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ORIGINAL ARTICLE

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A feasibility study of the Redesigning Daily Occupations (ReDO™-10) programme in an Irish context

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ABSTRACT

Background: Despite high demand, mental health services in primary care in Ireland are underdeveloped. People with mild/moderate anxiety, depression and unspecified psychological distress are frequently seen in primary care settings, mostly by general practitioners (GPs). Occupational therapists have the potential to contribute to service-provision with interventions specially designed for the targeted group e.g. the Redesigning Daily Occupations programme (ReDO-10).

Aims/objectives: This study aimed to explore the feasibility of a future RCT of the ReDO-10 programme in Ireland and the contextual factors that would influence future implementation.

Material and methods: Using a multi-phase, mixed-method design, qualitative and quantitative data were gathered from key stakeholders: ReDO-10 participants ($n = 10$), GPs ($n = 9$) and occupational therapists ($n = 2$). Acceptability, satisfaction, cultural fit and demand were explored, as well as methodological issues such as appropriateness of recruitment methods, outcome measures and randomization.

Results: ReDO-10 was acceptable to participants who reported improvements in their occupational patterns and valued the group-based format. GPs and occupational therapists welcomed the intervention, but acknowledged the limitations of time and resources in the Irish primary care context.

Conclusions: ReDO-10 is feasible to explore in a future RCT in Ireland and this study provides important context for future implementation and/or research.

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KEYWORDS
Occupational therapy; women; psychological stress; anxiety; feasibility study; pilot study; mixed methods; occupational balance

Background/introduction

In their seminal work about stress and coping, Pearlin and Schooler [1] insisted that coping and mastery be understood as an ongoing adaptive response to everyday living rather than something exceptional that people facing extraordinary pressures must achieve. Stress and difficulty managing everyday living is recognized as a European-wide concern by the WHO [2] and is a common reason for attending a general practitioner (GP) in primary care. One Irish study reported that 16.8% of GP attendees presented with signs of psychological distress and a further 16.2% with severe psychological distress [3]. While there is a perception of increased rates of mental health conditions like anxiety and depression, lifestyle characteristics of modern life e.g. poor sleep, low physical activity levels and work pressures may be contributing to this high level of unspecified psychological distress [4]. The DSM-V states that severe emotional reactions to common stressors such as unemployment, financial difficulties or marital disagreements, should not be considered as mental disorder [5]. Nevertheless, subthreshold anxiety and depression are perceived by patients as extremely distressing and disabling [6].

Primary care is the first point of access for those with psychological distress [7] and their experience is well understood by the GPs with whom they develop a trusting clinical relationship. The background to stress in daily life has been described by one British GP as '*a head-spinning cocktail of concern. Seemingly*

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well-intentioned guidelines have become confining and limiting like never before. Our society, which is driven by wealth, individualism and perfectionism, leaves many riven with introspection, indecision and full of unrealistic and unobtainable expectations. Modern life seems little more than a gilded cage for many, with anxiety hardwired in utero' [8, p. 526]. It is estimated that many more people do not seek treatment from their GP [9]. Stress and anxiety are risk factors for developing other medical conditions such as chronic fatigue and irritable bowel syndrome and research shows that high levels of GP attendance and severe psychological distress can predict the onset of these complications [10]. Appropriate treatment of this population with psychological and daily life management interventions in primary care is important and could prevent unnecessary interventions and over-treatment [2,8].

Women present with higher rates of depression and anxiety than men [11] and there is evidence that men and women face different challenges when navigating the occupations of daily life. For example, working mothers may experience more stress than working fathers because of the likelihood that women experience their professional and parenting identities as being in opposition to each other [12]. Working full-time is a protective factor against anxiety or depression for fathers, but not for mothers [11]. Men and women may also respond differently to treatment. Men with social anxiety show higher attrition rates from group-based interventions and it has been suggested that attending treatment can be more distress-inducing for men with anxiety [13], thus making them less likely to seek treatment. These differences have led to calls for a 'gender-sensitive' approach to mental health promotion and prevention programmes [14,15] to account for diversity.

In Ireland, general practitioners (GPs) have expressed concern about inadequate treatment for individuals with mental health problems in primary care with 53% stating that the multidisciplinary staff required to provide mental health interventions in the community are not in place [16]. Where available, treatments for those with stress, mild/moderate anxiety or depression in primary care demonstrate a stepped-care approach, as recommended by the National Institute of Clinical Excellence guidelines [17]. GPs offer self-management advice or refer to counselling services in the community [18], often at significant financial cost to the patient. The Committee on the Future of Healthcare in Ireland has called for an increase in multidisciplinary treatments for mild/moderate mental health conditions in primary care [19]. Occupational Therapists form part of the primary care team structure, but evidence for the effectiveness of interventions in this context and for occupational therapy mental health interventions generally needs to be developed [20].

Occupational therapy can contribute both to prevention of health problems, the treatment of heath conditions in the early stages and the management of individuals with complex multi-morbidity [21,22] A small number of such occupational therapy-led interventions are being explored for feasibility and effectiveness [23,24]. A systematic review was carried out by the authors to identify an occupational therapy-led intervention that could be implemented in an Irish context and improve the mental health and occupational participation of people with stress and anxiety in primary care [25]. This identified the Redesigning Daily Occupations (ReDO®) programme as having broad applicability and an emerging evidence-base. Thus, this programme was chosen to be explored for feasibility in an Irish primary care context.

