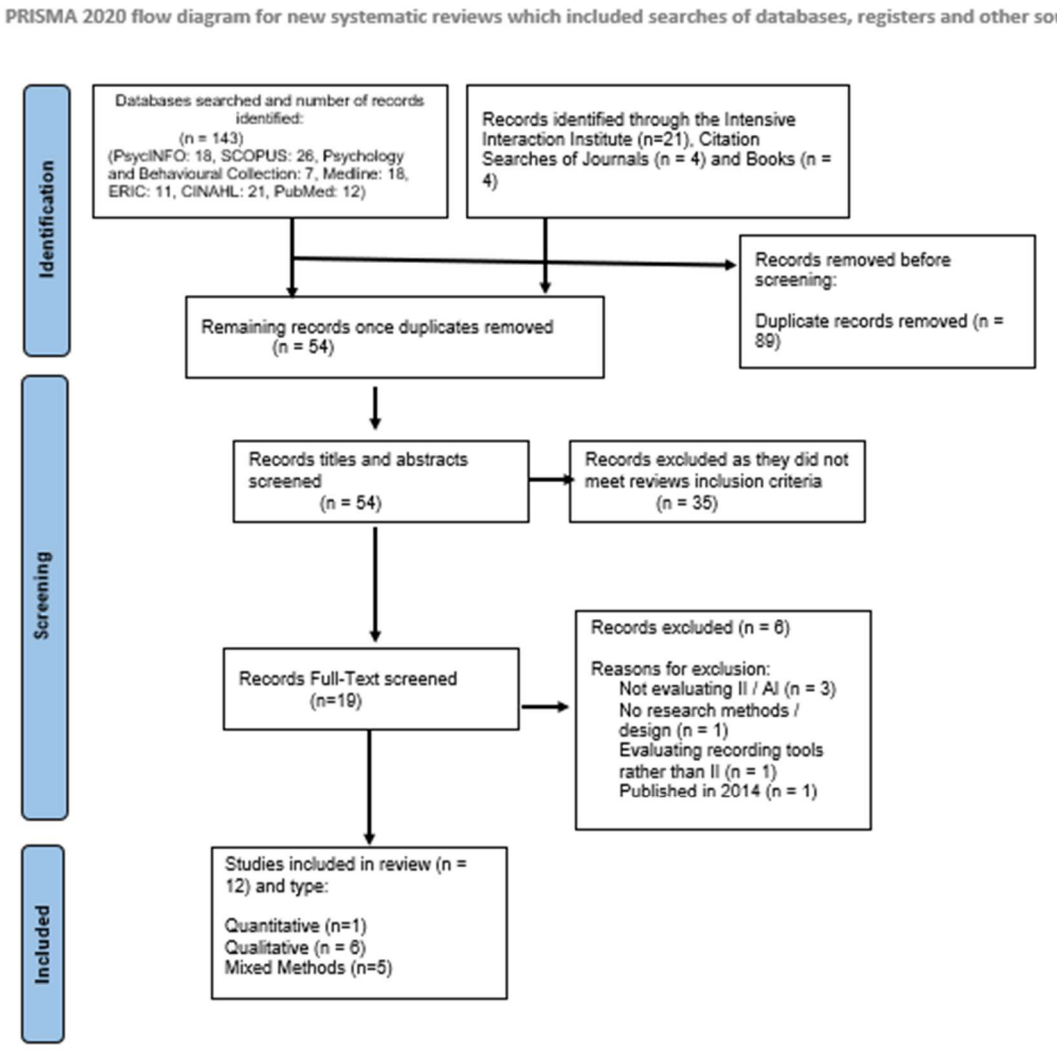
Study Selection

The papers that were identified were extracted into Excel for screening. Duplicates were then removed. The remaining papers titles and abstracts were screened to establish eligibility, and 20% (n = 11) were independently reviewed by another trainee AO. Measure of inter-rater reliability for the inclusion / exclusion decision was obtained using the Cohen's Kappa to establish level of agreement between the two raters (k=0.421). Discrepancies (n = 3) were then discussed and resolved with supervisor. Due to the moderate agreement, it was agreed a further 10% (n = 6) would be screened by the independent reviewer and there was high agreement (k=1.000). As a high level of agreement was reached the remaining papers titles and abstracts were screened by only the lead author.

Those papers that were screened as eligible following titles / abstracts screening then underwent full-text screening. A 25% sample was randomly screened by the lead author and an independent reviewer yielding a high level of inter-rater reliability (k=1.000). Due to a high level of inter-rater reliability, the lead author screened the remaining texts. One paper that was originally agreed for inclusion was excluded following discussion with supervisor due to lacking a clear research methodology and being deemed a reflective account.

The process regarding selection is illustrated in the PRISMA flowchart (see figure 1). This illustrates that there were 143 papers found at the beginning and the number of papers included and excluded at each point of screening. It highlights the reasons for exclusion in terms of the full-text screen and highlights the final number of papers (12).

Figure 1: PRISMA flow chart – study identification, screening, eligibility and inclusion



Data Extraction, analysis and Quality Assessment

In order to extract the required data, a data extraction tool was created on Microsoft Word. A variety of data regarding different characteristics of the studies were extracted from papers that were included. The data extraction was completed by the lead researcher, and an independent reviewer also extracted data from 100% of the studies. There were 10 discrepancies which related to differences in publication dates, publication country, mean ages and numbers of participants. These were resolved through discussion. The extracted data was organised into studies in the field of LD / ASD (see Table 2) and studies in the field of dementia (see Table 1).

All types of studies were included in the same tables. and the results of the extraction are indicated in the results / synthesis section.

Analysis was conducted by first grouping studies into categories in which they were similar (e.g. studies about II as an intervention, studies about II training, studies about parental experiences of II and studies about AI). Once the categories had been identified narrative syntheses were written about the similarities / differences between the studies, the facilitators / barriers and the quality of the included studies. Through this it was then possible to identify barriers to completing research in II / AI and consider ways in which the current evidence base could be further developed.

Quality Assessment was completed using two Quality Assessment tools. The Standard Quality Assessment Criteria (SQAC) for Evaluating Primary Research Papers from a Variety of Fields was used for purely Quantitative or Qualitative studies (Kmet et al., 2004) and The Mixed Methods Appraisal (MMAT) was used for Mixed Methods studies (Hong et al., 2018). The SQAC tool contained 14 questions that assessed Quantitative studies, and 10 questions that assessed Qualitative studies. The questions can be answered “yes”, “partial”, “no” and “N/A”. The MMAT consists of two screening questions which were met by all the papers included. It then consists of qualitative, quantitative (RCT), Quantitative (non-randomised), Quantitative (descriptive) and mixed methods sections. Each question was either answered as “yes”, “no” or “can’t tell”. In total 15 items were rated for Mixed Method Studies which related to the qualitative, quantitative and mixed method design. See Appendix C for quality questions and criteria.

All papers were reviewed by the lead researcher and an independent rater. The inter-rater reliability for the SDAC Qualitative studies was high with 90% agreement (k = 0.767), and the agreement for SDAC Quantitative studies was 78.57% agreement (k = 0.558). There was

89.53% agreement (k = 0.701) for the quality assessment ratings completed using the MMAT. Discrepancies were discussed (n=18) and rectified between the two raters.

Table 1: Studies in Dementia

Author	Year of Publication	Country	Study Aims	Study Design	Sample Size	Age	Participant Characteristics (e.g. person with LD / Autism or Dementia / Carer / Parent)	Presence of Intensive Interaction / Adaptive Interaction	Dose of Training / Frequency of Sessions / Level of spread of II within a service	Data Collection	Key findings (if quantitative: significance level, effect size reported)	Facilitators and Barriers to II / AI
(Astell et al.)	2022	England	To explore the effectiveness and impact of AI on the communication behaviours of both caregivers and individuals with advanced dementia	Descriptive Qualitative Study	N = 6 with dementia N = 6 care staff	N = 6 with Dementia between 78 – 92, mean age = 84.3	People with Dementia and Carers	Adaptive Interaction	Training: 3 days in total. Consisted of presentations, videos, case studies and peer teaching. Adaptive Interaction: 4 Sessions between each dyad which consisted of a Resident and an assigned communication partner, 1 session prior to training (baseline) and 3 during training period.	Fundamentals of Communication Coding Scheme. Inter-Rater Reliability ranged from 0.58-0.67 Interview 3 months post training	After training caregivers were able to recognise more communicative behaviours during interactions with their partner. They also had more positive and meaningful interactions with their partner.	Facilitators: Opportunity to watch sessions back, and ability to apply skills learnt in training.
(Heap & Wolverson)	2020	England	To explore medical discourses of dementia in care home carers, the impact of II training on these and to identify ways of improving personhood in dementia care	Qualitative	N = 5	34-58 years old	Care home Staff	Intensive Interaction	Training: 1 day, consisted of discussion, reflection, videos, presentation and practical exercises relating to communicating with people.	Focus Group.	Dementia discourses prior to training centred around loss of person / personhood and inability to communicate. After training discourses shifted to those of communication, and being with was considered as part of doing the work. Carers were positive about II and how it could impact their relationships.	Facilitators: Staff / management being trained in II and change to paperwork to recognise importance of socio-psychological needs. Barriers: Stigmatising attitudes about individuals with dementias ability to communicate, not having resources, not having permission, organisational attitudes that interaction =

												inactivity, lack of training in II at managerial level, and fear of criticism or reprimand.
(Ellis & Astell)	2017 2018	Scotland	To examine the use of Adaptive Interaction in identifying patterns of non-communicative behaviour in advanced dementia.	Mixed Methods including Experimental components	N = 5	Age ranging 77-89	People with Dementia	Adaptive Interaction	6 sessions, minimum of two sessions in baseline and 2 during intervention	Direct Observation of Behaviour Coding of Communicative behaviours Inter-rater reliability ranged from 0.58-0.91	Participants were able to communicate using a unique set of non-verbal communication behaviours (e.g. eye gaze, smiling and movement). There was significant increase ($p<0.001$) in smiling and imitation ($p<0.05$) by people with dementia in intervention sessions. There was significant decrease ($p<0.001$) in looking at ME's body / face.	Barrier: Anticipated barrier was being able to engage staff in training / convincing staff to use AI.

Table 2: Studies in Learning Disability / ASD

Author	Year of Publication	Country	Study Aims	Study Design	Sample Size	Age	Participant Characteristics (e.g. person with LD / Autism or Dementia / Carer / Parent)	Presence of Intensive Interaction / Adaptive Interaction	Dose of Training / Frequency of Sessions / Level of spread of II within a service	Types of measures used / Outcome measures	Key findings (if quantitative: significance level, effect size reported)	Facilitators and Barriers to offering II / AI

(McKim & Samuel)	2021	England	To present descriptions of cases who had been seen in an Intensive Support Team	Qualitative (Case-Description)	N = 3	22-36 Years old	Moderate / Severe Learning Disabilities and Autism	Intensive Interaction	All had attended the Trusts 1 day II training course. Case 1: Training included written reflection, videoed interactions and group supervision. II initiated after every 15 minutes if the individual hadn't already initiated it. Case 2: Training included videoing / analysing interactions (1:1 and in group). Not indicated how often II was used. Case 3: Training consisted of videoing interactions. Not indicated how often II was used.	Data was obtained as part of routine practice and staff / Family Interview Data	Intensive Interaction was able to be used within a PBS framework. Case 1: Increase in staff / family confidence and rapport, reintegrated into community activities, reduced intensity / frequency of CB, remained in community setting. Case 2: Increased staff confidence, staff who used II had less serious incidents, individual given autonomy / lead interactions, helped build relationships between individual and staff, less task focused care and more emotion focused care Case 3: Increase in non-verbal behaviours / communication (e.g. eye contact, smiling), enjoyment in interacting with others, improvements in CB and more relaxed presentation.	Facilitators: Having enough staffing, using video in training / on-going reflective practice to develop staff skills, having an intensive interaction coordinator who supports staff teams to overcome typical barriers to II, managers modelling II, developing specific guidelines r.e. II and person specific touch. Barriers: Staff anxiety about injury / self-harm, self-consciousness in staff, prioritising community presence / physical care over interactions that are enjoyable / meaningful and staff anxiety / reluctance to use touch.
(Berridge & Hutchinson)	2022	England	To explore the experiences of parents who use II	Qualitative	N = 6	Unknown	Mothers of children with ID / ASD / PMID, between age of 4-14. Knowledge of II through formal training, self-taught and portage	Intensive Interaction	Duration of II use varied between 5 months to 11 years.	Semi structured interview	Superordinate themes included 'The connection', 'Bittersweet', 'fighting for support' and 'challenging underlying low expectations & stigma'.	Barriers: Lack of external support and information relating to II, mothers having other challenges in their life, low expectations of child's ability.

(Mourière & Scott-Roberts)	2017	Wales	To explore whether intentional communication and joint attention are impacted by II To explore usefulness of FOCAL assessment tools in II	Action Research Design (Qualitative)	N = 1	10 Years old	Autism	Intensive Interaction	1 hourly intervention session a week over 12 weeks.	4 assessments completed by 4 observers across the intervention using the Fundamentals of Communication Assessment and Learning (FOCAL).	Most progression made on the Vocal / Auditory modality. Meaning greater awareness of sounds as a tool to interact. Large effect size (Cohen's D 1.6) in the difference at baseline and follow up. Slight progression in the interactive domain of the Tactile / Haptic modality. Meaning he was more able to engage in non-verbal interactions that involved patterns of touch. Large effect size (Cohen's D 1.6). There was a notable progression in his intentional use of eye contact and gestures (Cohens D between 1.2 and 2.1 across domains) FOCAL tools have potential to be useful tools in assessing communication progress	Facilitators: Practitioner having opportunity to reflect, utilising individuals interests and games.
(Nagra et al.)	2017	England	To explore the effectiveness of staff training in II	Qualitative	N = 8	Age 27-64	Carers who worked in LD	Intensive Interaction	6 weekly workshops that consisted of discussions, theory behind II, video examples of II, and practical learning through role play and applied practice at work.	Semi Structured Interviews completed 3 years after training.	Main theme was of 'Endurance', made up of emotional component and practical component.	Facilitators: Recognition from management, top-ups / refreshers, on-going supervision Barriers: More focus on physical care tasks, less priority of emotional needs, lack of support from management, unable to recall training / decay in knowledge, ambiguity, fear of implementing II inappropriately, noticing how others react could create anxiety, culture / institutionalisation.

(Lloyd)	2015	England	To explore staff comfort in doing II sessions in class To explore if II can increase socio-communicative interactions between teachers and pupils To explore whether daily II session in a group are practical within mainstream schools.	Mixed Methods (qualitative and quasi experimental)	N = 6 Classes, 17 adults using II, 141 Children attending classes, 54 being part of Communiplay groups 18 focus children who were experiencing II, 4 focus children with autism / learning difficulties and other SEND conditions.	Unknown (Children between 5-7 years old)	Education, Children with Autism / Learning Difficulties and other SEND conditions	Intensive Interaction	70 minute training session on II and Communiplay 15-20 minute daily session of Communiplay	Data collected through Relationship Interaction Assessment, Team evaluation form, Everyday Communiplay Log and Focus Group	The teachers and students enjoyed using Communiplay and the intervention was effective in building their relationships and communication with each other. Staff believed that it was impractical primarily due to staff busyness in delivering the national curriculum.	Facilitators: Better communication-enabling environment, using non-verbal communication to initiate play, and using Lego as a task, Barriers: Expectations for pupils to talk, unwillingness to allow child to take the lead non-verbally, busyness, lack of time, no TA present, no teacher present, focus pupil attendance on other classes, external activity, difficulties fitting it in, staff discomfort about waiting for focus pupil to initiate, variation in staff understanding, unwillingness to prioritise over other aspects of curriculum, short training session on II insufficient, pressures of national curriculum
(Clegg et al.)	(2018)	England	To evaluate II training that had been implemented city-wide to social care staff	Mixed Methods (survey, interviews)	N = 54 (Staff Survey) N = 28 Interviews	Unknown	Care staff working with LD / PMLD	Intensive Interaction	1 day, consisted of theory behind II, practical information about how to implement.	Survey Interviews	Survey: Participants had positive attitudes about II and the ways it helped those they worked with More variation and less positive responses regarding areas such as paperwork, requirement for training, difficulty to do and staff anxieties about doing II. Generally, most wanted to use II more or to continue using at same rate. Main Reasons staff not using II included poor staffing, no	Facilitators: Staff receiving training in II, availability and support from an advanced practitioner, reviewing recordings of II sessions, collaborative support from external agencies (e.g. SALT), enthusiasm and passion from staff, proactive support and advice from management. Barriers: Poor staffing, overuse of agency staff, staff ambivalence, lack of proactive managerial problem solving, focus on physical tasks rather than II, changes within services (e.g. re-structuring).

											time, and busyness of environment. Interview: (Key themes) "the Impact of II", "facilitating the implementation of intensive interaction" and "implementing intensive interaction: organisational support and barriers"	
(Tee & Reed)	2017	Wales	Explored the impact of II on problem behaviours in ASD children	Non-randomised control trial	N = 40 N = 10 II Group N = 10 Control group (treatment as usual)	Mean age of II group 9.90 Mean age of Mother II group = 43.20 Mean age of Control 9.85 Mean age of Control Mothers: 41.20	Children with diagnoses of ASD / PDD:NOS, Mothers	Intensive Interaction	Intensive Interaction Session that lasted 1-2 hours. Took place 5 days a week in home-setting for approximately 6 months. Overseen by supervisor who had 7-8 years' experience of using II, facilitators had 3 6o minute sessions of instruction from principal researcher.	Social Communication Questionnaire (ASD severity) Strengths and Difficulties Questionnaire (Problem Behaviour) Hospital Anxiety and Depression Scale (Mothers depression / anxiety)	SDQ scores went down for both groups and was only slightly lower in II group. Effect of Intervention was not statistically significant $F(1,37) = 1.84$, $P > 0.10$, g2 $p = 0.047$.) There were reductions in behaviour problems in both II and control groups. There were three in in both groups where the reduction would be considered clinically significant. Predictors of poorer outcomes included greater behavioural problems or maternal mental health difficulties at the start of intervention.	Barriers: Worse behaviour problems, greater maternal depression scores at baseline.

(Mourière & Hewett)	2021	England	To examine the effectiveness of an Intensive Interaction intervention with an Autistic boy.	Qualitative (Case Study) Verbal feedback from parent.	N=1	14 years old	ASD	Intensive Interaction	1-hour, weekly II Consultation sessions which over 6 months totalled 14 hours of and approximately 2 consultations a month	Fundamentals of Communication	II provides increased opportunities to engage in face-to-face interactions, which overtime facilitated non-verbal communication.	Facilitators: Having opportunities for playful, relaxed, and fun activities, guidance from II consultant (e.g. not correcting mistakes), and letting him lead,
(Donnelly et al.)	2015	England	To describe and audit practice within an NHS trust in England	Mixed Methods	N = 172 staff from an II introductory training course N = 32 services with at least one individual with PMID N = 20 Trust Managers N = 76 Support workers	Unknown	Staff, Services working with LD, Trust managers and Support Workers	Intensive Interaction	1-day Introductory Teaching on II	Feedback on Training Questionnaire to Trust Managers and Support Workers	96% of those who attended the training believed it was a good fit for them. A high percentage of the teams and services reviewed (81%) were found to have at least 3 staff and a manager trained in II. Key concerns for Managers / Support workers related to needing II discussions in supervision, whose responsibility it was for making sure II happened and how to share knowledge / stories of success regarding II	Facilitators: Access to training, personal development planning, supervision, whole team embracing responsibility for II, ensuring it is planned and included in daily schedule, meetings / recording sheets being used to transmit information to others and having an awareness of guidelines relating to touch, using II. Barriers: Challenges with organising / having supervision or having discussions in supervision relating to II, staff turnover / timing issues, delegation / uncertainty regarding whose responsible for ensuring II happens, challenges with sharing knowledge / successes regarding II, lack of awareness of relevant guidelines / policies.

Table 3: Percentage of Quality Criteria met for studies appraised using MMAT

Author	Quality Criteria Met
Clegg et al, (2018)	80%
Donnelly, Elsworth & McKim, (2015)	88%
Ellis & Astell, (2017)	53%
Lloyd, (2015)	87%
Mouriere & Scott-Roberts, (2017)	80%
Key: Y = Yes, N = N, CT = Can't Tell	

Table 4: Percentage of Quality Criteria met for quantitative studies appraised using SDAC

Author (Year)	Quality Criteria Met
Tee & Reed, (2017)	91%

Table 5: Percentage of Quality Criteria met for Qualitative studies appraised using SDAC

Author (Ye	Quality Criteria M
Astell, Shoaran & Ellis, (2022)	70%
Berridge & Hutchinson, (2022)	90%
Heap & Wolverson, (2020)	80%
McKim & Samuel, (2021)	40%
Mouriere & Hewett, (2021)	60%
Nagra et al, (2017)	90%

Most papers identified were related to II (n=10). Of these 10 studies, 9 were related to LD and ASD (Berridge & Hutchinson, 2022; Clegg et al., 2018; Donnelly et al., 2015; Lloyd, 2015; McKim & Samuel, 2021; Mourière & Hewett, 2021; Mourière & Scott-Roberts, 2017; Nagra et al., 2017; Tee & Reed, 2017) and 1 related to Dementia (Heap & Wolverson, 2020). Three of the studies looked at training in II with staff / carers (Clegg et al., 2018; Heap & Wolverson, 2020; Nagra et al., 2017) and 5 looked at II as an intervention (Lloyd, 2015; McKim & Samuel, 2021; Mouriere & Hewett, 2021; Mourière & Scott-Roberts, 2017; Tee & Reed, 2017). There was also one paper that looked at parental experiences of II (Berridge & Hutchinson, 2022) and one paper that explicitly looked at spread of II training and barriers to its implementation in services (Donnelly et al., 2015).

With regards to AI the review identified two papers one of which was later corrected (Astell et al., 2021; Ellis & Astell, 2017, 2018). Ellis and Astell (2017, 2018) looked at AI in Dementia and Astell et al. (2021) looked at staff training in AI.

Intensive Interaction (Intervention). The review identified 5 papers where II was an intervention (Lloyd, 2015; McKim & Samuel, 2021; Mouriere & Hewett, 2021; Mourière & Scott-Roberts, 2017; Tee & Reed, 2017). These focused on individuals with LD and / or ASD and utilised a variety of research designs (e.g. case study, qualitative, mixed methods and non-randomised control trials) to explore the effects of II.

McKim and Samuel (2021) presented a series of cases whereby II had been integrated within a Positive Behavioural Support (PBS) framework. These cases described how II could be successfully integrated into PBS and provided qualitative descriptions about its use in this framework. They found positive outcomes for the staff (e.g. increased self-confidence, reduced experiences of severe incidents and better relationships with clients) and the clients (e.g. increases in non-verbal communication, reduced levels of distress, better relationships with

staff and remaining in community placement). In each case clients received several interventions in addition to II (e.g. medication reviews, PBS Plans and changes to staff) which makes it difficult to ascertain the direct effects of II. Facilitators to II implementation included being well staffed, having access to reflective practice, II coordinator involvement, utilising video in training, managerial modelling and supportive guidelines. Barriers to implementation included staff anxiety / self-consciousness and prioritisation of other elements of care (e.g. physical care).

Mourière and Scott-Roberts (2017) and Mourière and Hewett (2021) used case studies to explore the impact of II in two individuals with ASD. They found that II enabled these two individuals to build and develop their non-verbal communication. In addition, Mourière and Hewett (2021) highlighted how II had resulted in several positive outcomes (e.g. better relationships with family, improved self-confidence / motivation, and reduced levels of distress). Facilitators to implementing II included doing II in a playful and relaxed manner, utilising the individuals' interests, accessing II consultant for guidance and the practitioner having opportunities to reflect.

Lloyd (2015) used a mixed methods design to explore the impact of an II intervention called "Communiplay" with 5–7-year-olds in a mainstream school. The results indicated that both the staff and students who undertook II enjoyed it, and that it helped build and strengthen positive relationships between them. Despite this the staff held beliefs about the II being impractical due to busyness and pressures of the National Curriculum. Facilitators to implementing II included having better communication environments, communicating non-verbally and having a fun activity to do (e.g. Lego). Barriers to implementation included staff preferring / requesting verbal communication, staff busyness, prioritisation of the National Curriculum and insufficient level of training.

Tee and Reed (2017) explored the impact of II on challenging behaviour (CB) in children with Autism. This was a non-randomised control trial study that found CB reduced in both the II group and control group, and that the II group only had slightly lower scores. There was no statistically significant difference in scores between those receiving II and those who were not. Barriers to the effects of II included the severity of CB and maternal depression prior to intervention. It concluded that II had limited effectiveness with regards to reducing CB in children with Autism.

Quality Appraisal

The quality of the papers outlined above is varied. Tee and Reed (2017) was a non-randomised control study and met 91% of the quality criteria. This provides high quality evidence regarding the impact of II on CB, however it should be noted that the lack of effect could have been due to an inappropriate sample size which is acknowledged by the authors. Therefore, it would be beneficial for future studies to calculate the required effect size and utilise this to establish an appropriate sample.

Lloyd (2015) and Mourière and Scott-Roberts (2017) also met a high percentage of the quality criteria with the first scoring 87% and the second scoring 80%. Therefore, providing good quality evidence that II can be a positive experience for those partaking in it, strengthen relationships and provide regular opportunities to gradually develop fundamentals of communication. Despite this the criteria scores were lowered by challenges relating to the intervention being administered as intended in the case of Lloyd (2015) and representativeness of the sample in the case of Mourière and Scott-Roberts (2017) where the sample consisted of one individual known to the researcher.

McKim and Samuel (2021) and Mourière and Hewett (2021) scored lower in terms of quality with the first meeting 40% of the criteria and the second meeting 60% of the criteria. These papers scored similarly in terms of limitations including the samples (e.g. small samples / lack

of comparison), lack of information regarding data analysis, lack of verification procedures and no reflexive account. McKim and Samuel (2021) had additional limitations in terms of lack of clarity relating to how and what data was collected as part of the cases presented. It provides helpful descriptions of how II can be incorporated in a PBS framework, however the conclusions that can be made regarding II's effects are limited due to several confounding influences.

