An Ethnography of Creative Practice in Forensic Mental Health

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Abstract

This original research was funded institutionally as part of a larger AHRC/RCUK Connected Communities programme grant (AH/K003364/1), 'Creative Practice as Mutual Recovery' (CPMR) which critically investigated how creative practices may afford an opportunity for mutual recovery. The CPMR programme aimed to extend the notion of mental health recovery beyond individual patients to include other participating members, for example, informal carers, healthcare practitioners, volunteers. The notion that creative practices could foster and connect communities to enhance mental health and wellbeing was a central theme to the programme of research. This thesis focuses uniquely on the potential for creative practice to promote mutuality within a forensic mental health setting.

The thesis adopts an ethnographic research design congruent with the exploratory nature of the aims of this project. The research design is purposely iterative, exploring the concepts such as creative practice, wellbeing, and the emergent concept of 'mutual recovery' within an interpretivist tradition. The thesis investigates creative practice across three units within one inpatient forensic mental health hospital in the UK. The methods include overt participant observation and semi-structured interviews.

The thesis presents an innovative microsociological model for understanding mutuality through creative practices within forensic mental health. This new theoretical model draws on Interaction Ritual Theory to explore the creative practice rituals observed during the fieldwork and to consider their contribution to wellbeing, social connectedness, and mutuality. The observations and interviews established three key contextual features of life which were found to influence creative practices, wellbeing, social connectedness, and mutuality in the forensic setting: a) surveillance, security and risk; b) the emotive environment; and c) boundaried relationships. The study found that mutuality is constrained within the forensic mental health inpatient context. However, it also identified that when hierarchies

are less prominent or foregrounded, engagement in creative practices can contribute to the wellbeing of residents and staff and promote social connectedness.

This thesis argues that the forensic mental health environment can present challenges to creative practice and notions of mutuality due to a culture of risk, boundaried practices, and highly emotive interactions that occur there. Other societal influences, such as sexism and racism, also present challenges to creative practices and notions of mutuality within the therapeutic setting.

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Abbreviations

AHRC	Arts and Humanities Research Council
BMI	Body Mass Index
CCTV	Closed Circuit Television
CJS	Criminal Justice System
CPMR	Creative Practice as Mutual Recovery
DoH	Department of Health
EBR	Early Bird Researcher
EE	Emotional Energy
FMH	Forensic Mental Health
GP	General Practitioner
HMG	Her Majesty's Government
IRT	Interaction Ritual Theory
IMH	Institute of Mental Health
MoJ	Ministry of Justice
NHH	Nottingham Health Humanities
NHS	National Health Service
NICE	National Institute for Health and Care Excellence
RPA	Research Priority Area
SoFu	Centre for Social Futures
TV	Television
UK	United Kingdom
UoN	University of Nottingham
WHO	World Health Organisation

Key terms

Creative Practice:	Creative activities from the fields of the Arts and Humanities
Forensic Patient:	A patient with an offending history receiving care for their mental health
Mutual Recovery:	This concept explores the possibility of a reciprocal relationship between those engaged in the recovery journey, for example, staff or carers (formal and/or informal) and those receiving care from mental health services.
Patient:	A mental health patient/service user with a clinical diagnosis
Resident:	A patient at Westmarch Hospital (pseudonym)
Service User:	A patient and/or a forensic patient who is in receipt of care from a mental health service

Single quotations are hospital parlances and double quotations indicates direct interview / participant quote / quotation from the literature.

Chapter One: Introduction to the research

1.1 Introduction

This thesis is relevant to the fields of Forensic Mental Health (FMH), arts and health, and mental health recovery. This chapter serves as an introduction to these key areas, contextualising the research in 5 core sections: 1.2 The researcher; 1.3 Study overview and rationale; 1.4 Arts, health, wellbeing, and recovery; 1.5 Forensic Mental Health; 1.6 Research aims and questions. The chapter concludes with an overview of subsequent chapters of the thesis.

1.2 The researcher

I was born in 1988, the youngest of three daughters in a white middle-class family. I grew up in a small farming village on the outskirts of Nottinghamshire. My mother, a primary school teacher and my father, an academic. I attended a comprehensive public school located within an ex-mining village; the catchment area served the families of the village and extended to the inner city, bringing a diverse peer group. I was far from underprivileged but would sometimes feel embarrassed by my father's rusting car and a home that resembled a building site as my parents worked hard to turn our bungalow into a large five-bedroom house overlooking a vast idyllic landscape.

I attended university in 2008 and as part of my Psychology degree I chose to study critical social psychology, which explored ethical debates, the use of creative methodologies in research, and challenged the predominant positivist tradition within psychology by exploring philosophical debates. In 2011, I graduated with a BSc in Psychology and began working in mental health research at the Institute of Mental Health (IMH), Nottingham. In 2013, I completed a telephone assessment following an online self-referral and I was informed that I was severely clinically depressed. I was on the waiting list for a National Health Service (NHS) cognitive behavioural

therapist for over two months. During this time, I lacked positive social networks and I had become estranged from my family. After five sessions, I was told that the quantitative data collated from a measure on wellbeing showed that my scores had improved, regardless of how I said I felt, and I had expressed concern over our sessions ending. I then found a private therapist, which I could not comfortably afford so my parents covered the cost over the preceding years. I learnt the value of positive relationships and I learnt to grow emotionally alongside new supportive networks.

At the IMH, I read multiple case formulations of women with personality disorder as part of an evaluation of new services in the UK – the Offender Personality Disorder (OPD) pathway. The aim of the project was to train probation officers in psychological approaches. I found the history of the women's abuse profoundly upsetting and appreciated my prior learning about attachment theory. This proved valuable in understanding the depths of the emotional damage fostered in toxic environments and the treatment of individuals who are both victims and offenders. Two publications resulted from this work:

Ramsden, J., Joyes, E., Gordon, N. and Lowton, M., 2016. How working with psychologists has influenced probation practice: Attempting to capture some of the impact and the learning from the Offender Personality Disorder Pathway project. *Probation Journal*, 63(1), 54–71.

Ramsden, J., Lowton, M. and Joyes, E., 2014. The impact of case formulation focussed consultation on criminal justice staff and their attitudes to work with personality disorder. *Mental Health Review Journal*, 19(2), 124–130.

Also, during 2013, I joined a Managed Innovation Network in Community and Capoeira at the Centre for Social Futures (SoFu) at the IMH. The project explored the development of community through engagement with capoeira as a creative practice (Jordan et al., 2018).

I also became a member, and later the deputy lead, of the Therapeutic Environments Integrated Research Group. The idea that communities can support and promote positive social relationships was fascinating to me and I valued the network's aims of sharing important research and practice developments across the field of mental health from a psycho-social-environmental perspective. That same year, I embarked on a MSc in Research Methods, at The University of Nottingham and continued to work part-time at the IMH on the evaluation of the OPD. I successfully applied for a funded studentship exploring creative practices as mutual recovery (see below), adopting an interpretivist, social interactionist approach to the situatedness of such phenomena in a FMH setting.

1.3 Study overview and rationale

This research was funded by the University of Nottingham within a £1.2m AHRC/RCUK Connected Communities grant (AH/K003364/1), led by Professor Paul Crawford, entitled 'Creative Practice as Mutual Recovery (CPMR): Connecting Communities for Mental Health and Wellbeing'. Creative practice concerns creative activities from the fields of the arts and humanities. Mutual recovery explores the possibility of a reciprocal relationship between those engaged in the recovery journey, for example, staff or carers (formal and/or informal) and those receiving care from mental health services. This research explores creative practice as mutual recovery within the FMH setting and focuses specifically on the staff and those who are residents of one privately run FMH site in the UK. The FMH hospital caters to those who have typically been diverted from the Criminal Justice System (CJS) in order to receive mental health care.

The CPMR programme of research ran for 5 years between 2013-18, critically investigating, through a range of projects, how creative practices may afford an opportunity for mutual recovery in mental health and wellbeing. The AHRC-funded programme aimed to extend the notion of mental health recovery from patients or service-users

to informal carers, healthcare practitioners, volunteers, etc. The hypothesis of the programme was that:

> Creative Practice could be a powerful tool for bringing together a range of social actors and communities of practice in the field of mental health, encompassing a diversity of people with mental health needs. (Crawford et al., 2013, p.55).

Further theoretical development and genealogy relating to this idea of mutual recovery in this context is emerging (Brown and Manning, 2018). This thesis uniquely explores the potential for creative practice as mutual recovery within the FMH context.

1.4 Arts, health, wellbeing, and recovery

This section introduces the broad fields of arts, health and wellbeing in relation to mental health recovery. Key literature relating to these fields is further explored and debated in section 2.4.

1.4.1 Arts, health, and wellbeing

The CPMR programme contributes to the field of arts, health, and wellbeing by exploring the influences of creative practice engagement on wellbeing. The growing interest in the field of arts and health which extends the notion of ill-health to that of holistic wellbeing has been noted by Stuckey and Nobel (2010, p.254), who state:

> [An] expansion of individual and community health-enhancing efforts worldwide and an acceptance of the definition of health as being more than the absence of illness are spurring active investigation into the fundamentals of whole-person approaches to creating and sustaining health.

Thus, Stuckey and Nobel (2010) maintain that wellbeing concerns the health of the individual beyond illness in a holistic way. Increasingly, a number of different initiatives in arts and health, which Crawford et al. (2015, p.1) call 'health humanities' are at "the intersection of the humanities and healthcare, health and well-being". Such initiatives consider the value of engaging in creative practices to enhance health and wellbeing. Relevant literature within this area of applied arts and humanities is further explored and debated alongside considerations of their contributing value to health and wellbeing, in section 2.4.

In 2017, the UK government published a report importantly "recognis[ing] the powerful contribution the arts can make to health and wellbeing" (All-Party Parliamentary Group on Arts, Health & Wellbeing, 2017, p.4). This report outlines the benefits of arts engagement to individuals and societies through improved wellbeing and reduced health and social care costs. The report outlines the current state of arts engagement in the UK and defines eight categories of creative practices, for example, community participatory arts programmes, and arts in health in care environments. Whilst the benefits of arts engagement is growing in recognition, in times of austerity, funding resources can be re-directed (All-Party Parliamentary Group on Arts, Health & Wellbeing, 2017) or create an unstable atmosphere within community projects which can serve to undermine the benefits promoted by arts engagement. For example, Lewis et al. (2016, p.9) notes:

> funding pressures and constant restructuring of the [Adult Community Learning] ACL sector … [is] highly detrimental both to traditional goals for ACL and the mental health and wellbeing agenda.

Such changes are argued to be due to the growing need for measures of accountability that require validity (White, 2009) and the resultant

political popularity of evidenced based practice through which funding decisions can be made based upon information about the effectiveness of interventions (Head, 2010).

However, Broderick (2011, p.105) notes that the broad field of arts and health may be better served by "negotiating a philosophical space of creative inquiry rather than clinical evidence-based benefit" and concludes that "[d]issatisfaction with the current approach of [Evidenced Based Medicine] EBM has led to a rethinking of what is wanted from evidence prompting a new philosophical research agenda". Thus, if "participation in social activities is seen as a powerful determinant of health and happiness" and creative activities can be a powerful tool for promoting social interaction (White, 2009, p.50), there is a need for not only creative approaches to research, but an acceptance of these.

In the 1960s the survivor/ex-patient/mental health consumer movement began and is often described as a civil rights campaign (Davidson et al., 2010). The root of this recovery movement was to fight for the fundamental rights of people with mental illness as their social and legal status declines following a psychiatric label (Thornicroft, 2006). The overarching aim of the recovery movement is "to afford people with serious mental illnesses the rights, opportunities and resources needed to lead meaningful and productive lives" (Davidson et al., 2010, p.3). Anthony (1993, p.527) provides one of the earliest and most highly cited definitions of recovery:

> Recovery is described as a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills, and/or roles. It is a way of living a satisfying, hopeful, and contributing life even with limitations caused by illness. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness.

According to Anthony (1993), recovery is, therefore, a personal journey that cannot be governed by others. This view sharply contrasts clinical recovery which is based on clinically significant symptoms (Slade, 2010). Crucially, Slade (2009b) argues that mental health services should focus on the priorities of the individual with a mental illness and focus on wellbeing rather than just on illness. The recovery movement promotes autonomy for those often oppressed (Deegan, 2001). Thus, the recovery movement advocates autonomy and the promotion of personally meaningful lives beyond a mental health diagnosis.

Bonney and Stickley (2008) conducted a review of the British literature on recovery and found that those who experience mental illness often find that their self-concept changes towards a more negative self-image. The prejudice and discrimination experienced by those termed mentally ill is widely discussed in the literature as major barriers to recovery. For example, Deegan (2001, n.p.) discusses the detrimental effects of being psychiatrically labelled and the:

> powerful messages from professionals who in effect tell us that by virtue of our diagnosis the question of our being has already been answered and our futures are already sealed.

Whilst the effects of discrimination can significantly influence the individual on a psychological level, for example, their self-esteem and self-confidence (Yanos et al., 2010), there have also been links to shorter lifespans as a result of widespread discrimination (Davidson et al., 2010). Poor mental health and physical health have been linked (Prince et al., 2007) and in 2011, the Department of Health published a policy paper with the strapline: "no health without mental health" (HMG/DoH, 2011). Consequently, mental health services are incentivised by the payment by results commissioning structure (Sugarman and Dickens, 2015; McDonald et al., 2013), with

indicators, for example, concerning reductions in Body Mass Index (BMI) and smoking, identified by those undertaking smoking cessation (NHS England, 2017). As such, current mental healthcare is increasingly governed and incentivised by a range of policy directives.