The Redesigning Daily Occupations programme

The Redesigning Daily Occupations (ReDO®) programme was developed in Sweden as a 16-week, occupational therapy-led group intervention (ReDO-16) for women with stress-related conditions aiming to improve return-to-work outcomes. The programme content was designed based on research on the complexity of women's patterns of daily occupations and the relationships of these patterns with stress and perceived health [26,27]. The purpose of the intervention is to provide participants with the tools to analyse their own occupational patterns and make individualized goals for change with the aim of having a more satisfying, healthy, everyday life [28]. It was originally evaluated between September 2007 and March 2009 [29], with a follow-up 3–4 years later [30]. Eighty-four women were assigned to either the ReDO-16 programme or to traditional vocational rehabilitation (CAU) in a quasi-experimental trial. At 12-month follow-up the return-to-work rate of the ReDO-16 participants was 59% as opposed to 37% in the CAU group [29]. However, this difference was no longer present 3–4 years later [30]. The ReDO-16 participants also showed some improvements in quality of life, self-mastery, anxiety and depression as compared to the CAU group, but these differences were not statistically significant [31,32]. There were significant

differences in the groups at baseline: the ReDO-16 participants had lower mental health and self-esteem and had less previous rehabilitation and this may have contributed to the lack of significant differences.

A primary care, 10-week version of Redesigning Daily Occupations (ReDO-10) was developed more recently and is being evaluated in a number of primary care contexts, particularly in Sweden [33]. This shorter version condenses the content and does not focus on return-to-work. It was adapted following feedback from primary care health providers about the feasible length of occupational therapy interventions in that context [34]. Olsson, Erlandsson and Håkansson [34] completed a longitudinal single-cohort study of the ReDO-10 with 152 participants, both male and female, in primary care in Sweden. Pre, post and follow-up data were available for only 86 participants. Statistically significant improvements in mastery, occupational balance, perceived health, work ability and occupational value were found post-intervention and for three of the outcomes at the 6-month follow-up [34]. The intervention content is described in detail in Olsson et al., [34] and in Erlandsson [28], but the session titles are as follows:

(Prior to programme) – Individual meeting with the occupational therapist

Group sessions:

1. Introduction
2. Occupational history
3. Occupational balance
4. Patterns of daily occupations and time (Part 1)
5. Patterns of daily occupations and time (Part 2)
6. Hassles and uplifts in daily life
7. Goal-setting
8. Occupational value
9. Evening seminar (for friends, family, partners or employers)
10. Goals and strategies
11. Concluding
12. Follow-up 1 (After 1 month)
13. Follow-up 2 (After 1 month)

ReDO® facilitators are required to complete a three-day training course and attain certification [28]. The full manual is available to facilitators with guidance for each session, seminar slides, worksheets and additional reading. ReDO® is led in a facilitative leadership style, with a mixture of directed activities (e.g. completing an occupational balance worksheet), occupation-focused exercises and guided discussion.

The feasibility of ReDO-10 in a new context

Carrying out a fully powered randomized controlled trial (RCT) in a new setting is not recommended without consideration of context, stakeholder views and feasibility [35]. The policies, supports and rights for people with mental health needs are considerably different between Ireland and Sweden and these differences mean that those with stress in primary care in the two countries may have different options and pressures regarding sick leave and rehabilitation. For example, people are required (unless they qualify financially for a medical card) to pay for both their GP visits and counselling in Ireland [18]. In addition, an individual has no right under employment law to be paid while on sick leave [36] and there are no statutory rehabilitation or return-to-work schemes for those with stress. This may affect the motivation, choices and feasibility of attending programmes such as ReDO-10. In Sweden, those on stress-related sick leave receive the support of a Social Insurance Officer, with regular follow-ups, meetings with their employer and the potential to avail of work rehabilitation interventions [37]. Both the 16-week and 10-week versions of ReDO® have been evaluated only in the Swedish context [29,34] and it is unknown how acceptable, feasible, potentially effective or practical this intervention will be in an Irish primary care setting.

Research questions

Bowen et al. [38] provide guidance on the appropriate areas of focus of a feasibility study. These eight areas are: acceptability, demand, implementation, practicality, adaptation, integration, expansion and limited-efficacy testing. They advocate the use of 'small-scale experiments that more closely approximate the clinical or community context of an RCT' (p. 456) to test these aspects of intervention feasibility. It was planned to run a pilot RCT for this purpose. However, due to lack of recruitment in the first six months it was deemed pragmatic to change to a pre-test, post-test design and to explore the issue of recruitment with key stakeholders. The ReDO-10 was implemented in 2018 and again in 2019 with the following research questions:

1. What is the feasibility of a future RCT of ReDO-10 in primary care in Ireland?
   - How successful were the recruitment procedures and how acceptable was the research process to stakeholders?

- How appropriate were the inclusion criteria and data collection tools?
- Was the intervention delivered with fidelity?
- Did the intervention show any trends towards effectiveness or perceived benefits in this new context?

2. What are stakeholders' perspectives of the future feasibility of ReDO-10 in primary care in Ireland?
   - How acceptable was the intervention to stakeholders? Were they satisfied with it?
   - How did it fit with current services?
   - What contextual factors could/did affect implementation and feasibility?

Methods

Design

This was a multi-phase, explanatory, sequential mixed-methods study. Two phases of quantitative (QUAN) data collection were interspersed with qualitative (QUAL) components and the qualitative data were given greater weight in the interpretation of results because of the small sample size [39]. The ReDO-10 programme was evaluated twice using a pre-test, post-test design with follow-up. The qualitative component of the study was influenced by the interpretive descriptive paradigm [40]. This methodology was developed by nurse researchers and academics as a means of generating rich qualitative data to improve understanding of clinical and healthcare situations. Using this methodology allowed the researcher to apply a framework to drive the research questions – in this case, published guidance on feasibility studies [38]. The sequence of data collection phases and analysis is given in Table 1.