Intensive Interaction (Training). There were three studies completed that sought to explore II training with staff / carers and to ascertain spread of training across a local service. These were all in the context of LD and ASD settings (Clegg et al., 2018; Donnelly et al., 2015; Nagra et al., 2017). There was also one study looking at II training in staff who worked in a Dementia care home setting (Heap & Wolverson, 2020).

Clegg et al. (2018) and Nagra et al. (2017) both utilised mixed methods design to explore II training in carers / care staff. Both studies recognised that staff had a greater awareness of II and felt more attuned to their client's communication needs post training. Staff also felt more confident and noticed that their relationships with clients improved. It was also noted that the training appeared to contribute to shifts in staff's attitudes regarding CB and beginning to see it as a form of communication.

The studies highlighted that there were a number of challenges that staff encountered in regard to implementing II and these related to issues regarding staffing (e.g. lack of staff, frequent use of agency staff and ambivalence about II), staff busyness, staff anxieties about the reactions of others, lack of support / proactiveness from management, cultural / institutional emphasis on prioritizing physical tasks, and gradual decay in II knowledge over time. They highlighted facilitators to implementing II included access to refresher training, access to

advanced II practitioners, evidencing practice through records, staff enthusiasm, supervision, managerial support and support from other professionals (e.g. SALT).

Heap and Wolverson (2020) aimed to explore the impact of II training on the narratives held by staff who worked in a dementia care home. They explored this using focus groups following the completion of training. The results highlighted that the training was able to shift certain discourses that were held prior to training (e.g. dementia being a loss of the person, people with dementia can't communicate and being with / communicating is inactivity). After training there was a recognition that everyone can communicate, and that behaviour was a form of communication. There was also recognition that II could be beneficial for individuals with dementia, and a sense that it helped explain some current staff practices. This paper highlighted that in order for II to be implemented in this field it required managers to be trained, and changes were needed so that paperwork highlighted the importance of socio-communicative needs. It recognised that stigmatising views of dementia, lack of resources / time / training, fear of reprimand and unhelpful cultural attitudes (e.g. interaction = inactivity) could be barriers to implementing II in Dementia care settings.

Donnelly et al. (2015) explored the spread of training / practice of II locally by using a Mixed-Methods design. The results suggested that a significant proportion of people believed the II training was a good fit. They also found that there was a significant spread of II training in the local area with 81% of teams / services having at least 3 staff members and a manager trained. Facilitators to II included access to training / supervision, team responsibility for II, II being scheduled / planned, evidence of practice / success through record keeping and having an awareness of relevant guidelines. Barriers identified included difficulties accessing / having supervision relating to II, poor staffing, ineffective sharing of II knowledge / successes and limited awareness of relevant guidelines / policies.

Quality Appraisal

There was less variation in the degree to which the quality criteria had been met for the studies relating to II training. All studies scored quite highly in terms of the degree to which they met the quality criteria. Nagra et al. (2017) and Heap and Wolverson (2020) met 90% of the quality criteria. Donnelly et al. (2015) met 88% of the criteria and Clegg et al. (2018) met 80% of the quality criteria. Areas where scores were lost related to issues regarding reflexivity, sampling methods, and uncertainty regarding risk of nonresponse bias. Despite this these studies still provide high quality evidence for training staff in II.

Parental Experiences of Intensive Interaction. Berridge and Hutchinson (2022) looked at the experiences of parents who had used II. This study used semi-structured interviews to explore a group of mothers who had experience of using II with their children. The results highlighted that II allowed some of the mothers to build a stronger connection with their children and also helped challenge the negative narratives and stigma that existed about what the child would be able to do. The mothers found accessing or being given information about II was significantly lacking, and they believed more proactivity would have been beneficial. They found using and engagement with II difficult at times due to some of their own expectations about their child's abilities and also having to cope with other challenges in their lives.

Quality Appraisal

This study scored highly when its quality was appraised meeting 90% of the quality criteria. The study would have scored 100% if further information / clarity was provided regarding the questions that were asked during the interviews. Despite this the study provides high quality evidence regarding the experiences of mothers, and their perceived benefits and barriers to II.

Adaptive Interaction.

The review identified two papers that explored the use of AI in dementia settings (Astell et al., 2022; Ellis & Astell, 2017, 2018). They used both qualitative and mixed methods to explore its use. Ellis and Astell (2017, 2018) were interested in whether AI could be used to establish patterns of non-communicative behaviours in people with advanced dementia. The results indicated that it was possible for these individuals to communicate using a range of non-verbal communicative behaviours (e.g. eye gaze, smiling and movement). It also found that there were significant increases in several non-verbal behaviours following the use of AI. Astell et al. (2022) went on to then explore the impact of training staff in AI and found that following training staff were more able to recognise non-verbal communications in their partners and also had more enjoyable interactions with them. Astell et al. (2022) highlighted that a facilitator to AI was having opportunities to apply the training and review II sessions. Ellis and Astell (2017, 2018) highlighted that a potential barrier to implementing AI could be engaging staff in AI training and convincing staff of its usefulness.

Quality Appraisal:

In terms of quality there was varied degrees of quality between the two studies. Astell et al. (2022) met 70% of the quality criteria, whereas Ellis and Astell (2017, 2018) met 53% of the quality criteria. In Astell et al. (2022) there were issues relating to lack of information regarding the study setting, lack of reasoning behind participant selection and a lack of reflexive account. (Ellis & Astell, 2017, 2018) met fewer quality criteria due to issues relating to confounders, being unable to blind independent raters, participant selection and intervention not being administered as planned. Due to lack of a control group / matching group it can limit the conclusions that can be drawn and generalised from this study.

Discussion

The purpose of this review was to provide a synthesis and appraisal of the current research in the field of II and AI. The review critically appraised 12 studies (13 papers), to explore the effects of II and AI as interventions, the effects of training in II and AI and the facilitators and barriers to their implementation. Studies were categorically grouped based on key similarities e.g. 'Intensive Interaction (Intervention)', 'Intensive Interaction (Training)' 'Parental Experiences of Intensive Interaction' and 'Adaptive Interaction'. A narrative synthesis of the studies in each category was achieved which enabled understanding of their similarities, differences and quality.

Several studies were identified in which II / AI was utilised as an intervention with individuals who had LD, ASD or Dementia. The studies regarding II provided positive evidence for how it can be used to help individuals with LD,ASD and Dementia to develop the fundamentals of communication, communicate non-verbally and have positive / meaningful interactions with others. This is consistent with previous literature (Argyropoulou & Papoudi, 2012; Nind, 1996).

The studies regarding the effect of II on CB is more unclear with one indicating as part of a PBS framework it aided the reduction of CB in individuals with LD and ASD, whilst another found minimal impact of II on CB. This lack of impact supports conclusions reported in the last review of II conducted in 2015 (Hutchinson & Bodicoat, 2015). The conclusions of these studies are impacted by the challenge of untangling II effects from other simultaneous interventions and their sample sizes. Most of the studies looking at II as an intervention were single case-studies and lacked more rigorous designs (e.g. experimental or RCT's). These would be beneficial for strengthening the quality and generalisability of the current evidence-base.

Studies exploring AI strengthen findings from earlier studies in that the approach appeared to enable the researcher to identify patterns of non-verbal communication in individuals with Dementia. The papers also found that training staff in AI enabled them to recognise non-verbal attempts at communication and enabled them to have more enjoyable interactions with those they supported. The quality of these studies varied, and for one study there were challenges regarding possible impact of confounders (e.g. no control comparison group, raters not being blinded) which could have impacted the conclusions and generalisability of the findings. Further research would be beneficial in this area particularly experimental studies, RCT designs and research with comparison groups.

The current findings regarding staff training in II / AI have found positive effects of training staff and carers. The studies highlighted that training could contribute to attitudinal shifts particularly regarding the value of a person, a person's ability to communicate and the value of engaging in socio-communicative tasks. Staff / carers also described several positives to the training including being able to recognise non-communicative behaviours, being more attuned and having stronger relationships / more meaningful interactions. These studies highlighted how staff found opportunities to video their practice, reflect and attuned practice on the skills taught was hugely beneficial. However, these studies highlighted several barriers to implementing the training including staff shortages / busyness, lack of managerial support, lack of supervision / reflective spaces, gradual decay in knowledge and self-consciousness / fear of reprimand. These are consistent with previous literature (Kellett, 2003; Samuel et al., 2008). The studies highlighted ways that these barriers could be addressed including refresher training, supervision / reflective practice spaces, managers being trained, access to II Practitioners and recording of II.

Strengths and Limitations of Literature

A significant strength of the studies is that they have provided valuable insights into areas which required further exploration. This is particularly true for the field of AI, whereby it was still in its infancy in Hutchinson and Bodicoat (2015) prior review. The empirical evidence exploring this area is positive. Research in II / AI is particularly challenging due issues relating to research design, heterogeneity, informed consent and capacity, establishing an appropriate baseline and measurement of effects or change (Kellett & Nind, 2014).

An additional strength of some of the literature reviewed was that it included high quality methodology when assessed using the MMAT and the SQAC (Berridge & Hutchinson, 2022; Clegg et al., 2018; Donnelly et al., 2015; Heap & Wolverson, 2020; Lloyd, 2015; Mourière & Scott-Roberts, 2017; Nagra et al., 2017; Tee & Reed, 2017). Studies also attempted to explore elements of II / AI using a range of methodologies including both qualitative and quantitative methods. The qualitative studies have provided opportunities to explore the experiences of services, parents, carers and staff and highlighted the challenges to implementing II / AI. The quantitative data provides opportunities to establish influencing factors or relationships that might impact intervention. Despite the varied methodologies these studies are still not considered to be as high quality as the gold standard of a Randomised Control Trial (RCT) (Jones & Podolsky, 2015). No RCT's were identified in this review, and authors have highlighted how challenging it would be to do in the field of II / AI due to issues relating to the vulnerability of the individuals, the need for ethical safeguards, informed consent and capacity (Hutchinson & Bodicoat, 2015). All of which impact the types of designs that can be utilised. Despite this there is currently a 3-year RCT called 'The INTERACT Trial' being conducted with children with profound and multiple learning disabilities to explore if II can improve communication skills (INTERACT-TRIAL, 2025).

Another limitation to the literature is that there are variations in dose of intervention and no current way of assessing quality / integrity of intervention in II / AI. Currently these interventions often follow no set programme, and this is encouraged due to their personalised nature (Nind & Hewett, 2001). However, due to this it can be difficult to draw conclusions across intervention studies and can make it difficult to ascertain whether a dose of II / AI is of a high standard or not. Therefore, future research should explore what doses yield the desired effect, and standards should be developed which holds practitioners to a particular standard. These factors would be hugely beneficial as it will ensure high standards are upheld and consistency can be established.

Additionally, there are limitations in terms of the range of different measures used to try and establish the effects of II / AI. In several studies the tools used were centred around the fundamentals of communication (Astell et al., 2022; Ellis & Astell, 2017, 2018; Mourière, 2021; Mourière & Scott-Roberts, 2017) . Other studies used self-report outcome measures that were based on relationship quality and symptoms of ASD, and less related to the fundamentals of communication (Tee & Reed, 2017). This can negatively impact the ability to compare and synthesise results from across studies. Therefore, further research into the reliability and validity of existing measures would be helpful to identify the most appropriate measures which could promote consistency.

Additional Implications

The literature reviewed in this study highlights the fundamental right that nonspeaking individuals should have to communicate and have meaningful interactions with others (Department of Health., 2009; Ellis et al., 2008). These individuals can experience social isolation, loneliness and lack of stimulation due to unhelpful narratives about their abilities. The areas of II / AI would benefit from more high-quality research that aims to address some

of the limitations of the research conducted so far such as small sample sizes, lack of controls and sample selection. This research will provide further evidence for the potential benefits of implementing II / AI in clinical settings where individuals have LD, ASD or advanced Dementia.

The literature highlighted several challenges to II / AI becoming embedded and sustaining itself in services long-term. In relation to the CFIR, barriers related to the outer setting (e.g. stigmatising societal attitudes) the 'Inner Setting' (e.g. organisational preferences for prioritising other tasks, poor staffing, lack of time, unhelpful organisational beliefs about interaction, lack of supervision / reflective spaces and lack of managerial support) and 'Characteristics of Individual (e.g. decay of knowledge, lack of belief in the approaches, stigmatising beliefs about individuals ability, self-consciousness and anxiety). Literature highlighted what can aid implementation including creating a relaxed / enjoyable / fun environment for interactions, practitioner space for reflection, access to initial / refresher training, managerial support, investment in champions / practitioners and access to supervision / reflective spaces. Further research evaluating and auditing training in these areas would be beneficial to ascertain if barriers are being addressed, and whether there are improvements in how embedded these interventions are.

Strengths and Limitations of the Current Review

A strength to the current review is that it is the first study to synthesise findings regarding both II and AI. This was beneficial as it provided further insights into how II can be adapted and applied to individuals across the lifespan. It also provided further findings that were consistent with previous literature looking at the effects of II.

Another strength of the current review was that both the quality appraisal and data extraction was also completed by an independent reviewer, and the independent reviewer reviewed 100%

of the papers included. This was important as it can enhance the reliability and rigour of the review completed and highlighted there was substantial agreement between the raters.

This review also shares similar limitations to those experienced by other reviews in the area in that the authors of those studies where qualities were rated as can't tell were not contacted to obtain further information to clarify these points. Therefore, there is a risk that as a result some studies were rated more harshly. However, significant efforts were made to rate all papers fairly and to methodically appraise their quality by using the information included in the paper and ensuring a second-rater also appraised all papers.

Conclusion

The review highlighted that both II / AI can be beneficial to individuals with LD, ASD and Advanced Dementia in aiding them to develop fundamentals of communication and access their social world. The evidence is less consistent regarding the impact of II on reducing CB, and due to methodological weaknesses further research into this would be beneficial. The review also highlighted that staff training in II / AI can aid shifts in staff attitudes and improve awareness of communicative behaviours. However, the literature highlights that there are challenges to the implementation of these approaches and makes suggestions about how these can be addressed. There were several good quality studies in this review, however the evidence base would benefit from further research that can address the sample biases and confounders that were identified in the studies contained in this review.

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PAPER 2: SERVICE IMPROVEMENT PROJECT

EXPLORING THE IMPACT OF ADOPTING A RESTORATIVE PRACTICE APPROACH IN A HOMELESSNESS HOSTEL: A SERVICE IMPROVEMENT PROJECT

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Abstract

Purpose:

This service improvement project (SIP) took place at Matilda House (MH), a homeless hostel in Oxford. It aimed to explore the impact of staff training in restorative practice (RP) approaches. It also aimed to understand the experiences of those who went through RP approaches, and the challenges to their implementation.

Design / methodology / approach

This SIP used a Plan-Do-Study-Act (PDSA) cycle to explore the possible impact of Restorative Practice (RP) training and implementation. The author used service outcomes, psychometric data and survey data to achieve its aims.

Findings

This cycle identified that there were low levels of RP being utilised at MH. Therefore, it was difficult to draw conclusions about its impact. Implementation barriers included low staffing levels, environmental challenges, staff and resident ambivalence and awareness issues. Improvement recommendations were put forward and shared with the service.

Originality / Value

There is growing interest in restorative approaches in homelessness settings. Despite this the evidence-base is still small, and there is a need for further research. Therefore, this report is important as it expands this and provides insights into how to implement these approaches in similar services.

Key words: *Restorative Approaches / Practice, Homelessness, service improvement, questionnaires.*

Introduction:

Homelessness is a complex and worldwide problem (Institute of Global Homelessness, 2019). A proportion of homeless individuals are rough sleepers, some of which require more in-person support than others. These individuals are often placed in homeless hostels, whereas rough sleepers more generally will reside in 'temporary accommodation'. Hostels aim to promote individual recovery, independence and hope (Aspinall, 2023). However they can be challenging environments for both residents and staff for a variety of reasons (e.g. complex health needs, challenging behaviour and inadequate training (Shulman et al., 2018; Shulman et al., 2023) .

There is a growing interest in Hostels adopting psychologically informed environments (PIE) (Fulfilling Lives & Impact Initiatives, 2019). PIEs emphasise the need for respectful and non-conflictual relationships and communication (No One Left Out: Solutions Ltd, 2015). RP has been evidenced to address conflict and repair relational harm (Rainer et al., 2023; Restorative Justice Council, 2016). RP is underpinned by Affect Script Psychology which emphasises separating the person from their behaviour, recognises that a person's harmful behaviour likely stems from being harmed and using methods that alleviate shame to repair harm caused (Thorsborne, 2015).

National Context:

In 2024, there was a 14% increase in the number of homeless individuals from the previous year, with approximately 354,000 people and 161,500 children in England. (Shelter, 2024). A range of policies, strategies and initiatives have aimed to reduce street homelessness (e.g. NHS Long Term Plan, 2019, The Rough Sleeping Strategy, 2018, and Homelessness Reduction Act, 2017) (MHCLG, 2018; Yousefzadeh, 2022).

It has been estimated that approximately 40,500 people will use homeless hostels in England at any single point in time . There is growing interest in initiatives that focus on improving these environments (e.g. Home Safe, Shaping the Future Together Strategy) (Homeless Link, 2022).

Evictions and abandonments are a common problem in these settings, and have been addressed using RP in the United Kingdom (Douglas, 2018; Fulfilling Lives & Impact Initiatives, 2019). Evaluations of RP in Bristol hostels have found reductions in evictions / abandonments and also increases in acceptance rates and staff positivity. Residents also appreciated being heard and alternative options to eviction being considered (Douglas, 2018; Fulfilling Lives & Impact Initiatives, 2019).

Service Improvement Context: Matilda House

MH is a 37 bed Homelessness Hostel based in Oxford, that provides a 24/7 service to predominantly rough sleepers. It is provided by A2Dominion and has 15 staff that support residents with complex health and social needs (Homeless Link).

Evictions (i.e. the legal process that local authority follows to remove somebody from a property), abandonments (i.e. tenant leaving hostel without notice or intention of returning) and serious incidents (i.e. incidents that involve fire, death or a serious assault that has ended in severe harm) have historically been a problem. Therefore, Oxfordshire Homelessness Alliance and MH were keen to find ways of reducing eviction rates and the number of serious incidents.

In 2023, introductory training in RP was delivered by Mint House (Oxford's Centre for RP) to the Lived Experience Advisory Forum (L.E.A.F). L.E.A.F consists of individuals who have lived experience of homelessness who aim to improve Oxfordshire homeless pathways. From

this it was agreed to pilot RP at MH to see if it could reduce conflicts and evictions. See Appendix 6 for outline of the planned pilot and expected timelines.

Aims

The SIP aimed to explore the possible impacts of RP training and experiences of RP at MH. The outcome of which would be to provide improvement recommendations for the service. The following objectives were put forward, and informed by a Plan-Do-Study-Act (PDSA) cycle:

i. Explore the possible impacts that implementation of RP has on the number of evictions / Serious Incidents / Abandonments and Staff Resignations.

ii. Explore generally the impact of adopting RP approaches on staff and clients, and to explore the experiences of the facilitators and clients who go through the RP process specifically.

iii. Explore any challenges and barriers there have been to implementing RPs in MH.

Method:

The SIP took place at MH. It was approved by the Oxford Clinical Psychology Course Quality Improvement Panel in July 2024 (See Appendix F). Due to this project being related to service improvement and being focused on staff and resident routine activities, no formal ethical approval from an ethics committee was required.

Plan-Do-Study-Act (PDSA):

The PDSA framework is used to evaluate and learn from healthcare improvement initiatives (NHS England, 2023). PDSA stands for 'Plan' (P) (i.e. creating a plan to test the initiative or

ascertain change), 'Do' (D) (i.e. doing the initiative), 'Study' (S) (i.e. analysing data from 'D') and 'Act' (A) (i.e. making improvement recommendations) (Institute for Healthcare Improvement, 2017). This framework was deemed appropriate by the Oxford Clinical Psychology Course Quality Improvement Panel.

Project Development (P)

The plan for the pilot had been established through prior consultation and training with L.E.A.F as outlined in the service context. The plan (P) for the SIP was developed through collaborative discussions with Mint House (Centre for RP, who sourced external funding and provided ongoing training and support), the Rough Sleeping & Single Homelessness Team (project developer), L.E.A.F and MH. The plan consisted of facilitating introduction to RP and Restorative Practitioner training (D), questionnaire development / analysis and collection of quantitative data (e.g. evictions, abandonments, serious incidents and staff leaving) (S) and making service improvement recommendations (A). Monitoring of the project took place in monthly meetings with the organisations above.

Restorative Practice Training (D)

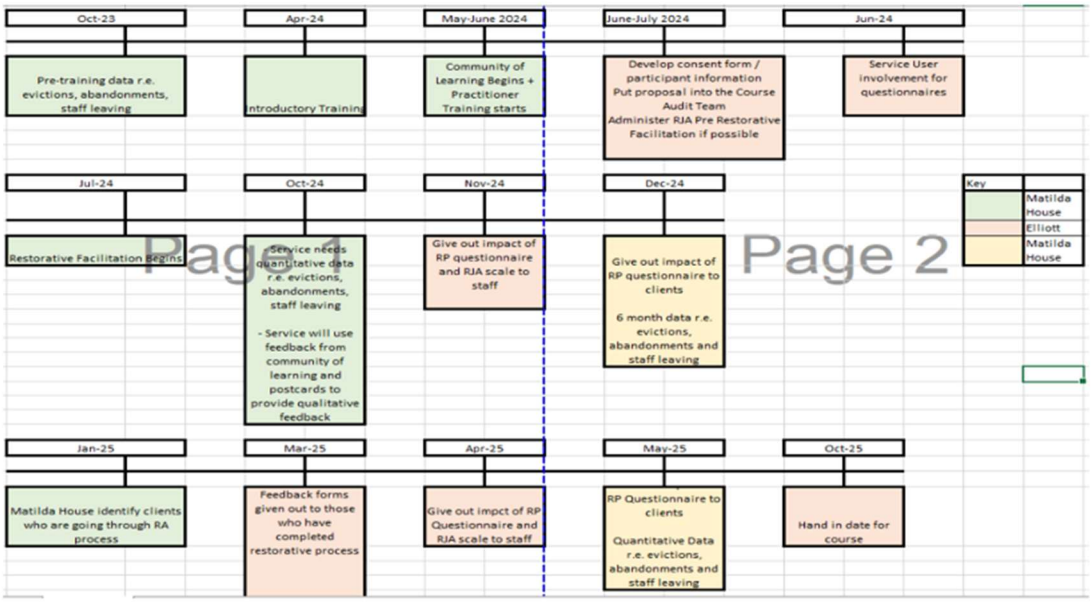
One day introductory RP training was facilitated with staff, volunteers and managers at MH prior to the SIP beginning. Following this staff at MH were able to attend the 3-day Restorative Practitioner Training. See Appendix 2 for outline of the pilot and what training included. The 3 days training was delivered on three occasions May 2024 (n = 5 staff), December 2024 (n = 2 staff) and June 2025 (n = 2 staff). All together 9 members of staff attended and completed the training.

Questionnaire and Service Data (S)

Base-line data (e.g. evictions, abandonments, serious incidents and staff leaving) was obtained prior to the implementation of introductory training (April 2021 to March 2024). This data was then collected in Timepoint 2 (December 2024) starting immediately after training up to 6-month post implementation and Timepoint 3 (May 2025) collected the data at 12 months post implementation to look at impacts over the course of the first year. See Figure 2 for Timeline of data collection.

Questionnaires were used to obtain a range of data relating to RP (i.e. attitudes, impact, barriers and feedback). The SIP author sought permission to use the Restorative Justice Attitudes Scale (RJAS) to explore staff restorative attitudes (Taylor and Bailey, 2022). Other questionnaires were developed by the author, which involved using background literature, consultation with MH's manager / L.E.A.F and review by the research team. This was consistent with the approach used by Taylor and Bailey, (2022) to develop the RJAS. See Appendix G for Questionnaires.

Figure 2: Timeline for Data Collection



In total 15 staff, 37 residents 4 stakeholders could have participated. In Timepoint 1, eight staff out of 15 completed the required questionnaires . In Timepoint 2, five staff (4 repeats and 1 new member of staff) and eleven residents completed the required questionnaire pack. At Timepoint 3, seven members of staff (5 repeats and 2 new staff), eleven residents (6 repeats and 5 new residents) and 3 stakeholders completed the required questionnaires. Staff and residents were often obtained through opportunistic sampling when the researcher was physically present in MH. However, some specific staff and residents were contacted to repeat the questionnaires and completed them either online on Microsoft Forms, in person when the researcher attended MH or through paper copies. Specific stakeholders were invited to participate and completed the questionnaires of Microsoft Forms. All participants were given an ID code to track them through the timepoints and link data together. Residents received a £5 Love2Shop voucher for completion of the questionnaires at each timepoint and received an additional £5 if they completed a feedback form. See Appendix H for list of what was included in questionnaire batches).

Recommendations (A)

Following the completion of the study phase, recommendations were then identified and shared informally via email and in meetings with the research team and MH management. The recommendations provided focused on positive action that the service could take to improve the use of RP at MH.

Results

Quantitative Data in relation to evictions, abandonments, staff leaving and serious incidents:

This data was obtained for up to three years prior to RP training (April 2021-March 2024), immediately after and up to a year post implementation (June 2024 – May 2025). Historically there had been high rates of evictions (n=6, October 2021-March 2022), abandonments (n = 3, April 2022-Sept 2022) and serious incidents (n = 2, April 2022-September 2022). However, these had considerably reduced prior to the training being completed. The rates of evictions and abandonments continued to be low throughout the duration. There had been a slight increase in evictions (n = 2) however this was still low in comparison to historical data. No serious incidents were reported during the project.