1.5 Forensic mental health

Forensic Mental Health (FMH) is a specialism that involves the assessment and treatment of individuals with mental illness who engage in or are at risk of offending related behaviour (2000). Rogers and Soothill (2008) extend the definition of FMH to include a preventative approach in working with individuals who have committed crimes who are also at risk of developing a mental illness. FMH services provide specialist care for the services across the Criminal Justice System (CJS), for example, the courts, prison, and probation for those requiring mental health services. FMH services cater for individuals whose mental health is deemed the causal factor in their offending behaviour or are considered at risk of offending behaviour and meet the criteria for detention under the Mental Health Act (1983/2007) (Joint Commissioning Panel for Mental Health, 2013). The Mental Health Act (1983/2007) authorises compulsory admission to hospital (Department of Health, 2008a). The Act was revised in 2007, following the White Paper: 'Reforming the Mental Health Act' issued by the Government (Chisnell and Mitchell, 2013). According to the Act, mental disorder is broadly defined as "any disorder or disability of the mind; and 'mentally disordered' shall be construed accordingly" (Leigslation.gov.uk, 2007). Debates regarding the suitability of the Act exist, for example, there are debates relating to the ethical implications of legal detention and involuntary treatment, whilst others argued that without the Act, "[p]eople in distress would go without help" (Szmukler and Weich, 2017, p.2).

Individuals within FMH services are referred to as offenders, patients, service users, and mentally disordered offenders (Prins, 2010). A multitude of professions now work within the field (Rogers and

Soothill, 2008) therefore, these terms are used interchangeably within and across FMH services and the CJS. The terms FMH resident and FMH patient are adopted in this report for brevity and without intentional alignment to a particular school of thought or field. In fact, the view of this thesis is that the use of labels (e.g., mentally disordered offenders) elicit a negative ethos for those who live with these and for those who utilise them (Dixon, 2015). An example of the negativity of labelling is that those who maintain or do not deviate from normalcy (however socially constructed) do not attract such descriptors. For example, Deegan (1997) interestingly introduced the term Chronically Normal People (CNP) to describe those who have not encountered a psychiatric disorder—indicating the power of labels for those deemed deviant from the norm and thus are less accepted. It should also be noted here that the use of the terms FMH resident or FMH patient does not imply overlooking the individuality of those in receipt of FMH care, but simply to identify individuals as living in such services or receiving care. I use the term FMH patient when discussing the FMH population more widely and FMH resident when referring specifically to the research site.

The cost of FMH services to the taxpayer is high, particularly when the relatively small population that it serves is taken into account (Sugarman and Dickens, 2015). The landscape of secure mental health services in England is provided by (NHS Commissioning Board, 2012, p.3) who state that:

> Commissioners in England currently purchase approximately 6000 inpatient beds in secure mental health services
>
> - Approximately 680 in high secure (commissioned for England and Wales)
> - Approximately 2800 in medium security and
> - Approximately 2500 in low security.

Sugarman and Dickens (2015) note that secure care in England and Wales accounts for approximately 15 percent of direct funding for mental health. The private sector provides approximately 50 percent of secure psychiatric beds in England and Wales (Thomson, 2008), and is suggested to cost at least three times more than a bed in a general hospital (Ramon, 2018). Within this context of expense, effective models of care are then paramount. Section 2.2.1 explores the development of secure FMH care in England in more detail.

1.6 Research aims and questions

Research Aims:
The research aims to explore creative practice within one FMH residential site and consider:

- its relation to mental health and wellbeing for staff and residents
- the possibility of mutual recovery of mental health and wellbeing for staff and residents.

Research Questions:

- What formal and informal creative practices occur in the forensic mental health service?
- How do creative practices in the setting contribute to or negatively influence the mental health and wellbeing of both the residents and staff?
- Do creative practices in the setting offer an opportunity for shared benefit or recovery among residents and staff?

1.7 Overview of chapters

This thesis comprises seven main chapters. Chapter one, acts as a preface to the thesis, introducing the researcher and the three scholarly fields which underpin this doctoral work: FMH, arts and health, and mental health recovery. Chapter two explores the key literature in relation to these fields including: institutional life for staff and patients; recovery and mental health and a socially sensitive view of recovery, that is, mutual recovery, and recovery in secure settings; arts, health, and wellbeing; and the theoretical framework Interaction

Ritual Theory (IRT), which is utilised within this thesis to explore mutual recovery through creative practices. Chapter three presents the research design and methods adopted in this doctoral work and debates: ontology; epistemology; the research questions and study aim; methods; analysis; and ethical considerations.

Chapter four presents the three key contextual features of life at Westmarch Hospital. It serves as an introductory analysis chapter to the field-study-site utilising data from the fieldnotes and interviews. The key contextual features of institutional life are presented and analysed as a prelude to subsequent chapters. This chapter introduces the microsociological model of therapeutic social capital, which is utilised as a theoretical framework in chapter five. Chapter five presents the novel findings related to mutual recovery through creative practice and utilises the model introduced in chapter four to explore a series of formal (i.e., timetabled) and informal (i.e., spontaneous) creative practice moments and considers their contribution to mutual recovery. Chapter six explores mutuality at the field-study-site and considers a valenced approach to explore a more negative side of the relational concept. Chapter seven returns to the research questions and reflects upon the methodology, methods, and considers implications for future research, policy and practice.

Chapter Two: Literature review

2.1 Introduction

This chapter debates the key literature relevant to this thesis, plus where the gaps in literature exist to which this thesis speaks. The literature review is, therefore, also a justification for this research. The relevant scholarly fields are Forensic Mental Health (FMH), arts and health, mental health recovery, and a theoretical framework: Interaction Ritual Theory (IRT). FMH has been briefly introduced in section 1.5, the debate within this chapter focuses on notions of risk and mental health recovery. It is recognised that broader debates exist, for example, in relation to clinical diagnosis and treatment for mental health (particularly in relation to personality disorder) however, these debates are not within the scope of this thesis.

The literature review approach adopted explored the background literature in relation to institutional life, mental health recovery and arts and health before data collection took place to develop further understanding of context. The search strategies within these areas included the terms deinstitutionalisation, personal recovery, mutual recovery, arts in/and health. The emergence of themes during field work led to exploration of IRT, which is introduced in this chapter. Debates covered in this review extend beyond the UK and thus relevant international literature has been included which contribute to the wider debates. However, where possible, literature which focuses specifically on the UK context was included due to the field-study-site's location.

This thesis frames mental ill health as existing on a continuum of fluctuating wellbeing. Furthermore, it is argued that health and illness are instable and temporary constructs (DeNora and Ansdell, 2014). While debates in relation to wellbeing are explored in section 2.4.1, this section provides an overview of both the literature contributing to knowledge about wellbeing in general and also mental health

recovery for those with a clinical diagnosis. This thesis indirectly challenges care that views the medical model as central by considering a socially focused approach and contribution to wellbeing.

2.2 Institutional life

The aim of this section is to understand the context in which the doctoral work was undertaken. The premise of this thesis is to understand the situatedness of creative practices embedded within FMH practice. This section begins with an exploration of a marked journey in the history of mental healthcare—the deinstitutionalisation of mental health hospitals. The competing frameworks of care and custody in relation to FMH services are then considered, which inevitably influence the experience of the patients and staff, which are also considered.

2.2.1 Brief history of deinstitutionalisation

The history of mental health hospitals is firstly discussed, followed by current FMH provision in the UK. The asylums were first marked within the Victorian era; these institutions were created to cater for those who were deemed mentally ill and were governed by the Lunacy Act (1845) (Turner, 2004). This institutional approach to the containment and treatment of those considered unwell was reflected across Europe (Wright et al., 2008). In the 1940s the population living within the asylums hit their peak (Kim, 2016). Shortly after this time in the 1960s, the field of sociology argued for a more sensitive approach to language use and labelling, such terms such as lunatics were suggested to be dehumanising and derogatory. Goffman's (1961) seminal work, Asylums, have been argued to have also contributed to the debate of humane treatment for those receiving mental healthcare within the large institutions (Turner, 2004). The notion that those with social problems were being perceived and treated as though they were second class citizens was delineated as unfair, and a more holistic viewpoint was argued for. Labelling theory and deviance theory became popular tenants for psychiatry, criminology, and sociology (Jones, 2004). During this time there was also the anti-

psychiatry movement (Turner, 2004), in which psychiatry was criticised for utilising mechanisms of social control, such as, the mental hospitals and prison establishments. The problem was attributed to society labelling the individual as deviant (Jones, 2004). It is also for these reasons that such institutions are viewed ambivalently, as they house the delinquent, economically deprived, criminal, mentally disordered, poorly educated, and poorly integrated into society (Davies, 2004). The negative descriptions of mental institutions in the 1960s and 1970s were argued to be based on those in the United States with much larger inmate numbers than those reflected in British institutions (Jones, 2004). Nonetheless, the movement was underpinned by civil rights and thus the notion of humane treatment continued to be questioned.

In the late 1960s to the early 1970s therapeutic institutions were under scrutiny and as a result there were many reports of scandals in the media (Jones, 2004). For various reasons, for example, the development of pharmacology treatments (Hinshelwood, 2001; Killaspy, 2006; Turner, 2004; Wright et al., 2008), inquiries into scandals (Turner, 2004), reductions in public spending, the normalisation concept (McNelis, 2018), and the anti-psychiatry movement (Turner, 2004), the closure of the asylums and the era of deinstitutionalisation began. In the UK, the political shift of decentralisation of the NHS, prompted by neoliberalism, led to the closure of 100 psychiatric hospitals between 1985–2000 (Ramon, 2008). From a sociological viewpoint, this movement was underpinned by a moral reasoning which aimed to treat mental health patients more humanely by allowing individuals, once housed in institutions, to be re-integrated back into the community (Fisher et al., 2016). The idea was that society should be able to cater for the needs of those with mental health issues by providing outreach services. The success of care in the community is hotly debated, with some viewing such ideals as a myth, a myth that many believed in, but had little tangible support (Turner et al., 2015), and some viewing the return of individuals to the community a success where individuals

are fully integrated into society (Killaspy, 2006). Furthermore, the process of deinstitutionalisation was argued to have assisted in the release of those housed as a form of social control and catered for drunks or those who exhibited other unfavourable behaviour for which prisons would not be able to house such individuals for extended periods of time (Fisher et al., 2016). However, the view that some individuals still require specialist care due to the perceived risk to themselves and others prevails (Robertson et al., 2011). Thus, institutional treatment is still viewed as an acceptable treatment method for some individuals.

Medium secure psychiatric provision began following the publication of the Butler report (Department of Health and Social Security, 1975) and subsequently, the Reed report (Department of Health and Home Office, 1992) outlined the provision for services between medium secure and open community services (Dye et al., 2016). The Reed report also called for a national network to provide assessment and diversion services and promoted joint working between criminal justice and health agencies (Rutherford, 2010). Rehabilitation services were also commissioned in the UK however, the addition of locked rehabilitation services have not been formally specified by the Joint Commissioning Panel for Mental Health but are known to provide services for those who require specialist care and "most closely resemble a high-dependency rehabilitation unit" and are provided most prominently by the independent sector (Killaspy et al., 2012, p.14).

A high-profile case, Christopher Clunis, who was an ex-patient released into the community who then re-offended in an unprovoked attack in London, led to a reconsideration of the need for continuity of care across services, which led to the publication of the Care Programme Approach (CPA) (Chisnell and Mitchell, 2013; Killaspy, 2006), which is prevalent in UK mental healthcare today. The CPA provides a coherent structure for the management of individuals with complex needs by advocating joint working across services (Glasby and Tew, 2015). However, the CPA's focus on monitoring has been

suggested to represent social re-institutionalisation in the UK (Turner, 2004). Whilst there has been much development in the landscape of mental health service provision since the process of deinstitutionalisation began, continuous reports highlight the shortfalls of mental health service provision, particularly across the criminal justice system (Rutherford, 2010), indicating developments are further required for mental health provision in the UK.

This research was undertaken within one privately run secure FMH hospital in the UK, with two low secure wards and one locked rehabilitation ward. FMH services cater to those who engage in or are at risk of offending-related behaviour and are also in need of mental health care (Mullen, 2000). The level of security provided is determined by their perceived risk of harm to themselves and/or others and corresponding services are classified as high, medium, low, and open, "which are the generally accepted levels of security in England" (Crichton, 2009, p.341). It has been suggested that the privatisation of secure mental health services in the UK is underpinned by the rising demand and the reallocation of public spending away from psychiatric services during the deinstitutionalisation period, leaving a gap in the market for the private sector (Turner, 2004). Ramon (2008, p.119) suggests that:

> Many of the secure units are run by the private sector, costing at least three times more than a psychiatric bed in a general hospital, and generating profit for their owners.

Furthermore, the private sector provides approximately 50 percent of secure psychiatric beds in England and Wales (Thomson, 2008). Thus, this research is undertaken within a significant healthcare sector in the UK.

This section has highlighted salient debates for the treatment of individuals within an institutional environment, such as the promotion of humane treatment for individuals with a mental health diagnosis. Such debates are further explored within this chapter and consideration is given to institutionalisation theory and the competing debates from psychiatry in relation to the therapeutic features of a secure care.

2.2.2 Forensic services: care and custody

This section explores the competing frameworks in relation to the containment and treatment of forensic patients, followed by considerations of the experiences of institutional life for staff and patients in the 21st century.

FMH services cater for both the protection of the public through custody and aim to provide a mental health recovery service for those detained. However, it is often argued that the services more readily cater for the protection of the public (Mann et al., 2014) and do very little for recovery (Sugarman and Dickens, 2015). Furthermore, Robertson et al. (2011, p.473) explains that:

> modern forensic services have their theoretical roots in two quite different paradigms — the treatment of mental illness (a psychopathology paradigm) and the assessment and management of risk (a risk paradigm).