Setting

This study involved a change in usual practice for occupational therapists and to the usual referral pathways for GPs, so a full understanding of the context was required [41]. The Health Research Board Primary Care Clinical Trials Network (HRB PC CTNI) provided support for the study by promoting it to GPs and providing them with a small financial incentive to participate. A Health Service Executive Primary, Community and Continuing Care (HSE PCCC) Occupational Therapy Department in the west of Ireland supported the study by granting protected time to therapists taking part. The HRB PC CTNI Public and Patient Involvement committee reviewed the study protocol and participant information materials for acceptability and clarity. Full ethical approval was granted for the study by the Irish College of General Practitioners Research Ethics Committee in March 2017 and a protocol was published [42].

Participants

Women were recruited by GPs in both urban and rural areas of the west of Ireland, from practices with a wide range of socioeconomic representation. Posters were placed in primary care centres and family resource centres so women could self-refer. The ReDO-10 groups took place in a city-based primary care centre. Inclusion criteria were; (a) female, (b) between the ages of 18–66, (c) diagnosed with anxiety or had stress-related concerns with/without another diagnosis, (d) had visited their GP on at least two occasions with concerns about stress and/or anxiety (e) self-identified to the GP or researcher as feeling that their life was out of balance, overburdened or lacking in meaningful occupation. Exclusion criteria were; (a) in acute crisis, (b) had current alcohol or drug addiction issues or (c) had other reasons why

Table 1. Data collection phases and analysis.

Year	Type of data	Dec-Jan	Spring (Jan–April)			Summer (May–July)	
2018	QUAN	Recruitment & Baseline assessment	ReDO-10 Phase 1	Post-intervention assessment	ReDO-10 follow up groups	Follow-up assessment (2 months)	
	QUAL		OT self-reflections	GP interviews			ReDO-10 participant interviews
	QUAL and QUAN analysis. Results guided recruitment strategy for Phase 2						
2019	QUAN	Recruitment & Baseline assessment	ReDO-10 Phase 2	Post-intervention assessment	ReDO-10 follow up groups	Follow-up assessment (2 months)	
	QUAL		OT self-reflections				ReDO-10 participant interviews

QUAL and QUAN analysis. Integration of results.

group participation could have been difficult e.g. cognitive impairment. These inclusion criteria were designed to be broad given the high proportion of comorbidity of other conditions along with anxiety in primary care settings [43], to include women across the working age-range and to maximize recruitment.

Data collection

Interview protocols were developed addressing the research objectives and were piloted. Audio-recorded qualitative interviews were carried out with the nine GPs who referred to the study, the two occupational therapists who facilitated the ReDO-10 groups and consenting women who attended the ReDO-10 groups in 2018 and 2019. Interviews were between 25 and 60 min long. To evaluate intervention fidelity, the therapists completed a written reflection after each session on how closely they had adhered to the manual, any adjustments made and notes on their facilitation [44].

Quantitative data were gathered to determine whether the outcome measures chosen were appropriate, acceptable and whether the participants showed any improvements [38]. Validated and reliable outcome measures were selected to assess mental health symptoms and daily functioning, as well as outcomes theorized to be influenced by the ReDO-10. The specific outcomes were: levels of depression, anxiety and stress (Depression, Anxiety and Stress scales (DASS) [45]), disability (WHO Disability Assessment Schedule 2.0 (WHODAS 2.0) [46]), occupational value (Occupational Value instrument with predefined items (OVal-pd) [47]), mastery (Pearlin-Schooler Mastery Scale (PMS) [1] and perception of health (visual analogue scale of the EQ-5D-5L (EQ-VAS) [48]). The self-report measures were completed by the participants at baseline, after the main 10-week portion of the programme and again 2 months later, after the two follow-up group sessions. The post-intervention and follow-up measures were returned to the researcher by post or in person.

Data analysis

The Framework Method was used to analyse the qualitative data. This method allows qualitative data to be analysed at a thematic level across all stakeholders, but also allows the words of a single participant to be connected to all their other statements [49]. This is important where there could be differing/divergent views on feasibility depending on context. Data analysis followed the steps of the Framework Method: (i) transcription of interviews, (ii) familiarization with interviews, (iii) inductive line-by-line coding, (iv) developing a framework (defining and reducing codes before clustering them into categories. This stage was both inductive and deductive – influenced by the research objectives), (v) sorting the coded transcript sections into the framework and (vi) interpretation (exploring connections, finding disparity, developing conclusions) [49,50]. Using the Framework Method also allowed for the quantitative data to be integrated to better understand the participants' outcomes. Because of the small sample size, no inferential statistical tests were carried out [51]. The non-parametric Friedman test was used to investigate differences over the three time-points.

Results

During the qualitative analysis, an overarching framework of four themes and thirteen subthemes was developed. The quantitative results were integrated during analysis and informed the understanding of outcomes. The four themes (with subthemes) developed are given in Table 2.

Research design, conduct and processes

Recruitment and retention

In total, 31 women were referred or expressed interest in participating in the study over the two phases of feasibility-testing in 2018 and 2019. It is unknown how many women were approached by their doctor or saw the recruitment posters and declined participation. Of this 31, 15 women gave consent and began the ReDO-10 (6 in 2018 and 9 in 2019). The mean age was 44.2 years (Range: 21–65). Participants had a range of work/study experiences: working fulltime (2),

Table 2. Themes and subthemes developed.

(1) Research design, conduct and processes
- a. Recruitment and retention
- b. Suitability of the inclusion/exclusion criteria
- c. Acceptability and understanding of research

(2) Intervention content and delivery
- a. Acceptability of ReDO-10 in principle
- b. ReDO-10 structure, layout and format
- c. Practical implementation and group facilitation considerations

(3) Outcomes and outcome measurement
- a. Collecting data
- b. Perceived benefits of ReDO-10
- c. Contextual factors and outcomes
- d. Harms or unintended consequences

(4) Context.
- a. Stress in the Irish context
- b. Treatment options in primary care
- c. Occupational Therapy in primary care in Ireland

working part-time (5), on leave from work (2), working full-time in the home (3) and other, including studying or retired (3). Most women lived with a partner (8) or with a parent (3), while four lived alone. Finally, four women had no children, six had 1–2 children and five had three or more children. There were an average of four participants per week in 2018 and six participants per week in 2019 and the minimum/maximum number of attendees in a session was 3/9.