Three staff left between June 24 and May 2025. In April 2025 a member of staff also passed away. At least three of these staff were trained in RP. Only two staff would receive Restorative Practitioner Training just after T2, no other staff would be trained until after T3. Therefore, the team was running on less staff, and there were fewer staff who could implement the approach. See Figure 4 for more information.

Figure 3: Graph for rates of evictions, abandonments and serious incidents

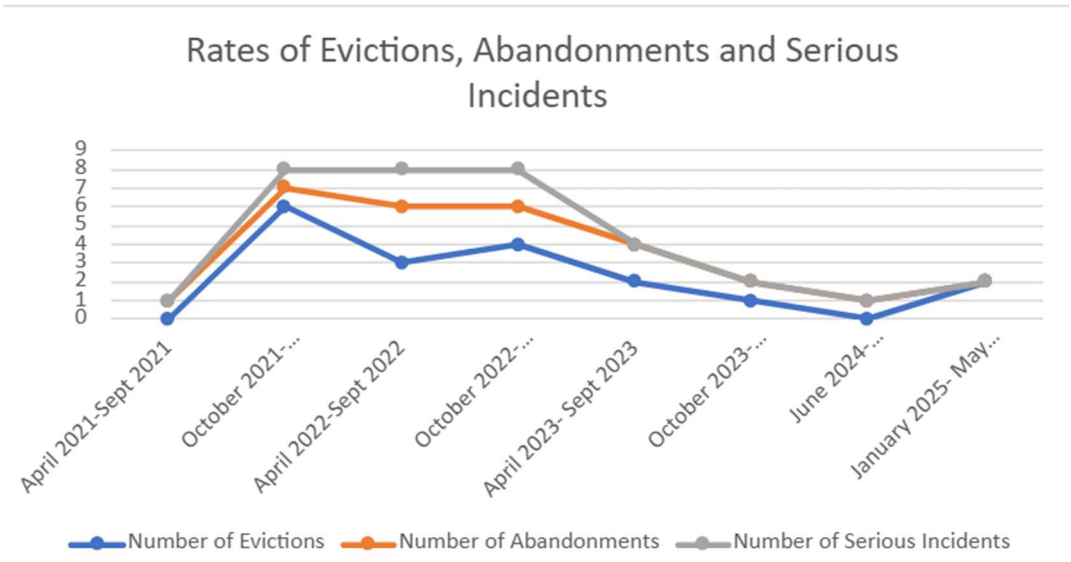


Figure 4: Rates of Staff Leaving



Questionnaire results

In total 28 respondents provided questionnaire responses for analysis. This comprised of 10 staff (1 excluded due to incomplete data at T1), 16 residents and 3 stakeholders. There were no formal inferential statistics or thematic analysis due to small amounts of data. The findings were used to inform the recommendations provided to the service (see Table 9).

Demographics:

Demographic data was collected for both the staff and residents. A breakdown of this information can be found in Table 6 and 7. Although demographic data was obtained for the stakeholders this was not included to minimise identifiability.

Table 6: Staff Demographics

Staff Demographic	
Gender	
Male	3
Female	7
Age:	
18-24	1
25-34	3
35-44	1
45-54	1
55-64	1
70+	2
Ethnicity	
White British	6
Black British	2
Black African	1
Demographic: Education	
Secondary or High School Completed	6
University Degree Completed	4
Civic Status:	
Married	2
Single	5
Living as couple	2
Employment at Matilda House	
0-2 years	4
2-5 years	3
10+ years	2
Training in Restorative Practice	
None	3
Introductory Restorative Approaches Training	2
3 Day Restorative Practitioner Training	6

Table 7: Resident Demographics

Resident Demographic	
Gender	
Male	15
Female	1
Age:	
35-44	4
45-54	9
55-70	3
Ethnicity	

White British / English / British	12
White Irish	1
White European	1
Jewish	1
Other White	1
Demographic: Mental Health Diagnosis	
Yes	6
No	9
What Mental Health Diagnosis:	
Depression	5
BPD	1
CPTSD	1
Number of times been homeless	
1	2
2	6
3	3
4	2
5	1
28	1
Length of Homelessness:	
0-11 months	2
1 years – 1 year 11 months	4
2 years – 2 years 11 months	2
3 years – 3 years 11 months	1
6 years – 6 years 11 months	1
8 years – 8 years 11 months	1
10 years	2
20 years	1
Experienced being evicted:	
Yes	8
No	8

Impact of Restorative Approaches:

Attitudes:

The RJAS was completed by 10 staff in total, however only 6 completed at more than one timepoint (See Table 8). Only the covering team leader had received the three-day Restorative Practitioner Training at the start. Three staff received this training between December 2024 and June 2025. The degree of alignment with Restorative Justice (RJ) attitudes varied with some staff being more aligned than others. Two members of staff appeared more aligned, and four staff appeared less aligned as time went on. Staff seemed more aligned with attitudes relating to accountability, and less aligned with attitudes regarding restoration processes. Overall, it is unclear to what extent training impacted attitudes that aligned with RJ.

Table 8: Participant scores on the RJAS

Participant	RJA Total T1	RJA Total T2	RJA Total T3	Empathic Understanding T1	Empathic Understanding T2	Empathic Understanding T3	Harms and Needs T1	Harms and Needs T2	Harms and Needs T3	Restoration Processes T1	Restoration Processes T2	Restoration Processes T3	Accountability T1	Accountability T2	Accountability T3	Community Engagement T1	Community Engagement T2	Community Engagement T3
1	69	92		16	19		16	19		10	18		16	20		11	16	
2	74	63	69	15	13	13	14	14	14	12	10	10	19	15	17	14	11	15
4	90	91	80	19	17	17	20	18	19	15	18	9	20	20	20	16	18	15
6	66	64	61	11	11	11	11	12	10	8	7	9	18	18	20	18	16	11
7	81		72	12		9	15		15	15		14	20		18	19		16
8		90	92		14	17		20	20		16	15		20	20		20	20

Staff and Resident experiences of Restorative Practice

The Impact of Restorative Practice (IoRP) was completed by four staff across T2 and T3. Staff appeared to generally feel safe and respected at MH. General positive changes included feeling more supported, more able to be honest with colleagues, and being more aware of how to get

support. Some staff however indicated slight increases in the frequency of irritability, anxiety and feelings of hopelessness. Staff felt able to help residents with mental health issues and managing emotions. Some staff felt less confident in addressing substance use, identifying alternatives to eviction and supporting residents to talk and resolve conflicts.

The IoRP also highlighted that staff recognised the value of RP's in terms of promoting talking, enabling accountability, fostering understanding, providing questioning strategies and reducing harm. They recognised that residents were ambivalent about RP's and believed this was because of fear of snitching / reprisal, level of readiness, complex needs (e.g. mental health and substance use) and reluctance to talk or address problems. Further training in therapeutic approaches (e.g. CBT/ DBT), substance misuse and rehabilitation was indicated as potentially being helpful.

The Homeless Hostel Experience (HHE) (Residents) questionnaire was completed by six residents across T2 and T3. Generally, the residents felt safe, had good relationships with staff, felt staff had the skills to help them, and knew where to get support for problems with other residents. Positive changes included feeling more able to speak to other residents about problems and more listened to by staff. Despite this some indicated they felt less safe and aware of support for addressing problems with staff, felt slightly more anxious and had slightly less positive relationships with other residents. Areas for improvement centred around 1:1's, more social opportunities / spaces and having paid provisions completed. One participant made negative comments that centred around lack of support and care, poor response to complaints and environmental cleanliness.

Restorative Facilitation:

Two staff had completed Restorative facilitation (RF) and provided feedback. The staff each stated they facilitated a restorative meeting / conference. Comments indicated that the positives of RF were they enabled balanced conversations, accountability, change and understanding. They recognised RP got easier with practice, and that supervision is needed if the problem was personal.

The resident had no prior awareness or information about RP. The restorative conversation was facilitated by staff / L.E.A.F. It was experienced as helpful, well-organised and safe, however they didn't feel heard. They used the approach to help others understand their problems and perspective, and believed staff were more respectful and supportive afterwards. They indicated they would likely recommend to others.

Challenges and Barriers to Implementing Restorative Approaches:

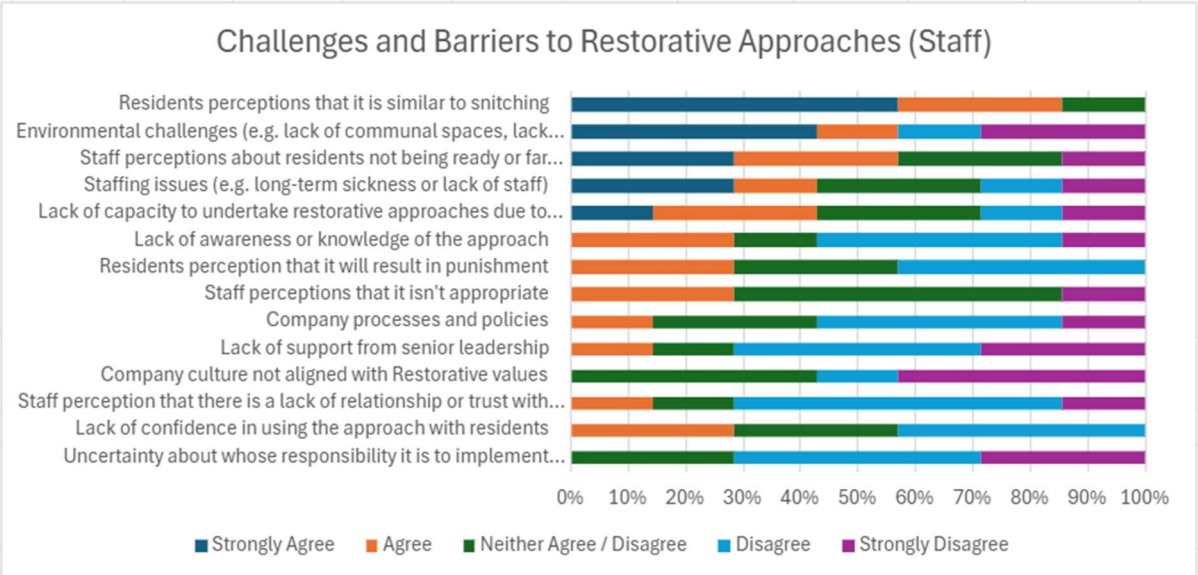
Questionnaires exploring the challenges and barriers to implementing restorative approaches were administered to staff, residents and stakeholders. The quantitative data was analysed through ascertaining the frequency of responses and seeing which ones had higher agreement. Each question then had space for them to qualitatively expand on why they answered a certain way. These qualitative responses were then analysed using content analysis to identify key points across the data initially. These were then grouped into wider themes that helped understand the key barriers further.

Staff:

Key barriers identified were environmental challenges (e.g. bed-bugs, scabies, lack of appropriate space for RF) (n = 4), staff perceptions that residents aren't ready (e.g. perceptions it might not work, would work better in rehab settings) (n = 4) and resident perceptions its snitching (e.g. lack of understanding about the approach) (n = 6). One staff member also

highlighted some additional factors that could be impacting RP's including resident perceptions that nothing will be done if they bring something to staff (i.e. "what's the point, nothing happened"), and the challenges of facilitating a restorative process (e.g. maintaining anonymity of those who told them, not being able to provide an outcome) which can fuel the "nothing happening" narrative.

Figure 5: Frequency of staff scores on the Challenges and Barriers to Restorative Approaches Questionnaire



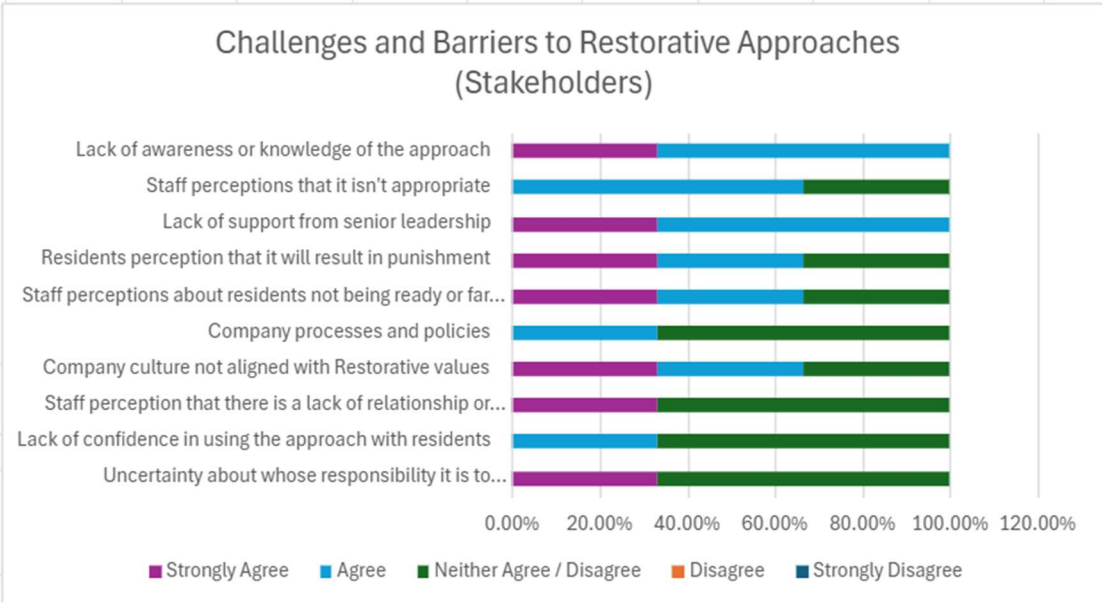
Stakeholders

Similarly to staff, stakeholders recognised the key barriers of environmental challenges (e.g. bedbugs, scabies, lack of appropriate space), staff perceptions of residents not being ready and the resident's perceptions of it being seen as snitching. They differed in that they highlighted other key barriers including lack of awareness / knowledge of the approach (e.g. gaps in knowledge / training), resident perceptions it could result in punishment, lack of support from senior leadership, staffing issues (e.g. staff being poorly), and lack of capacity (e.g. high caseloads). They also recognised the challenge of building enthusiasm and buy-in for the

approach. All these factors likely contributed to the approach not being embedded, delegation taking place and unhelpful attitudes / narratives to be unchallenged.

Stakeholders identified that implementation could have been improved by waiting until there was stability in the environment and leadership, ensuring system wide understanding, proactive staff approach, less L.E.A.F involvement, greater access to communal space / private spaces and access to additional training (e.g. conflict coaching).

Figure 6: Frequency of Stakeholder Scores on the Challenges and Barriers to Restorative Approaches Questionnaire



Residents

Most residents had no prior knowledge (n=8) or information (n=9). Conflicts with other residents and staff were reported by some residents, and they managed these by speaking to staff, not speaking to anyone or speaking to other residents. On the occasions where the question about whether they were offered RA's was appropriately completed four residents indicated that RA's hadn't been offered.

Barriers identified included worries that other residents would think they were snitching and that they would get into trouble with residents if they spoke to staff (n=5). Comments highlighted fear of being perceived as a grass and being physically hurt as a result. Therefore, they preferred to keep quiet / silent. Other residents indicated they wouldn't talk to staff due to not having faith in what staff can and can't do, it being seen as dangerous and lacking trust in staff. Some spoke about how they can trust their keyworker and spoke about how they trust L.E.A.F because they know them.

Residents indicated that they would do various things in the event of a conflict (e.g. talking to staff, L.E.A.F, sort themselves or none of the above). Half said Yes (n = 5) and half said No (n=5) to whether they would like to be offered RAs at those times. There was recognition that they might not talk to somebody because of worries relating to confidentiality, trusting staff and being seen as grassing. There were also perceptions about lack of professionalism in relation to support structures and that complaints wouldn't be dealt with. Solutions identified included residents being provided with more accessible / professional information, further training and staff adopting a present / compassionate approach.

Discussion

The SIP was collaboratively developed with various agencies. It used a PDSA cycle to explore the possible impacts of RP training, the experiences of staff / residents who used these approaches and the barriers to implementation. At the end improvement recommendations were provided to MH.

Data collection included quantitative data (e.g. rates of eviction) and questionnaire data. In total 29 individuals completed a series of questionnaires. Most staff completed questionnaires at either two or three time-points, some residents completed at 2 time-points and stakeholders completed in time-point 3.

Significant efforts were made by MH and wider stakeholders (e.g. L.E.A.F, Mint House) to make the implementation a success including multiple training sessions, L.E.A.F attending MH, and a community of practice group was held to aid reflection and learning. Staff recognised how the approach could be helpful (e.g. encouraging talking, promoting accountability and facilitating understanding). They recognised that using the approach helped build their confidence. Resident feedback also highlighted that the approach was helpful, allowed them to put across their perspective and felt more respected / supported by staff after. These are similar to those found by other literature (Douglas, 2018; Fulfilling Lives & Impact Initiatives, 2019).

Despite the efforts and the recognition of the approaches value the results indicated low levels of implementation of RA's at MH. Only two of the seven staff (28.57%) who responded at T3 had used RA's, there was a large percentage of residents who had no prior knowledge or awareness of the approach (81.81%), and only two residents were identified as experiencing RA's by the end of the first year of implementation. The L.E.A.F stakeholder also indicated that the approach 'didn't work', and one member of staff highlighted that they hadn't been told that any RA's had taken place in T3.

There were a number of factors that contributed to the difficulties with implementing RA's at MH. Firstly, there were early losses in trained staff and the team leader changed in December 2024. Other literature has highlighted this has been a challenge with implementing these approaches in these settings and could have contributed to difficulties with consistency of driving the approach, staff capacity / enthusiasm and staff resource available (Douglas, 2018). Furthermore, implementation appeared to be impacted by lack of social space / cross-over space, resident fears of snitching / getting into trouble with other residents and staff perceptions about it not being an appropriate approach / residents not being ready. These indicated

challenges in a number of areas that would be important in creating a PIE (e.g. relationships, physical environment) (No One Left Out: Solutions Ltd, 2015).

The low rates of RP's could be due to more recognition / expectation for more formal methods (e.g. conferences). It is possible that more informal uses were being used but were more subtle in nature (e.g. changes in language use, the questions asked, and the conversations had) and therefore harder to recognise and capture using questionnaires. It has been recognised in the literature that these informal uses are more common in these settings due to a variety of client and staff factors (e.g. limited time, conflicting work pressures, issues of client understanding and guarded nature of clients), and that they help raise awareness and understanding for residents, which can increase more engagement with formal methods (Douglas, 2018).

Service Improvement Implications

The SIP used a PDSA cycle to inform recommendations relating to ways of improving the use of RP at MH. The Act (A) step of the PDSA cycle involves identifying possible recommendations that could help inform service improvement at Matilda House (See Table 9). The recommendations were initially shared informally via email and meetings with external supervisors / stakeholders, and then more formally shared via a report that was submitted to MH. More general recommendations and lessons learned were also identified (See Table 10).

The recommendations put forward have been produced in the context of relevant guidelines from the National Institute of Clinical Excellence, the Restorative Justice Council, and Homeless Link. These guidelines outline how to promote engagement with service users, how to establish RA's and how to provide TIC or create a PIE (No One Left Out: Solutions Ltd, 2015).

Table 9: *Recommendations for service improvement at Matilda House*

Recommendation	**Reasoning**	**Example quotes from staff, residents and stakeholders**
(1) Increase staff awareness and engagement with Restorative Approaches	- 100% of the Stakeholders believed that a barrier to implementation was lack of awareness - Over 50% of staff and 60% of stakeholders agreed that staff beliefs about residents not being ready was a barrier to implementation - Over 60% of Stakeholders agreed that staff perceptions that the approach wasn't appropriate was a barrier.	*Staff:* *"couldn't do the training for ages. Heard others talking about it but lost interest for a good while. Understaffed for a good year and so couldn't participate when he first wanted to. Didn't know too much about it in advance. He was drowning in clients, and it put him off taking on more training"* *"A refresher every 12 months would be good though for all staff in case people don't ever use it and lose that knowledge"* *Stakeholder:* *"we didn't get to train the entire staff group at Matilda, therefore there are knowledge gaps amongst the team"* *"I think staff turnover means that some staff are more familiar with restorative approaches than others".*

`Act – How this could be done:

Raise Awareness of Approach

- **Induction Programme** includes some form of introduction to Restorative Approaches so that new starters are familiar with its general principles from the start.
- **Restorative Practice Refresher training** accessed as an annual part of mandatory training that enables staff to top-up their current knowledge and skills about the approach.
- **Restorative Practitioner Training** to be offered regularly to ensure opportunities for staff to build their skills and knowledge.
- **Advanced Practitioner Training** made available to select experienced restorative practitioners to enable them to manage more complex or challenging cases and to support new practitioners.
- **Intranet Resources** that can be accessed by new and existing staff that outlines what Restorative Practices are, different types of restorative techniques (e.g. informal and formal), current guidance (e.g. Restorative Practice Guidance), process flowcharts, relevant documentation (e.g. copies of outcome measures, consent forms, feedback forms, scripts) and useful contacts for further information.
- **Information Folder** that agency / night staff can be directed to in order to find out more information about the approach.
- **Incorporation of the approach in Assessment / Care-Planning documentation (e.g. brief summaries / scripts)** could help keep it on the agenda and could seek consent to use Restorative Approaches from the residents initial arrival at Matilda House**.**

Promoting Engagement with the Approach

- **Consultation with staff** to ascertain their views about the approach and concerns about it's use. This would be important to ascertain whether it is something they can get on board with, or whether there are other approaches or skills (e.g. conflict resolution, CBT skills) that could be invested in.
- **Consider doing a relaunch** where there can be food, information about the approach, have other services that have used the approaches (e.g. St Mungo) come over and have residents from other accommodations talk about there experiences of the approach.
- **Establishing a Restorative Practice Champion** who can provide resources / guidance to staff at Matilda House. Ideally the champion would be someone who is enthusiastic and sufficiently trained in the role.

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- **Ensure there is space in Team meetings / Supervision** to discuss positives, challenges and ask questions about the approach and keep it on everyone's agenda.
- **Reflective Practice** to ensure there are opportunities for practitioners to reflect on successes, barriers and next steps for residents where restorative approaches have been used.
- **Access to more advanced practitioners** particularly for cases where there is greater degree of complexity, risk or relational challenges. Enables them to manage cases that are suitable to their level of knowledge and skill, thus providing challenge but enabling confidence to be built.
- **Ensure record keeping** of restorative cases and sharing of positive cases / lessons learned.

All documentation / videos / psychoeducation materials should be created with staff and residents at Matilda House
</td></tr>
<tr><td>2) Improve the sense of community and culture at Matilda House</td><td>

- 90% of staff agreed that resident perception that RAs would be seen as snitching was a barrier to implementation of the approach
- Over 60% of stakeholders agreed that the resident's perception that RAs would result in punishment was a barrier to implementing the approach.
- 5 Residents were worried about talking to staff due to the fear that other residents would see it as snitching and potentially result in them being harmed by other residents.

</td><td>

Resident:

"The grass culture, its like talking to police, it's not good being known to talk to staff".

"Residents don't like people who grass, people take the law into your own hands. 'A silent tongue is a wise head"

"No issue about getting in trouble with staff, would get physically hurt by other residents, he believes"

Stakeholder:
"they felt like they would be evicted if they spoke up"
</td></tr>
<tr><td colspan="3">**Act – How this could be done:**</td></tr>
</table>

- **About me sheets** could be completed by residents and staff so that they have a way of getting to know basic information about the people they are living with.
- **Creating prosocial opportunities** to interact and get to know other residents, but also for positive interactions with staff (e.g. BBQ's, Film Nights, Art club). These opportunities could be identified through a resident survey and implemented on an activity timetable.
- **Identifying Social Representatives / employ an activities coordinator** so there are individuals responsible for identifying and implementing social activities.
- **Community Meetings** organised on a weekly basis (1 block a week, and then a meeting as a whole) where residents attend in person maybe in the Pod or online through a team's link. This creates a forum where they bring issues or problems that they are encountering, but also where staff can share successes, news and important information.
- **Increase group space** by potentially identifying other options (e.g. community halls, purchasing a marquee to expand outside space or holding groups in each self-contained flat kitchen).
- **Raise awareness of Restorative Approaches** from their arrival at Matilda House to highlight how conflicts will be addressed, and to reduce concerns about punitive action (e.g. eviction). Information (leaflets / videos) provided should be accessible to individuals with varying degrees of communication ability (e.g. easy read, pictorial information, simplified language). Potentially also having translated versions could be helpful for residents whose first language isn't English.
- **Share examples of positive resident outcomes / experiences of Restorative Approaches** from other sites (e.g. St Mungo) to help highlight that the approach works, that other people like them have found it beneficial. Service users from another site could come and talk to Matilda House residents.
- **Empowering residents** by giving them access to skills and therapeutic interventions they can use to help them build emotion regulation and interpersonal effectiveness skills (e.g. CBT / DBT skills).
- **Staff use Restorative approaches** in 1:1 session to help resident to understand their thoughts, feelings and behaviours when a conflict has arisen and consider the perspective of others involved.
- **Identify safe and neutral** places whereby discussions can be had between residents and staff about problems that have arisen.
- **Consider having a problems / improvement suggestions box** that residents can put in about any problems they are having and things that could be improved. The box should make it clear that it is ok if they would prefer to remain anonymous, but staff might be able to help more if they know who is raising the problem.
- **Ensure Complaints / Conflict Resolution policies** have restorative practice incorporated within them, and accessible resources are provided to residents so they are aware of how staff will manage these elements.