The competing frameworks of care and custody are complex within the field of FMH (Hinshelwood, 2001). For those that have offended, they have been identified as having a mental illness, which is considered to have underpinned the offence and thus are theorised to be excused of responsibility (Robertson et al., 2011). These individuals are often detained for longer than those who commit a similar crime who's mental illness is not considered to be contributing factor to their offending behaviour (Adshead, 2000). International

provision of FMH services has increased as a response to media coverage and thus the growing public concern in relation to risk (Robertson et al., 2011). Thus, creating a culture where therapeutic optimism for mental health is overshadowed by risk minimisation (Pilgrim, 2008). The return of those once housed in institutions to community care invoked fear in the public perceptions of mental illness about the unpredictability and dangerousness of those with a mental health diagnosis, even if such fears were not underpinned by evidence (Ramon, 2008). Furthermore, public concern in relation to risk and mental illness has been linked to what Beck (1992) calls the "risk society" (as cited in Pilgrim, 2008, p.296), in that a risk-adverse culture influences mental health law and is argued to be rooted in anxiety.

Risk assessments are a core component of psychiatric care (Sugarman and Dickens, 2015). Individuals being placed in the level of security which is considered to match the risk of the individual is an accepted notion in UK practice, as outlined in the Reed report (Crichton, 2009). Safety is highly valued within the psychiatric inpatient environment and risk management is "the cornerstone of nursing care" (Slemon et al., 2017, p. 1). However, it has been argued that risk management procedures are underpinned by pervasive stigmatisation of those with a mental illness (Slemon et al., 2017). In a move to promote patient autonomy, least restrictive policies are monitored in the UK in order to ensure that security levels meet the needs of individuals in care. It is suggested that the least restrictive philosophy values undue loss of liberty (Tomlin et al., 2018). However, restrictions in relation to autonomy are often justified when the patient's or another individual's welfare is in jeopardy (Adshead, 2000) and risk management decisions may override the patient's best interest (Völlm et al., 2016). Furthermore, Adshead (2000) argues that whilst pharmacological management of violence decreases the risk of violence, such treatment also potentially decreases the health of the patient. Thus, judging what

may be the most appropriate interventions, which balance risk and care practices for patients and the protection of others, is complex.

Furthermore, risk assessments have been suggested to be inaccurate at predicting risk and have been described as "operating in a political arena" (Markham, 2018, p.16; Morgan, 2013, p.346). Thus, it has been argued that the accuracy of risk assessments is questionable, but nonetheless are politically driven by a risk-adverse agenda. Such assessments of risk have been suggested to be fraught with human biases, such as anchoring—initial judgements that are unlikely to be changed (Towl, 2005). Debates exist which purport that the measurement of clinical and risk remain unproven in relation to whether such "risk outcomes improves 'real' outcomes such as patient-reported quality of life and recovery experience" (Sugarman and Dickens, 2015, p.8). Thus, whilst the loss of liberty is rooted in individual risk assessments, arguments exist in relation to the validity of such measures of risk prediction.

Security has been argued to be a necessary prerequisite for therapeutic work to be conducted (Crichton, 2009) and attachment theory proposes that psychological security is required before therapy can begin (Bowlby, 1988). The safety of the ward environment can provide psychological safety and security. For example, Adshead (2004) argues that the institution may become an individual's secure base, in that the institution can provide a therapeutic environment in which trauma can be explored. Furthermore, those acutely unwell have been argued to express a wish for containment, and some may need the refuge which an institution can provide (Winship, 2000). Thus, debates exist in relation to the therapeutic features of secure care.

Whilst physical security, also known as environmental security, is an important feature of psychiatric care and medium, secure, low, and open services have different physical features, for example, high perimeter fences are associated with high secure services (Crichton,

2009), other forms of security, such as procedural and relational security are also required to achieve their therapeutic aims (Department of Health, 2010). Procedural security includes "policies and practices relating to patients which control access, communication, personal finances and possessions", examples include searches of personal items on return from leave from the institution or room searches (Kennedy, 2002, p.434). The Department of Health published the See, Think, Act guidance to outline the importance of relational security (Department of Health, 2010). Relational security is defined by the Department of Health (2010, p.5) as:

> the knowledge and understanding staff have of a patient and of the environment, and the translation of that information into appropriate responses and care.

However, it is important to note that it is argued that security is compromised when neither physical, procedural, or relational security are not present, for example, Exworthy and Gunn (2003, p.469) note: "ignore or neglect one feature and security overall is weakened". However, fear of putting the public at risk can result in institutional anxiety and restrictive practices (Mann et al., 2014) and an over application of procedural and physical security can undermine therapeutic work (Tomlin et al., 2018). Thus, balancing the different types of security is highly important to create a suitably therapeutic environment, one which protects the public, and also cares for the forensic patient.

2.2.3 Patient experience

It is reported that those who have been admitted to inpatient secure care have reported feelings of a loss of identity and a failure to society (Quirk et al., 2004). Forensic patients are suggested to be doubly stigmatised due to their mental illness and offending behaviour (Marshall and Adams, 2018) and their dual status has been found to negatively influence a sense of self (Sullivan et al., 2013). Mezey et

al. (2010, p.691) found patients to describe themselves as "mad and bad", and a patient further suggests that their identity is "probably as big a stigma as you can get". Thus, mental health stigma can influence the patient experience.

Goffman (1961) reports of the loss of social roles and the detrimental effect that this can have on individuals admitted to a psychiatric institution. Furthermore, social exclusion has been identified as a significant barrier to recovery (Mann et al., 2014) and a synthesis of the patient experience in inpatient care found that connectedness and sense of self were key themes prevalent in the literature (Clarke et al., 2016). Affirmation and connectedness were also found to be positive experiences associated with recovery (Thibeault et al., 2010). Recovery orientated services have been suggested to promote social inclusion, which can be offered by developing social and occupational roles for individuals (Wolfson, 2009). However, it has been argued that social inclusion policies and practices uncritically assume that those with a mental health diagnosis can be included without recognising the political influences of being labelled excluded (Wright and Stickley, 2013). Thus, social inclusion is a complex phenomenon which is situated within a political landscape.

Davies (2004) outlines the following potential harmful consequences of living in an institution as a patient: loss of liberty, social isolation, institutionalisation, deteriorating mental and physical health, and death (whether through neglect, suicide or murder). A lack or loss of liberty is often reported by patients within the secure FMH environment (Norvoll and Pedersen, 2018) and presents a challenge to notions of patient choice and autonomy, identified in the recovery literature (see section 2.3). Research has found that patients report a withdrawal of freedom within a secure mental health service in the UK (Gillard et al., 2012). The health and wellbeing of the individual, therefore, is reported as being significantly influenced by the restrictive and non-autonomous environment associated with institutional care. Goffman (1961) observed the great amount of personal details which are documented and available for review by

members of staff. It is this which Goffman (1961, p.32) refers to as a "'violation of one's informational preserve regarding self'. Furthermore, the patient's behaviour may be pathologised (Quirk and Lelliott, 2004), for example, patients can find approaches to care as discriminatory when those who hold different views to that of staff are presumed to be unwell (Norvoll and Pedersen, 2018). Thus, institutional life can feel intrusive for patients coupled with a loss of autonomy.

It has been argued that the helplessness experienced by the individual is one that such individuals become accustomed to and so begin to fulfil the role of a recipient of care and fitting in with institutional routines, rather than adopting an active role within their own care (Livingston et al., 2012). Goffman (1961) discussed the concept of disculturation and describes the process whereby inmates become temporarily untrained in the management of daily life outside of the institution. Goffman (1961, p.24) suggests that disculturation is a consequence of the total institution environment where tension between the home and institutional world is created and maintained which in turn affords "strategic leverage in the management of men". Paternalistic models of care have been argued to promote dependency upon the care system (Greenall, 2006). More recently, there has been attempts to move away from the attributes of a total institution, that is, attempts to include the service user in the decision-making process, for example, the Care Programme Approach (CPA). However, it has been found that the patient's voice in mental healthcare is often marginalised, this can be due to a lack of resources, such as, a lack of choice in relation to discharge and available beds (Wright et al., 2016), or hierarchical decision-making (Stacey et al., 2016). Research has found, however, that patients perform their role as the patient by "playing the game" to avoid coercive treatment or to lead to release (Gillard et al., 2012, p.247). Furthermore, Reynolds et al. (2014) found that forensic patients played the game in order to manage their perceived risk status. Moreover, Morris et al. (2016) suggests that forensic patients are

obliged to engage in therapy in order to progress in treatment. Thus, the dependency observed may be due to a level of performativity exhibited by the forensic patient.

Psychiatric institutions have been argued to be therapeutic and can offer psychological containment required for recovery (see section 2.2.2), which is supported by research exploring patient perspectives of the ward environment. For example, Stenhouse (2013) found that participants experienced a sense of safety from the outside world and Mezey et al. (2010) also found that those detained in secure care expressed that the service provided sanctuary. However, whilst some patients may feel protected from the outside world, the ward environment can also be experienced as turbulent. For example, the acute ward has been described as "an especially volatile and unpredictable place in which to live" (Quirk et al., 2004, p.2581). Research also found that patients on an inpatient mental health ward described the environment as a culture of violence, with violence being exhibited from both staff and patients through restraint from staff and violent attacks from patients (Gillard et al., 2012) Furthermore, risk in mental healthcare is typically viewed from the non-patient perspective, whilst there are attempts to include patients in their risk assessments (Markham, 2018), the patient's perspective is largely ignored as they are deemed to be the risky individual. However, patients often feel that fellow patients pose a risk to them through aggression and violent acts (Stenhouse, 2013), and patients have been found to use avoidance techniques in order to keep safe, such as retreating to their rooms (Quirk et al., 2004). Moreover, Livingston et al. (2012) found that when patients felt safe, they were more inclined to feel that their choices were respected and valued by staff. Thus, feeling safe within the ward environment potentially has implications for the relational experiences of patients.

Other negative experiences include feelings of fear and embarrassment when physical restraint has been used (Bonner et al., 2002), and fellow patients report being upset when another patient is in a seclusion room (Thibeault et al., 2010). Thus, the therapeutic

milieu can be interrupted or influenced by the presence of disturbance from other patients, which is a common feature of secure psychiatric care. Furthermore, containment strategies, such as, restraint and seclusion reduce physical autonomy and may be unfavourable approaches to care, from the view of the patient (Adshead, 2000).

The Department of Health (2002, p.8) report that a "lack of 'something to do', especially activity that is useful and meaningful to recovery" is a problem facing inpatient provision in the UK. A sense of boredom with little stimulation via activities has been expressed by patients (Gillard et al., 2012) and time in-between therapy has been reported as detrimental to patient wellbeing (Shattell et al., 2008). There is evidence that keeping occupied, via meaningful activity, is central to a patient's recovery (McKeown et al., 2016). The National Institute for Health and Care Excellence (National Institute for Health and Care Excellence (NICE), 2011, p.24) recommends that patients in hospital should:

> have access to a wide range of meaningful and culturally appropriate occupations [which]… include creative and leisure activities, exercise, self-care and community access activities. Activities should be facilitated by appropriately trained health or social care professionals.

The Royal College of Psychiatrists also recommend that patients have access to a minimum of 25 hours of structured activity a week (Nicholls and Goossens, 2017). FMH services have developed ways of capturing activity engagement by adopting a quantitative approach to evidencing engagement however, it is noted that there are challenges in relation to defining what is meaningful (Wenman, 2010). Research has found that participation in enjoyable and interesting occupations has been noted as beneficial to individuals in psychiatric care (Kennedy and Fortune, 2014; Stickley and Hui,

2012). Therefore, whilst the inpatient ward environment may be restrictive, access to and engagement in meaningful activities can promote wellbeing and recovery.

2.2.4 Staff experience

There are five main professions that work within FMH, these are: mental health nursing, forensic psychology, forensic psychiatry, social work, and occupational therapy (Rogers and Soothill, 2008). Clinical staff roles within the FMH environment are underpinned by two core principles, to protect the public and to treat their patients (Robertson et al., 2011). Clinicians within such environments have been described as double agents, where the roles of social control and helper are undertaken (Blackburn, 2004). However, it has been noted that undertaking the dual role of therapeutic and custodial duties is challenging (Kurtz, 2002). Robertson et al. (2011) argues that the emphasis of the differing roles is debated in practice, and staff have been found to adopt a custodial approach over the therapeutic one due to fears of job loss through failure to protect the public (Mann et al., 2014). Fears of dismissal are also a prominent concern (Moore, 2012), due to the media interest in FMH care. Staff burnout amongst forensic psychiatric nursing staff is reported to be the key influence of absenteeism and turnover (Looff et al., 2018). Burnout is commonly reported within the literature, with the emotionally charged environment theorised to be a core influence (Johnson et al., 2018; Nathan et al., 2007). Thus, it is recognised that psychiatric staff are required to undertake an emotionally challenging role.

Witnessing violence, including self-harm, is distressing and is commonly experienced by staff working in such environments. Staff who have witnessed patient self-harm report being emotionally affected and can also feel powerless in their roles as carers (Tofthagen et al., 2014). Experiences of violence and aggression leads to high stress amongst staff within the FMH environment (Johnson et al., 2018; Looff et al., 2019). Furthermore, emotional exhaustion and depersonalisation have been found to be highly reported for staff who experience high levels of aggression (Looff et al., 2018). Such

exhaustion can leave staff feeling overwhelmed. Job satisfaction has also been suggested to be influenced by staff in such environments often witnessing destructive behaviour (Mann et al., 2014). In one study staff were found to report concern over the potentially unsafe environment in FMH, above that of the patients (Livingston et al., 2012). Thus, staff can not only feel emotionally drained and dissatisfied with their roles as carers but can also feel unsafe.