It was evident from the GP interviews and using the Framework Method that the GPs who spent more time discussing the study with their patients and actively encouraged participation recruited more women. One particular GP selected patients whom they thought would be suitable, rather than asking everyone who met the inclusion criteria. All GPs reported some refusal when women were told about the study. Patients who refused counselling and other self-management interventions also tended to refuse ReDO-10. This was viewed by GPs as sometimes a '*personality thing*' (GP4) or showing a belief that such interventions are '*airy-fairy*' (GP1). Other GPs felt the 10-week length and 2-hour sessions were a barrier to working or time-poor women. One GP discussed more subtle reasons why recruitment was difficult. For some women, taking time out for therapy would be viewed as '*a luxury*', '*indulgent*' or '*like telling their partner "I'm going to get my hair done"*' (GP3). Interestingly, this view was echoed by one ReDO-10 participant who had chosen not to tell any of her family she was attending because it felt '*self-indulgent*' and '*a bit American*' (3656). The characteristics of the women who participated demonstrate that a degree of acceptance of self-analysis is necessary for successful recruitment to studies involving therapies like ReDO-10. Those who were recruited wanted to '*better myself*' (6686), were '*always doing bits and pieces of work on myself*' (9421) or wanted to '*start changing myself*' (1558). Participation was considered essential by a further three women who were more acutely distressed, were '*struggling*' (1262) or had '*reached a tipping point*' (1558).

Self-referral (posters and leaflets) and GP referral were used to recruit to the 2019 ReDO-10 group. This was more successful than GP referral alone and participants were recruited more quickly and retained more successfully. OT1 felt that those who self-referred were '*proactive in change*' and were '*motivated to make changes*', leading to more dynamic group discussions. There was reasonable retention of participants. Three women (1 in 2018 and 2 in 2019) dropped out or withdrew. Text reminders sent by the therapists about the follow-up groups were helpful in encouraging attendance. For three women, attending ReDO-10 consistently was a goal they set for themselves. This (for one woman) involved having the assertiveness to ask her spouse to bring their child to an appointment where '*normally, I would just take a back seat and make sure they all get wherever they have to be*' (1558). Two other women cited strong principles about commitment '*I said I'll go, so I will go*' (9421).

Suitability of the inclusion/exclusion criteria

Generally, the inclusion/exclusion criteria were appropriate and broad. In 2018, women who were seeing a Psychiatrist or were over the age of 60 were excluded. Two GPs noted the Psychiatry restriction reduced recruitment – therefore this was changed for 2019. The age limit was also raised and three woman in their 60's were recruited for the second group. GPs appreciated the broader inclusion criteria, as one remarked '*It's what we're seeing every day of the week*' (GP6). Another appreciated that there didn't need to be a formal diagnosis, '*just having difficulty with life-… very realistic*' (GP8).

Stakeholders reflected on who could be suitable for future ReDO-10 programmes in this context. Carers or ex-carers, women with responsibility for children and/or grandchildren or people managing stress along with chronic conditions were all mentioned. Stakeholders indicated that this intervention is best as a preventative measure, in order to prevent people '*ending up on medication*' (GP3). One participant in her 60's reported that ReDO-10 would have been more effective earlier in her life, but now she '*has been there – done that*' (9421).

Acceptability and understanding of research

The idea of research was acceptable and understandable to participants. Some had an altruistic motive: '*I hope it'll help someone, the way it's helped me*' (1262). Others reported that they had had gained personally from the experience; '*It was for myself… growth*' (6686). Trust in their doctor and in the researcher made the idea of research more acceptable; '*I asked my doctor first*' (4678). The occupational therapists saw research as a welcome '*break from routine*' (OT1) and are open to future participation if resources are made available. Participation in research involved a time commitment for both therapists, particularly in 2018, when they were less familiar with the material. The occupational therapy manager supported their

participation, but there was corresponding pressure on waiting lists and other clinical work as a result: '*It's not as if there was someone picking up the slack, you know?*' (OT2)

Randomization was viewed by some GPs as; '*not something that everybody appreciates*' (GP8) and two believed that future research should not include randomization; '*if people … had the guarantee that they would get the service?*' (GP4). However, it was viewed as acceptable by both the ReDO-10 participants and other GPs. The method of recruitment to the study was viewed as '*very straightforward*' (GP5) by one GP but was acknowledged by another to '*take a bit of extra time*' (GP8). The post-group reflections showed that occupational therapists understood the concept of intervention fidelity in the context of a trial: '*Followed manual as presented*' (OT Reflection)

Intervention content and delivery

Acceptability of the redesigning daily occupations programme in principle

Overall, stakeholders spoke positively about ReDO-10 as an intervention. Most participants felt that the content resonated with their experiences and their stress: '*No matter what people were talking about, I was like – Yeah, I get that*' (1558) and '*it made sense*' (4678). The central occupational ideas of the programme were described accurately by most participants – indicating that the content delivered matched the theoretical background of ReDO-10: '*it's redesigning daily occupations*' (6686), '*learning how to do things differently so I'm not so stressed*' (3656). Some participants described ReDO-10 to friends and family as '*an educational thing*' (6686), whereas another saw it as '*group therapy*' (4572). However, two participants found it was not so helpful to them. Both had a long history of anxiety and some content '*was stuff that I had already figured out on my own*' (5505). Interestingly, ReDO-10 was welcomed personally by the occupational therapists who '*both felt it in our personal lives*' (OT1). One of the therapists made changes to her working hours to have better life balance as a result of ReDO-10 discussions '*I used to work four full days….we changed everything around… which makes life so much easier*' (OT2).