All of documentation / videos / psychoeducation materials should be created with residents at Matilda House

Table 10: General Recommendations and Lessons Learned

Recommendation	Reasoning
1) Ensure staff consultation takes place prior to implementing a new initiative	- It is unclear to what extent staff consultation happened at Matilda House prior to RA training being implemented. - It is possible that had the consultation took place a lot of the staff ambivalence could have been identified and addressed before the approach was implemented. - If the ambivalence was significant, meaningful engagement with the staff about what they felt their needs were could have identified valuable development opportunities.
2) Ensure there is enough stability in the system before implementing change	- Throughout the project there was periods of instability at Matilda House in terms management changes and staff leaving. - Systemic instability can make it more difficult for new initiatives to take hold or be successfully integrated. - Therefore, holding off on implementing new initiatives until systemic instability has eased can be beneficial and was recognised by one of the stakeholders.
3) Ensure that there is an actual service need for an improvement initiative.	- The RA training was implemented to reduce evictions, abandonments and serious incidents. However, the levels of these were considerably low during the project and had been just prior to the onset of the training. This made it difficult to ascertain impact of the training on quantitative measures. - If there isn't an actual service need for improvement it will likely make it harder to ascertain the effectiveness of improvement initiatives because there isn't anything to improve.

Methodological Considerations and Limitations:

There were several obstacles when it came to conducting this SIP. Firstly, it received approval to go ahead as the first round of RP training was due to begin. Therefore pre-training attitudinal or environmental measures could not be implemented.

There was also a challenge when it came to measuring restorative attitudes. The RJAS was utilised as this appeared to be the only tool available. It is possible that this measure does not capture all aspects of RP and rather is more focused on RJ. Therefore, future evaluation of the approach might benefit from the creation and evaluation of a more general Restorative Practice Attitudes scale.

To capture the potential impacts of RP a repeated measures design was used to assess changes in attitudes and the environment at MH. However, this was problematic due to a number of staff and residents leaving throughout the project, which was unexpected. This limited the number of people that could be followed through and lead to a loss in staff and residents that were familiar with the approach. This attrition could have contributed to the problems in implementing the approach.

To explore impact and barriers we relied on the use of questionnaires. To aid engagement the researcher based themselves at MH to try and reach as many staff and residents as possible. A research assistant was also utilised to increase the physical presence of the project and increase engagement at timepoint 2 and 3. A challenge with this was that there were differences in administration and support levels provided to residents throughout the questionnaire process with some making errors and appearing to require more support to navigate the ‘challenges and barriers’ questionnaires.

The researcher encountered challenges with being able to be physically present at times during the SIP due to outbreaks of bedbugs and scabies. Bedbugs broke out during Timepoint 2 at which point the researcher did still go to MH to promote engagement. However, an outbreak of bedbugs and scabies at Timepoint 3 delayed data collection.

Conclusions

This paper presented a SIP that was completed within a homeless hostel in Oxford. The project aimed to explore the impact of RP training on evictions, serious incidents, abandonments and staff leaving. It also planned on exploring the experiences of those who facilitated restorative approaches and those who experienced the process. A PDSA cycle was utilised as the improvement framework. Due to a number of barriers and challenges in implementing a RP approach it is difficult to draw any conclusions as to its potential impacts and recommendations therefore centre on how to improve the embedding and implementation of restorative approaches at MH in order for it to be further evaluated. Recommendations centred around approach awareness, access to RP training, access to other relevant training, social opportunities and evidencing RP. Recommendations were then initially shared informally via email and meetings with stakeholders and MH and then shared with the service via a written report.

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PAPER 3: THEORY DRIVEN RESEARCH PROJECT

HOARDING DISORDER (HD) AND OBJECT ATTACHMENT: THE ROLE OF OBJECT IMPORTANCE AND OBJECT QUALITIES.

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Submission Date: 22/05/2026

Suggested Journal: Journal of Obsessive-Compulsive and Related Disorders (JOCRD)

Joint Working: Another Trainee Clinical Psychologist jointly completed aspects of the project (Appendix M; Faye Denham). The purpose of this was to limit the time burden on participants. Elements contributed to by Elliott House included conceptualising the research idea and design, creating the Object Qualities questionnaire, administering an imagery experimental task to HD and NCCC, analysing research data and writing up the project. Faye Denham jointly completed elements of developing ethics documentation, recruitment and elements of data collection (e.g. some SCID completion and setting the scene for experimental tasks).

Abstract

Background and aims

Literature suggests that people with Hoarding Disorder (HD) experience strong emotional attachments with their objects, research has yet to examine the extent of subjective importance of such objects and how this impacts HD symptoms. The present study aimed to evaluate the role of importance in the distress caused when imagining the loss of particular objects, and to explore other object characteristics.

Method

A mixed method experimental design was used which involved questionnaire data and an experimental imagery task. It was completed with two groups: hoarding (HD) (n = 46) and non-clinical community controls (NCCC) (n = 35). Both groups identified two important and two unimportant objects, and completed a variety of questionnaires. Object qualities were measured using a purposely designed questionnaire the Quality of Objects Questionnaire (QoOQ). The experimental imagery task involved imagining the loss of the two important and two unimportant objects.

Results

The HD group scored significantly higher regardless of importance on distress linked to loss of all objects and qualities such as negative / positive emotion, memories and link to self when compared to NCCC's. They were also able to distinguish between objects in terms of subjective importance. However, the pattern in scores across objects was similar for both groups.

Discussion

Object importance influenced the distress during the imaginary task, and ratings for negative / positive emotions, memories and links to self. The HD group scored higher overall in these ratings. The pattern of scores across objects was not unique to the HD group.

Introduction

Hoarding Disorder (HD) as a problem has been receiving growing levels of attention within the United Kingdom (BBC News, 2025). HD involves difficulties with acquiring and discarding significant amounts of possessions, that are typically seen as having no value by the general public. This can make using living spaces for their required purpose incredibly difficult and impair quality of life (Frost & Gross, 1993).

Prevalence estimates of HD in adults have varied between 2.5% to 10% (Nutley et al., 2025; Postlethwaite et al., 2019; Sinopoli et al., 2020; Zaboski II et al., 2019). It typically starts around 16.7 years old and is often comorbid with other mental health conditions and suicidality (Frost et al., 2011; Pellegrini et al., 2021; Zaboski II et al., 2019). It can impair an individual's quality of life due to the poor living conditions, loneliness and difficulties working (Bratiotis et al., 2019; Frost et al., 2000; Mathes et al., 2019; Woody et al., 2020).

Cognitive Behavioural Approach to Hoarding

The Cognitive behavioural model posits that discarding difficulties are maintained by negative beliefs, biases in processing information and strong emotional attachments to objects (Frost & Hartl, 1996). CBT for HD targets cognitive and behavioural maintenance factors through various techniques including problem-solving skills, thought challenging and exposure (David et al., 2021; Fernández de la Cruz et al., 2013; Steketee & Frost, 2013).

Meta-analyses have found that HD individuals pre and post measures demonstrate reliably moderate improvements following CBT (Bodryzlova et al., 2019; Tolin et al., 2015),

for example when compared to waitlist control (Fitzpatrick et al., 2018). Despite this, many participants' HD symptoms remain significantly elevated after CBT indicating the need to improve CBT outcomes intervention (David et al., 2022). It remains unclear why individuals with HD appear to form intense emotional attachments to objects understanding this may be key to improving treatment (Mathes et al., 2020).

Attachment and Hoarding

An Attachment approach to HD has proposed that a key part of their intense emotional attachment to objects is due to object attachment. Object Attachment (OA) has been defined as "the psychological or emotional bond that individuals experience between their sense of self and an object" (Norberg & Rucker, 2021, p. 2). A persons OA can either be secure (e.g. makes the person feel comforted, safe and motivates them to maintain or fix object) or insecure (e.g maladaptive emotional connection, objects linked to self-identity and feelings of vulnerability without them) (David & Norberg, 2022). The OA has been theorised to be a compensatory mechanism for unmet interpersonal and attachment needs in childhood. This object attachment becomes problematic because the objects cannot meet the indiivduals attachment needs which can worsen emotional and interpersonal difficulties (Chia et al., 2021; Mathes et al., 2020; Yap & Grisham, 2021).

Support for the attachment approach has come from evidence indicating that individuals with HD score higher on OA generally than healthy controls, and that insecure object attachment has been found to be associated with greater HD symptoms (Grisham et al, 2009). The insecure object attachment has also been a predictor for saving more items during discarding tasks (Neave et al., 2016; Norberg et al., 2015; Yap & Grisham, 2021).

HD research has more recently focussed on the emotional world of individuals with HD and examined factors that maintain emotional attachment such as the objects link to

identity, emotions or memories connected to possessions and ownership (Burgess et al., 2018; Frost et al., 1995; Mulligan-Rabbitt et al., 2023; Nedelisky & Steele, 2009). Objects may hold importance, however there is no research to date that has examined the qualities of more or less important items in those with HD, and how this may impact HD symptoms. Addressing this could help to better understand problematic object attachment and inform treatment adaptions.

Aims and hypotheses

The aim of the study was to explore what qualities are present in particular objects and whether these differ from NCCCs. Additionally, it aims to evaluate whether the importance of an object influences the level of distress experienced by a person with HD when they are considering its loss and to what extent different factors impact the distress.

Primary Hypotheses

1. People who experience HD will rate their possessions higher than NCCC's on qualities such as negative emotions or an extension of self.
2. The importance quality ratings of the items chosen as important vs unimportant items will be more similar in the HD group relative to NCCC's.
3. Importance of objects will interact with group in terms of response to the idea of loss; that is, there will be a smaller differential in ratings between important and unimportant objects in the HD group relative to controls.

Method

Design

A mixed model design was used where there was a between-subject factor of participant group (HD, NCCC) and a within subject factor of object (Important , Unimportant) with the dependent variables being ratings of object characteristics. An

experimental imagery manipulation evaluated potential differences in relation to the idea of losing the objects.

Sample Size

A priori power analysis was completed for a repeated measures analysis with within and between interactions (e.g. group x object type) on G*Power (version 3.1) (Faul et al., 2009). A small to moderate effect size was chosen (f = 0.2) using Gordon et al. (2013) as a guide due to lack of direct comparison available, power (0.9), alpa (0.05), groups (n = 2) and measurements (n = 4). This analysis indicated a total sample (n = 66) would be required to detect a small to moderate effect size.

Participants

Participants were over the age of 18 (no upper limit) and lived in the United Kingdom. Inclusion for the HD group was established through self-identification with HD difficulties and then verification using SCID-RV Opt. OC-Related Disorder Opt-G.1 HD to ascertain if they met diagnostic criteria for HD. NCCC were included if they self-identified as only not having HD difficulties. They would be excluded if they scored over 39 which is the clinical cut-off for HD (Kellman-McFarlane et al., 2019).

Participants would be excluded if they self-reported current substance dependence, moderate to severe Learning Disabilities, diagnoses indicating memory difficulties / cognitive impairment, or were unable to consent and did not have capacity. This is because it would impact their ability to complete aspects of the study, and also because they wouldn't be able to make informed decisions about participating.

Sample characteristics

In total the telephone SCID was completed with 58 individuals and 125 individuals completed the questionnaires. Exclusions occurred (n = 19) see Appendix 2 for more information. In total data analysis was completed on 81 participants: HD = 46 and NCCC = 35. Experimental data analysis was completed on 80 participants: HD = 45 and NCCC = 35.

Procedure

Expert by Experience Involvement

The development of the QoOQ and piloting of aspects of the study (e.g. questionnaire and experimental task) involved individuals with lived experience of HD (n = 10). There feedback was used to improve these aspects of the research.

Recruitment and procedure

Recruitment took place through specialist charities (e.g. Hoarding UK, Hoarding Disorders UK), Facebook, Instagram, X and Reddit. Participants emailed a joint research mailbox accessed by both EH and FD if interested. Participant information was sent and they were asked to respond by confirming the group they identified with and their agreement to participate. Afterwards an ID number and a Qualtrics questionnaire link was sent.

The email for those who self-identified as having HD invited them to a SCID phone call (First et al., 2015). Verbal consent was sought at the start of the calls and these were conducted by both EH and FD who were jointly collecting data. Both were trained by principal researcher (PS) in administering the SCID-RV. Those who did not meet diagnostic criteria on the SCID did not proceed with the rest of the study. In order to ensure consistency in administering, 15% were rated by both EH and FD. The inter-rater reliability was high with a Cohen's Kappa of 1.

The Qualtrics link contained an online consent form, debrief page, an invitation to repeat the two specific questionnaires developed by EH and FD and Trap Questions. The overall battery was estimated to take around 30-40 minutes to complete. Those who consented to repeat the two measures were sent a link approximately a week later.

Invitations to the online experimental tasks were sent once questionnaires were completed. It was facilitated over Microsoft Teams predominantly, or over the phone where required. Written consent was obtained at the start, and confidentiality discussed. Orientation tasks were completed and baseline scores for specific emotions and imagery completed. The experimental task involved imagining the loss of each important and unimportant object in a predetermined randomised order identified by Sealed Envelope Ltd (2024). They were required to rate vividness of the image, anxiety, sadness and distress in the imagined situation.

HD participants also were required to complete FD's experimental task. In these cases which experimental task went first was randomised using Sealed Envelope Ltd (2024). Participants received a £10 Love2Shop voucher upon successful completion of the study.

Measures

The measures in this study are outlined in Table 11. The Quality of Objects questionnaire was specifically designed for this study. Its development involved discussions with principal researcher PS, reviewing the literature and feedback from individuals with lived experience of HD.

There were two additional measures that were included in the questionnaire batch for FD's study which included a Collectors Measure and the Family Attitudes Questionnaire (Denham & Salkovskis in preparation).

Table 11: Questionnaires used in the order presented

Questionnaires	Overview of Measure
Structured Clinical Interview for the DSM- Research Version (SCID-5-RV; (First et al., 2015)	The Hoarding Disorder (HD) version of the SCID-5-RV was used to ascertain whether participants would meet DSM-5 criteria for HD. The SCID-RV has demonstrated strong inter-rater reliability with Cohen's Kappa's ranging from 0.59 to 1.00 (Tolin et al., 2018). The inter-rater reliability for this study was also high with a Cohen's Kappa of 1.00.
Demographic Questionnaire	A questionnaire that contained 7 questions about different demographic characteristics including gender, ethnicity, age, education, employment, whether they are a parent / have children and relationship status.
The Patient Health Questionnaire-8 (PHQ-8; (Kroenke & Spitzer, 2002)	A questionnaire that has 8 questions in relation to symptoms of depression. It asks the respondent to identify how frequently they have experienced these symptoms over the last two weeks. The questionnaire has a 4-point Likert scale to measure frequency from *0 (not at all) to 3 (nearly every day*). The lowest that can be scored is 0, and the highest that can be scored is 21. The higher the score the greater the depression severity. The ideal cut-off in terms of being sensitive and specific enough for identifying depression that is clinically significant is a score greater than 10.

	This measure has been found to be highly reliable and valid when it comes to measuring depression symptoms. The internal consistency for this measure has been found to be high with Cronbach Alphas ranging between 0.772 to 0.905 (de la Torre et al., 2023)
The Generalised Anxiety Disorder Assessment (GAD-7; (Spitzer et al., 2006)	A questionnaire that measures symptoms of generalised anxiety disorder. Respondents are asked to answer 7 items in relation to how often they have experienced the symptoms over the last 2 weeks. Frequency of symptoms is assessed on a 4-point Likert scale which ranges from 0 to 3 (0 = not at all and 3 = nearly every day). The highest score that can be obtained is 21, and the lowest possible score is 0. Higher scores indicate that the respondent is experiencing more severe levels of GAD. The ideal cut-off for optimal sensitivity and specificity in identifying symptoms of GAD that are clinically significant is a score greater than 10. The GAD-7 has been evidenced to have strong reliability and validity when it comes to assessing anxiety severity, with internal consistency ranging from 0.89 k to 0.92 k and high test-retest reliability (Löwe et al., 2008; Spitzer et al., 2006)

The Beliefs about Hoarding Questionnaire (Gordon et al., 2013)	A 28-item questionnaire developed to assess the experiences and beliefs of people with HD. Particular items are combined to acquire a score for each of the three subscales which are harm avoidance, material deprivation and attachment disturbance). The questionnaire has been found to have strong reliability with internal consistency alphas ranging from .79 to. 96, and inter-rater reliability was high with r's between .69 and .89.
Savings Inventory Revised (Frost et al., 2004)	A questionnaire that has 23 items which assess severity of hoarding symptoms across 3 core areas: discarding, clutter and acquisition. An ideal total cutoff score for sensitivity and specificity in detecting HD is 39 (Kellman-McFarlane et al., 2019). The evidence suggests that the SIR has good reliability and validity. Internal Consistency has been very high with alpha's being around 0.93; (Kellman-McFarlane et al., 2019).
The Work and Social Adjustment Scale (WSAS; (Mundt et al., 2002)	A self-report questionnaire with 5 items that measures the persons functioning in different areas of their life (e.g. work, managing home environment, social activities, private / leisure activities and relationships). These areas are rated in terms of how much the respondent's problems impact these areas of their life using a 9-point Likert scale. The scale

	ranges from 0 (not at all) to 8 (very severely). The highest that can be scored is 40, and the lowest possible score is 0. The greater the score the greater the overall level of impairment. The WSAS has been found to has been found to have strong internal consistency with Cronbach Alpha's ranging from 0.70 to 0.94 (Mundt et al., 2002). This was only completed by the HD group.
Experiences of Close Relationships – Relationships Structures (ECR-RS; (Fraley et al., 2011)	A self-report measure that consists of 9 items that measure types of attachment. Typically measures attachment patterns for mother, father, romantic partner and a best friend. With permission from the Author, we changed the format in that they only answered the questions in relation to the person who they felt closest too.
Spontaneous Use of Imagery Scale (SUIS; (Reisberg et al., 2003)	A 12-item questionnaire that is used to measure day-to-day use of mental imagery. It uses a 5-point Likert scale from 1 (never appropriate) to 5 (always appropriate) to measure the appropriateness of different types of visual imagery day-to-day. Research has indicated that the internal consistency and convergent validity is acceptable (Nelis et al, 2014).

Measure created for this study:	
Qualities of Objects Questionnaire (QoOQ; House & Salkovskis, in prep)	A self-report questionnaire that consists of four sections. Section 1 and 2 will ask the respondent to identify 2 important objects. Section 3 and 4 will ask the respondent to identify 2 unimportant objects. Each section consists of the same 19 questions. The first 4 items ask about what the object is, how long they have owned it, how they acquired the object and whether they own more than one of the exact items. Questions 5 to 19 then ask the respondent to rate each item on a series of qualities (e.g. importance, condition, attached to memories, link with identity, link to past self, link to future self, link to positive / negative emotions, usefulness to others, current usefulness to self, practical use, aesthetics and status / achievement. Questions 5-19 are rated on a 10-point Likert scale from 0 (Not at all) to 10 (Extremely).

Ethical Considerations:

The study was approved by the Central University Research Ethics Committee for the University of Oxford (R96236/RE003). Verbal and written consent was obtained during the study. Research supervision was provided by research supervisors (PS & SF), and no adverse events occurred during the study.

Data analysis

Statistical analysis was completed using IBM SPSS (version 30) with an alpha .05 significance level used for interpretation. One participant is missing a second unimportant object therefore 45 HD participants were included in the analysis of the experimental task. All questionnaires were completed online, and they were unable to complete the questionnaires if answers were missing.

Demographic questionnaires were analysed using Chi-Square analysis where data was categorical; Continuous data was analysed using mixed model ANOVAs or t-tests.

Results

Demographic and descriptive variables

A summary can be found in table 12. The participants were all aged between 19 and 75 (M= 43.22, SD = 16.084). The participants were predominantly female (83.9%), Caucasian (80.2%), educated from secondary school or above (100%) and employed (51.8%).

There was a significant difference between the two groups in age ($t_{(79) = -}$ 6.22, $p < .001$) and significant associations between the two groups and a number of other demographic characteristics including education ($\chi^2_{(2)} = 12.122^a$, $p < .002$), employment ($\chi^2_{(1)} = 9.461_a$, $p <.002$) and relationship status ($\chi^2_{(1)} = 6.290^a$, $p <.012$)

The SIR subscales were analysed using a mixed-model ANOVA with within subject factors (SIR Acquisition, SIR Discarding and SIR Clutter) and between subject factors (HD, NCCC). Due to Mauchley's Test of Sphericity being violated the Greenhouse-Geisser was used which showed there was a significant main effect of subscale $F_{(1.7, 139.91)} = 5.216$, G-G $p <.009$) and group ($F_{(1, 79)} = 458.317$, $p <.001$). The interaction (subscale x group) was significant ($F_{(1.7,}$

$_{139.91)}$ = 15.717, G-G p <.001). Multiple comparison t-tests were completed and these found that the HD group scored significantly higher than NCCC's

The BAH subscales were analysed using a mixed-model ANOVA with within subject factors (BAH HA, BAH MD, BAD AD) and between subject factors (HD, NCCC). Subscale ($F_{(2, 158)}$ = 40.616, p <.001) and group ($F_{(1, 79)}$ = 105.83, p <.001) were significant effects, as was the interaction ($F_{(2, 158)}$ = 15.51, p <.001) between them. Multiple comparison t-tests were completed and these found that the HD group scored significantly higher than NCCC's.

The ECR was analysed using a mixed-model ANOVA with within subject factors (ECR Anxiety, ECR Avoidance) and between subject factors (HD, NCCC). Subscale ($F_{(1, 34)}$ = 4.04, p <.048) and group ($F_{(1, 79)}$ = 30.974, p <.001) were significant effects, but the interaction between them wasn't ($F_{(1, 79)}$ = 2.24, p >.14).

There were no statistically significant differences between the groups in terms of spontaneous imagery ($t_{(79)}$ = -1.36, p =.179).

Table 12: Group Demographic characteristics

	HD (n=46)		**NCCC (n=35)**			
	Mean (SD)		**Mean (SD)**		**Main effect**	**Effect Size**
Age	51.22 (14.24)		32.71 (11.83)		$t_{(79)}$ =-6.22, p<.001	Cohen's d = –1.39, 95% CI [–1.88, –0.90]
	n	**%**	**N**	**%**		
Gender					($\chi^2_{(1)}$ = 0.025$_a$, p >.875)	φ = .18.
Female	38	55.9	30	44.1		
Male	7	58.3	5	41.7		

Other	1[†]	100	0	0		
Ethnicity					($\chi^2_{(1)} = 0.265_a$, $p > .607$)	φ = .57
Caucasian	36	78.3	29	82.9		
Other	10	21.7	6	17.1		
Relationship Status					($\chi^2_{(1)} = 6.290^a$, $p < .012$)	φ = .28.
Married / Living with Others	16	42.1	22	57.9		
Other	30	69.8	13	30.2		
Parent					($\chi^2_{(1)} = 2.136_a$, $p > .144$)	φ = .16.
Yes	19	67.9	9	32.1		
No	27	50.9	26	49.1		
Highest educational level					($\chi^2_{(2)} = 12.122^a$, $p < .002$)	Cramér's V = .39
Secondary School	14	82.4	3	17.6		
University Degree	22	64.7	12	35.3		
Postgraduate Degree	10	33.3	20	66.7		
Employment Status					($\chi^2_{(1)} = 9.461_a$, $p < .002$)	φ = .03

Employed	17	40.5	25	59.5
Other	29	74.4	10	25.6

Table 13: Psychopathology measures (with multiple comparisons used)

	HD (n = 46)	**NCCC (n = 35)**		
	Mean (SD)	Mean (SD)	Main effect of group	Effect Size
SIR				
Total	62.91 (11.23)	13.23 (8.61)	($t_{(79)}$ = -21.75, *p* <.001)	Cohen's d = –4.88, 95% CI [–5.75, –3.99]
Clutter	26.35 (5.87)	3.86 (4.45)	($t_{(79)}$ = -19.62, *p* <.001)	Cohen's d = –4.24, 95% CI [–5.03, –3.44]
Discarding	20.26 (3.39)	4.49 (3.72)	($t_{(79)}$ = -19.87, *p* <.001)	Cohen's d = –4.46, 95% CI [–5.27, –3.63]
Acquisition	16.30 (5.64)	4.89 (3.74)	($t_{(77.707)}$ = -10.94, *p* <.001)	Cohen's d = –2.33, 95% CI [–2.89, –1.75]
BAH				
Total	1446.74 (598.01)	304.29 (276.49)	($t_{(66.853)}$ = -11.45, *p* <.001)	Cohen's d = –2.35, 95% CI [–2.92, –1.77]
Harm Avoidance	36.63 (24.33)	6.81 (8.73)	($t_{(59.274)}$ = -7.69, *p* <.001)	Cohen's d = –1.55, 95% CI [–2.05, –1.05]
Material Deprivation	61.47 (22.28)	12.67 (11.63)	($t_{(70.969)}$ = -12.75, *p* <.001)	Cohen's d = –2.64, 95% CI [–3.24, –2.04]
Attachment Difficulties	50.71 (24.97)	10.24 (11.22)	($t_{(65.902)}$ = -9.77, *p* <.001)	Cohen's d = –2.00, 95% CI [–2.54, –1.46]
PHQ-8	11.61 (5.03)	4.69 (4.51)	($t_{(79)}$ = -6.41, *p* <.001)	Cohen's d = –1.44, 95% CI [–1.93, –0.94]

GAD-7	10.41 (4.88)	4.05 (3.69)	($t_{(78.99)}$ = -6.66, p <.001)	Cohen's d = –1.44, 95% CI [–1.93, –0.94]
WSAS	21.65 (8.59)	-		

Table 14: Attachment and Imagery Questionnaires

	HD (n = 46) Mean (SD)	**NCCC (n = 35)** Mean (SD)		**Effect Size**
SUIS Total	41.07 (10.47)	38.06 (9.05)	($t_{(79)}$ = -1.36, p =.179)	Cohen's d = –.304, 95% CI [–.745, –.139]
ECR Total	30.80 (10.34)	18.97 (9.18)	($t_{(79)}$ = -5.35, p <.001)	Cohen's d = –1.20, 95% CI [–1.68, –0.72]
ECR-Avoidant	3.20 (1.26)	2.07 (1.19)	($t_{(79)}$ = -4.09, p <.001)	Cohen's d = –.92, 95% CI [–1.38, -.45]
ECR-Anxious	3.86 (1.78)	2.17 (1.16)	($t_{(77.365)}$ = -5.13, p <.001)	Cohen's d = –1.09, 95% CI [–1.56, –.62]