Staff take care of the most vulnerable and unwell people in society (Gilbody et al., 2006). Those within psychiatric institutions deal with unwanted anxieties, in that they are unwanted by society and staff have to endure their own anxieties related to their work (Hinshelwood, 2001). Staff, therefore, are tasked with "confront[ing] … human anxieties as their job, but as human beings, they cannot be unaffected by the agony of others—their charges" (Hinshelwood, 2001, p.43). Psychiatric staff then necessarily undertake anxiety work as part of their roles (Campling, 2004; Hinshelwood, 2001). Defensive strategies relating to anxiety may include denying the offender part of an individual by focussing on more positive qualities or struggling with interpersonal work by becoming emotionally unavailable (Aiyegbusi, 2009a, 2009b). Inexperienced or poorly supervised staff may hold positive and perhaps unrealistic aspirations of their caregiving, which can lead to staff feeling helpless and may lead to avoidance behaviour, such as, avoiding the patient (Watts and Morgan, 1994). Furthermore, intense disturbances, such as learning the details of crimes, can lead to primitive reactions of anxiety, such as projection (Aiyegbusi, 2009a). This defence mechanism is evidenced by staff projecting unwanted or aspects of themselves onto another person through the process of denial (Campling, 2004). Furthermore, society's ambivalence relating to individuals who have offended may be reflected in staff attitudes (Davies, 2004). Defensive strategies exhibited by staff can negatively influence the therapeutic milieu by creating a divide between staff and patients.

The maintenance of the therapeutic relationship between staff and patients is discussed in the next section of this chapter. However, it

is important to note here that staff can work therapeutically through their anxiety in clinical supervision (Aiyegbusi, 2009a) and such practices can minimise untherapeutic defences so that the mind can have space to reflect (Hinshelwood, 2001); thus reflective practice and supervision can positively influence the therapeutic milieu for both staff and patients.

2.2.5 Staff-patient relationships

Forensic patients are defined by the act of boundary violations, typically in the form of violating societal values as a response or re-enactment of violations they themselves have been victims of (Kelly and Wadey, 2012). There is compelling evidence that serious mental illness is rooted in childhood experiences and is associated with social deprivation (Middleton, 2017). Thus, whilst it has been argued that the staff role is inherently underpinned by "maintaining control is a level of power over patients" (Gilburt et al., 2008, p.10), the introduction and maintenance of positive relationships within care hold an important therapeutic value (Marshall and Adams, 2018). Furthermore, the "social skin" is a key component of secure mental health services (Winship, 2000, p.176) and thus this section explores the staff-patient relationship in mental healthcare.

As discussed in section 2.2.2, staff can struggle with their anxieties and develop maladaptive behaviour, such as avoidance. However, the influence of such behaviour is important to consider for the patient who has often experienced unhealthy relationships, particularly with their caregiver. The trauma experienced by patients can be intensely painful (Aiyegbusi, 2009) and forming new attachments is fraught with difficulties (Adshead, 2004). Moreover, the process of building trust is often problematic for the forensic patient and is commonly played out through psychological or physical attacks; such behaviour is argued to be underpinned by past neglect and abuse and childhood disruptions are re-enacted within the staff-patient relationship (Mann et al., 2014). However, as Hinshelwood (2001, pp.52–3) explains "[b]oth sides are active in creating this division" between staff and

patients and staff should make use of the knowledge of projections in order to avoid the actively complicit patient. Furthermore, Hinshelwood (2001, p.52) asserts that "patients fear their active selves … [and] [t]hat fearful side of themselves is attributed to staff and feared therein". Thus, there is an interplay between the patient projections of staff through fear which can result in a passive patient who presumes to inhabit inadequacies not shared by the staff identity. Within this disruptive environment clinical supervision is mobilised to create the space for staff to explore their interpersonal issues and to work though their anxieties (Aiyegbusi, 2009b). It is argued that when staff are sufficiently supported, they are able to focus on holding the patient and working therapeutically through the patient's trauma (Ramsden and Moore, 2012).

There's a potential for FMH patients to form strong attachments to staff as they may represent their first experience of supportive relationships. Research supports this claim, for example, Mezey et al. (2010, p.690), found that patients expressed that they felt a "sense of belonging, acceptance, inclusion, and companionship that they had never previously encountered". Moreover, "supportive relationships in healthcare are undoubtedly integral features of mental health and well-being" (Middleton, 2017, p.264). However, such attachments may become threatened by hope of moving on to a new life, as such patients may disengage with therapy in order to remain within care (Mann et al., 2014). Furthermore, threat to attachments can lead to violence and such incidents are evident in psychiatric care (Borg and Kristiansen, 2004), however the presentation of violence is the result of a myriad influences that are situated both within the individual and the environment (Adshead, 2004). One such influence is coercive approaches to treatment. For example, within the FMH environment boundaries can become punitive when viewed through a lens of risk (Kelly and Wadey, 2012) and enacting hard boundaries that restrict patient autonomy can lead to violence (Papadopoulos et al., 2012). Struggles for patient autonomy versus a risk-adverse approach is a "recurrent point of tension" for staff and patients (Pilgrim, 2008,

p.298). Coercive practices in care can lead to a lack of trust between staff and patients and, whilst it has been argued to be inevitable within secure care, such practices can be damaging to the therapeutic relationship (Miles, 2016). Such inevitability of practice is debated, Kelly and Wadey (2012) argue that such punitive practices hold little therapeutic value and tighter restrictions often lead to more creative behaviour exhibited by the patient. Furthermore, it has been argued that forensic patients often find it difficult to express their emotions directly and can be left feeling frustrated (Bernstein et al., 2015). Thus, the staff-patient relationship is complex and can be supported through clinical supervision.

Good practice within mental healthcare is often described utilising language such as "maintaining professional boundaries" (Doyle and Dolan, 2008, p.261). However, boundary violations are commonly enacted by staff within FMH practice, and usually are the result of personal self-disclosure to the patient (Adshead, 2012). The role of helper and helpless is commonly reinforced in care through the clear power disparities between staff and patient (Adshead, 2012) and can be identified by the physical separate spaces. For example, Thibeault et al. (2010, p.225) suggests that such separations "are symbols of social separation [and] power imbalance". The power disparity between staff and patients is also enacted through the enforcement of ward rules. For example, as part of their role, staff have been found to utilise behavioural correction techniques in order to modify patient behaviour within the secure setting (Gildberg et al., 2012). Whilst the role of carer and custodian are assigned to staff in forensic care, the quality of relationships are of high importance to the building of therapeutic relationships. For example, patients often report that the quality of therapeutic relationships is an important element of their recovery (Gilburt et al., 2008) and the development of helpful relationships has been found to be a key turning point for patients (Borg and Kristiansen, 2004). Gildberg et al. (2012) found that staff who engaged with forensic patients in informal activities were highly valued. Furthermore, positive risk taking has also been argued to

promote recovery through an increase of independence and autonomy (Felton et al., 2017; Sustere and Tarpey, 2019). Thus, the staff-patient relationship, whilst complex, is an important influence on mental health recovery. Practices which promote therapeutic relationships are thus important to consider.

2.2.6 Institutional life: Summary

Risk assessments, which underpin the assessment and treatment of forensic patients, have been suggested to be influenced by political debates (Markham, 2018; Morgan, 2013) and are underpinned by public fear over the unpredictability of those with a mental health diagnosis (Ramon, 2008). Thus, whilst FMH services provide care and custody to patients (Hinshelwood, 2001), the emphasis on the custodial approach has been noted (Mann et al., 2014). The dual role of carer and custodian for staff creates tensions in their role (Kurtz, 2002) and the emotionally challenging environment is argued to influence the high burnout within forensic mental health staff (Johnson et al., 2018; Nathan et al., 2007). Furthermore, forensic patients also find the ward environment challenging (Bonner et al., 2002; Gillard et al., 2012; Quirk and Lelliott, 2004; Stenhouse, 2013; Thibeault et al., 2010), and have been found to utilise avoidance techniques to stay safe (Quirk and Lelliott, 2004), and adopt a performative role in order to avoid coercive treatment (Gillard et al., 2012). However, some patients have reported feeling safe inside the institution and protected from the outside world (Mezey et al., 2010; Stenhouse, 2013). Furthermore, forensic patients can often experience a sense of boredom with a lack of meaning engagement through activities (Department of Health, 2002; Gillard et al., 2012; Shattell et al., 2008) and keeping occupied, via meaningful activity, has been viewed as central to patient's recovery (McKeown et al., 2016).

The staff-patient relationship can be challenging for both staff and patients (Adshead, 2004; Aiyegbusi, 2009b) and the introduction and maintenance of positive relationships within care hold an important

therapeutic value (Marshall and Adams, 2018; Middleton, 2017). Clinical supervision has been suggested to be crucial for managing relationships to promote a therapeutic environment (Aiyegbusi, 2009b). This research importantly explores the wellbeing of both staff and patients and considers the contribution of creative practice engagement in promoting reciprocal communities and enhance wellbeing. The next section explores recovery and mental health and considers a social recovery perspective.

2.3 Recovery and mental health

This section explores the relevant literature in relation to mental health care broadly and also considers care in secure services relevant to FMH. Current models in mental healthcare, which are relevant to this thesis, are briefly explored, followed by debates surrounding inequality and mental health and then the recovery movement. This section also includes the recent focus on relational aspects of recovery, such as mutual recovery and its links to social capital. The application of recovery principles in secure institutions, such as FMH, are then considered. Finally, a summary of key debates explored in this section is provided.

2.3.1 Current models in mental healthcare

The Care Programme Approach (CPA) has been implemented in the UK mental health service provision since 1991 (Schneider et al., 1999) and advocates inter-disciplinary working, informed care and involvement for service users and carers, along with joint working across health and social care. Care plans are negotiated with service users and its holistic and collaborative approach to assessment and treatment within mental healthcare has been commended (Kingdon, 1994). The CPA approach formally introduces the ethos of inclusion and decision-making in care for service users in mental healthcare in the UK. However, criticisms were voiced shortly following implementation relating to the inappropriateness and irrelevance for some patients (Knowles and Haigh, 1998) and the inclusion of those with severe mental health issues has been criticised (Kingdon, n.d.).

It has been argued that when the principles of the CPA are implemented successfully patients reported satisfaction with the approach due to its participatory nature (Simpson et al., 2003), and more recent developments to the strategy outlined by the Department of Health in their publication Refocusing the Care Programme Approach has reportedly reduced bureaucracy issues highlighted by staff (Chisnell and Mitchell, 2013).

Service user involvement is argued to be at the heart of mental health services and is evidenced through the implementation of practices, such as, my shared pathway and the associated tool, the recovery star (Morgan and Rees, 2018). Personal recovery plans are argued to promote the assessment of individual's resources which can assist in providing an understanding of how recovery goals may be influenced by their resources (Shepherd et al., 2008). A service user involvement model is prominent within Therapeutic Communities, where patients are involved in decision making. Furthermore, empowerment, collective responsibility, and citizenship are argued to be the principles which guide care (Stern, 2012). However, Therapeutic Communities have received much criticism due to the adoption of a treatment model which challenges conventional professional frameworks in that the focus of the community is on the development of social relationships, rather than on professional expertise (Manning, 2010). Such models of care are underpinned by mutuality and cooperation (Winship, 2016). However, service user involvement models can seem antithetical to traditional clinical models of care which values professional knowledge.

Within offender rehabilitation, the Good Lives Model (GLM) offers an approach to treatment which is underpinned by the assumption that all individuals strive for a personally meaningful life (Barnao et al., 2016) and the model can provide a basis to explore how the individual can be rehabilitated to live a good or better life (Craig et al., 2013). This approach to rehabilitation is underpinned by a risk-need theoretical approach, which is the dominant approach in the UK,

Canada, Australia and New Zealand (Ward and Brown, 2004). The GLM focuses on the offender's needs and also their associated risk and thus is a suitable model for forensic patients (Barnao et al., 2016). The model focuses on the enhancement of the offender's capabilities so that primary goods can be obtained (Ward and Gannon, 2006). The GLM is based on the assumption that primary human goods, such as, actions and experiences, are sought and provide meaning in people's lives and individuals can gain access to such goods in socially acceptable and personally meaningful ways (Ward and Brown, 2004). Within offender rehabilitation, risk is associated with obstacles in obtaining primary goods (Ward and Brown, 2004). The barriers associated with maintaining primary goods are referred to as criminogenic needs and the GLM focuses on the assessment of the internal and external barriers to obtaining the primary goods that are valued by the individual (Barnao et al., 2016). The GLM is known as a strengths based model and promotes the development of a self-determined life, one that promotes wellbeing (Wilson and Yates, 2009). It has been noted, however, that noncriminal alternative routes to goods must be available to the individual (Andrews et al., 2011). Therefore, it is important to consider societal influences on the availability and obtainment of goods. The next section considers the social landscape of mental health.

2.3.2 Inequality and Mental Health

The stigma associated with mental illness has been argued to lead to lower self-esteem (Yanos et al., 2010), treatment avoidant behaviour (Corrigan, 2004), and social isolation and exclusion (Boardman, 2011). Individuals within FMH services are doubly stigmatised (Marshall and Adams, 2018), "with repeated or prolonged contact with the criminal justice system in addition to mental health problems" (Drennan and Wooldridge, 2014, p.1). Sugarman and Dicken (2015, p.1) argue that FMH patients are:

> more often successfully categorised and labelled by local juridical and medical practice, and subject to other processes of social stigmatisation, than they are helped towards recovery.

Additionally, due to their offending behaviour, such individuals have been argued to be viewed as "valueless" to society (Adshead, 2000, p.304), and forensic patients have expressed that being an offender and patient, both "mad and bad" has stigmatising connotations (Mezey et al., 2010, p.691), as discussed in section 2.2.1.