The fact that only women were in the group was welcomed strongly by almost all the stakeholders. Many participants said they felt it was '*easier to share your feelings with just women*' (3656) or even more strongly, that having men in the group would have restricted their participation – '*I wouldn't have said some things*' (1558). This was echoed by the therapists who reported that participants '*wouldn't have felt safe and open to have the conversations they were having*' (OT2) particularly around issues like sexual relationships and the menopause. The only participants who would have been '*comfortable enough with a mixed group*' (6797) were two women in their mid-60's, who felt that gender-specific groups weren't '*that important… at this stage of life*' (9421). Stakeholders felt that a male-only group using ReDO-10 could work, but only if the material was adapted. This appeared to be due to perceived differences between the genders; '*it's not the same for women as it is for men*' (3656) and the importance of female support for women;' '*I think women supporting women is very important*' (4678). One GP felt that while a male-only group might be '*a hard one to run… as they got familiar, it would be very beneficial*' (GP1).

ReDO-10 structure, layout and format

Although the length of the programme (10 weeks plus two follow-ups) was felt by GPs to restrict recruitment, those who participated stated that it should be longer. There were two aspects to this. Firstly, several women felt they were only starting to make changes by the end of the course; '*you are only kind of getting into the swing of it and it's over*' (2612) and secondly, that they needed a longer period of follow-up and support to really embed changes; '*you need to be reminded*' (6686) '*It's harder to keep it going when you're not meeting up with someone, because you forget and you revert back to your own ways*' (1262). Of note however, the evening seminar, which is designed to synopsize the programme content so that women can feel supported in their families or workplaces to make changes, or for family units to make changes together to reduce stress was not acceptable to participants. All but one who spoke about the evening seminar did so negatively. There was a strong view that this group was their personal space and that changes to be made were theirs individually. This came through in the use of the words 'I' and 'my' in their accounts: '*It was my course*'(1558), '*This is my thing….my stuff…. It's for me to get independent'(2612), 'It's my own personal journey*'(3656). This was corroborated by the therapists who reported that group members were '*horrified*' by the idea of the seminar; '*It was for them to be making changes and it was about what they could do and empowering themselves….I would have thought… they were making changes that were affecting the whole family, but they felt that this was their change to make. Not*

someone else's' (OT2). One participant spoke at length about another reason for disliking the idea of the evening seminar – relating to vulnerability and the perceptions of others; '*I was mortified. I was like, there's no way I can bring somebody. … people would think of me, "doesn't she think highly of herself now that she needs to get us all involved in her life plan?"*' (3656). One participant spoke positively about the evening seminar, but as a person born outside of Ireland, she felt this could be related to cultural differences; '*I think it's very good. In Ireland … .people really feel embarrassed if the other people knows you going to the psychologist or counselling. I don't know why? It's the same like other doctors*' (4572). Because of this feedback, the evening seminar was not held in either 2018 or 2019.

Another aspect of the ReDO-10 programme was the homework given during the ten weeks. This may have included an occupation-based task e.g. to do a pleasant, uplifting occupation, or a reflective task e.g. to write a goal. The therapists reported that '*some did and some didn't*' (OT2) do the homework tasks, reflecting that '*that's people*' (OT1) and participants' own accounts reflect this. One women had a strong sense of personal responsibility towards the homework '*I want to do it for me … .I was trying to do it to be honest with myself*' (6797), whereas another found it hard to priorities this over family responsibilities '*I didn't do the going for walk things, really, because with kids there, it doesn't suit timewise. And when my husband would get home, it's too late to go and it didn't suit and I'd get tired and whatever*' (1558). The homework tasks were viewed as important by those who did do them: '*another week was, you write down everything you do for one day. And it was funny, because it made me do a small bit more because I wanted to look good even though no one was going to see it. But even now I can still do, like if I might write down in my diary, I did this, did this, did this and I can check off a few things that I did during the day*' (1262).

Practical implementation and group facilitation considerations

The therapeutic effects of the group-based format were mentioned frequently by participants and were perceived as instrumental to changes that occurred according to the therapists: '*It was the group dynamics within themselves that was creating the change*' (OT2). Dynamics between people at different life stages or with different levels of occupational dysfunction required careful management and the occupational therapists reported that a therapist would require '*really advanced facilitation skills*' to '*keep it cohesive*' (OT1). Most participants valued the group experience strongly and it seemed to offer different experiences to different people: catharsis '*I was just able to tell somebody*' (1558), a sense of peer support '*you're getting it from people who also have their own issues*' (1558), finding a role model '*If she can do it and she's a single mom … .I can try it*' (3656), problem-solving '*the girls has kind of similar problems so we can give advice to each other*' (4572) or reducing isolation '*knowing that you're not alone or … .that people will say 'Oh yeah – that's the way I feel too*' (4678). Three participants reported less positive experiences. The experiences of participant 6797 indicate the importance of strong boundaries and rules in a group setting to maintain a therapeutic environment: '*I was getting resentful towards the late timekeeping and it was getting worse as the time was going on. … I was feeling more for the other people … .that were there on time, that wanted to talk and wanted the group*'. Participants 9421 and 5505 both felt that that the content was not so relevant to them and, understandably, they did not form the same connection with others; '*it was interesting to see what other people's stresses and things were. And kind of frustrating in other ways because I'd hear about something that seemed so miniscule and irrelevant to me but that was a massive thing for them*' (5505)

The strict manual-based intervention required adaptations by the therapists while remaining within the limits of intervention fidelity. Adaptations made included changing the order of content delivered within a session or adapting some of the occupation-based sessions. A particular issue for facilitators was that they believed that essential content had been removed from the ReDO-10 when it was adapted from ReDO-16 and so they reinstated some of this material: '*what we had to do sometimes was take stuff that was in the main manual that they had taken out from the primary care one and put it back in. Because for flow, it didn't work without it*' (OT1). Another adaptation was to do the homework within the sessions.