Characteristics of Objects:

Table 15: Quality of Objects Questionnaire Outcomes

	HD (n=46)	**NCCC (n = 35)**	
	Mean (SD)	**Mean (SD)**	**Main effect**
Monetary Value			Group: ($F_{(1, 79)}$ = 0.32, p =.574, ηp^2 = *.004*)
I	8.89 (5.81)	8.94 (4.34)	Interaction: ($F_{(1, 79)}$ = 0.68, p =.412, ηp^2 = *.009*)
UI	4.02 (4.14)	3.06 (3.05)	

Importance			Group: ($F_{(1, 79)}$ = 1.91, p =.171, ηp^2 = *.024*)
I	17.72 (3.32)	17.57 (2.93)	Interaction: ($F_{(1, 79)}$ = 1.62, p =.207, ηp^2 = *.020*)
UI	5.74 (5.05)	4.09 (3.83)	
Positive Emotion			Group: ($F_{(1, 79)}$ = 4.39, p =.039, ηp^2 = *.053*)
I	14.93 (4.21)	13.89 (4.23)	Interaction: ($F_{(1, 79)}$ = 0.84, p =.362, ηp^2 = *.011*)
UI	5.76 (5.03)	3.54 (4.35)	
Negative Emotion			Group: ($F_{(1, 79)}$ = 11.27, p =*.001,* ηp^2 = *.125*)
I	5.39 (5.30)	2.71 (2.98)	Interaction: ($F_{(1, 79)}$ = 0.19, p =*.664,* ηp^2 = *.002*)
UI	4.65 (4.93)	1.57 (3.09)	
Link to Self			Group: ($F_{(1, 79)}$ = 14.61, p <*.001*, ηp^2 = *.156*)
I	12.87 (5.92)	9.03 (5.16)	Interaction: ($F_{(1, 79)}$ = 1.11, p = *.296*, ηp^2 = *.014*)
UI	4.00 (4.28)	1.63 (2.97)	
Damage			Group: (($F_{(1, 79)}$ = 3.822, p =.054, ηp^2 = *.046*)
I	3.85 (4.23)	3.34 (3.49)	Interaction: ($F_{(1, 79)}$ = 1.83, p =.180, ηp^2 = *.023*)
UI	4.59 (4.96)	2.34 (3.92)	
Memories			Group: ($F_{(1, 79)}$ = 4.19, p =.044, ηp^2 = *.050*)
I	11.89 (6.82)	10.34 (5.26)	Interaction: ($F_{(1, 79)}$ = 0.19, p =.668, ηp^2 = *.002*)
UI	5.83 (5.15)	3.57 (4.16)	
Link to Past Self			Group: ($F_{(1, 79)}$ = 17.13, p < . 001, ηp^2 = *.178*)
I	11.19 (7.08)	7.46 (5.29)	Interaction: ($F_{(1, 79)}$ = 0.18, p =.670, ηp^2 = *.002*)

UI	5.98 (5.69)	1.57 (2.93)	
Link to Future Self			Group: ($F_{(1, 79)}$ = 11.34, p =. 001, ηp^2 = *.125*)
I	10.15 (6.81)	6.66 (5.80)	Interaction: ($F_{(1, 79)}$ = 0.12, p =.725, ηp^2 = *.002*)
UI	4.09 (4.80)	1.09 (2.41)	
Usefulness to Others			Group: ($F_{(1, 79)}$ = 0.90, p =*.765,* ηp^2 = *.001*)
I	7.98 (5.38)	7.54 (5.59)	Interaction: ($F_{(1, 79)}$ = 0.93, p =*.338,* ηp^2 = *.012*)
UI	8.35 (5.94)	9.37 (5.04)	
Current Use to Self			Group: ($F_{(1, 79)}$ = 0.730, p =.395, ηp^2 = *.009*)
I	12.26 (6.01)	11.89 (5.22)	Interaction: ($F_{(1, 79)}$ = 2.40, p =.125, ηp^2 = *.030*)
UI	6.37 (5.20)	8.40 (5.60)	
Future Use to Self			Group: ($F_{(1, 79)}$ = .066, p =*.797,* ηp^2 = *.001*)
I	12.76 (5.59)	11.54 (5.48)	Interaction: ($F_{(1, 79)}$ = 3.42, p =*.068,* ηp^2 = *.042*)
UI	7.33 (5.51)	9.03 (5.23)	
Practicality			Group: ($F_{(1, 79)}$ = 15.12, p = < . 001, ηp^2 = *.161*)
I	14.72 (5.50)	17.20 (3.72)	Interaction: ($F_{(1, 79)}$ = 2.41, p =.124, ηp^2 = *.030*)
UI	7.43 (6.43)	12.31 (5.41)	
Aesthetics			Group: ($F_{(1, 79)}$ = 0.07, p =.789, ηp^2 = *.001*)

I	13.54 (5.12)	13.23 (4.95)	Interaction: ($F_{(1, 79)} = 0.69$, $p = .407$, $\eta p^2 = .009$)
UI	6.69 (4.93)	7.49 (4.67)	
Achievement			Group: ($F_{(1, 79)} = 11.27$, $p = .001$, $\eta p^2 = .125$)
I	11.57 (5.91)	8.66 (6.05)	Interaction: ($F_{(1, 79)} = 0.03$, $p = .873$, $\eta p^2 = .000$)
UI	4.48 (4.72)	1.34 (3.01)	

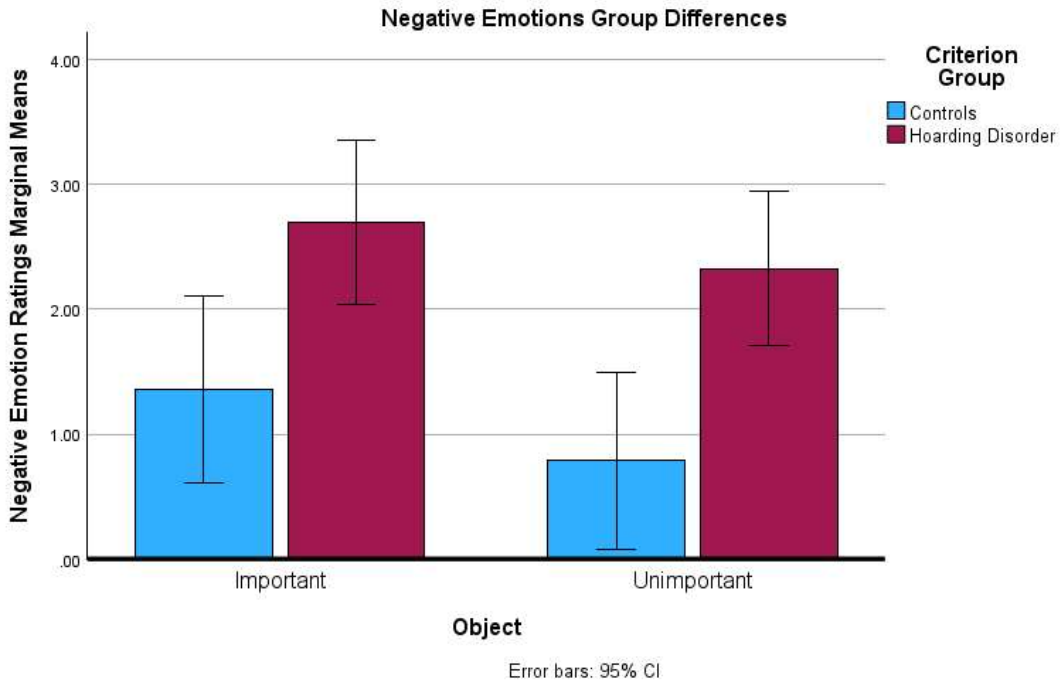
Important and Unimportant object scores are an average of the two important and two unimportant items, therefore maximum score possible is 20.

I = Important, UI = Unimportant

Negative Emotions

A mixed model ANOVA found there was a significant main effect of object on reported negative emotions ($F_{(1, 79)} = 4.12$, $p < .046$), and significant difference between groups ($F_{(1, 79)} = 11.27$, $p = .001$) (see Figure 6). Contrary to hypothesis the interaction between negative emotion and group was not significant ($F_{(1, 79)} = .190$, $p = .664$). This indicates that the type of object and group impacted the negative emotions ratings. However the pattern of scores were similar across the objects for both groups.

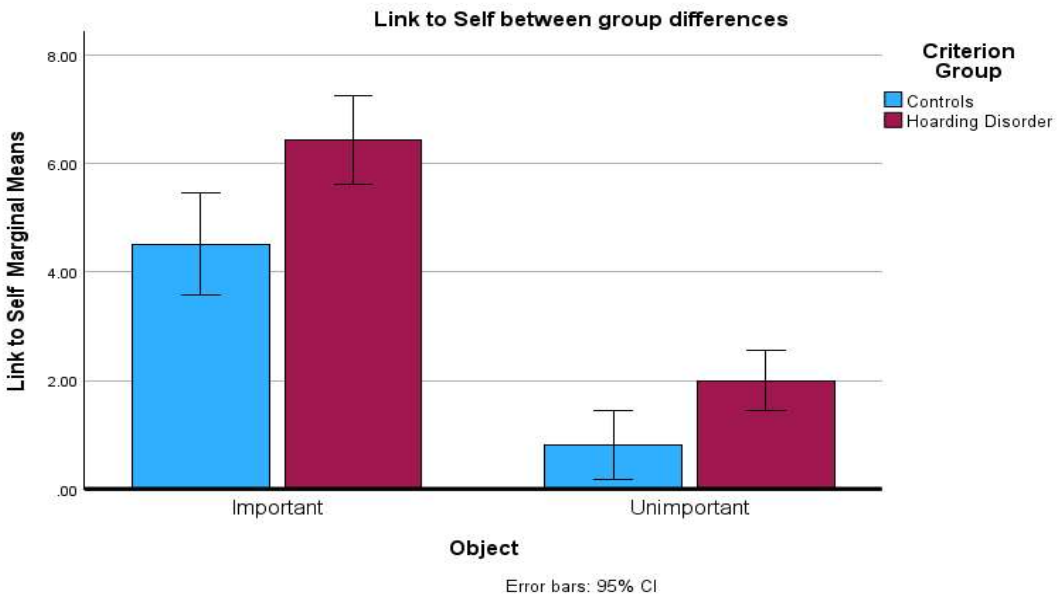
Figure 7: Group Marginal Means for Negative Emotions



Self-Identity

A mixed model ANOVA found a significant main effect of object on the reported links to self ($F_{(1, 79)} = 135.40$, $p < .001$), and significant effect of group ($F_{(1, 79)} = 14.61$, $p < .001$) (See Figure 7). Contrary to hypothesis the interaction between link to self and group was not significant ($F_{(1, 79)} = 1.11$, $p = .296$). This indicates that the type of object and group effected the link to self ratings. However the pattern of scores were similar across the objects for both groups.

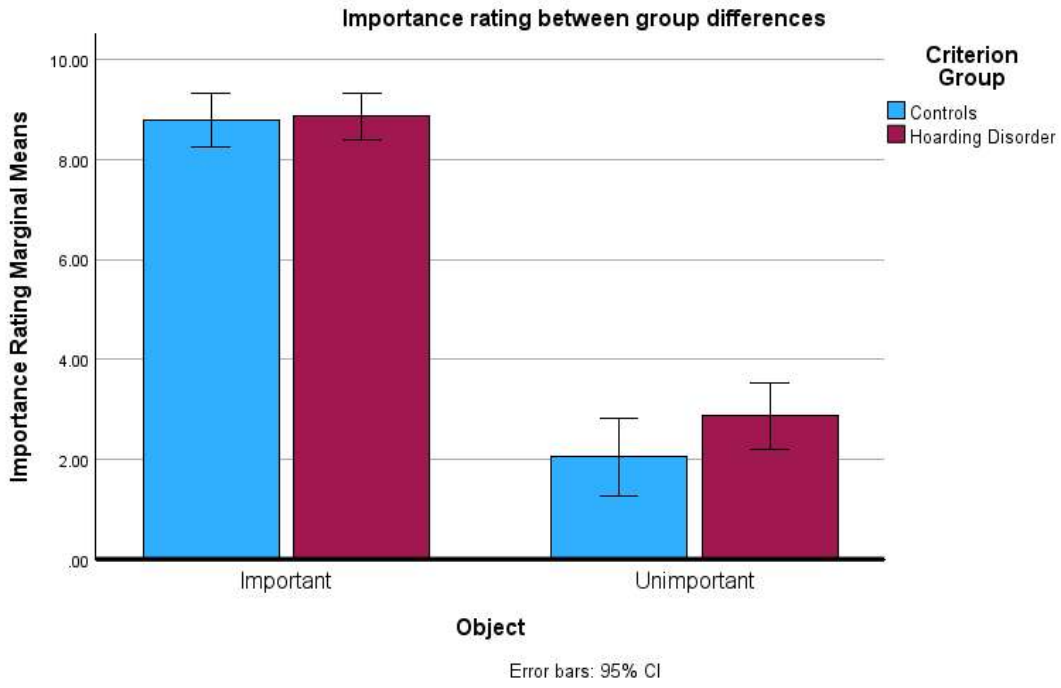
Figure 8: Group Marginal Means for Link to Self



Importance

A mixed model ANOVA found a significant main effect of object ($F_{(1, 79)} = 461.60$, $p < .001$). There was no significant effect of group ($F_{(1, 79)} = 1.91$, $p = .171$) or interaction between object x group ($F_{(1, 79)} = 1.62$, $p = .207$). Paired samples t-test showed a significant difference in important / unimportant objects in terms of subjective importance rating for both HD ($t_{(45)} = 14.33$, $p < .001$) and NCCC ($t_{(34)} = 16.89$, $p < .001$). Important objects scored significantly higher than unimportant objects on subjective importance ratings (<.001).

Figure 9: Group marginal means for Importance



Secondary Outcomes

There was a significant main effect of objects ($F_{(1, 79)} = 234.14$, $p < .001$) and group ($F_{(1, 79)} = 4.39$, $p = .039$) for the positive emotion's quality. There was also a main effect of objects ($F_{(1, 79)} = 61.42$, $p < .001$) and groups ($F_{(1, 79)} = 4.19$, $p = .044$) for the memories quality. Despite this there were no interactions between object x group for memories ($F_{(1, 79)} = .186$, $p = .668$) and positive emotions ($F_{(1, 79)} = .840$, $p = .362$). This indicating that the type of object and group effected the positive emotions and memories ratings. However the pattern of ratings was similar across ratings for both groups.

Test retest of Quality of Objects Questionnaire

There were 30 participants who agreed to repeat the QoOQ after a week. Two were excluded due to having different items and missing data for an object. In total 29 were included for important objects and 28 included for unimportant objects. Analyses were completed using

Intraclass Correlation Coefficient (ICC) for the four objects. The ICC's ranged from .557 to .734 which indicated there was moderate consistency in ratings over a week period.

Experimental task

Table 16: Experimental Task Outcomes

	HD (n=45)		**NCCC (n=35)**		
	Mean	**SD**	**Mean**	**SD**	
Experimental Task Outcomes					Main effect
Vividness					Group: ($F_{(1, 78)} = 0.79$, $p = .376$, $\eta p^2 = .010$)
I	18.24	1.83	17.69	2.15	Interaction: ($F_{(1, 78)} = 0.54$, $p = .465$, $\eta p^2 = .007$)
UI	16.76	3.14	16.54	2.78	
Distress					Group: ($F_{(1, 78)} = 25.42$, $p < .001$, $\eta p^2 = .246$)
I	16.00	4.40	12.63	5.06	Interaction: ($F_{(1, 78)} = 0.26$, $p = .609$, $\eta p^2 = .003$)
UI	6.18	5.89	1.94	2.59	
Anxiety					Group: ($F_{(1, 78)} = 34.33$, $p < .001$, $\eta p^2 = .306$)
I	16.54	3.52	12.97	4.18	Interaction: ($F_{(1, 78)} = 1.00$, $p = .320$, $\eta p^2 = .013$)
UI	7.38	5.51	2.49	3.04	
Sadness					Group: ($F_{(1, 78)} = 19.37$, $p = < .001$, $\eta p^2 = .199$)
I	16.67	3.30	14.94	3.32	Interaction: ($F_{(1, 78)} = 3.37$, $p = .070$, $\eta p^2 = .041$)
UI	7.18	5.19	3.14	3.58	

Important and Unimportant object scores are an average of the two important and two unimportant items, therefore maximum score possible is 20.

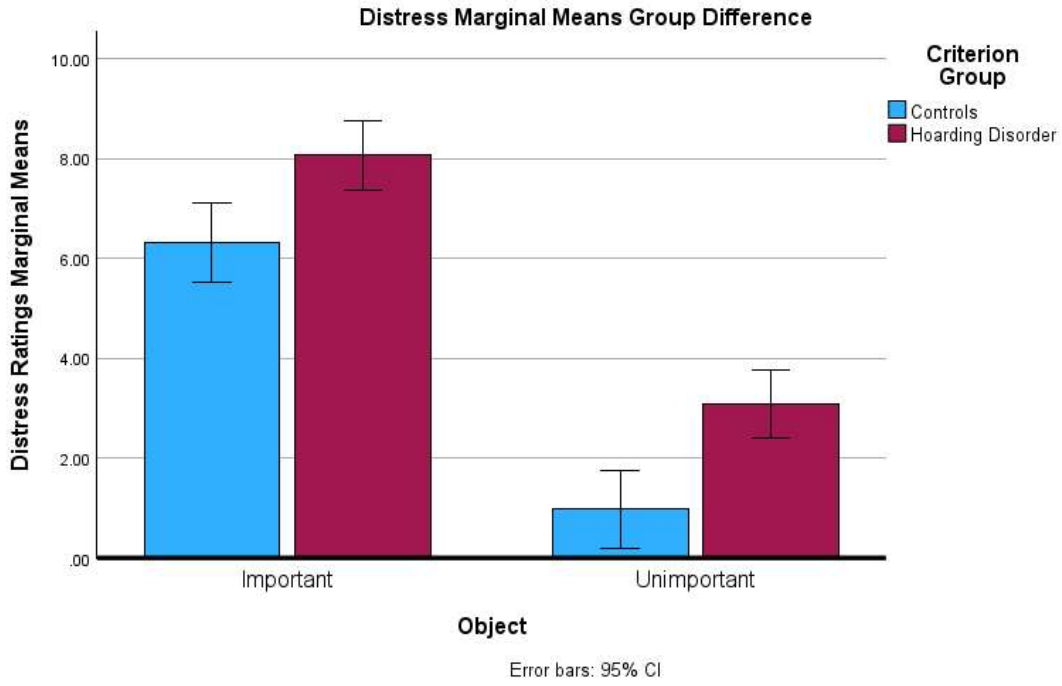
I = Important
UI = Unimportant

Primary Outcomes:

Distress

A mixed model ANOVA found there was a significant main effect of object on distress reported ($F_{(1, 78)} = 211.23$, $p < .001$). There was also a significant main effect of group ($F_{(1, 78)} = 25.42$, $p < .001$) (see Figure 5). Contrary to hypothesis, the interaction between group and distress was not significant ($F_{(1, 78)} = 0.26$, $p = .61$). This indicating that the object type and the group significantly effected the ratings of distress when considering the loss of the objects. The pattern of scores across the items was similar for both groups.

Figure 10: Group Marginal Means for Distress



Secondary Outcomes

Mixed model ANOVA's found no significant interactions between any of the experimental outcomes and group. There was a significant effect of object ($F_{(1, 78)} = 263.29$, p

<.001) and group ($F_{(1, 78)} = 34.33$, $p < .001$), but no modifying interaction ($F_{(1, 78)} = 1.00$, $p = 0.320$) for anxiety when imagining loss of the objects. This indicates that the type of object and group effected the anxiety rated during the task. The pattern of scores was similar for both groups, and therefore not a HD specific pattern.

Exploratory Analysis

A hierarchical linear regression was used to investigate the extent to which Model 1: (PHQ-8, GAD-7, SIR discarding), Model 2: (Link to Self) and Model 3: (Group) could explain the variance in the important object distress. The first model was significant ($F_{(3, 77)} = 6.19$, $p < .001$) with it accounting for 19.4% of the variance (R^2 change = .194). The addition of Model 2 (R^2 change = .027, $p = .112$) and Model 3 (R^2 change = .021, $p = .150$) did not significantly add to the variance. The only significant individual predictor of distress in the final model was the SIR discarding score ($\beta = .64$, $p = .017$). Overall, these factors explained 24.2% of the variance in distress.

A second hierarchical linear regression was used to investigate the extent to which Model 1: (PHQ-8, GAD-7, SIR discarding), Model 2: (ERC Avoidance / Anxiety) and Model 3: (Group) could explain the variance in the important object distress. The first model was significant ($F_{(3, 77)} = 6.19$, $p < .001$) with it accounting for 19.4% of the variance (R^2 change = .194). The addition of Model 2 (R^2 change = .006, $p = .770$) and Model 3 (R^2 change = .026, $p = .121$) did not significantly add to the variance. The only significant individual predictor of distress in the final model was the SIR discarding score ($\beta = .75$, $p < .004$). Overall, these factors explained 16.3% of the variance in distress.

Discussion

The study hypothesised that individuals with HD would rate their possessions higher than NCCCs on qualities such as negative emotions and extension to self. The study found that the importance of the object influenced the ratings of negative emotions and link to self, and that

overall individuals with HD scored higher. However, there was no evidence of interaction between the object type and group, which indicated it wasn't a HD specific pattern.

The second hypothesis was that the difference in ratings of subjective importance would be less for HD participants and greater for NCCCs across the important and unimportant objects. This study found that there was a significant effect of object, however there wasn't a significant difference between groups in the subjective ratings of importance. There was no evidence of interaction between the object type and group, which indicated the pattern of subjective importance responses across objects was not HD specific. Important objects were rated significantly higher on subjective importance than unimportant objects in both groups.

The final hypothesis was that individuals with HD would experience greater and more similar distress than NCCC across their important / unimportant objects. It was found that the importance of the object influenced the distress ratings, and overall, those with HD reported higher distress ratings. However, there was no interaction between the object type and group, which indicated the pattern of distress responses were not unique to the HD group.

Previous research examining emotional attachment to objects has found that this can be associated with a number of factors including links to self, emotions and memories (Burgess et al., 2018; Frost et al., 1995; Mulligan-Rabbitt et al., 2023; Nedelisky & Steele, 2009). The present study's findings were consistent with this prior research, in that HD participants scored higher than NCCC in terms of links to negative emotions, positive emotions, memories and self. Surprisingly the pattern of responses across more or less important objects did not differ between groups.

The study required individuals to identify important and unimportant objects. The choice of identifying these objects is very subjective and would largely depend on what they think makes something important or unimportant. Due to this it is possible that they are tapping into different components of what makes something important. There was quite a variety in the

objects chosen, but their a large proportion of individuals who identified their phone or laptop as their important objects. This typically wasn't because of the item itself, but rather what they contained. It is possible that this was a consequence of having a younger NCC group where technology might be more present but also highlight an emergence of digital hoarding which has been identified in recent years (Bravo-Adasme et al., 2026).

Limitations:

A limitation of this study was that it used a convenience sample. This resulted in there being significant differences in age between the two groups. As a result, direct comparisons between the two groups should be done considered in this context. It is possible that this age difference impacted the objects individuals chose and explains why so many of the NCCC group chose mobiles / laptops as their important objects. The convenience sample also means that it is likely not a full representation of the HD population, and therefore it may not be generalisable to the whole population. Despite this, efforts were made to ensure the HD sample met diagnostic criteria for HD through the use of the SCID, and 15% were jointly rated to ensure consistency in administration.

This study also utilised visual imagery which some participants struggled with. Therefore, adaptions were made to make it accessible (e.g. adding auditory, tactile imagery, utilising memories and ensuring objects are present). Despite difficulties in imagery arising there wasn't significant differences between the HD and NCCC groups' scores on the SUIS.

There could have been some influence of order effects. However, these were mitigated by randomising object presentation.

Clinical implications:

There are a few direct clinical implications of the study here. The most obvious is seeking to better understand factors driving the overall elevation of importance of objects and the distress anticipated in relation to their loss as part of assessment. The QoOQ could be a

helpful tool to use clinically for understanding an individual's emotional attachment. It could help assess which qualities are present in an individual's hoard and inform areas to target during intervention.

Research implications:

Clinical observation contradicts the findings in terms of distress in relation to loss of unimportant objects in that individuals with HD can become very distressed when considering getting rid of items that others would consider unimportant (e.g. rubbish). It's possible that the level of distress would have been different if they were considering having to get rid of important and unimportant objects themselves rather than imagining the loss of the item.

Some individuals with HD described feeling relieved during the experimental task when considering their items being 'gone'. This seemed to be because it meant they didn't need to consider what to get rid of. The regression also highlighted that the only significant factor for important object distress was the SRI discarding score. Therefore, it's possible that discarding could cause more distress because they are in control about what too discard. Therefore, future research would benefit from repeating the study but change the imagery task to explore the individual discarding of the items.

During the study some participants reported that they struggled to identify all the required items. This was particularly present for the unimportant objects, and this was more difficult for the HD group. Some HD participants did highlight how all their items were important. It's possible that for the HD group it would be more beneficial to consider two objects that would be easy to discard and two objects that would be hard to discard instead. This could be done using imagery like this study, however future research could also go one step further and use

virtual reality or real-life objects instead to see if the findings can be further replicated *in vivo*.

Additionally future research could add items to the current quality questionnaire that relate to anthropomorphism, bereavement, trauma and neurodivergence to see whether these additional factors can account for the variance in the distress identified for important objects. It would also be beneficial to conduct further analyses (e.g. factor analysis) to establish if there are any relationships between the qualities or whether they can be grouped into a larger overarching qualities.