Empowerment has been argued as an approach to challenge the stigma experienced by individuals with mental health issues (Thornicroft, 2006). Whilst service user involvement in treatment decisions in mental health is a reported aim relating to the recovery movement, which promotes empowerment opportunities, research has found evidence for "pervasive influence of coercive processes" in relation to the administration of antipsychotic medication in community mental health services (Morant et al., 2018). If we also consider that social determinants of health, such as socioeconomic status, are argued to be a stable predictor of mental health (Elliott, 2016; Rogers and Pilgrim, 2014), the inevitable outcome is that those with a lower socio-economic class are disproportionally represented within mental health services and further stigmatisation continues to marginalise those with a mental health diagnosis.

Furthermore, whilst those with a mental health diagnosis experience inequality and social exclusion (Boardman, 2011), some groups, such as Black Minority and Ethnic (BME) individuals, are over-represented in mental health services (Browne, 2009) and within the population of those detained under the Mental Health Act (1983/2007) (Singh et al., 2007), highlighting further debates regarding inequality and mental health. An inquiry into the death of a psychiatric patient under the care of the NHS found evidence of institutional racism (Blofeld et

al., 2003). Debates continue into the causes of institutional racism in Britain, however Pilgrim (1997, p.82) argues that:

> it looks likely that the relative silence within psychotherapeutic theory and practice about race and ethnicity is a result of the following factors: the imperialist national and historical context of its innovators; the restrictive attention of methodological individualism; the under-representation of black and ethnic minorities in the talking treatments; and the relative powerlessness of people from racial and ethnic minorities.

Social capital relates to the capital or resources available to an individual through their social networks, thus this concept also relates to an individual's social positioning in society. The term was coined by Bourdieu (1985) in his sociological account of resources of power (as cited in Best and Laudet, 2010) and has since been used within the recovery literature to describe the importance of social relationships, which can contribute to wellbeing (Argyle and Winship, 2015; Leamy et al., 2011; Winship and Barker, 2016). Bourdieu defines social capital as an:

> aggregate of the actual and potential resources which are linked to possession of a durable network of more or less institutionalised relationships of mutual acquaintance and recognition – or in other words, membership in a group. (Bourdieu, 1986, as cited in Brown, 2016, p.1468)

Those who have an active citizenship through social roles and a perceived sense of belonging are suggested to be socially included in

society (Tew et al., 2012). Thus, participation within social networks can afford opportunities for social capital. Social networks have also been argued to promote resilience (Saavedra et al., 2017b) and wellbeing (Saavedra et al., 2017a, 2017b; Winship and Barker, 2016) through shared experiences (Hogan, 2015; Vallejos et al., 2016); build social identities (Winship and Barker, 2016), strengthen social capital (Argyle and Winship, 2015), and such networks can be strengthened through knowledge sharing (Wang et al., 2017).

BME patients are more likely to be diagnosed with schizophrenia, this has been suggested to be the result of cultural insensitivity, due to a lack of understanding of symptoms (Pilgrim, 1997; Singh and Burns, 2006). Furthermore, patients with a lower socio-economic background are more likely to be diagnosed with Schizophrenia (Rogers and Pilgrim, 2014). Such exclusion and discrimination have been suggested to be potential determinants of mental illness (Singh and Burns, 2006), which have led to debates relating to the cultural sensitivity of mental illness assessments (Fernando, 2000; Singh and Burns, 2006), and debates relating to a broader influence of racism and social deprivation, such as, economic disadvantage and social exclusion (Singh and Burns, 2006). The link between race and mental health has, unsurprisingly, historical roots and is underpinned by medical-scientific knowledge thought to evidence differences in race (Rogers and Pilgrim, 2014) however, the over-representation of BME individuals is prevalent in modern mental healthcare and is evidenced by the count me in census (Care Quality Commission (CQC), 2011). Such findings were prevalent within the current research and racism was observed and reported as an issue by residents (see section 5.3.5.2). It is recognised that there is no national strategy which focuses on the mental health of minority ethnic groups in the UK and the problems experienced by minority groups are suggested to be getting worse (Department of Health, 2003). Therefore, social inequality and discrimination exist for those with a mental health diagnosis and has been argued to disproportionately influence the BME community.

2.3.3 The recovery movement

Section 1.4.1 introduced the recovery movement which began as a civil rights campaign (Davidson et al., 2010). This section considers literature relating to the application of personal recovery concepts highlighted by the movement in relation to modern mental healthcare in the UK. The personal recovery movement has been conceptualised into a set of recovery principles to help guide services to become recovery focused (see South London and Maudsley NHS Foundation Trust and South West London, 2010). A literature synthesis by Leamy et al. (2011, p.449) revealed the key categories associated with recovery, these were: "connectedness; hope and optimism about the future; identity; meaning in life; and empowerment (giving the acronym CHIME)". The CHIME framework outlines best practice in supporting recovery, which has guided research in this area. For example, the research project REFOCUS explored the implementation of CHIME recovery principles within mental health services (Slade et al., 2015).

However, personal recovery principles can sharply contrast healthcare professional practice. For example, notions of personal recovery are overshadowed in the clinical context where mental ill health is viewed as a deficit or a disorder (Brown and Manning, 2018; Davidson and Roe, 2007). Furthermore, notions of empowerment and choice have been implemented in practice through offering alternative medicines for patients to choose from often without the choice of no medication, the implementation of recovery principles in practice have thus been argued to be distorted (Slade, 2009c). Recovery-oriented practice which promotes patient centred care can conflict with the dominant care practices which focus on risk and containment (Stickley and Wright, 2011b). Incorporating personal recovery within current practice in mental healthcare, therefore, can be challenging.

Clinical recovery models typically focus on the individual "getting back to normal" and thus the landscape of mental health services cater for

the needs of one type of service user — those who, for the most part, have led a relatively healthy life but then experience difficulties (Slade, 2009a, p.4). However, not all individuals who experience mental health difficulties have a way of living that they would like to return to. Social capital is an important concept to consider which explores notions of power or capital in relation to resources available through social networks, and as section 2.3.2 outlines, those with a diagnosis of mental health issues are stigmatised within society and may lack the resources required to flourish. Furthermore, secure residential environments have been found to be unintentionally toxic (Glouberman, 1990) and may exasperate problems or hinder recovery (Drennan and Wooldridge, 2014). There are also those who are already exposed to pre-existing social disadvantages, such as, employment and educational issues, family problems *etc.* (Drennan & Alred, 2012), which makes the journey of recovering more complex as hopes and aspirations may seem difficult to reach.

2.3.4 Mutual recovery

Traditional recovery models, such as clinical recovery, have focused on the recovery of the individual through the alleviation of symptoms (Slade, 2009a). Recovery models have begun to recognise the importance of a more holistic view of recovery, one that includes and values social relationships (Yates, 2014). As a result, personal recovery frameworks include social connectedness as one of the key elements of recovery (Leamy et al., 2011) and this is particularly important when diminished social networks are found to negatively influence wellbeing (Hare-Duke et al., 2018; Kawachi and Berkman, 2001). As such, it is argued that "[s]ocial inclusion and the availability of supportive relationships are undoubtedly integral features of mental health and well-being" (Middleton, 2017, p.264). The social roles undertaken by individuals has also been noted as a key part of recovery (Stickley and Wright, 2011a), which have been argued to contribute towards social inclusion. These concepts (social roles and networks) are further explored through the lens of social capital within the therapeutic relationship.

2.3.4.1 A hierarchical model of mutual recovery

This section debates the term social connectedness, which has links to the personal recovery literature (Hare-Duke et al., 2018; Leamy et al., 2011); mutuality, which has links to the nursing literature (Brown, 2015); and considers their relationship to mutual recovery (Crawford et al., 2013). A model is then provided which outlines the relationship between these social concepts, one that is proposed to be hierarchical.

This thesis considers wellbeing from a social-interactive perspective, a perspective that considers the contribution of the social to wellbeing, as such mutual recovery is a relational concept and is underpinned by the assumption that this view can offer "new opportunities to build egalitarian, appreciative and substantively connected communities" (Crawford et al., 2013, p.55). Furthermore, it is proposed that mutual recovery is a form of therapeutic social capital resource. As discussed in section 2.3.2, social capital relates to the capital or resources available to an individual through their social networks and reciprocal relationships. Within this thesis, it is argued then that social interactions can be a key resource for social capital, and accordingly this thesis centres on social interactions between one or more people. Collins (2004, p.3) explains:

> [at] the centre of microsociology …is not the individual but the situation … [t]he smallscale, the here-and-now of face-to-face interaction, is the scene of action and the site of social action

One microsociological approach to exploring interactions is Interaction Ritual Theory (IRT), where the micro-behaviours of everyday interactions are explored through a theory of rituals. This theory is explored in depth in section 2.5. However, for the purposes of this section, which is exploring the key relational concepts of mutual recovery, it is important to note that, according to IRT, a key

outcome of successful interactions is group solidarity (Clarke, 2017; Collins, 2014). Thus, group solidarity will also be explored in this section and consider its relationship to mutual recovery.

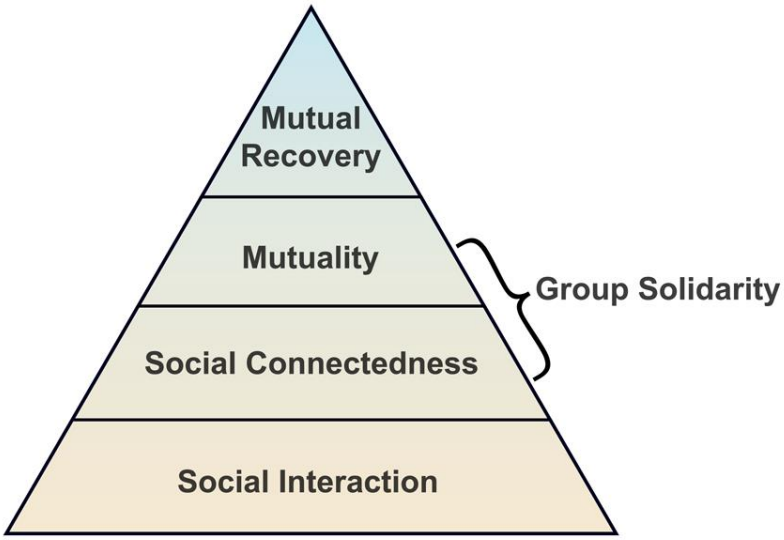


Figure 2.1: A hierarchical model of therapeutic social capital

The model in figure 2.1 depicts a hierarchical relationship, which begins with social interaction. The model is a dynamic system and moments of social interaction can lead to mutual recovery. Therapeutic social capital can be built, however, opportunities for social interaction must be available. A systematic review and narrative synthesis of personal recovery found social connectedness to be a key recovery process (Leamy et al., 2011), this is the second concept in the model. A further conceptual framework of social connectedness was conducted and found five dimensions, which are: closeness; identity and common bond; valued relationships; involvement; cared for and accepted (Hare-Duke et al., 2018). Closeness is defined as "[t]he degree of mutual dependence between two people" (Hare-Duke et al., 2018, p.193), thus some degree of closeness is a requirement of mutuality. Social connectedness has been theorised to also include mutuality however, mutuality within this thesis is proposed to be a higher order and it is theorised that

individuals can be socially connected but their closeness can be determined by the degree of mutuality within the relationship. The third concept is then mutuality, which is linked to social capital, for example, Brown (2015, p.831) states that "social capital involves connections with others and the participants deriving mutual benefit from these connections". Thus, individuals must have some level of connection and benefit in some way in their relationship with the other to gain social capital.

The conceptual model is situated within the framework of therapeutic social capital, which explores social capital within a therapeutic framework. Thus, as individuals "forge relationships with others, this often leads to changes in our social status or position"(Brown, 2015, p.833). Recovery has been argued to be about citizenship through participating in society (Slade et al., 2014), which can be challenging for those who have been oppressed through a series of social systems, as discussed earlier in this chapter. The view that an individual has resources that can be used at their disposal (Winship, 2015), such as social relationships, is recognised within the recovery literature, for example Burns (2011) describes this as an assets-based approach. This assets-based approach links back to Slade's (1999) notion that mental health services should act as a resource to individuals. However, it is important to note that this viewpoint also positively frames the individual as an actor that has agency in their recovery and that they are able to utilise their resources with little resistance, section 2.3.2 highlighted some of the barriers to recovery and social inclusion. Furthermore, research has found that those who have returned to community care do not always feel that they are socially included thus, Bredewold et al. (2018) suggests that deinstitutionalisation may not have led to real inclusion in the community. The notion of intentional social capital importantly delineates social capital in relation to opportunities and agency. For example, research has found that as individuals moved from institutional care to the community, participants expressed the importance of being able to choose to participate in social networks

that were viewed as valuable (Brown and Baker, 2018). Thus, notions of agency and choice are important concepts when exploring social capital opportunities within the secure environment.

Mutuality within the healthcare context has been suggested to be usefully explored through social capital, as this framework provides a lens for the staff-patient relationship which is central to care and provides an understanding of this within the embedded context of power and knowledge (Brown, 2016). The promotion of healthcare professionals being encouraged to build reciprocal relationships is evidenced in the nursing literature (Spiers and Wood, 2010). Mutuality also underlies many models and theories in Nursing (Brown, 2015; Curley, 1997) and has been argued to "balance power and respect" (Henson, 1997, p.77). Whilst the literature suggests that mutuality within the healthcare context is beneficial, the application of such ideals within the institutional context is problematic (Brown, 2015). For example, where professionalism is considered a high priority, building personal relationships with patients can threaten this ethos. However, research has found that staff who extend the boundaries of professionalism promoted a mutual relationship, one that was highly valued by patients (Borg and Kristiansen, 2004). Furthermore, boundary violations viewed through the lens of attachment frameworks are problematic, particularly within FMH care, as discussed earlier in this chapter (see section 2.2.5).