Outcomes and outcome measurement

Collecting data

Baseline data collection was completed without difficulty ($n = 15$) and post-intervention questionnaires were collected from all those who completed the ReDO-10 programmes ($n = 12$). There was some

attrition after the 2-month follow-up period ($n=9$). This may have been due to differences in how questionnaires were collected (in person vs by return of post). Completing the five outcome measures took longer than expected for participants. In their interviews, participants reported that most questionnaires seemed appropriate apart from the WHODAS 2.0. Many items on this measure were seen as not relevant, particularly those relating to basic activities of daily living; '*some of it wasn't so relevant for me….-about your day-to-day, like getting up and dressing and washing*' (4678). This assessment caused some confusion for participants about how to score themselves. Participants couldn't accurately say they were unable to do a task e.g. household chores – feeling instead that they were avoiding these tasks due to stress; '*The one I found difficult to do was the 'has it stopped you from doing stuff' one. Well, not physically no. …I decided not to. I chose not to do it because I was feeling down. So did it stop you? Or did you stop yourself? ….so I found them difficult to answer*' (3656).

Perceived benefits of ReDO-10

The intended occupational outcomes of ReDO-10 [28] were reported by participants. For example, participants reported choosing more meaningful occupations and enjoying them with full awareness: '*I made a conscious effort of being aware of my surroundings and it was a really nice day and listening to the birds and seeing the cattle in the field and just being present in the moment. It was really, really enjoyable*' (1262). These kinds of occupations were seen as important for reducing rumination and improving health; '*I've always loved gardening. But I kind of realize now that the reason why I do love it so much is because it does give me that break and it is a kind of break for myself. I'm doing the stuff that's physical; I'm looking at things and it might be weeding, it might be planting; it's whatever I'm doing, I'm just doing that. My mind kind of goes blank. I just concentrate on what I'm doing. Mindfulness. And that helps. But prior, I suppose I wasn't.*' (1558). Choosing these occupations meant that women sometimes had to be assertive, say no to other demands or delegate housework to others in the home. For example, participant 3656 implemented a routine whereby her children help out more with household tasks. As a result she '*was having that hour every evening of just sitting down… the kids were in bed, on time. No messing. …definitely that time is a massive improvement*'. The programme gave women the opportunity to identify their personal health-promoting occupations and a drive to choose to priorities time to participate in them: '*I gave myself permission to lie in bed in the morning*' (6797), '*This is my thing. I'm going out with the choir. The choir is all I have and that's my thing*' (4678) '*I started to book stuff for myself, because they were saying, "do you ever do anything just for yourself?"*' (3656). Other small, but important changes reported by individual participants were increasing physical exercise (2612), reducing smartphone and social media use (5505) and returning to valued occupations such as reading (4572).

Improvements were also seen on the outcome measures after ReDO-10 and these results were maintained or slightly improved at the 2-month follow-up. These improvements were statistically significant ($p < 0.05$) for all outcomes apart from perceived health. Mental health changes were clinically significant with for example, three women improving from 'Extremely severe depression' to 'Normal mood' on the DASS instrument. Table 3 outlines the pre, post and follow-up results.

Contextual factors and outcomes

From the integration of the qualitative and quantitative data it was evident that contextual and individual person factors could either have contributed to the benefits seen or restricted a woman's ability to make changes during ReDO-10. A clear example was where medication or lifestyle changes occurred at the same time as attending the programme; '*Since January, I started going to the gym and getting more exercise. And I've been having a better balanced diet and I just find that between that and the new anti-depressants – it makes a big difference*' *(5505)*. Participants with

Table 3. Results.

	Baseline mean ($n=15$)	*SD*	Post-intervention mean ($n=12$)	*SD*	Follow-up mean ($n=9$)	*SD*	*Difference over 3 time points ($n=9$)*
Perceived Health	55.67	*20.077*	72.92	*13.561*	70.00	*19.203*	$\chi^2(2) = 5.097$, $p=0.078$
Depression	18.60	*8.65*	6.67	*6.555*	6.89	*10.624*	$\chi^2(2) = 11.529$, $p=0.003$
Anxiety	14.93	*9.924*	6.25	*5.379*	6.67	*5.590*	$\chi^2(2) = 7.185$, $p=0.028$
Stress	21.20	*6.889*	11.25	*9.275*	10.44	*8.676*	$\chi^2(2) = 6.220$, $p=0.044$
Mastery	17.33	*3.559*	20.58	*4.166*	20.8889	*3.5862*	$\chi^2(2) = 9.484$, $p=0.009$
Occupational Value	38.73	*7.564*	48.67	*7.750*	47.11	*10.752*	$\chi^2(2) = 8.222$, $p=0.016$
Disability	31.4913	*13.623*	22.0408	*14.155*	17.239	*11.162*	$\chi^2(2) = 8.629$, $p=0.013$

other health challenges such as fibromyalgia or chronic pain continued to have daily disability as measured on the WHODAS 2.0 and one found it difficult to engage with group materials; '*My memory isn't good*… .*I can't retain stuff*' (2612). A participant with autism said that some ReDO-10 topics (such as managing complexity in daily life) were not as relevant to her because '*I can't be interrupted when I'm doing something*' (5505). Several participants had experience of other support groups or psychotherapeutic methods and the qualitative data showed that this experience led them to interact with the programme content in a different way, possibly influencing outcomes; '*Cognitive behavioural*… .*I did that one*… .*I kind of brought that element into this course. I definitely feel this course helped me with the last one' (3656).*

Harms or unintended consequences

There were few unintended consequences of ReDO-10 or of this study. Some participants reported feeling tearful or upset during some sensitive group conversations that reminded them of an issue in their own lives: '*They were talking about* … .*their parents, because a lot of their parents were still alive.* … *that just got to me a bit*' (1558). The self-analysis involved in ReDO-10 caused one woman some upset as the extent of her occupational imbalance became apparent; '*I found it very hard because a lot of my time was getting overwhelmed* … .*to go back to bed and I was really ashamed of it*… . *seeing it made me feel worse. Seeing it down on paper*… *something I knew to be true*' (1262). For all participants who experienced such incidents however, the support and sensitive group facilitation meant that they continued to feel safe in the group environment: '*They were saying, "you don't have to share anything you don't want to share"*' (3656).