Conclusion:

The study found that HD individuals scored higher on several qualities (e.g. positive / negative emotion, memory and link to self) relative to NCCC's, that HD individuals were able to distinguish items in terms of their importance and experienced more distress than NCCC's when considering the loss of their important / unimportant objects. The research was carried out primarily to evaluate the hypothesis that individuals with HD would respond to important and unimportant objects in a similar way, while controls would discriminate in terms of the object characteristics and the response to the idea of losing them. Had this been so, then helping those with HD to better categorise and differentiate the characteristics of their possessions would be an avenue for treatment as has been suggested in the clinical literature. The present results suggest that this is not likely to be helpful.

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EXECUTIVE SUMMARY

Why has this research been conducted: Hoarding Disorder (HD) is a condition that has been receiving growing attention in the UK. There has been a lot of research trying to understand what contributes to people developing the condition and what keeps it going. The Cognitive Behavioural approach is the main form of treatment and understanding for HD. Previous studies have shown that CBT can result in moderate reductions in HD symptoms, but many people continue to have significant symptoms after CBT. Another criticism of this approach is that it struggles to explain why people with HD form such strong emotional attachments to their possessions.

Attachment Theory has been helpful in trying to understand this emotional attachment to objects. It suggests that the emotional attachment forms because people didn't have their emotional needs met as a child. They therefore used objects to try and meet these needs. Previous studies have found that there are different mechanisms that can influence a person's emotional attachment including negative emotions / memories, items being linked to a person's identity and certain beliefs about the object.

Despite studies looking at the items hoarded and mechanisms behind their emotional attachment there hasn't been any research exploring the role of importance and how this impacts hoarding symptoms. Importance here is defined as the subjective rating of importance. Therefore, we aimed to explore important and unimportant possessions of HD and those without HD to see if there were differences in ratings of importance and other object qualities (e.g. negative emotions and link to self). We also aimed to explore how the importance of an object impacts the distress of losing possessions.

What the research involved: It involved creating a questionnaire which asked participants to rate two important and two unimportant objects on different qualities. People with HD

(n=46) and without (n=35) completed self-report questionnaires looking at mental health symptoms, hoarding symptoms, relationships and the object qualities questionnaire. They then completed an experimental task where they had to imagine permanently losing their important / unimportant objects with a view to comparing these; we expected that those with HD would score higher and there would be less of a difference in HD relative to controls.

The participants were all over the age of 18, spoke English and lived in the UK. People who self-identified as having HD difficulties completed a short phone call to establish if they met diagnostic criteria for HD. In the event they didn't they were excluded. Other exclusions included not answering specific questions correctly, being unable to consent and self-reporting memory problems or learning disabilities.

What the research found: As expected people with HD scored significantly higher than those without HD on qualities such as negative emotions, positive emotions and link with self. They were also able to identify how important an object is, and important objects scored significantly higher than unimportant objects. People with HD reported more distress than those without HD when considering the loss of their important / unimportant objects. However, the patterns in the ratings were similar in both HD and the NCCC group, indicating it wasn't a unique finding to people with HD.

The Qualities of Objects Questionnaire was found to be moderately consistent when retaken after a week.

Conclusion: People with HD score higher than NCCC on several qualities (e.g. positive / negative emotion, memory and link to self). People with HD were able to distinguish items in terms of their importance and experienced more distress than NCCC when considering the loss of their objects. The findings suggest that object importance is relevant to the experience

of HD, but it likely isn't a mechanism that specifically influences people with HD, and that it generally can influence levels of distress when considering loss of possessions.

CONNECTING NARRATIVE

This connective narrative highlights the reflective process undergone during the completion of the three projects that make up this thesis. I was very fortunate that my three projects reflect several of my areas of interest within clinical psychology – learning disabilities, homelessness and hoarding. The projects are vastly different from one another; however, what they have in common is that they are all underpinned by various psychological theories, and they demonstrate how these theories can be applied in practice to inform treatments and improve the care experienced by these vulnerable populations.

Systematic Review of the Literature:

The systematic review was conducted looking at an intervention called Intensive Interaction. I found myself surprised that despite the growing interest in the approach I hadn't encountered it when I worked in a community LD team. This made me reflect on the clients I worked with as part of the community LD team, and how the therapeutic and psychological interventions available for individuals with more severe and profound LD can often be very limited. Therefore, learning about this approach was very exciting.

The project evolved quickly from its original conception as it became increasingly clear that several reviews had looked at Intensive Interaction with specific populations (e.g. LD and ASD). However, through discussions with the research team and scoping the literature it became evident this approach was used and had been adapted for other populations (e.g. dementia). This was exciting as there had been no attempts to pull these evidence bases together at the time. Therefore, the original idea became broader and more aimed to explore the literature across these populations.

It was exciting to see a range of high-quality studies being conducted in this area. It was our hope to highlight how this approach can help these clients and the staff / family that support them. It was also helpful to reflect with the research team on the implementation barriers identified in the literature, and how these were consistent with their experiences in practice. We hope that the review can help to promote the approach, enhance its implementation and offer ways to address the barriers in the field.

Service Improvement Project

This project was developed to explore the impact of restorative practice staff training in an Oxford homelessness hostel. At the beginning I had very limited awareness of restorative approaches. It was a great privilege to meet a range of stakeholders who were passionate about helping this very vulnerable group. I was grateful to have their support throughout the project and having them to help problem solve challenges in the project that arose as it progressed.

I was very anxious at the start particularly when it came to data collection. Despite having worked with individuals who were homeless in the community I didn't have any experience of working in homeless services. I found that I was drawing on a lot of skills that I would in therapy and assessment to build strong rapports with the staff, management and the wider stakeholders. This aided engagement and I believe helped staff to be transparent about their experiences.

I think my skills as a researcher grew throughout this project. As the project progressed, I was less passive as a researcher and valued the support of L.E.A.F about how to engage this population in research. I completed the questionnaires with them, asked further questions and really tried to understand what was going on for these residents. Many of the challenges in

implementing the approach also impacted data collection (e.g. lack of space, bedbugs, scabies, lack of staffing) and these were interesting and unique challenges to navigate.

Theory Driven Research Project

I was keen to do a research project in hoarding due to past experiences I have had in my pre-qualification roles. I was fascinated by an individual who had animal hoarding and keen to contribute to the field of hoarding and help inform support and treatment. I have felt out of my depth on multiple occasions during this project primarily due to my lack of significant research experience. I really enjoyed the process of designing the questionnaire and the study. It was a great privilege to work with individuals who had hoarding to help develop my measure and learn about the experiences of this population.

I think this project highlighted to me just how important rapport and relationships are in research. Alot of the HD participants described experiences of being criticised, ridiculed and shamed. As a result, they were often nervous about participating. Despite this I was able to build good rapports with the individuals I met, and we received feedback on multiple occasions that they had found the process helpful and some even asked if we could work with them after. It means a lot to me knowing that they had such a positive experience participating in my study.

The relationships I formed with other agencies were also pivotal to the success of this project. This client group was hard to access and for quite some time progress was slow. It was only through working with charities and meeting people who worked closely with these individuals that we were able to build a positive reputation and engage this population. It highlighted to me just how much great work is being done for this population, but also how there is still so much need and lack of understanding. There is still a lot to explore, but I hope that the work myself and FD have done helps contribute to better services and understanding.

Summary:

The three projects together are a culmination of my journey and the work it has taken to get through this course. I believe I have come a long way from where I started and grown hugely doing these projects. I have loved working with a range of passionate individuals and charities, and I am looking forward to seeing how I can further utilise these skills in my qualified career.

Acknowledgements

I want to thank all the services, charities and people who made this research happen. It was a privilege to meet and work with you all and being able to learn about the work you do, and the experiences you have had.

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A huge thanks goes out to Faye Denham who I joint worked with during my TDRP. The decision was made early on that to reduce the burden on participants we would joint work for elements of our study. I was hugely grateful for her support, drive, encouragement and attention to detail during project administration (e.g. ethics applications) recruitment and data collection. I don't know how I would have ever managed this project without your support, and I am very grateful to have worked alongside you.

I want to say a huge thank you to my wife and my two beautiful children. I could not have got to the doctorate or through the doctorate without your unwavering love, support and encouragement. I am eternally grateful to my wife and children for being a constant source of enrichment, joy, support and silliness who have reminded me all the way through what's important and who I am doing all this hard work for. I can't wait to celebrate in Disney at the end of the course.

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would like to thank my dad for giving me some well needed distractions and some great cinema trips during the course.

Appendices

SRL Appendices:

Appendix A: Journal of Applied Research in Intellectual Disabilities Author Guidelines

JARID Author Guidelines

Sections

1. Submission
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8. Post Publication
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1. SUBMISSION

Authors should kindly note that submission implies that the content has not been published or submitted for publication elsewhere except as a brief abstract in the proceedings of a scientific meeting or symposium.

Once the submission materials have been prepared in accordance with the Author Guidelines, new submissions should be made via the Research Exchange submission portal: https://authors.wiley.com/journal/JAR. Should your manuscript proceed to the revision stage, you will be directed to make your revisions via the same submission portal. You may check the status of your submission at anytime by logging in to authors.wiley.com and clicking the "My Submissions" button. For technical help with the submission system, please review our FAQs or contact submissionhelp@wiley.com.

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Education and Developmental journals simplifies and speeds up the publication process, helping authors find the right home for their research. At the Editors' judgement, suitable papers not accepted by one journal may be recommended for referral to another journal(s) in the network. Authors decide whether to accept the referral, with the option to transfer their paper with or without revisions. Once the referral is accepted, submission happens automatically, along with any previous reviewer reports, thereby relieving pressure on the peer review process. While a transfer does not guarantee acceptance, it is more likely to lead to a successful outcome for authors by helping them to find a route to publication quickly and easily.

2. AIMS AND SCOPE

JARID is an international, peer-reviewed journal which draws together findings derived from original applied research in intellectual disabilities. The journal is an important forum for the dissemination of ideas to promote valued lifestyles for people with intellectual disabilities. It reports on research from the UK and overseas by authors from all relevant professional disciplines. It is aimed at an international, multi-disciplinary readership.

In order for a paper to be considered for publication, it must be about people with intellectual disabilities. Manuscripts which focus upon autism will be considered only when the focus is also upon intellectual disabilities. Papers which focus upon autism and exclude people with intellectual disabilities will not be considered.

The topics it covers include community living, quality of life, challenging behaviour, communication, sexuality, medication, ageing, supported employment, family issues, mental health, physical health, autism, economic issues, social networks, staff stress, staff training, epidemiology and service provision.

Theoretical papers are also considered provided the implications for therapeutic action or enhancing quality of life are clear. Both quantitative and qualitative methodologies are welcomed. All original and review articles continue to undergo a rigorous, peer-refereeing process.

3. MANUSCRIPT CATEGORIES AND REQUIREMENTS

Original Articles, including Clinical Trials (see guidance within section 5), *Review Articles* and *Brief Reports* are accepted by the Journal. *Theoretical Papers* are also considered, provided the implications for therapeutic action or enhancing quality of life are clear. Both quantitative and qualitative methodologies are welcomed. Articles are accepted for publication only at the discretion of the Editor. Authors who are submitting original articles where qualitative methods have been used must ensure that their choice of method is well justified and issues relating to methodological rigor are effectively addressed.

Articles and *Theoretical Papers* should not exceed 6000 words;

Review Articles should not exceed 7000 words;

Brief Reports should not exceed 2000 words.

All word limits are inclusive of the abstract. References, Words in Tables, Captions/Legends, Figure and Figure captions/legends are excluded from the word limits.

Please note that papers submitted for Special Issues should also not exceed 6000 words.

4. PREPARING THE SUBMISSION

Use of Language

The language used to describe disability differs across countries, cultures and disciplinary fields, and continues to evolve. All manuscripts submitted to JARID must use language that promotes the value of all people as full members of our shared society. Pejorative language inclusive of euphemisms must not be used. For JARID this includes the use of older language that has been used to describe people with intellectual disabilities such as “retarded”, "special needs", "disease", “handicapped”, or “mentally handicapped”. Using any terms which are offensive, or patronising may lead to rejection of your submitted manuscript.

JARID recommends using person-first and/or identity-first language thoughtfully and appropriately. For example, the language used to describe both people with intellectual disabilities and autistic people has evolved based on recent advocacy efforts. When referring to people with autism, it is acceptable to use either identity-first language (e.g., “autistic people”) or person-first language (e.g., people with autism”), while identity-first language is not used to describe people with intellectual disabilities, where person-first language is preferred. Thus, people with intellectual disabilities should be referred to as people with intellectual disabilities.

We have consulted with over 40 self-advocates through Learning Disability England which included the North West Self-Advocacy Group, as well as Self-Advocacy Together and asked them what language we should use when writing about people with intellectual disabilities.

People with intellectual disabilities said that they do not like to be referred to by acronyms or abbreviations. Authors must therefore not use an abbreviation to describe intellectual disabilities such as “ID” or “LD”. Instead, use person-first language such as children, teenagers, adults, or people with intellectual disabilities, avoiding acronyms or abbreviations.

The terms “learning disabilities” and “learning difficulties”, though used in some countries to refer to people with intellectual disabilities, can cause confusion among readers. These terms are not used by the journal to refer to people with intellectual disabilities. Authors must only use the term “learning disabilities or difficulties” where this refers to a specific learning disability/disorder– such as a specific learning difficulty in reading, written expression or mathematics. If “learning disabilities” or “learning difficulties” are used, authors must not use an abbreviation.

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Abstract
All papers should have a structured abstract (maximum 150 words) as follows: Background, Method, Results, and Conclusions. The abstract should provide an outline of the research questions, the design, essential findings and main conclusions of the study. We kindly request that authors place the abstract and title at the beginning of the main manuscript document.

Lay Summary
Please provide 3 or 4 bullet points summarizing the main finding of your work, the impact of it for people with intellectual disabilities and for the research community.

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Acknowledgments
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9. EDITORIAL OFFICE CONTACT DETAILS

For queries about submissions, please contact the *JARID* Editorial Office.
jarid.office@wiley.com

Appendix B: Search Terms

The search terms were generated to identify studies related to Learning Disability, Autism, Dementia and Intensive Interaction or Adaptive Interaction. Terms were used that historically

described individuals who had intellectual disabilities. These were used to ensure breadth of search and are not endorsed by the author.

1. “menta* deficien*” OR “mental* handicap*” OR “mental* retard*” OR “mental* impair*” OR “mental* disab*” OR “mental* subnormal*” OR “learning disab*” OR “learning difficult*” OR “intellectual difficult*” OR “intellectual*disab*” OR “intellectual* impairm*” OR “developmental disabilit*” OR “Pervasive Developmental Disorder*” OR “ASD” OR “Neurodevelopmental Disorder*” OR “Asperger*” OR “autis*” OR “Preverbal” OR “Prelingual” OR “develop* dela*” OR “Nonverbal”
2. “Dementia” OR “Memory Disorder*” OR “Alzheimer*” OR “Lewy Body Disease” OR “Neurocognitive Disorder*”
3. “Intensive Interaction” OR “Adaptive Interaction”.

Appendix C: Questions on the Standard Quality Assessment Criteria & Mixed Methods Appraisal Tool.

SQAC Qualitative Appraisal Tool:

		2	1	0
1	Question / objective suffi ciently described?			
2	Study design evident and appropriate?			
3	Context for the study clear?			
4	Connection to a theoretical framework / wider body of knowledge?			
5	Sampling strategy described, relevant and justified?			

6	Data collection methods clearly described and systematic?			
7	Data analysis clearly described and systematic?			
8	Use of verifi cation procedure(s) to establish credibility?			
9	Conclusions supported by the results?			
10	Reflexivity of the account?			

SQAC Quantitative Appraisal Tool:

		2	1	0
1	Question / objective sufficiently described?			
2	Study design evident and appropriate?			
3	Method of subject/comparison group selection or source of information/input variables described and appropriate?			
4	Subject (and comparison group, if applicable)			

	characteristics sufficiently described?			
5	If interventional and random allocation was possible, was it described?			
6	If interventional and blinding of investigators was possible, was it reported?			
7	If interventional and blinding of subjects was possible, was it reported?			
8	Outcome and (if applicable) exposure measure(s) well defi ned and robust to measurement / misclassifi cation bias? Means of assessment reported?			
9	Sample size appropriate?			
10	Analytic methods described/justified and appropriate?			
11	Some estimate of variance is reported for the main results?			
12	Controlled for confounding?			
13	Results reported in sufficient detail?			
14	Conclusions supported by the results?			

MMAT Quality Appraisal Tool:

Category of study design	Methodological Quality Criteria	Yes	No	Can't Tell	Comments
Screening Questions (for all types)	S1. Are there clear research questions				
	S2. Do the collected data allow to address the research questions?				
	Further appraisal may not be feasible or appropriate when the answer is 'No' or 'Can't tell' to one or both screening questions.				
1. Qualitative	1.1. Is the qualitative approach appropriate to answer the research question?				
	1.2. Are the qualitative data collection methods adequate to address the research question?				
	1.3. Are the findings adequately				

	derived from the data?				
	1.4. Is the interpretation of results sufficiently substantiated by data?				
	1.5. . Is there coherence between qualitative data sources, collection, analysis and interpretation?				
2. Quantitative randomized controlled trials	2.1. . Is randomization appropriately performed?				
	2.2. Are the groups comparable at baseline?				
	2.3. Are there complete outcome data?				
	2.4. Are outcome assessors blinded to the intervention provided?				
	2.5. Did the participants adhere to the assigned intervention?				

3. Quantitative nonrandomized	3.1. Are the participants representative of the target population?				
	3.2. Are measurements appropriate regarding both the outcome and intervention (or exposure)?				
.	3.3. Are there complete outcome data?				
	3.4. Are the confounders accounted for in the design and analysis?				
	3.5. During the study period, is the intervention administered (or exposure occurred) as intended?				
4. Quantitative descriptive	4.1. . Is the sampling strategy relevant to address the research question?				
	4.2. Is the sample representative of the target population?				

	4.3. Are the measurements appropriate?				
	4.4. Is the risk of nonresponse bias low?				
	4.5. Is the statistical analysis appropriate to answer the research question?				
5. Mixed Methods	5.1. Is there an adequate rationale for using a mixed methods design to address the research question?				
	5.2. Are the different components of the study effectively integrated to answer the research question?				
	5.3. Are the outputs of the integration of qualitative and quantitative components adequately interpreted?				

	5.4. Are divergences and inconsistencies between quantitative and qualitative results adequately addressed?				
	5.5. Do the different components of the study adhere to the quality criteria of each tradition of the methods involved?				

Appendix D: Quality Agreement

MMAT:

Author	1.1	1.2	1.3	1.4	1.5	2.1	2.2	2.3	2.4	2.5	3.1	3.2	3.3	3.4	3.5	4.1	4.2	4.3	4.4	4.5	5.1	5.2	5.3	5.4	5.5	Quality Criteria Met
Clegg et al, (2018)	Y	Y	Y	Y	Y											Y	Y	Y	CT	Y	Y	N	CT	Y	Y	80%
Donnelly, Elsworth & McKim, (2015)	Y	Y	Y	Y	Y											Y	Y	Y	Y	Y	N	N	Y	Y	Y	88%
Ellis & Astell, (2017)	Y	Y	Y	Y	Y						CT	Y	Y	N	N						N	N	N	Y	CT	53%
Lloyd, (2015)	Y	Y	Y	Y	Y						Y	Y	Y	Y	N						N	Y	Y	Y	Y	87%
Mouriere & Scott-Roberts, (2017)	Y	Y	Y	Y	Y						N	Y	Y	Y	Y						N	Y	N	Y	Y	80%

Key: Y = Yes, N = N, CT = Can't Tell

KMET Quantitative:

Author (Year)	1	2	3	4	5	6	7	8	9	10	11	12	13	14	Summary Score	Quality Criteria Met
Tee & Reed, (2017)	2	2	2	2	N/A	N/A	N/A	2	1	2	2	2	2	2	1.4	91%

Key: 2=Yes, 1=Partial, 0=No

KMET Qualitative:

Author (Year)	1	2	3	4	5	6	7	8	9	10	Summary Score	Quality Criteria Met
Astell, Shoaran & Ellis, (2022)	2	2	1	2	1	2	2	2	2	0	0.8	70%
Berridge & Hutchinson, (2022)	2	2	2	2	2	1	2	2	2	2	0.95	90%
Heap & Wolverson, (2020)	2	2	2	2	1	2	2	2	2	0	0.85	80%
McKim & Samuel, (2021)	2	1	2	2	1	1	1	0	2	0	0.6	40%
Mouriere & Hewett, (2021)	2	2	2	2	1	2	1	0	2	0	0.7	60%
Nagra et al, (2017)	2	2	2	2	2	2	2	2	2	0	0.9	90%

Key: 2 = yes, 1=partial and 0= No

SIP Appendix

Appendix E: Housing, Support and Care Author Guidelines

Before you start

For queries relating to the status of your paper pre decision, please contact the Editor or Journal Editorial Office. For queries post acceptance, please contact the Supplier Project Manager. These details can be found in the Editorial Team section.

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Appendix F: Quality Approval Form / Confirmation Email

Title	Exploring the impact of adopting a Restorative Practice Approach in a homelessness hostel in Oxford		
Lead Unit	Oxford Institute of Clinical Psychology Training and Research	Other Units involved (ie where data is to be collected	Matilda House, Oxford
Name and Title of project lead(s)		Elliott House (Trainee Clinical Psychologist) Nicola Lane (Internal Supervisor)	
Contact telephone number		01865 226431	
Contact email address		Elliott.House@stx.ox.ac.uk Nicola.Lane@hmc.ox.ac.uk	
Named leads in other units		Thomas Douglas (Commissioning Officer) Rosie Chadwick (Chair of Trustees, The Mint House, Oxford Centre for Restorative Practice) Kate Hudson (Manager of Matilda House)	
Proposed start date		June 2024	
Proposed finish date		October 2025	
This project is a:			
☒ First audit/ quality improvement		☐ Re-audit/ quality improvement	

	If yes, date of last audit/ quality improvement _____
What is the resource implication for carrying out project	This will be carried out as part of DClinPsy Thesis

Reason for audit or evaluation (tick all that are applicable)			
☐ National priority	☐ Trust priority	☐ Course priority	☐ CCG priority
☐ NICE guidance	☒ Third sector organisation priority	☐ Other (please state)	

If NICE guidance, please state which guidelines:

Background to Project

This project will take place within Matilda House, a 37 bed Homelessness Hostel based in Oxford. The service is for individuals who are experiencing homelessness and is provided by A2Dominion a leading housing provider in the area. Matilda House provides a 24/7 service and in total has 15 staff that support these individuals who live here (Homeless Link).
The Oxfordshire Homelessness Alliance and Matilda House want to reduce eviction rates and number of serious incidents.

In 2023, introductory training in restorative practice (RP) was delivered by Mint House (Oxford's Centre for Restorative Practice) to the Lived Experience Advisory Forum (LEAF) group. This is a group who have lived experience of homelessness and are working to improve homeless pathways in Oxfordshire. The training was well-received, and it was felt that this approach could help prevent and resolve conflicts that could end up in eviction. It was therefore decided to conduct a pilot project in a specific housing setting which would be Matilda House. See Appendix 1 for outline of the planned pilot and expected timelines.

This Service Improvement Project will explore the impact of RP and the overall experiences of those going through Restorative Facilitation. The questionnaires regarding the impact and feedback will have questions about what could have been improved, what additional skills staff feel they need and what could have been better for the service users. The questionnaires will also enable us to capture data relating to staff confidence, perceptions of safety, staff / client's skills and relationships. The data from the questionnaires could be used to further improve the service and potentially make suggestions about other training or initiatives that could be considered in the future.

Standard(s) for audit or quality improvement

The project will fall in a PDSA Model of Improvement. This model has been utilised to develop the proposal and has been used to inform how we would address how to reduce evictions, abandonments, and staff absences at Matilda House. We will use this approach to study the changes of implementing a restorative practice

approach and from the data obtained make suggestions about further changes and adaptations that could be made to either to the restorative facilitation or wider adoption of the restorative practice approach.

Scope and Methodology for Project

Relevant Literature

Homelessness is a complex and increasingly prevalent worldwide problem. National guidelines have defined a person as experiencing homelessness if they are 16 years and older, rough sleeping, residing in temporary accommodation (e.g. hostels / B&Bs), accessing homeless centres, staying with others / sofa surfing, squatting, recently became homeless or had a history of homelessness (NICE, 2022).

The charity 'Shelter' identified that 271,421 people were homeless on a nightly basis in 2022. This consisted of approximately 250,094 in some form of temporary accommodation, 2,440 sleeping rough, 15,329 in homeless shelters / hostels and 3,558 in social service provided accommodation. The research identified that in Oxford there were 227 people homeless on a given night in 2022 (Shelter, 2023).

There has been a growing presence of hostels since the beginning of the 19th century (Busch-Geertsema & Sahlin, 2007). These environments provide support to a wide range of individuals including those who are rough sleeping or have only temporarily lost their housing (Edgar & Meert, 2005). They aim to help individuals recover, become independent, facilitate hope, and ultimately end a person's homelessness (Aspinall, 2023). These environments are challenging because the individuals that often get referred have histories of trauma, mental health problems, substance use and at times forensic histories (Aspinall, 2023). Staff can experience aggressive / chaotic behaviour, hear the traumatic experiences of service users, and also have to support individuals who are very wary / untrusting due to their experiences (Aspinall, 2023; Meddings, 1996). Staff can experience burnout, frustration, and vicarious trauma, which can contribute to high turnover (Ferris et al., 2016; Figley, 1995; Robinson, 2014). Hostel users can also report negative experiences in these settings such as not being heard, being treated like a child and unprofessional staff conduct (Stevenson, 2014). Due to these negative experiences, there has been growing recognition that homelessness hostels need to move towards adopting approaches are trauma and psychologically informed and focus on wellbeing (Fulfilling Lives & Impact Initiatives, 2019).