Mutual recovery is achieved in the context of a therapeutic relationship, where individuals find meaningfulness together either through their relationship or through activities. Meaning has been identified as a key element of wellbeing, for example, Seligman (2011, p.17) describes meaning as "belonging to and serving something that you believe is bigger than the self". Furthermore, meaningfulness has been linked to recovery, for example, Anthony (1993, p.527) states that "[r]ecovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness". Social roles and networks are

argued to provide an opportunity to find meaning through the development of social identity (Winship and Barker, 2016). Furthermore, Crawford et al. (2013, p.55) state that mutual recovery:

> extends out of the increasingly influential notion of 'recovery' in mental healthcare, and refers to the possibility of achieving a meaningful and more resilient life irrespective of mental health 'symptoms' or disabilities.

It is argued then that meaningfulness is associated with both personal and mutual recovery. Furthermore, mutual recovery relates to the therapeutic and mutual relationship between two or more individuals. Vallejos et al. (2016, p.263) defines mutual recovery as:

> a reciprocal relationship in which all members – service users, residents, professionals, clinicians and everyone else involved – benefit together.

This benefit is proposed to be underpinned by meaningfulness, which can be promoted through engagement in creative practices. For example, Perkins et al. (2016, p.13) found that the "mutual experience…appeared central to allowing all members to find meaning and recovery in the [drumming] activity". Therefore, engagement in creative practices can promote a mutual experience in which meaning can be found, which can lead to a mutual benefit and thus mutual recovery within the therapeutic context.

Within IRT, group solidarity is proposed to be an outcome of successful social interactions (Collins, 2014). Group solidarity is theorised to include social connectedness and mutuality—see figure 2.1. Shea et al. (2017), proposes that "solidarity refers to a psychological attachment and commitment to one's in-groups and closely resembles the notion of the relational self" (p.442-3). Thus, group solidarity results in a level of perceived connection and

mutuality amongst group members. Collins (2014) further explains that "[l]ow diversity should produce local solidarity", thus it is proposed that some level of mutuality must be perceived between group members (p.116–7). However, it is further proposed, within this thesis, that mutuality may be facilitated through a shared experience or shared aims. For example, mutual recovery values the bringing together of a range of individuals, from clinicians to carers (Crawford et al., 2013). Jordan et al. (2018, p.11) suggests that the intra-group heterogeneity of new capoeiristas is theoretically similar to that of a bridging network, proposed by Putnam, as engagement in the creative practice "connect[ed]…people who are unlike one another, whilst also facilitating coordination and cooperation for *mutual* benefit" (italics in original). Therefore, engagement in creative practice can promote the building of communities with a diverse membership and provide a mutual benefit. Group solidarity is then placed within the hierarchy and incorporates social connectedness and mutuality, as it is argued that the individuals in the group must perceive a level of mutuality, which may be experienced through a shared experience or activity. Within the FMH setting, the patient-staff relationship can be fraught with difficulties (Mann et al., 2014; Adshead, 2004), as discussed in section 2.2.5, and mutuality has been argued to underpin nursing theories in mental healthcare (Brown, 2015) thus, engaging in mutually beneficial activities that promote a shared experience may provide opportunities for therapeutic social capital.

Situating mental healthcare in the UK within its broader context provides important insights for the concept of mutuality. For example, the concept of mutuality within individualistic societies, such as Western societies, is problematic (Price-Robertson et al., 2017), as such societies value the role of independence and the use of the term dependence often is coupled with negative connotations (Adshead, 2004; Bowlby, 1988; Winship, 2000). However, it is argued that interdependency, rather than dependency, is a concept related to mutuality (Brown, 2016). A wider societal shift is required to fully

embrace the value of reciprocity, particularly within the realm of mental health and, importantly, professional healthcare. Such arguments also extend to notions of inclusion where society openly embraces those who may require support in order to fully gain citizenship (Slade et al., 2014). Within the context of an individualistic society, there is still ample evidence that social networks can promote wellbeing. For example, the notion that people do not recover in isolation (Borg and Davidson, 2008; Shepherd et al., 2008; Stuart et al., 2017) is central to the concept of mutual recovery. However, notions of social connectedness within recovery frameworks often view the value of such relationships from the point of view of those in need of recovery and does not extend beyond the individual at the centre of the recovery journey. Mutual recovery extends this notion of social value to include the reciprocity of a mutual relationship, one that is sensitive to the value of a two-way relationship. As such, mutual recovery conceptually extends the notion of social connectedness to include the other, such as the care giver and the person being cared for as potentially gaining benefit from the relationship.

Research in the field is expanding and supports the notion of a mutually beneficial relationship, between carers, service users, mental health professionals, artists, researchers, and community members. Such research was formed as part of the Creative Practice as Mutual Recovery (CPMR) consortium exploring how creative practices may afford opportunities for mutuality through social connectedness and support notions of mutual recovery for mental health and wellbeing (Crawford et al., 2015). Therefore, the notion then that "[r]ecovery can embrace carers and practitioners as well as sufferers from mental health problems" is gaining support (Crawford et al., 2013, p.55).

Mutual recovery recognises the value of social connection to wellbeing and can be achieved through social connectedness and mutuality. Positive social networks are theorised to develop social identity, thus the quality of such relationships can have a powerful influence on

identity development and wellbeing (Winship and Barker, 2016). The creative practice interventions aimed to be inclusive in order to challenge the stigmatisation of marginalised groups (Saavedra et al., 2017a) through expanding the participant groups to include those with different identities, such as carers, clinicians, artists, and researchers. Establishing groups with mixed identities assisted with the development of the broadening of social identity (Saavedra et al., 2017a). Such claims are particularly important when considering the wellbeing of marginalised groups; as such those who have a mental health diagnosis often experience social exclusion and stigmatisation, as discussed in section 2.3.2.

The interventions explored within the CPMR programme aimed to increase or develop social networks to promote wellbeing amongst the community of participants. As such, mutual recovery was evidenced by increased social connectedness (Callahan et al., 2017; Hogan, 2018; Jordan et al., 2018; Lewis et al., 2016; Perkins et al., 2016; Saavedra et al., 2017a, 2017b; Vallejos et al., 2016; Wang et al., 2017), mutuality (Argyle and Winship, 2015; Callahan et al., 2017; Hogan, 2018; Jordan et al., 2018; Lewis et al., 2016; Perkins et al., 2016; Vallejos et al., 2016), and developed identities (Jordan et al., 2018; Saavedra et al., 2017a) beyond symptoms of illness amongst participants and improvements in wellbeing (Argyle and Winship, 2015; Callahan et al., 2017; Fancourt and Perkins, 2018; Hogan, 2018; Lewis et al., 2016; Saavedra et al., 2017a, 2017b; Winship and Barker, 2016).

The institutional and professional constraints which can limit the potential for mutuality is acknowledged (Brown, 2015), which are further explored in section 2.4.1.4.3, and these barriers are particularly relevant in the field of FMH. As within such settings as the FMH and secure institutions, power imbalances are inherent parts of the structure (Phillip, 2012). Thus, within the exploration of social connectedness, mutuality, and opportunities for therapeutic social capital within the embedded context of secure care, it would be an important endeavour to understand the opportunities and boundaries

of such important concepts which have been found to promote wellbeing and personal recovery. This is recognised as a gap in the literature which the research reported in this thesis seeks to address.

2.3.5 Recovery in secure settings

This section explores the principles of personal recovery within inpatient services, with a particular focus on FMH. A theoretical framework, provided by Chow and Priebe (2013) is utilised to explore the key features of psychiatric institutions and recovery principles within mental health service provision in the UK. Research has highlighted four key features of psychiatric institutions to build a modern theory of institutionalisation (Chow and Priebe, 2013). The key themes of policy and legal frameworks regulating care; clinical responsibility and paternalism in clinician-patient relationships; patients' adaptive behaviour to institutionalised care; and bricks and mortar of care institutions are explored in turn.

2.3.5.1 Policy and legal frameworks regulating care

Chapter one outlined the definition for mental disorder according to the Mental Health Act (MHA) (1983/2007) for which an individual may be detained under compulsory admission to hospital on the grounds of their perceived dangerousness to either themselves or others. The mental health legislation is "fully compatible with the Human Rights Act 1998" (Department of Health, 2000, n.p.). Whilst the Government's White paper Reforming the Mental Health Act states that "[t]he vast majority of people receive care and treatment on a voluntary basis" (Department of Health, 2000, n.p.), detention under the act has been found to be a common threat to those receiving voluntary care in psychiatric hospitals (Gilburt et al., 2008) and detention rates under the MHA are increasing (Care Quality Commission (CQC), 2018).

The MHA (1983/2007) provides a framework for detaining mentally disordered offenders and restrictions may apply for individuals, such as, whether an individual has restrictions to the community,

depending on their perceived dangerousness, or Ministry of Justice (MoJ) involvement in relation to conditions of their treatment, transfer or discharge (Edworthy et al., 2016). Thus, those detained under the MHA (1983/2007), such as a forensic patient, will have restrictions applied to their detention, which may involve the MoJ. England and Wales adopt a paternalistic model of decision making which allows professionals to override a detained patient's refusal to consent even if they have capacity to make decisions (Edworthy et al., 2016), this is based on their perceived risk to self and/or others. One of the aims of containment, then, is to protect the patient from self-harm, but such an approach has been suggested to be "benevolently paternalistic" (Slemon et al., 2017, p.1). The relationship between the patient and clinician in relation to paternalistic models of care is further explored in the section below (see section 2.3.5.2).

Intervention strategies, for patients within FMH care, have been debated and such questions have been raised in relation to the appropriate emphasis, for example, if strategies should address psychological needs or a reduction in reoffending (Robertson et al., 2011). However, whilst, mental healthcare has been argued to be underpinned by risk management and relapse prevention (Pilgrim, 2008), the recent focus on strengths-based frameworks have been argued to address both psychological need and risks associated with offending-related behaviour. For example, the Good Lives Model (GLM) explores risks and needs within a comprehensive framework (Ward and Gannon, 2006), which is the dominant approach utilised within offender rehabilitation practice in the UK (Ward and Brown, 2004). However, as discussed in section 2.3.1, alternative routes to goods must be available to the individual (Andrews et al., 2011) and thus a socially sensitive model to mental health recovery should be explored.

2.3.5.2 Clinical responsibility and paternalism in clinician-patient relationships

Forensic psychiatric care in England and Wales has been argued to be dominated by the medical model which places the patient as passive and in need of care (Edworthy et al., 2016) and long stay patients may experience a loss of "hope and independence and a non-patient identity" (Mann et al., 2014, p.125). Thus, notions of autonomy and hope associated with personal recovery become problematic within the FMH context. Furthermore, the emphasis on empowerment and choice also becomes complex (Drennan and Alred, 2012) and Mezey et al. (2010, p.683) argues that aspects of the recovery approach:

> appear to be less meaningful to individuals, who are detained for serious and violent offences [thus] [t]he recovery approach may need to be modified for use in forensic psychiatric services.

Therefore, applying recovery principles to the secure setting is highly challenging due to the conflicting nature of the restricted and locked environment versus the promotion of independent decision making (McKeown et al., 2016). The forensic institution has been suggested to be the most difficult setting to apply recovery principles (Drennan and Wooldridge, 2014) however, evidence from staff and patients in one study suggests that recovery principles are not incompatible within FMH services and can be achieved (Livingston et al., 2012).

Anthony (1993, p.1) suggests that recovery "means taking charge of one's life even if one cannot take complete charge of one's symptoms". However, the application of such principles within the secure setting raises some important questions which threaten the ethos for such a movement. For example, those receiving care in a FMH environment are often isolated from the community and under compulsory care that curtails liberty (Simpson and Penney, 2011).

Drennan and Alred, (2012) advocate shared decision making, but warn that practices should not pose as tokenistic. Research has found that patients taking responsibility for their own recovery was a key component of successful recovery for those in a high secure FMH environment however, balancing risk and responsibility was viewed as a tension for both staff and forensic patients (McKeown et al., 2016). Slade (1999) suggests, mental health services should exist as a resource to those with a mental illness and thus should not exist to govern the lives of those with a mental illness. However, within the FMH setting, such ideals are difficult to implement when practices emphasise risk, as discussed in section 2.2.2—risk that is decided by the staff and is an inherently subjective exercise (Mann et al., 2014; McKeown et al., 2016). Compulsory treatment and risk assessments can foster and promote paternalistic care. However, even within the landscape of power disparity, researchers have found that engaging in meaningful occupation and relationships between staff and patients were seen of high importance for those receiving care in the FMH environment (McKeown et al., 2016). Furthermore, research has found that staff who had received training on the implementation of recovery principles in secure care reported positive attitudes towards the implementation of such principles (Gudjonsson et al., 2010).

Recovery principles promote an equal partnership between staff and residents, so that staff undertake a supportive role in an individual's recovery (Slade et al., 2014). However, staff may feel ambivalent to enact such an ethos in practice (Mann et al., 2014), and the process of othering is prevalent in mental healthcare. Othering is the process of engaging with others who "are perceived as different from [the] self" and is considered to be "perhaps inevitable" within forensic psychiatry due to the hierarchical power structure (Peternelj-Taylor, 2004, p.130). Such staff reactions within FMH care evokes oppositional differences which often attribute negative connotations to that of the other (Jacob et al., 2009). Thus, protective approaches to anxiety may undermine notions of equality and partnership working. Furthermore, witnessing pathologising behaviour may distil

notions of hope for staff (Mann et al., 2014) and lead to a disengagement with ideas of connection. However, evidence suggests that a mutual relationship is a powerful tool for de-escalating violence, for example, Robertson et al. (2012, p.96) notes that "interpersonal skills such as empathy, reciprocity, respect, and mutuality were also seen as important components of de-escalation". Such approaches to care promote a therapeutic environment, which in turn promote the wellbeing of both staff and patients.