Context

Stress in the Irish context

There was consensus among the general practitioners (GPs) that issues of stress and anxiety formed a large part of their clinical practice: '*every second consultation has an element of anxiety and stress. It's so pervasive*' (GP2). Stress was seen by the GPs as '*having trouble with life*' (GP8) and they cited a wide variety of reasons for stress-related complaints: including '*marital stress*' (GP6), '*anxiety around medical symptoms*' (GP3),'*financial stress*' (GP6), '*post-natal symptoms*' (GP3), '*social anxiety*' (GP2), '*work stress*' (GP7) and even just difficulty managing modern life: '*life is so fast for everybody and everyone is trying to do so many things*' (GP2).

Treatment options in primary care

The doctors make carefully-considered treatment decisions based on a sometimes long-term GP-patient relationship that demonstrate a stepped-care approach [52]. Cardiovascular exercise, mindfulness apps and time off work were recommended first, followed by a referral to the primary care counselling service before medication was prescribed. Frustration about the length of waiting lists for primary care counselling was expressed and there was a perception that referral to the more acute Psychiatric services was unhelpful: '*the feedback (from patients) is*… '*they always just ask me the same questions. I know what they're going to ask. They tick boxes and then they just put me on more medication*' *and so (patients) tend to disengage*' (GP2)

Occupational therapy in primary care in Ireland

For the GPs, making a direct referral to occupational therapy in the primary care context for a mental health reason was a new experience. The doctors were aware of the occupational therapy service, but until then had only referred elderly or physically disabled patients: '*the only time I'd tick that box to be honest is something for*… *an elderly person*' (GP5), '*people with disabilities where* … .*they need home modifications done*… .*that'd be it. I'd say it would only be once a month at max*' (GP4). While the GPs were supportive of this study, as it provided '*a positive treatment option*' (GP9), they were equally firm that it shouldn't increase waiting list times for priority occupational therapy recipients; '*occupational therapists already have such a big waiting list for physical disability and you need them for that*' (GP1). The occupational therapists also discussed waiting lists and their frustration with what they referred to as their narrow scope of practice as '*equipment providers*' (OT2). While both therapists reported it had been a positive personal and professional experience to run this new intervention, they commented that adequate resources would be necessary to continue this; '*if you had your OT for every primary care team of 8000 people, you would be able to do these things*… .*this is probably the kind of initiative you would be rolling out within primary care*' (OT2).

Discussion

In this section, the feasibility of ReDO-10 in the Irish primary care context will be discussed from two perspectives: (a) the feasibility of a future randomized-controlled trial (RCT) of ReDO-10 in this context and (b) the feasibility of future implementation of this programme more generally in Irish primary care [53]. When considering a future RCT, it is important to note that evidence for the effectiveness of both ReDO-16 and ReDO-10 is still emerging and research has not yet been conducted outside of Sweden where the intervention was developed. Based on this study, a RCT in Ireland is feasible but would require amendments to be successful in recruitment and implementation. Being part of a research study was acceptable to these women with stress and anxiety, but it is not known how many women declined to participate. Recruitment through GP referral only in 2018 was very slow and a pilot RCT could not be completed as intended. One GP selected patients purposefully for this study and telephoned them directly – achieving a higher recruitment rate. Telephoning patients directly has been shown to improve recruitment to trials that have low recruitment rates and should be considered for a future RCT [54], as would having a dedicated staff member in a GP practice for this work, using self-referral methods and targeting GP practices with a particular interest in women's mental health. The non-diagnostic title 'Redesigning Daily Occupations' in the information materials is likely to have been attractive and less stigmatizing to a wide range of individuals [55]. As with other studies involving recruitment by GPs to a psychological intervention in primary care, some of the GPs were uncomfortable with the idea of randomization and felt that discussing research took extra time out of their consultation with patients [56]. An active comparison condition that is perceived as equally effective as ReDO-10 could overcome discomfort of randomization and aid recruitment to a future RCT [55].

There was a degree of assessment burden for the participants in this study and there was some uncertainty about how to self-assess daily functioning. The ICHOM core outcome sets recommend measuring social, physical and work functioning using the WHODAS 2.0 as was done in this study [57]. Despite this perceived uncertainty, use of the WHODAS 2.0 should be continued in future trials so that results can be interpreted in comparison to other treatments for anxiety. Other assessments that could be used include measures of occupational value and occupational balance. The OVal-pd was acceptable to participants in this study, but it has not been validated in the Irish context [58]. Participants described feeling more empowered to make choices in the occupations they did every day, so concepts like volition, mastery or assertiveness would also be outcomes of interest to measure. Longer-term measurement of outcomes should be considered, as follow-up evaluations of ReDO-16 have shown that improvements in stress-related sick-leave rates following the intervention were not maintained 3–4 years later [30], although the ReDO-16 participants continued to report better occupational balance after that time-period.