An approach that that has been utilised to reduce the risk of conflict, repair harm and build therapeutic environments is Restorative Practice (RP). RP has been used in a range of settings including schools, hospitals, children services and more recently homelessness services (Rainer et al., 2023; Restorative Justice Council, 2016; Fulfilling Lives & Impact Initiatives, 2019). The current literature in homelessness services has shown RP's reduce incidents, evictions, call outs, abandonments and staff resignations (Douglas, 2018; Fulfilling Lives & Impact Initiatives, 2019). The approach is underpinned by a variety of psychological theories including Attachment Theory, Social Learning Theory and Affect Script Psychology (Hopkins, 2009; Kelly &

Thorsborne, 2014). The Affect Script Psychology theory indicates that RP's work because there is an emphasis on separating the person from their behaviour and recognising that a person's harmful behaviour will likely stem from having been harmed themselves. It also consists of methods that recognise and address a person's shame, which can help them move towards repairing the harm caused (Kelly & Thorsborne, 2014).

Method

Procedure:

- Quantitative data in relation to evictions, serious incidents, abandonments, and staff resignations are currently collected and recorded by the service. These figures will be analysed for 6 months prior to commencement of training (Oct 2023), at 6 months post practitioner training (December 2024) and at 11 months post practitioner training (May 2025).

The participants will be primarily reached virtually. The manager will publicise the SIP to staff. Staff will contact the trainee directly with their consent. The trainee will send an identifier code and a link to access the required questionnaire pack. If there are difficulties with this method of recruitment then paper copies will be made available to staff to be completed in person.

In terms of accessing the residents, staff will be asked to go through the participant information sheet with residents in there 1:1's. If following this, they consent to participating the staff can send the completed form to me via email and a link can be given to them so they can access the relevant questionnaire packs with the resident. If there is a preference to have a paper copy, then staff can support them to complete the forms and send it back to me in the pre-paid envelope. The trainee is aware that potentially they might be required to meet the residents in person to improve uptake and completion rates, and this is something that will be supported by service manager and the research team.

In terms of the procedure for the restorative facilitation process feedback the external agencies will inform the trainee of individuals who have completed this process. The trainee will then provide them with information and consent forms. Again, following receiving consent forms, the trainee will then send them a link to the relevant feedback forms. If paper copies are preferred these could be given to them and they can send them back in pre-paid envelopes. In terms of the clients, the trainee can send their link to a member of staff once they have consented, and the staff can support them in filling the forms in. Alternatively paper copies can be given and sent back using pre-paid envelopes or they researcher could complete the forms in person to aid uptake and completion.

Questionnaire Development:

- Consultation / PPI with L.E.A.F to develop the client questionnaire exploring experiences of adopting RP / Feedback on going through RP Process.

- Consultation / PPI with Matilda House Manager, External Supervisor and Rough Sleeping team to develop the staff experiences of adopting RP / Feedback on going through RP Process.

- PPI will be included in the research budget at £15 per hour. It will require approximately four slots that are three hours long. 2 for questionnaire development and piloting with L.E.A.F and 2 with staff consultation for questionnaire development and piloting.

- Questionnaires will be piloted to ensure they are collecting the data required.

- There will be in total 6 questionnaires, 1 for demographic information, 2 for staff and clients perspective on the impact of RA practices, 1 will be the Restorative Justice

Attitudes Scale and 2 will be for staff and client feedback at the end of restorative facilitation. More details will be in Appendix 2.

Recruitment:

- We will seek to recruit 15 staff to complete the demongraphic questionnaire, RJA scale and Questionnaire relating to impact of Restorative Practice

- We will see to recruit 37 Residents to complete the questionnaire relating to impact of Resporative Practice.
-
- We will recruit an additional small number of Restorative Practitioners (Staff & L.E.A.F) and Residents who have been through a Restorative Facilitation Process to obtain their feedback. Numbers are uncertain due to it being dependent on how many cases are suitable for Restorative Facilitation.

- Each person who participates in the study will be assigned a code to try and ensure we are capturing the same persons experience when we repeat the questionnaires.

Inclusion criteria:

· Employed or Reside at Matilda House

· L.E.A.F Restorative Practitioners

· Speak English

· Able to provide consent and have capacity.

How are you going to collect the data (tick all that are applicable)

☐ Case notes (paper/ electronic)	☐ Observations	☒ Patient/ Staff Survey	☒ Other (please state) service data r.e. evictions, abandonments, staff leaving.

Data Protection Act

Please tick to confirm "yes" you will comply with:

☒ All data collected will be anonymised (specify when and how here)

Each participant will be assigned a code following them completing a consent form / reading participant information. This code will enable us to track a person's experience throughout the project. A password protected linkage spreadsheet will be used to separate the personal data from the research data. The linkage spreadsheet will hold the identifier code and the questionnaire data. A separate document will hold personally identifiable data and again will be password protected.

In terms of data storage, the questionnaires and consent forms will be stored on a password protected encrypted University of Oxford laptop where the data can only be accessed through a University network. Any hard copies will be stored in a locked filing cabinet to maintain safety of the records.

☒ No patient or staff identifiable data will be reported

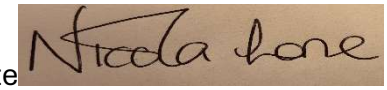
Ethics Screening	
Gather any information about a patient beyond that collected in routine patient care ☒ Yes ☐ No	
Pose any risk for or burden on a patient beyond those of his/her routine patient care ☒ Yes ☐ No	
Infringe on any patient's rights ☐ Yes ☒ No	
Risk breaching any patient's confidentiality or privacy ☐ Yes ☒ No	
Involve the use of any untested clinical or systems intervention ☐ Yes ☒ No	
Do you intend to publish the findings? ☒ Yes ☐ No	
Requested Support from the Course Team	
Matthew Hotton	

Trainee and Supervisor:

Indicate here why this form is being used, and which other avenues were explored by the investigators.

I was advised by Matthew that this form needed to be completed due to my SIP being conducted in a homelessness hostel in Oxford and therefore a non-NHS agency.

Trainee Signature and Date: E.House; 23/05/2024

Lead Supervisor Signature and Date  23/5/24

Course Review Group (Service Improvement Projects)

Myra Cooper, Louise Johns, Neil Carrigan, Alasdair Churchard, Matt Hotton, Paul Salkovskis

Comments:

No numbers for recruitment are mentioned.

How will participants (service users) be approached?

How will data be collected and where will data be stored? Data is pseudonymised so some confidential data (patient identifier) needs to be kept separately.

Given the planned completion of survey and questionnaire measures the additional burden beyond routine care box should be checked.

Approved ☐

Approved subject to amendments in comments ☒

Not approved ☐

Name of Reviewer One:.....Fiona Challacombe.....

Signature - Reviewer One:..... .....

Date of Approval – Reviewer One:.....04/06/24.....

Name of Reviewer Two:...Neil Carrigan

Signature - Reviewer Two:.....

Date of Approval – Reviewer Two:...06.06.2024



MC

Myra Cooper

To: Elliott House

Wed 03/07/2024 16:47

Dear Elliott

I'm pleased to say that you now have Course approval for your study.

All the very best

myra

Myra Cooper, DPhil.
Isis Education Centre
University of Oxford
Warneford Hospital, Oxford, OX3 7JX

Appendix G: Self-Report Questionnaires

Impact of Restorative Practice Questionnaire (Staff Version)

Instructions: Below are 28 questions that explore different aspects of working in a Homelessness Hostel. Please read the statements carefully, and for questions 1-25 rate how often you have felt that particular way recently. Tick the box that best captures this. Questions 26-28 give you space to write in more detail about your experiences of restorative approaches.

	Not at All	Slightly	Sometimes	Often	A lot of the time
1) I feel safe working at Matilda House	○	○	○	○	○
2) I feel I am treated with respect	○	○	○	○	○
3) I feel my opinion is valued by the team	○	○	○	○	○
4) I feel supported by my team	○	○	○	○	○
5) I feel able to express new thoughts and ideas about how Matilda House could be improved	○	○	○	○	○
6) I feel I am able to be open and honest with my colleagues	○	○	○	○	○
7) I feel I know where to go for support at work	○	○	○	○	○
8) I feel able to talk to a colleague if I have a problem	○	○	○	○	○
9) I feel deflated at work	○	○	○	○	○

10) I can feel irritable when at work	○	○	○	○	○
11) I can feel overwhelmed by my emotions at work	○	○	○	○	○
12) I feel hopeless when I am at work	○	○	○	○	○
13) I feel unhappy when I am at work	○	○	○	○	○
14) I feel enthusiastic about my work	○	○	○	○	○
15) I look forward to coming to work	○	○	○	○	○
16) I feel anxious when I come to work	○	○	○	○	○

	Not at All	Slightly	Sometimes	Often	A lot of the time
17) I feel able to manage my emotions in difficult situations at work	○	○	○	○	○
18) I feel able to manage challenging behaviour when it arises	○	○	○	○	○
19) I feel hopeful for the residents I work with	○	○	○	○	○
20) I feel I have the skills I need to help the residents with their mental health needs	○	○	○	○	○

	Not at All	Slightly	Sometimes	Often	A lot of the time
21) I feel I have the skills I need to help the residents with their substance use	◯	◯	◯	◯	◯
22) I feel I can help the residents when they are struggling to manage their emotions	◯	◯	◯	◯	◯
23) I feel able to work with residents to identify solutions to problems	◯	◯	◯	◯	◯
24) I feel able to consider alternative solutions to eviction to manage difficult behaviour	◯	◯	◯	◯	◯
25) I feel able to help residents talk to each other if a problem arises	◯	◯	◯	◯	◯

26) What do you think has been helpful about using restorative approaches? *

27) What do you think the barriers are to using restorative approaches? *

28) Are there any additional skills or knowledge that you would like to develop at work? *

Challenges of Implementing Restorative Approaches Questionnaire (Staff)

We are interested in finding out more information about what some of the challenges have been in implementing Restorative Approaches at Matilda House as part of the trailblazer project. Please rate to what extent you agree or disagree with the statements in relation to being challenges to implementing Restorative Approaches.

*

	0 Strongly Disagree	1 Disagree	2 Neither agree / disagree	3 Agree	4 Strongly Agree
1) Lack of awareness or knowledge of the approach	◯	◯	◯	◯	◯

Please give further information for your answer to question 1 *

*

	0 Strongly Disagree	1 Disagree	2 Neither Agree / Disagree	3 Agree	4 Strongly Agree
2) Resident Perceptions that it is similar to snitching	◯	◯	◯	◯	◯

	0 Strongly Disagree	1 Disagree	2 Neither Agree / Disagree	3 Agree	4 Strongly Agree
3) Residents perception that it will result in punishment	◯	◯	◯	◯	◯

Please give further information for your answer to question 3 *

	0 Strongly Disagree	1 Disagree	2 Neither Agree / Disagree	3 Agree	4 Strongly Agree
6) Company Processes and policies	◯	◯	◯	◯	◯

Please give further information for your answer in question 6 *

*

	0 Strongly Disagree	1 Disagree	2 Neither Agree / Disagree	3 Agree	4 Strongly Disagree
7) Lack of support from senior leadership	◯	◯	◯	◯	◯

Please provider further information for your answer in question 7 *

	0 Strongly Disagree	1 Disagree	2 Neither Agree / Disagree	3 Agree	4 Strongly Agree
8) Staffing issues (e.g. long-term sickness or lack of staff)	◯	◯	◯	◯	◯

Please give further information for your answer to question 8 *

*

	0 Strongly Disagree	1 Disagree	2 Neither Agree / Disagree	3 Agree	4 Strongly Agree
9) Environmental Challenges (e.g. Lack of Communal Spaces, lack of appropriate meeting space)	◯	◯	◯	◯	◯

Please provide further information for your answer in question 9 *

	0 Strongly Disagree	1 Disagree	2 Neither Agree / Disagree	3 Agree	4 Strongly Agree
10) Company Culture not aligned with Restorative Values	◯	◯	◯	◯	◯

Please provide further information for your answer in question 10 *

*

	0 Strongly Disagree	1 Disagree	2 Neither Agree / Disagree	3 Agree	4 Strongly Agree
11) Staff perception that there is a lack of relationship or trust with residents	◯	◯	◯	◯	◯

Please provide further information for your answer to question 11 *

	0 Strongly Disagree	1 Disagree	2 Neither Agree / Disagree	3 Agree	4 Strongly Agree
12) Lack of confidence in using the approach with residents	◯	◯	◯	◯	◯

Please provide further information for your answer to question 12 *

	0 Strongly Disagree	1 Disagree	2 Neither Agree / Disagree	3 Agree	4 Strongly Agree
13) Lack of capacity to undertake Restorative Approaches due to high workloads	◯	◯	◯	◯	◯

Please provide further information to your answer on question 13 *

*

	0 Strongly Disagree	1 Disagree	2 Neither Agree / Disagree	Option 4	Option 5
14) Uncertainty about whose responsibility it is to implement Restorative Approaches	◯	◯	◯	◯	◯

Please provide further information for your answer in question 14 *

Feedback Form

- Restorative Approaches / the Trailblazing project aims to address harm or conflicts that might have arisen at Matilda House.
- You might have been part of the project if you have had restorative conversations with residents where you talked about an argument, disagreement or conflict, what happened during these, there thoughts at the time and now, the effect of the event then / now and what they needed to move forward.
- You might have also been part of the project if you arranged meetings or mediation between the people who had the argument, disagreement or conflict. In these the resident and people involved would have been supported to understand each other's perspective, address the impact, and problem solve.
- You might have also been an independent person who was brought in to support conversations between the people involved in an argument, disagreement or conflict. This might have involved trying to get the people to understand each other's perspective, address impact and problem solve.
- Below are some questions that we would like you to answer in relation to your experiences of facilitating the approaches outlined above.

1) Have you facilitated any Restorative Approaches like the ones outlined above? *

- ◯ Yes
- ◯ No

2) What type of Restorative Approaches have you facilitated? *

- ◯ Restorative Conversation
- ◯ Restorative Mediation
- ◯ Restorative Meeting / Conference

3) How did you find facilitating these approaches? *

4) What do you think was helpful about the approaches you have facilitated? *

5) Were there any challenges to facilitating these approaches, and if so, what were they? *

Demographic Questionnaire

Please select your gender from one of the following options: *

- ◯ Male
- ◯ Female
- ◯ Prefer not to say
- ◯ Other

What is the highest level of education you have completed? *

- ◯ No formal schooling
- ◯ Less than primary school
- ◯ Primary School Completed
- ◯ Secondary or High School Completed
- ◯ University degree Completed
- ◯ Post Graduate degree completed

How old are you? *

- ◯ Under 18
- ◯ 18-24
- ◯ 25-34
- ◯ 35-44
- ◯ 45-54
- ◯ 55-64
- ◯ 64-70
- ◯ 70+

How would you describe your ethnicity? *

What is your civic status? *

- ◯ Married
- ◯ Living as couple
- ◯ Divorced or separated
- ◯ Single
- ◯ Widow
- ◯ Prefer not to say
- ◯ Other

How long have you worked at Matilda House? *

- ◯ 0-2 years
- ◯ 2-5 years
- ◯ 5-10years
- ◯ 10+ years

Which best describes the training you have received in Restorative Approaches? *

- ◯ None
- ◯ Introductory Restorative Approaches Training
- ◯ 3 Day Restorative Practitioner Training

Demographic Questionnaire

Please select your gender from one of the following options: *

- ◯ Male
- ◯ Female
- ◯ Other
- ◯ Prefer not to say

Do you have any current mental health diagnoses that you have been given by a healthcare professional? *

- ◯ Yes
- ◯ No

What diagnoses are they? *

How old are you? *

- ◯ Under 18
- ◯ 18-24
- ◯ 25-34
- ◯ 35-44
- ◯ 45-54
- ◯ 55-64
- ◯ 64-70
- ◯ 70+

How would you describe your ethnicity? *

How many times have you been homeless? *

How long have you been homeless? *

Have you ever been evicted? *

- ◯ Yes
- ◯ No

How many times have you been evicted and what were the reasons for eviction? *

Homelessness Hostel Experiences Questionnaire

Below are some questions relating to different elements of your experience of living at Matilda House. Please indicate how much the below statements relate to you.

*

	Not at all	Occasionally	Sometimes	Often	All the time
1) I feel safe at Matilda House	◯	◯	◯	◯	◯
2) Staff help me address problems I have with other residents	◯	◯	◯	◯	◯
3) I feel safe talking to staff if I have a problem with them	◯	◯	◯	◯	◯
4) I feel safe talking to other residents if I have a problem with them	◯	◯	◯	◯	◯
5) I feel listened to by staff	◯	◯	◯	◯	◯
6) I feel anxious living at Matilda House	◯	◯	◯	◯	◯
7) I feel I have good relationships with staff	◯	◯	◯	◯	◯

If there are any comments you would like to add for question 7 you can here. If you have no comments then please put N/A *

*

	Not at all	Occasionally	Sometimes	Often	All the time
8) I feel I have good relationships with other residents	◯	◯	◯	◯	◯

If there are any comments you would like to add for question 8 you can here. If you don't have any comments then please put N/A *

*

	Not at all	Occasionally	Sometimes	Often	All the time
9) I feel staff have the knowledge and skills to help me	○	○	○	○	○
10) I know how to get support if I have a problem with a member of staff	○	○	○	○	○
11) I know how to get support if I have a problem with another resident	○	○	○	○	○

12) How do you think your stay at Matilda House could be improved? *

If you have any other thoughts or comments you would like to add then you can here: *

Challenges and Barriers to Restorative Approaches Questionnaire (Residents)

- Restorative Approaches / the Trailblazing project aims to address harm or conflicts that might have arisen at Matilda House.

- You might have been part of the project if you had restorative conversations with staff or L.E.A.F where you talked about what happened during a conflict, your thoughts at the time and now, the effect of the event then / now and what you need moving forward.

- You might have also been part of the project if you had a restorative meeting , mediation or conference where you met with the person / people involved and were supported by an independent person to understand each other's perspective, address the impact, and problem solve.

- Below are some questions that we would like you to answer in relation to this project.

1) Did you know anything about Restorative Approaches / Trailblazer Project before now?

- ◯ Yes
- ◯ No

2) Have you been given any information about Restorative Approaches / the Trailblazer project?

- ◯ Yes
- ◯ No

3) Have you had any conflicts / arguments or disagreements recently with other residents?

- ◯ Yes
- ◯ No

4) Have you had any conflicts / arguments or disagreements recently with staff?

- ◯ Yes
- ◯ No

5) If you have had a conflict / disagreement or argument with staff what did you do?

- ☐ Speak to LEAF
- ☐ Speak to Staff
- ☐ Didn't speak to anyone
- ☐ Speak to another resident
- ☐ Other

6) If you chose "other" what did you do?

9) Were you offered a Restorative Approach to address the conflict / disagreement or argument? (See the above for more information about what Restorative Approaches you might have been offered)

- ◯ Yes
- ◯ No

7) If you have had a conflict / disagreement or argument with another resident what did you do?

- ☐ Speak to Staff
- ☐ Speak to LEAF
- ☐ Didn't speak to anyone
- ☐ Speak to another resident
- ☐ Other

8) If you chose "other" what did you do?

Restorative Approaches Feedback Form

What type of Restorative Approaches did you experience?

- ☐ Restorative Conversation
- ☐ Restorative Mediation
- ☐ Restorative Conference

	Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree
I found the approaches helpful	◯	◯	◯	◯	◯
I found the elements I experienced well organised	◯	◯	◯	◯	◯
I felt better after taking part in Restorative Approaches	◯	◯	◯	◯	◯
I felt heard during the process	◯	◯	◯	◯	◯
I felt safe during the process	◯	◯	◯	◯	◯

How likely is it that you would recommend Restorative Approaches?

- ◯ Very likely
- ◯ Likely
- ◯ Neither likely nor unlikely
- ◯ Unlikely
- ◯ Very unlikely

What made you decide to go ahead with Restorative Approaches?

What did you find helpful about the Restorative Approaches you experienced?

Was there anything you found unhelpful about the Restorative Approaches you experienced?

Is there anything that you have improved your experience of Restorative Approaches overall?

Challenges and Barriers to Restorative Approaches

Below are some statements about why someone might not have spoken to LEAF or staff about a conflict or problem. We were wondering which of these might apply to you. Please rate to what extent you agree or disagree with the statements below:

	0 Strongly Disagree	1 Disagree	2 Neither agree / disagree	3 Agree	4 Strongly Agree
I worry that other residents might think I am snitching	○	○	○	○	○

Please explain why you answered the above question how you did?

	0 Strongly Disagree	1 Disagree	2 Neither agree / disagree	3 Agree	4 Strongly Agree
I don't think it will help	◯	◯	◯	◯	◯

Please explain why you answered the above question how you did:

	0 Strongly Disagree	1 Disagree	2 Neither agree / disagree	3 Agree	4 Strongly Agree
I worry that I will get into trouble	◯	◯	◯	◯	◯

Please explain why you answered the above question how you did

	0 Strongly Disagree	1 Disagree	2 Neither Agree / Disagree	3 Agree	4 Strongly Agree
I think A2Dominion's rules would get in the way	◯	◯	◯	◯	◯

Please explain why you answered the above question how you did:

	0 Strongly Disagree	1 Disagree	2 Neither agree / disagree	3 Agree	4 Strongly Disagree
I worry about whether staff can be trusted	◯	◯	◯	◯	◯

Please explain why you answered the above question how you did:

	0 Strongly Disagree	1 Disagree	2 Neither Agree/ Disagree	3 Agree	4 Strongly Agree
I worry about whether LEAF can be trusted	◯	◯	◯	◯	◯

Please explain why you answered the above question how you did:

Are there any other things that have stopped or would stop you from talking to staff / LEAF?

If you would like to provide any more information to any of your answers above, then please do so below

Which of these would you do if you had a conflict or problem?

- ◯ Talk to LEAF
- ◯ Talk to Staff
- ◯ Talk to both LEAF and Staff
- ◯ None of the above
- ◯ Other

If you chose other what would you do?

If you had a conflict / argument or disagreement would you like the opportunity to use Restorative Approaches?

- ◯ Yes
- ◯ No

Is there anything that would stop you talking to staff or LEAF if you had a conflict, argument or disagreement?

What could be done to support you in bringing conflicts or problems to LEAF?

What could be done to support you in bringing conflicts or problems to a member of staff?

Demographic Questionnaire

Please select your gender from one of the following options: *

- ◯ Male
- ◯ Female
- ◯ Other
- ◯ Prefer not to say

How old are you? *

- ◯ Under 18
- ◯ 18-24
- ◯ 25-34
- ◯ 35-44
- ◯ 45-54
- ◯ 55-64
- ◯ 64-70
- ◯ 70+

How would you describe your ethnicity? *

What is the highest level of education you have completed? *

- ◯ No formal schooling
- ◯ Less than primary school
- ◯ Primary School Completed
- ◯ Secondary or High School Completed
- ◯ University degree Completed
- ◯ Post graduate degree Completed

What is your civic status? *

- ◯ Married
- ◯ Living as couple
- ◯ Divorced or separated
- ◯ Single
- ◯ Widow
- ◯ Prefer not to say
- ◯ Other

How long have you been familiar with Restorative Approaches? *

Enter your answer

Have you received any training in Restorative Approaches? *

- ◯ Yes
- ◯ No

What level of training have you received in Restorative Approaches? *

- ◯ None
- ◯ Introductory Restorative Approaches Training
- ◯ 3 Day Restorative Practitioner Training
- ◯ Other

If you answered Other for Question 8 please outline the training you have had in Restorative Approaches? *

Challenges of Implementing Restorative Approaches Questionnaire (Stakeholders)

We are interested in finding out more information about what some of the challenges have been in implementing Restorative Approaches at Matilda House as part of the trailblazer project. Please rate to what extent you agree or disagree with the statements in relation to being challenges to implementing Restorative Approaches.

*

	0 Strongly Disagree	1 Disagree	2 Neither agree / disagree	3 Agree	4 Strongly Agree
1) Lack of awareness or knowledge of the approach	◯	◯	◯	◯	◯

Please give further information for your answer to question 1 *

	0 Strongly Disagree	1 Disagree	2 Neither Agree / Disagree	3 Agree	4 Strongly Agree
2) Resident Perceptions that it is similar to snitching	◯	◯	◯	◯	◯

Please give further information for your answer to question 2 *

	0 Strongly disagree	1 Disagree	2 Neither agree nor disagree	3 Agree	4 Strongly Agree
3) Residents perception that it will result in punishment	○	○	○	○	○

Please give further information for your answer to question 3 *

	0 Strongly disagree	1 disagree	2 Neither agree nor disagree	3 Agree	4 Strongly Agree
4) Staff perceptions that it isn't appropriate	○	○	○	○	○

Please give further information for your answer to question 4 *

	0 Strongly Disagree	1 Disagree	2 Neither Agree / Disagree	3 Agree	4 Strongly Agree
5) Staff perceptions about residents not being ready or far enough in their journey	◯	◯	◯	◯	◯

Please give further information for your answer in question 5 *

	0 Strong Disagree	1 Disagree	2 Neither agree / disagree	3 Agree	4 Strongly Agree
6) Company processes and policies	◯	◯	◯	◯	◯

Please give further information for your answer in question 6 *

	0 Strongly Disagree	1 Disagree	2 Neither Agree / Disagree	3 Agree	4 Strongly Agree
7) Lack of support from senior leadership	◯	◯	◯	◯	◯

Please provide further information for your answer in question 7 *

	0 Strongly Disagree	1 Disagree	2 Neither Agree / Disagree	3 Agree	4 Strongly Disagree
8) Staffing issues (e.g. long-term sickness or lack of staff)	◯	◯	◯	◯	◯

Please give further information for your answer to question 8 *

	0 Strongly Disagree	1 Disagree	2 Neither Agree / Disagree	3 Agree	4 Strongly Agree
9) Environmental Challenges (e.g. Lack of Communal Spaces, lack of appropriate meeting space)	◯	◯	◯	◯	◯

Please provide further information for your answer in question 9 *

	0 Strongly Disagree	1 Disagree	2 Neither Agree / Disagree	3 Agree	4 Strongly Agree
10) Company Culture not aligned with Restorative Values	◯	◯	◯	◯	◯

Please provide further information for your answer in question 10 *

	0 Strongly Disagree	1 Disagree	2 Neither Agree / Disagree	3 Agree	4 Strongly Agree
11) Staff Perception that there is a lack of relationship or trust with residents	◯	◯	◯	◯	◯

Please provide further information for your answer to question 11 *

	0 Strongly Disagree	1 Disagree	2 Neither Agree / Disagree	3 Agree	4 Strongly Agree
12) Lack of confidence in using the approach with residents	◯	◯	◯	◯	◯

Please provide further information for your answer to question 12 *

	0 Strongly Disagree	1 Disagree	2 Neither Agree / Disagree	3 Agree	4 Strongly Agree
13) Lack of capacity to undertake Approaches due to high workloads	◯	◯	◯	◯	◯

Please provide further information to your answer on question 13 *

	0 Strongly Disagree	1 Disagree	2 Neither Agree / Disagree	3 Agree	4 Strongly Agree
14) Uncertainty about whose responsibility it is to implement Restorative Approaches	○	○	○	○	○

Please provide further information for your answer in question 14 *

15) If there are factors that haven't been captured by the above statements, then please provide further information below *

16) What do you think would help address some of the barriers you have identified in this survey *

17) What do you think has been positive about the Trailblazing Project / Restorative Approaches at Matilda House. *

Feedback Form

- Restorative Approaches / the Trailblazing project aims to address harm or conflicts that might have arisen at Matilda House.
- You might have been part of the project if you have had restorative conversations with residents where you talked about an argument, disagreement or conflict, what happened during these, there thoughts at the time and now, the effect of the event then / now and what they needed to move forward.
- You might have also been part of the project if you arranged meetings or mediation between the people who had the argument, disagreement or conflict. In these the resident and people involved would have been supported to understand each other's perspective, address the impact, and problem solve.
- You might have also been an independent person who was brought in to support conversations between the people involved in an argument, disagreement or conflict. This might have involved trying to get the people to understand each other's perspective, address impact and problem solve.
- Below are some questions that we would like you to answer in relation to your experiences of facilitating the approaches outlined above.