Whilst the focus of mental healthcare in the UK today is suggested to be focused on patient-centred care, there is no evidence that the clinical measures utilised to measure such care (e.g., risk) are synonymous with patient reported recovery or quality of life (Sugarman and Dickens, 2015). Thus, what constitutes an outcome measure for services may not be congruent with meaningful change for the forensic patient.

2.3.5.3 Patients' adaptive behaviour to institutionalised care

Barton (1966, p.5) introduced the term institutional neurosis, which resulted from living within institutional asylums and was described as a disease consisting of symptoms such as "apathy, loss of interest, lack of initiative, and sometimes a characteristic posture and gait result from institutional life". The manmade disease was suggested to be caused by loss of contact with the outside world, enforced idleness, brutality and bossiness of staff, loss of friends and personal possessions, poor ward atmosphere, and loss of prospects outside the institution. Modern institutions offer a programme of care which promotes stimulation for patients and attempts have been made to ensure the environments are therapeutic (National Institute for Health and Care Excellence (NICE), 2011), theorised by Barton (1966) to evade such a disease.

The permeability of secure institutions has been found to exist on a continuum (see Quirk et al., 2006), and is promoted through

initiatives, such as the CPA and least restrictive care. However, Dixon (2015, p.1309) found that forensic patients:

> may benefit from a diagnosis of mental illness because it exempts them from everyday tasks, although this diagnosis is seen to be conditional on the patient drawing on advice from doctors in order to recover.

Such a view provided by patients in the study was theorised to be underpinned by a Parsonian perspective (i.e., Parson's sick role). There are four related characteristics of the sick role; the sick person is exempt from normal social roles; are not responsible for their condition; have an obligation to want to become well; and they have an obligation to seek and cooperate with technically competent help (Lubkin and Larsen, 2009). Parson's sick role relates to institutional expectations (Mik-Meyer and Obling, 2012) and sanctions on sickness (Dixon, 2015). It was noted in section 2.2.5 that both patients and staff are active in creating the division between them (Hinshelwood, 2001), and section 5.3.4.1 further debates the complicity of both groups within institutional care.

Section 2.2.3 discussed the loss of social roles associated with institutional care (Goffman, 1961), which has been suggested to be a significant barrier to recovery (Mann et al., 2014). However, extending social roles can be complex and connections with the outside world may be monitored, depending on perceptions relating to risk. As previously discussed, forensic patients may be detained under the MHA (1983/2007) with restrictions, which may include restrictions to the community (see section 2.3.5.1). Social roles, such as, work or volunteering, may be challenging to obtain (Mezey et al., 2010). Thus, contact with the outside world may be restricted, for some individuals. However, for those who have leave permissions, success has been reported with a service assisting FMH patients into employment (Samele et al., 2018).

Whilst, building therapeutic relationships is "fraught with difficulties" (Mann et al., 2014, p.126), the emotional security experienced may provide a sense of safety for the first time (Adshead, 2004), which may be threatened when the patient is nearing the end of their care, as discussed in section 2.2.5. Thus, the patient may exhibit behaviour which jeopardises their release. As discussed in section 2.2.5, some patients may re-enact unhelpful attachments when admitted to care and thus may regress (Humphreys and Bree, 2004), leading to a dependency on the institution. Moreover, the forensic patient faces further obstacles, such as, "discrimination, public fear, and social exclusion" (Simpson and Penney, 2011, p. 302), and as such the institution may be viewed as a safe haven, as discussed in section 2.3.3, which also may lead to jeopardising-related behaviour in order to stay within the institution. Furthermore, due to the paternalistic nature of care within the FMH setting, the forensic patient may find themselves conforming in such a way that it is observed that the patient has become institutionalised, however patients have reported learning to play the game and undertaking a level of performativity (Gillard et al., 2012; Reynolds et al., 2014; Morris et al., 2016), as discussed in section 2.2.3.

2.3.5.4 Bricks and mortar of care institutions: The built environment

Environmental security, offered by the physical attributes of a secure building, have also been identified as key features of the modern institutional care. The level of environmental security is suggested to match the risk associated with the individuals, in terms of an absconding risk (Crichton, 2009). Thus, aspects of physical security offer practical assistance with the containment of those within secure services.

Goffman (1961, pp.15–16) describes total institutions as:

> symbolized by the barrier to social intercourse with the outside and to departure that is often built right into the physical plant, such as locked doors, high walls, barbed wire, cliffs, water, forests, or moors.

However modern institutions offer a different landscape to that described by Goffman (1961) and have been described as permeable in nature. Institutions are theorised as existing on a continuum of permeability, from total to permeable (Quirk et al., 2006). Quirk et al. (2006, p.2105) found evidence for permeability, through temporary ward membership, short stay patients and a high turnover of staff; contact with the outside world was maintained for patients; and the staff/patient identities were found to be "blurred". The authors recognised that the permeability of the three psychiatric wards minimised the risk of institutionalisation, but however, risks associated with unwanted visitors and contraband items increased (Quirk et al., 2006). Furthermore, the built environment has been found to be restrictive. For example, Tomlin et al. (2018) conducted a systematic review of the qualitative literature and found that patients viewed the physically restrictive environment negatively and described the institutional environment as prison-like. However, it is argued that a less permeable institution may also provide an element of psychological safety for patients. For example, previous research has shown that patients have reported feeling safe from the outside world in institutions, as discussed in section 2.2.3 (Mezey et al., 2010; Stenhouse, 2013).

Furthermore, the institutional building can provide the physical security that can facilitate the therapeutic milieu (Crichton, 2009) and emotional or psychological safety can be supported through physical containment (Adshead, 2004). Additionally, there is a growing body of literature which explores the psychological impact of physical spaces and architectural literature extends to exploring the mental health institutional environment (Dvoskin et al., 2002; Sine, 2008). Howard (2004, p.70) states that "[an] appropriate physical space

does much to enhance the provision of emotional space", thus recognising the importance of inpatient design to promote wellbeing.

Goffman's (1961) description also explores the geographic location of institutions, suggesting that they are isolated from civilisation through their locality. However, since the deinstituionalisation of large mental health asylums, modern institutions are smaller in size and embedded within communities, which is congruent with the research site explored within this thesis (see section 4.2 for further detail in relation to the study site). Although, such developments have been argued to be naïve simplistic solutions to the negative views of the old asylums (Hinshelwood, 2001) and care within modern institutions can still be problematic (Rutherford, 2010).

2.3.6 Recovery and mental health: Summary

Current models in care promote individualised care plans and treatment and are supported through the philosophy of least restrictive practices. However, the application of such principles, including the promotion of agency which underpin personal recovery, is complex within the FMH environment due to custodial and paternalistic practices (Drennan and Alred, 2012; Mann et al., 2014; McKeown et al., 2016; Mezey et al., 2010), which underpin service provision in the UK.

Inequality in mental health is prominent (Boardman, 2011) and social determinants of health have been found to be a stable predictor (Elliott, 2016; Rogers and Pilgrim, 2014). Furthermore, care and treatment models can further delineate discrimination and oppression and have been argued to promote inequality through cultural insensitivity, for example, for the BME community (Pilgrim, 1997; Singh and Burns, 2006). Forensic patients face additional challenges through their role as perpetrator and an individual with a mental health diagnosis (Drennan and Wooldridge, 2014; Marshall and Adams, 2018; Mezey et al., 2010), and thus recovery can be challenging.

Positive social relationships and roles have been linked to personal recovery (Leamy et al., 2011; Stickley and Wright, 2011a) and social capital (Brown, 2015, 2016). Mutual recovery extends this concept by valuing reciprocal relationships (Crawford et al., 2013). Evidence supports the building of communities through engagement in creative practices, which has been found to promote wellbeing and mutual recovery (Argyle and Winship, 2015; Hogan, 2018; Lewis et al., 2016; Perkins et al., 2016; Saavedra et al., 2017a, 2017b; Vallejos et al., 2016). Thus, it is proposed that the building of communities and wellbeing can be promoted for staff and residents through engagement with creative practices. The building of communities within the FMH environment is argued to be highly important due to the emotional challenges that both staff and forensic patients endure, as discussed in section 2.2.

2.4 Arts and health

The aims of the literature review in relation to arts and health are twofold. Firstly, the literature is explored in order to understand the terms relevant to this thesis, which are: wellbeing and creative practices. Thus, the literature in relation to the broad field of arts and health is explored in the light of the underpinning assumptions related to arts engagement and implications for health and wellbeing. Definitions of these terms are then provided based on the exploration of the literature. Secondly, relevant literature in relation to the context of creative practices within the secure healthcare environment (i.e., secure inpatient services, such as, inpatient mental healthcare and forensic mental health) is explored to understand current research and practice.

2.4.1 Arts, health and wellbeing

Much of the literature within the vast field of arts and health often quote the World Health Organisation's (WHO) definition of health which was first published in 1948, which states that: "[h]ealth is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (World Health

Organization, 1995, p.1). Thus, the definition of health extends beyond the notion of ill health and supports a more holistic approach to wellbeing. However, healthcare within the UK tends to address health in the acutely ill through modern biomedicine (All-Party Parliamentary Group on Arts, Health & Wellbeing, 2017). The dominant biomedical model of care is underpinned by a reductionist model of health and illness (Hunter, 2008), which is argued to be insufficient in treating ill-health (Wade and Halligan, 2004). Global perspectives of health are rooted in the understanding of the social determinants of health and illness (World Health Organization, 2010) and are recognised by Public Health England (2017, n.p.) who define such determinants as "[t]he broad social and economic circumstances that together influence health throughout the life course". The social determinants of mental health were further debated in section 2.3.2.

A unified approach to health which includes both physical and mental health is prevalent within global perspectives of health and wellbeing. For example, the WHO state that "there is no health without mental health" (World Health Organization, 2005, p.11). Such an ethos is prevalent in NHS plans in the UK, where the integration of mental health and physical health service has been listed as a recognised aim (NHS England, 2014). It is argued that a lack of integrated services for mental and physical health "perpetuate inequalities in health outcomes" leading to a lack of effectiveness in healthcare (The King's Fund, 2016, p.4). Therefore, mental and physical health are considered to be important aspects of health and healthcare globally. Mental health has been defined as the following by the WHO (2004, p.59):

> a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community.

Thus, health includes both physical and mental health and mental health adopts a capabilities and resilient approach to daily living in which the individual can contribute to their community. Wellbeing incorporates two psychological perspectives: hedonistic and eudaimonic (Saavedra et al., 2017a). The hedonistic perspective relates to the subjective understanding of happiness, life satisfaction, and pleasure, whilst the eudaimonic perspective relates to meaning, self-realisation and also functioning (Ryan and Deci, 2001; Tennant et al., 2007). Thus, the WHO focuses primarily on functioning, thus an eudaimonic perspective underpins their definition of mental health. However, arts and health interventions can contribute to both perspectives and includes the subjective hedonistic experience, which is explored later in this chapter. Furthermore, the Warwick-Edinburgh Mental Well-being Scale (WEMWBS) (Tennant et al., 2007), which has been widely adopted in research exploring wellbeing (Fancourt et al., 2016a; Hogan, 2018; Saavedra et al., 2017b; Vallejos et al., 2016; Winship and Barker, 2016), includes both perspectives and is underpinned by the assumption that poor mental health relates to limitations in both hedonistic and eudaimonic wellbeing. Moreover, Huta (2017, p.5) explains that:

> [t]he pursuit of hedonia tends to be more linked with feelings of carefreeness…while the pursuit of eudaimonia tends to be more linked with feelings of meaning…and self-connectedness.

However, it is also proposed that the two perspectives are inextricably linked (Ryan and Deci, 2001). Therefore, carefreeness or happiness may be linked with meaningfulness found in activity or social roles. Furthermore, the recovery literature suggests that the promotion of social roles can promote personal recovery (Wolfson, 2009), which can provide meaning for individuals (Leamy et al., 2011). Thus, conversely, those who feel that they have diminished social roles, in which Goffman (1961) attributes to institutionalisation, the individual may also feel that they lack meaning in their life. Moreover, it is

theorised that hedonic pursuits are more transient in nature while eudaimonic pursuits are longer lasting (Huta, 2017). Thus, hedonism may be associated with transient emotions, such as happiness and joy, and eudaimonism may be associated with long term wellbeing and can be provided by meaningfulness found in social or occupational roles. Within this thesis both hedonistic and eudaimonistic perspectives of wellbeing linked to health are incorporated. Furthermore, notions of wellbeing and recovery are considered to be subjective and the consideration of the individual's wellbeing and/or recovery is viewed as determined by the residents and staff at Westmarch Hospital. Such a view is in keeping with the personal recovery literature which proposes that recovery goals and wellbeing are defined by the individual (Slade, 2009b).

2.4.1.1 Art in and as therapy

As stated in chapter one, the term art therapy has been used in various divergent forms in the literature and often refers to art in therapy. Art therapies however encompasses both arts in therapy and arts as therapy and within this thesis these distinctions are important. Art in therapy is underpinned by psychotherapeutic principles. For this reason, it is valued as an evidenced based practice and its focus is argued to be appropriately on clinical outcomes (Broderick, 2011). Arts engagement within art in therapy is utilised within healthcare in order to facilitate a therapeutic relationship between the patient, the art therapist and the artwork (Edwards, 2014). The National Institute of Clinical Evidence (NICE) recommends that art in therapy, which is listed as a psychological therapy, can be used as a method for creating expression to work through problems through the medium of art, drama, music and dance for adults with a diagnosis of Psychosis or Schizophrenia (National Institute for Health and Care Excellence (NICE), 2014). Within the context of art in therapy, the artwork is described as a communicative method for expression (Stevenson and Orr, 2013). Thus, the value of the artwork within art in therapy is the product, in which emotions can be expressed and represented in the product. Art therapists are registered practitioners,

such as, art therapist or psychotherapist and music or drama therapist and are regulated by the Health Professionals Council (Clift et al., 2009) or the British Association of Art Therapy (Stickley et al., 2017), in which an arts in therapy approach is adopted. The assumption that the therapeutic relationship established between the artwork, the patient, and the art therapist is a route to wellbeing, underpins art in therapy approaches (Edwards, 2014).