When evaluating complex interventions, it is understood that maintaining rigid fidelity to a manual is not likely to be responsive in local contexts or to individual learning needs of participants [59]. In this study, the occupational therapists were aware of fidelity but made clinical decisions to change some of the content. In this way, they maintained adherence to the underlying theory and 'function' of the intervention, while adapting some aspects of its 'form' e.g. using material from the original ReDO-16 programme [35]. The therapists called for the manual to be adapted and improved before a trial and this could include allowing for flexibility in the occupation-based activities of the programme or doing an exercise in the group session, rather than for homework.

Randomized controlled trials may provide guidance about the effectiveness of interventions, but have been criticized as not considering how the intervention will be implemented in practice or in real-world contexts [59]. In this study, it was evident that ReDO-10 was valued both personally and professionally by the therapists who facilitated it – notwithstanding the time commitment involved in facilitating it. However, they acknowledged that longer-term use of this intervention in Irish primary care would require more resources, staff and a reconfiguration of the current occupational therapy role in this context as '*equipment providers*' (OT2). GPs recognized the high level of demand for interventions such as ReDO-10 in primary care, but had no experience of referring to occupational therapy for people with mental health concerns in this context. These insights show the importance of close collaboration with stakeholders to understand potential barriers to intervention implementation [44]. Future research/implementation should be contextualized within the growing emphasis on mental health promotion and prevention in primary care in Ireland [19] and the corresponding policies, strategies and potential funding sources that are

emerging e.g. the Healthy Ireland Strategy [60]. There should also be clear reciprocal benefits to any future clinical/research partnership. Providing training in the ReDO-10 free of charge to participating therapists is one such example.

This study was the first to implement either version of ReDO without measuring stress-related sick-leave outcomes and sick-leave was not an inclusion criterion for this study. Participants were in full-time work, part-time work, full-time mothers, students and in retirement. This suggests that ReDO-10 is acceptable to a wide range of people experiencing mild/moderate stress, anxiety, depression or emotional distress in primary care, regardless of their work status. Women can be susceptible to parental burnout as well as work-related burnout and researchers have seen a relationship between feelings of guilt and anxiety symptoms in mothers identified as at risk of burnout [61]. The women who participated in ReDO-10 described letting go of guilt and choosing occupations to protect their own wellbeing and health, pointing to the possibility of ReDO-10 as a preventative intervention for women at risk of burnout. The intervention does not focus on a diagnosed condition or a set of symptoms and this was welcomed by GPs. With regard to suitability, those with cognitive difficulties or those with autism may find the group process more difficult, as two participants in this study discussed. The female-only nature of the group was welcomed by almost all participants and the content was felt to be relevant. This may be due to the strong theory base of ReDO-10 which was developed based on the perspectives of women experiencing stress and complex daily lives [26]. Men may express and react to mental health issues quite differently and masculine-sensitive components could need to be incorporated into ReDO-10 if men are recruited to future trials. [62]. A recent study of the ReDO-10 recruited only 10 male participants out of 165 [34]. It is also unknown how acceptable ReDO-10 would be to those who identify as non-binary or transgender and future research of this intervention should consider the inclusion criteria carefully so as not to alienate gender-diverse people [63].

The World Mental Health Surveys have shown that attitudinal barriers prevent many people worldwide from seeking help for mental health issues. For people with mild/moderate conditions, having a low perceived need for help is a particular barrier [64]. GP3 reported that some women declined to take part in ReDO-10 because it would be seen as '*a luxury*' and participant 3656 echoed this – saying that it felt '*self-indulgent*'. Another common barrier to availing of mental health treatment is the desire to handle the problem by oneself. Again, this could be seen in some of the responses to GPs when they suggested ReDO-10. Despite a reported high demand for mental health services at primary care level from the GPs in this study, future ReDO-10 programmes may encounter these attitudinal barriers, as well as the structural barriers that prevent people in their middle years from availing of treatment e.g. time and finances [64]. Offering ReDO-10 in the evenings or at weekends could be considered, although this requires a substantial change to current primary care service provision models in Ireland.

Methodological limitations

This was a small feasibility study with a number of methodological limitations. While a pilot RCT would have allowed for some comparison between ReDO-10 and a control group, this was not possible because of slow recruitment rates. While stakeholder perspectives provide valuable insights, they can be subject to biases such as (i) demand characteristics – clients reporting improvement in line with what they believe the researcher's hypotheses to be, (ii) selective attrition – those who drop out of treatment tending to have worse outcomes, (iii) palliative benefits – clients feeling better about their symptoms without tangible improvements in them or simply (iii) maturation – the tendency for improvement to occur in treatment because of naturally occurring psychological growth [65]. A large RCT of ReDO-10 is required to determine effectiveness. Recruitment, data collection and interpretation were carried out primarily by the first author for this study – meaning that there is the potential for bias in interpretation. Member checking of the final qualitative themes could have provided some stakeholder confirmation, but this was not within the scope of this study.

Conclusion

When making decisions about future research following feasibility studies, including a wide variety of stakeholders in the generation and assessment of solutions to problems may help to understand issues that could hamper a future trial of an intervention, or affect the likelihood that the intervention is feasible in the real world [53]. The qualitative data from occupational therapists, GPs and ReDO-10 participants provided valuable context and differing perspectives on

the feasibility of the programme in the new context of Irish primary care. After the two phases of this feasibility study, it is evident that ReDO-10 was acceptable and valued by the participants who received it and had some perceived benefits in occupational participation and engagement. The group support and the dynamics between members were instrumental in any changes that took place as in other occupational therapy mental health group-based interventions [66]. Both GPs and occupational therapists supported the study although they highlighted the additional workload involved. The intervention itself was acceptable to the therapists who had facilitated it with fidelity to the underlying theory and with a high degree of clinical skill. A future trial of ReDO-10 in the Irish primary care context is feasible with modifications and stakeholder collaboration. However, this intervention is in an early stage of development and this study provides some insights into future adaptations, implementation considerations and contextual factors that need to be considered in future research.

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