1) Have you facilitated any Restorative Approaches like the ones outlined above? *

- ◯ Yes
- ◯ No

2) What type of Restorative Approaches have you facilitated? *

- [ ] Restorative Conversation
- [ ] Restorative Mediation
- [ ] Restorative Meeting / Conference

3) How did you find facilitating these approaches? *

4) What do you think was helpful about the approaches you have facilitated? *

5) Were there any challenges to facilitating these approaches, and if so, what were they? *

Appendix H: Questionnaire Time-point administration

Time Point 1: Staff (Demographic and RJAS)

Time Point 2:	Staff (RJAS, Impact of Restorative Approaches Scale), new staff also did Demographic Questionnaire
	Residents (Demographic, Homeless Hostel Experience Questionnaire)
Time Point 3:	Staff (RJAS, Impact of Restorative Approaches Scale, Challenges and Barriers to Restorative Approaches Questionnaire, Feedback from if they had completed RF), New staff also completed Demographic Questionnaire

Residents (Homeless Hostel Experiences Questionnaire, Challenges and Barriers to Restorative Approaches Questionnaire, Feedback form if experienced RF), new residents also completed Demographic Questionnaire.

Stakeholders: (Demographic Questionnaire, Challenges and Barriers to Restorative Approaches Questionnaire, L.E.A.F could have completed a feedback form if they felt they had completed RF).

Appendix I: Pilot Plan / Training information

Using restorative approaches to prevent and resolve homelessness: Proposal for a pilot project

Introduction

1. Partners in Oxfordshire's Homelessness Alliance are working hard and collaboratively to prevent and resolve homelessness so that no-one sleeps rough in Oxfordshire. Partners recognise that success depends on fresh approaches, core elements of which include:
    - a central role in programme development for people with lived experience of homelessness
    - intensive, co-ordinated and sustained support for people facing multiple disadvantages
    - an approach that recognises each person's strengths
    - building relationships of trust and
    - flexible responses.[1]

2. Experience also shows that supporting someone who is homeless to access hostel or supported accommodation in itself is not enough. Conflicts can easily arise - between resident or between residents and staff - made more likely by traumatic events or experiences in a person's past that affect their functioning or how they react in certain circumstances. Action is needed to tackle the ever-present risk that people who are or have been homeless, and who have known multiple rejections and exclusions, find themselves excluded yet again because of conflict situations.

About restorative justice and practice

[1] HOMJ6444-MEAM-wheel-190208-WEB.pdf

3. *Restorative justice* brings people affected by crime or conflict together (directly or indirectly) to look together at the harms caused, and what needs to happen to heal the harms and put things as right as possible.

4. *Restorative practice* takes the principles, values and approaches of restorative justice and applies these in non-criminal justice settings to resolve difficulties and repair harm when conflicts arise and relationships break down. The same core ethos and approaches can also be used to build relationships of trust and promote respectful dialogue, reducing the risk of conflicts arising in the first place. These approaches are being used increasingly in schools, hospitals and other settings.[2] They have also been used by housing and homelessness services, showing good results. Examples include their use by housing officers in Camden; in supported accommodation in Bristol; an initiative by Stopover, a Brighton-based service for young women who are homeless; and use by local housing association the Aster Group (the first organisation outside the criminal justice system to receive Registered Restorative Organisation Status with the Restorative Justice Council).[3]

Exploring uses of restorative practice in Oxfordshire

5. From February to April 2023 the Mint House (Oxford's Centre for Restorative Practice) delivered introductory training in restorative practice to members of Oxfordshire's Lived Experience Advisory Forum (LEAF) a group run by and for people with lived experience of homelessness that is working to improve homeless pathways in Oxfordshire. Training was delivered via three bite-sized sessions, with sixteen LEAF members taking part in one or more sessions.

6. The training was enthusiastically received by most participants, with interest expressed in further training. LEAF members identified many ways that restorative approaches were relevant for their work, from improving communication skills generally to supporting resolution of conflicts between service users and services (where LEAF often ends up in the middle) to resolving conflicts between LEAF members and helping LEAF develop positive relationships with other organisations. Benefits highlighted included:

helping both sides to hear the other where disputes arise
taking the heat or personal animosity out of situations
helping work towards solutions, enabling all concerned to move forward

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[2] Punitive school behaviour policies are harming children's mental health says new report | CYPMHC; RJC CoP (restorativejustculture.org)

[3] Developing-staff-support-learning-from-workforce-development-initiatives-at-Stopover-2018.pdf (bht.org.uk) Registered Restorative Organisation Status | Aster Group

giving LEAF members more understanding and confidence in being the middle person.

What next?

7. LEAF's feedback gives us confidence that restorative practice can play a valuable role in preventing and resolving conflicts that risk perpetuating homelessness. Following discussion with LEAF co-ordinator Lucy Stokes, Tom Douglas from the city council's Rough Sleeping and Single Homelessness team and Nikki Aitchison, Homeless Alliance programme manager, we suggest testing this initially via a small-scale pilot project in a specific housing setting. In practice the pilot would involve:

   Delivering (1 day) introductory training in restorative practice to all staff/volunteers (including managers) in the setting. Aims for this training will be to:

   - help participants understand restorative approaches, including the difference between a "traditional" vs "restorative" approach to harm and conflict
   - introduce restorative language and values
   - reflect on how these practices might support participants to manage conflict and build connections with others
   - share some practical skills
   - share knowledge and learn from each other.

   Following up the introductory training with 3 day restorative practitioner training for a smaller group drawn from both the housing provider and from LEAF. This training will delve deeper into the principles and values of restorative practice, the philosophy and mindset that underpins the approach, what distinguishes restorative practice from other ways of addressing harm and conflict, restorative languages and the themes that underpin restorative processes. It will also have a strong skills dimension, enabling participants to:

   - learn and practice skills to have a restorative conversation with one other person
   - learn and practice skills to prepare and facilitate informal and formal restorative meetings
   - understand the importance of risk assessment, follow-up and review
   - explore a range of different restorative processes and how to adapt the approach for use within their own context.

   As with the introductory training, emphasis will be placed on sharing knowledge and expertise, and with restorative principles and values modelled throughout the training.

Drawing on the team of trained restorative practitioners to offer restorative facilitation where conflicts arise in the housing setting. Practitioners will in each case work in pairs, made up of one practitioner from the housing provider and one practitioner from LEAF. The offer of restorative facilitation will always be made where conflict brings with it the risk of a resident being evicted. Practitioners will have access to support from an experienced practitioner on whom they can call for help to assess risks and advice on aspects of specific cases.

Support for a community of learning. We envisage this consisting of periodic (6 weekly) reflection sessions, providing the space and opportunity for facilitators and other staff members to reflect on, and share learning from, their experiences; problem-solve together on challenges that the team are facing; make suggestions on adjustments (e.g. to environments, policies or procedures) identified through the restorative dialogue and that would benefit the setting more generally.

Suggested timelines:

We suggest a 12 month pilot initially, with milestones as follows, and with a 3 month lead in period allowing time for training team preparation, confirmation of training arrangements etc :

Month 1: Introductory training

Month 2-3: Initial community of learning session for colleagues involved in introductory training

Practitioner training

Month 4: Start of restorative facilitation.

Month 6-7: Mid-point review, including to take stock of the number and types of conflict being responded to and emerging learning, e.g. on the time requirements for restorative facilitation.

Month 12: End of year review.

TDRP Appendix:

Appendix J: Journal for Obsessive-Compulsive and Related Disorders author guidelines

About the journal

Aims and scope

Journal of Obsessive-Compulsive and Related Disorders (JOCRD) is an international journal that publishes high quality research and clinically-oriented articles dealing with all aspects of obsessive-compulsive disorder (OCD) and related conditions (OC spectrum disorders; e.g., trichotillomania, hoarding, body dysmorphic disorder). The journal invites studies of clinical and non-clinical (i.e., student) samples of all age groups from the fields of psychiatry, psychology, neuroscience, and other medical and health sciences. The journal's broad focus encompasses classification, assessment, psychological and psychiatric treatment, prevention, psychopathology, neurobiology and genetics. Clinical reports (descriptions of innovative treatment methods) and book reviews on all aspects of OCD-related disorders will be considered, as will theoretical and review articles that make valuable contributions.

Suitable topics for manuscripts include:

- The boundaries of OCD and relationships with OC spectrum disorders
- Validation of assessments of obsessive-compulsive and related phenomena
- OCD symptoms in diverse social and cultural contexts
- Studies of neurobiological and genetic factors in OCD and related conditions
- Experimental and descriptive psychopathology and epidemiological studies
- Studies on relationships among cognitive and behavioral variables in OCD and related disorders
- Interpersonal aspects of OCD and related disorders
- Evaluation of psychological and psychiatric treatment and prevention programs, and predictors of outcome.

Article types

Research paper:

Clinical and non-clinical research dealing with all aspects of obsessive-compulsive disorder (OCD) and related conditions (OC spectrum disorders; e.g., trichotillomania, hoarding, body dysmorphic disorder)

Review:

The journal welcomes systematic reviews and meta-analysis that make valuable contributions on all aspects of OCD-related disorders.

Viewpoint:

These are concise discussion papers on important topics in obsessive-compulsive and related disorders. For example, they may include new research developments, emerging innovations,

critical challenges, and debates in the field. They are a platform for author(s) perspective with the aim to generate discourse on important issues. Viewpoint articles are by invitation only. Potential authors who wish to be considered may email the Editor for approval (cougle@psy.fsu.edu)

Viewpoints should have a maximum 1,000 words (not including references), no more than 10 references, up to 1 figure or table and no abstract.

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Correspondence:

Letters in response to papers published in journal.

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These are concise review articles on new and emerging topics, summarizing current information and advances in the field. The review should be approximately 2000 words (not including references or reference notes), with up to 50 references.

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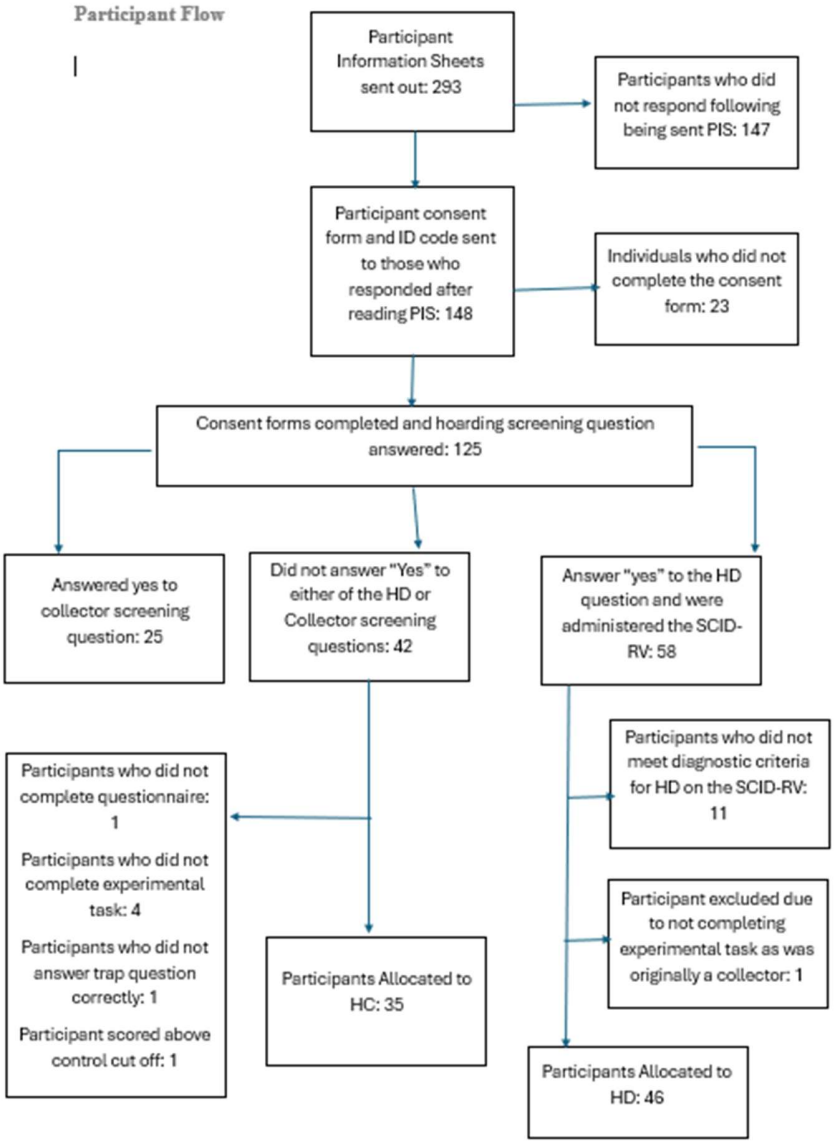
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Appendix K: Participant Flowchart



Appendix L: Quality of Objects Questionnaire

Q1 (S1) QoOQ Qualities of Objects Questionnaire. Below there are four sections. Sections 1 and 2 will ask you to identify important objects and answer some questions about these. The remaining sections 3 and 4 will ask you to identify objects that you do not identify as important

Section 1: Very Important Object 1

Please think of a very important object that you have, and answer the questions below in relation to that object.

1) What is the item?

_____

_____

_____

_____

_____

Q2 (S1) QoOQ 2) How long have you owned this item?

_____

Q3 (S1) QoOQ 3) How did you acquire the item (e.g. purchased, gifted, borrowed or made it)

_____

Q4 (S1) QoOQ 4) Do you own more than one of this exact item?

- ○ Yes
- ○ No

Q5 (S1) QoOQ Section 1: Very Important Object 1 continued

5) How important is this item to you?	○ Not at all important 0	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8	○ 9	○ Extremely Important 10
6) How much is this item worth to you in terms of money?	○ Not at all worth any money 0	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8	○ 9	○ Worth an extremely large amount of money 10
7) How damaged or broken is this object?	○ Not at all damaged / broken 0	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8	○ 9	○ Extremely damaged / broken 10
8) How often does this object bring up memories of others?	○ Not at all 0	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8	○ 9	○ Extremely Often 10
9) Do you consider this object to be an important part of who you are?	○ Not at all 0	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8	○ 9	○ Extremely important part of who you are 10

10) Do you consider this object to be an important part of who you used to be?	○ Not at all 0	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8	○ 9	○ Extremely important part of who you used to be 10
11) Do you consider this object to be an important part of who you want to be?	○ Not at all 0	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8	○ 9	○ Extremely important part of who you want to be 10
12) Does this object bring up positive feelings? (e.g. happiness, joy, safety, security, pride)	○ Not at all 0	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8	○ 9	○ Extremely strongly 10
13) Does this object bring up negative feelings? (e.g. guilt, shame, fear, anger, sadness)	○ Not at all 0	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8	○ 9	○ Extremely strongly 10

14) How useful would this object be to other people?	○ Not at all useful 0	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8	○ 9	○ Extremely useful 10
15) How useful is this object to you now?	○ Not at all useful 0	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8	○ 9	○ Extremely useful 10
16) How useful would this object be to you in the future?	○ Not at all useful 0	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8	○ 9	○ Extremely useful 10
17) How practical (e.g. having the space) is it for you to keep this object?	○ Not at all 0	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8	○ 9	○ Extremely practical 10
18) How attractive or visually appealing is this object?	○ Not at all 0	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8	○ 9	○ Extremely attractive / visually appealing 10
19) How much has this object provided you with feelings	○ Not at all 0	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8	○ 9	○ Extremely strongly 10

of importance
or
achievement?

Page Break

Q1 (S2) QoOQ Section 2: Very Important Object 2

Please think of another very important object that you have and answer the questions below in relation to that object.

1) What is the item?

_____

_____

_____

_____

_____

Q2 (S2) QoOQ 2) How long have you owned this item?

_____

Q3 (S2) QoOQ 3) How did you acquire the item (e.g. purchased, gifted, borrowed or made it)

_____

Q4 (S2) QoOQ 4) Do you own more than one of this exact item?

- ○ Yes
- ○ No

Q5 (S2) QoOQ Section 2: Very Important Object 2 Continued

5) How important is this item to you?	○ Not at all important 0	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8	○ 9	○ Extremely Important 10
6) How much is this item worth to you in terms of money?	○ Not at all worth any money 0	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8	○ 9	○ Worth an extremely large amount of money 10
7) How damaged or broken is this object?	○ Not at all damaged / broken 0	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8	○ 9	○ Extremely damaged / broken 10
8) How often does this object bring up memories of others?	○ Not at all 0	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8	○ 9	○ Extremely Often 10
9) Do you consider this object to be an important part of who you are?	○ Not at all 0	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8	○ 9	○ Extremely important part of who you are 10

10) Do you consider this object to be an important part of who you used to be?	○ Not at all 0	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8	○ 9	○ Extremely important part of who you used to be 10
11) Do you consider this object to be an important part of who you want to be?	○ Not at all 0	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8	○ 9	○ Extremely important part of who you want to be 10
12) Does this object bring up positive feelings? (e.g. happiness, joy, safety, security, pride)	○ Not at all 0	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8	○ 9	○ Extremely strongly 10
13) Does this object bring up negative feelings? (e.g. guilt, shame, fear, anger, sadness)	○ Not at all 0	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8	○ 9	○ Extremely strongly 10

14) How useful would this object be to other people?	Not at all useful 0	1	2	3	4	5	6	7	8	9	Extremely useful 10
15) How useful is this object to you now?	Not at all useful 0	1	2	3	4	5	6	7	8	9	Extremely useful 10
16) How useful would this object be to you in the future?	Not at all useful 0	1	2	3	4	5	6	7	8	9	Extremely useful 10
17) How practical (e.g. having the space) is it for you to keep this object?	Not at all 0	1	2	3	4	5	6	7	8	9	Extremely practical 10
18) How attractive or visually appealing is this object?	Not at all 0	1	2	3	4	5	6	7	8	9	Extremely attractive / visually appealing 10
19) How much has this object provided you with feelings	Not at all 0	1	2	3	4	5	6	7	8	9	Extremely strongly 10

of importance
or
achievement?

Page Break

Q1 (S3) QoOQ Section 3: Not very Important Object 1

Please think of an object you have that is not very important and answer the questions below in relation to that object.

1) What is the item?

_____

_____

_____

_____

_____

Q2 (S3) QoOQ 2) How long have you owned this item?

_____

Q3 (S3) QoOQ 3) How did you acquire the item (e.g. purchased, gifted, borrowed or made it)

_____

Q4 (S3) QoOQ 4) Do you own more than one of this exact item?

- ○ Yes
- ○ No

Q5 (S3) QoOQ Section 3: Not Very Important Object 1 continued

5) How important is this item to you?	○ Not at all important 0	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8	○ 9	○ Extremely Important 10
6) How much is this item worth to you in terms of money?	○ Not at all worth any money 0	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8	○ 9	○ Worth an extremely large amount of money 10
7) How damaged or broken is this object?	○ Not at all damaged / broken 0	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8	○ 9	○ Extremely damaged / broken 10
8) How often does this object bring up memories of others?	○ Not at all 0	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8	○ 9	○ Extremely Often 10
9) Do you consider this object to be an important part of who you are?	○ Not at all 0	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8	○ 9	○ Extremely important part of who you are 10

10) Do you consider this object to be an important part of who you used to be?	○ Not at all 0	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8	○ 9	○ Extremely important part of who you used to be 10
11) Do you consider this object to be an important part of who you want to be?	○ Not at all 0	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8	○ 9	○ Extremely important part of who you want to be 10
12) Does this object bring up positive feelings? (e.g. happiness, joy, safety, security, pride)	○ Not at all 0	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8	○ 9	○ Extremely strongly 10
13) Does this object bring up negative feelings? (e.g. guilt, shame, fear, anger, sadness)	○ Not at all 0	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8	○ 9	○ Extremely strongly 10

14) How useful would this object be to other people?	○ Not at all useful 0	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8	○ 9	○ Extremely useful 10
15) How useful is this object to you now?	○ Not at all useful 0	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8	○ 9	○ Extremely useful 10
16) How useful would this object be to you in the future?	○ Not at all useful 0	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8	○ 9	○ Extremely useful 10
17) How practical (e.g. having the space) is it for you to keep this object?	○ Not at all 0	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8	○ 9	○ Extremely practical 10
18) How attractive or visually appealing is this object?	○ Not at all 0	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8	○ 9	○ Extremely attractive / visually appealing 10
19) How much has this object provided you with feelings	○ Not at all 0	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8	○ 9	○ Extremely strongly 10

of importance or achievement?

Page Break

Q1 (S4) Section 4: Not very Important Object 2

Please think of another object you have that is not very important and answer the questions below in relation to that object.

1) What is the item?

_____

_____

_____

_____

_____

Q2 (S4) QoOQ 2) How long have you owned this item?

_____

Q3 (S4) QoOQ 3) How did you acquire the item (e.g. purchased, gifted, borrowed or made it)

_____

Q4 (S4) QoOQ 4) Do you own more than one of this exact item?

- ○ Yes
- ○ No

Q5 (S4) QoOQ Section 4: Not Very Important Object 2 continued

5) How important is this item to you?	○ Not at all important 0	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8	○ 9	○ Extremely Important 10
6) How much is this item worth to you in terms of money?	○ Not at all worth any money 0	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8	○ 9	○ Worth an extremely large amount of money 10
7) How damaged or broken is this object?	○ Not at all damaged / broken 0	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8	○ 9	○ Extremely damaged / broken 10
8) How often does this object bring up memories of others?	○ Not at all 0	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8	○ 9	○ Extremely Often 10
9) Do you consider this object to be an important part of who you are?	○ Not at all 0	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8	○ 9	○ Extremely important part of who you are 10

10) Do you consider this object to be an important part of who you used to be?	○ Not at all 0	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8	○ 9	○ Extremely important part of who you used to be 10
11) Do you consider this object to be an important part of who you want to be?	○ Not at all 0	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8	○ 9	○ Extremely important part of who you want to be 10
12) Does this object bring up positive feelings? (e.g. happiness, joy, safety, security, pride)	○ Not at all 0	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8	○ 9	○ Extremely strongly 10
13) Does this object bring up negative feelings? (e.g. guilt, shame, fear, anger, sadness)	○ Not at all 0	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8	○ 9	○ Extremely strongly 10

14) How useful would this object be to other people?	○ Not at all useful 0	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8	○ 9	○ Extremely useful 10
15) How useful is this object to you now?	○ Not at all useful 0	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8	○ 9	○ Extremely useful 10
16) How useful would this object be to you in the future?	○ Not at all useful 0	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8	○ 9	○ Extremely useful 10
17) How practical (e.g. having the space) is it for you to keep this object?	○ Not at all 0	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8	○ 9	○ Extremely practical 10
18) How attractive or visually appealing is this object?	○ Not at all 0	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8	○ 9	○ Extremely attractive / visually appealing 10
19) How much has this object provided you with feelings	○ Not at all 0	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8	○ 9	○ Extremely strongly 10

of importance
or
achievement?

Appendix M: Joint Working Statement

Elements of this project were completed jointly with Faye Denham, Trainee Clinical Psychologist. Initially the plan was to complete the project independently, however prior to the submission of my ethics proposal our research supervisor highlighted that it would be beneficial to work together for elements of the projects to reduce the time burden on the individuals who participated as both studies were lengthy. As a result, a joint ethics proposal was developed for CUREC, which highlighted where our methodologies overlapped, but also where they differed. It highlighted we would work together to create shared research materials (e.g. information sheet, research posters), recruiting participants (e.g. advertisements, contacting HD support groups, networking with helpful agencies, conducting some SCIDS, and setting up of some experimental tasks). The participants also completed one batch of questionnaires that included questionnaires relevant to both studies including two newly developed measures. The decision to do this was to maximise recruitment and to reduce the time burden on participants. The studies aims, methodology, experimental variables, measure development, imagery script development, and imagery task administration were all independently designed. The analysis of the data and the write up were all done independently. Prior to starting the research cycle, it was clear how we would jointly work together and the boundaries of this. It was agreed that to recognise the separate and joint contributions manuscripts would be published as co-authorship.