Art as therapy recognises the process of creating artwork as therapeutic for the creator (Edwards, 2014) however, a therapeutic clinical outcome is not explored. The distinction between the two schools of art in or as therapy is the emphasis on either healing or therapeutic change (Edwards, 2014). Research in support of art as therapy has shown that engaging in the arts has led to an improvement in physical health (Gordon-Nesbitt, 2015) and in both physical and psychological wellbeing (Staricoff & Clift, 2011) and has contributed to holistic health, which encompasses the physical, mental and social wellbeing as contributing features of wellbeing (Fancourt et al., 2016a, 2016b; Stuckey and Nobel, 2010). The implications for arts engagement, therefore, extend beyond the clinical implications associated with art in therapy.

There are core differences between those who are trained specialist art therapists that utilise an art in therapy approach, and occupational therapists, who utilise both an art in and as therapy approach within practice, which are differentiated through specialist training within the psychodynamic field. Some occupational therapists may utilise creative therapies from a psychodynamic perspective and thus adopt projective understanding as part of their work—thus adopting traditional art in therapy approaches however, such techniques require further training (Griffiths and Corr, 2007). Thus, not all occupational therapists will utilise art in this way in practice. The psychodynamic tradition of art in therapy has been suggested to be a trend between the 1950s and 1970s (Thompson and Blair, 1998). In addition, within art as therapy there are art specialists who work with

a range of individuals across various settings, for example, community arts centres or institutional care.

The All-Party Parliamentary Group on Arts, Health and Wellbeing published a report exploring research and practice in the UK (All-Party Parliamentary Group on Arts, Health & Wellbeing, 2017). The report identifies eight categories of arts engagement, showcasing the vast field of creative practice engagement. Many of the categories extend beyond the more formal approach of art in therapy and to approaches which focus on engagement with arts practices as therapeutic. The arts and health diamond (see figure 2.2) has been utilised, within this section of this thesis, to map the various categories of arts and health as captured by the All-Party Parliamentary Group (2017) and explore relevant literature. The dimensions range from a focus on health promotion or engagement with the arts, and the second dimension is whether the focus is on individual or group wellbeing (Clift et al., 2009).

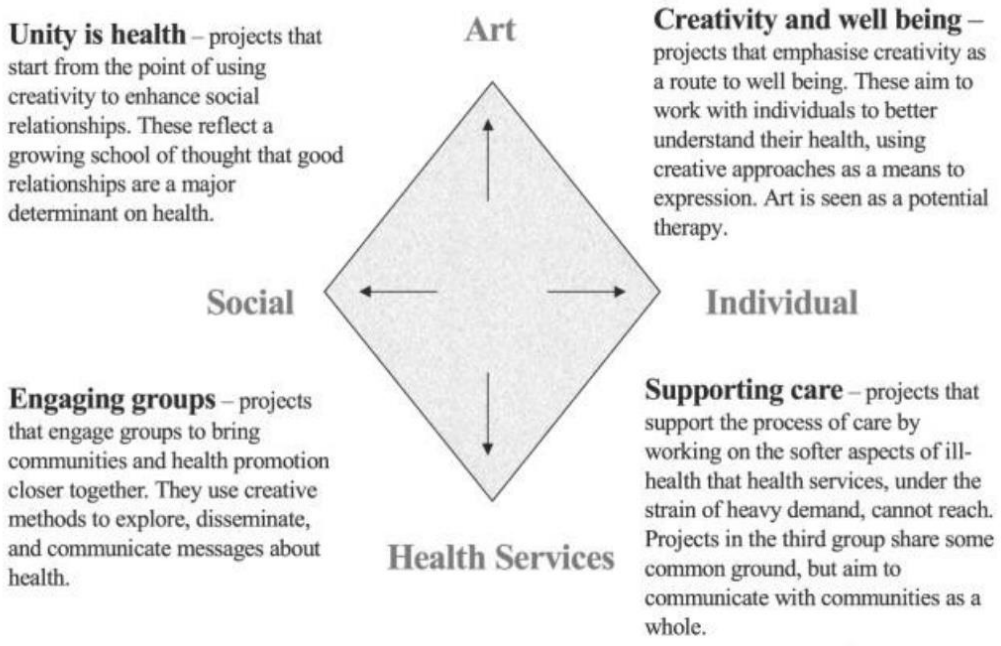


Figure 2.2: The arts and health diamond (Macnaughton et al., 2005, p.337)

2.4.1.1.1 Unity is health

Unity is health is situated on the social and art end of the continuum, indicating that such initiatives focus on the social benefits and the art

itself (Fancourt, 2017). The All-Party Parliamentary Group on Arts, Health and Wellbeing provides two categories of arts engagement which can be defined as unity is health. One of which is attendance at cultural venues and events. Research suggests that cultural participation correlates with social capital measures (Vella-Burrows et al., 2014). Thus, cultural participation can promote social capital through social engagement with the arts. The All-Party Parliamentary Group on Arts, Health and Wellbeing (2017) outline research conducted by Ander et al. (2013) who reports the value of handling museum objects for individuals in hospitals. However, whilst this research explores cultural participation, it was aimed at those who are unwell and thus such projects fit within the supporting care group of the arts and health diamond.

Whilst cultural participation has been linked to social capital, research also suggests that there are inequalities in arts participation, in which social capital can be mobilised through cultural participation (Miles and Gibson, 2016). The authors provide an example where governmental policies can create barriers to inclusion by promoting certain types of cultural activities, activities which suit middle-class ideologies. Thus, the cultural programmes that are promoted establish what cultural practices become subsidised and available to the public and also in turn sets the agenda for what is valued which can "obscure… the significance of other forms of cultural participation which are situated locally in the everyday realm" (Miles and Gibson, 2016, p.151).

2.4.1.1.2 Creativity and wellbeing

The creativity and wellbeing category of the arts and health diamond includes projects which have an art focus for the individual. Such engagement with the arts is what is referred to as everyday creativity. The All-Party Parliamentary Group on Arts, Health and Wellbeing (2017, p.20) report that there are a series of amateur arts groups in England which involve 17% of the population and such activities:

> might be undertaken alone or in company and has an immense contribution to make to happy, healthy lives without necessarily having a connection to health or social care.

Everyday creativity is thus provided as another category. Stickley (2012) proposed a common sense argument in relation to the notion that arts are good and promote wellbeing. Everyday creativity is defined as:

> only in terms of making an *original* contribution of some sort, and one that communicates to others and is thus *meaningful*, rather than being random or idiosyncratic. (italics in original, Richards, 2007, p.502-3).

However, the All-Party Parliamentary Group on Arts, Health and Wellbeing (2017) do not define their category beyond who might be involved in such activities and that engagement can promote health and wellbeing. It is argued, within this thesis, that there are wider implications of everyday creativity and wellbeing that extend beyond an original contribution. For example, listening to music can promote wellbeing by offering respite from pain or distress (DeNora, 2016). DeNora and Ansdell (2014), however, argue for an alternative view to wellbeing when considering what music can do, that is flourishing, which is suggested to extend the bounds of health and illness to consider how someone may flourish even if they are experiencing illness. This view extends the field of everyday creativity to include music listening and thus a broader perspective of the field is proposed, one that extends beyond the idea of originality and considers the appreciation of the audience member. This thesis recognises the geographies of creativity, in that the "local social contexts of arts production" are considered (DeNora, 2000, p.4) and a qualitative and interpretive inquiry is adopted which extends beyond the experimental manipulation (DeNora and Ansdell, 2014), which takes creativity out of the context of practices, situations, and people.

Hawkins (2016, n.p.) argues that the "geography matters to understanding creativity" and creativity is:

> an embodied, material and social practice that produces both highly specialist cultural goods and is a part of every day life, and it offers a myriad possibilities for making alternative worlds.

Thus, the geography of arts engagement within this thesis will be considered and a broad holistic perspective of everyday creativity which considers individuals within their social context and the meaning of creative pursuits will be explored.

2.4.1.1.3 Supporting care

One of the categories outlined by the All-Party Parliamentary Group on Arts, Health and Wellbeing (2017), is arts in health and care environments. Research has found engaging in arts practices which focus on the process and not the product, akin to the field of art as therapy, can promote wellbeing within a range of individuals, for example, those with a diagnosis of dementia (Beard, 2012; Broome et al., 2017), and post-natal depression (Fancourt and Perkins, 2018). Furthermore, health psychologists adopt arts as health interventions in the areas of health promotion and prevention (Camic, 2008). Thus, such engagement with the arts is centred on health promotion, with arts engagement as a facilitator.

Arts Therapies is another category proposed by the All-Party Parliamentary Group on Arts, Health and Wellbeing (2017), which adopts both an art in and as therapy approach to health promotion, as discussed in section 2.4.1.1. Art therapists describe the use of art in therapy in practice in a range of settings. For example, in breast cancer patients (Puig et al., 2006) and for those with a physical illness (Broadbent et al., 2018) as a communicative method. Thus, projects can utilise both arts in and as therapy approaches to support healthcare with a focus on health promotion for the individual. The

implications for this research are that both approaches to creative engagement can promote health and wellbeing within healthcare, a further discussion on approaches in the secure setting is provided in section 2.4.1.2.

2.4.1.1.4 Engaging groups

One of the arts engagement categories outlined by the All-Party Parliamentary Group on Arts, Health and Wellbeing (2017) is participatory arts programmes, which have been utilised across a range of groups, such as, older age (Bungay et al., 2010; Noice et al., 2014), offenders, the homeless, and mental health service users (Arts Council England, 2010). Whilst physical and mental health benefits have been found following engagement in such activities (Castora-Binkley et al., 2010), participatory arts are suggested to be inherently social (Stickley et al., 2017), with the arts activity suggested to be the catalyst to social engagement (Bungay et al., 2010). Thus, participatory arts fit within the engaging groups category of the arts and health diamond, which promote health through engagement with the arts—see figure 2.2, however, such projects also fit within the unity is health category as they aim to bring together individuals to engage socially in art creation practices and build communities. Similarly, arts on prescription is offered as a form of social prescribing in the UK which is not typically run by an art therapist however, the evidence suggests that such interventions promote wellbeing through a preventative strategy and promotion of wellbeing through social inclusion (Bungay and Clift, 2010). The arts activities thus are viewed as a social intervention for wellbeing. Furthermore, social prescription practices can also promote health benefits by teaching breathing techniques (Robinson, 2018). Such an individual focus extends social prescribing to include supportive care as well as engaging groups—as identified by the arts and health diamond, see figure 2.2.

However, arts engagement practices are suggested to be inaccessible for some individuals, through social exclusion. For example, Robinson

(2018, p.1) suggests that in some circumstances with social prescribing, those most vulnerable in our society:

> are often the least empowered or motivated to take up the suggestions and may live in areas where accessing community activities is hard without guidance.

Therefore, social inequalities can influence engagement with the arts.

2.4.1.1.5 Measurement in arts in and as therapy

The approaches to arts in health and arts as health approaches not only differ in relation to their approach to wellbeing, as discussed in section 2.4.1.1, but in the value attributed to the outcomes of arts engagement (Broderick, 2011). It is important to consider the breadth of arts and health initiatives in the UK, which predominantly focus on engaging communities to promote health through engagement with arts activities. Such projects are underpinned by the assumption that such engagements can improve health through an arts as health approach—an approach that considers the value of engagement for individuals and groups but traditionally does not focus on clinical outcomes. Thus, whilst evidenced based approaches are sought after within the field of arts and health (Stuckey and Nobel, 2010), it is argued that the evidence base for influences or impact on health focusses on clinical outcomes rather than process. For example, the aims of art in therapy and art as therapy practices differ, thus evaluation and research techniques should also differ in their approach in a way that is sensitive to their fundamental aims (Broderick, 2011). Furthermore, Raw et al. (2012) argue an interdisciplinary theoretical framework for arts practice, which adopts and art as therapy approach, should be explored.

The focus of a clinical approach to evidence base for arts as therapy practices, as discussed in section 1.4, has implications for the commissioning landscape of arts and health projects, and projects are often under threat, which can undermine the value that these projects

can provide to communities (Lewis et al., 2016). The value of creative practice engagement is growing in its evidence base, whether this evidence is empirical or anecdotal, this section has explored the evidence that suggests that there are positive implications for health and wellbeing for those who participate in some form.

The categories and related research introduced by the All-Party Parliamentary Group on Arts, Health and Wellbeing (2017) have been explored to understand the scope of arts and health initiatives in the UK and to understand their underlying focus in relation to their aims and assumptions regarding engagement and wellbeing. The categories explored predominantly fit within the scope of arts as health, which focuses on the value of arts engagement in relation to wellbeing extending beyond the clinical implications associated with art in therapy. The exception is the utilisation of art in therapy within the healthcare context. Within the context of exploring mutual recovery through creative practice, art practices that focus on the individual are theorised to limit the extent of mutuality experienced in an egalitarian sense and thus, projects which focus on individual therapeutic clinical outcomes are considered beyond the scope of mutual recovery and thus this thesis. Furthermore, art as therapy practices will be explored from a social perspective and consider the social context in which the activities are embedded and the contribution of the shared art experience, thus a suitable research method was adopted which explored the social relationships centred on creative practice engagement. Arts, health, and wellbeing in relation to arts in and as therapy, including the issues related to the evaluation of such practices, are mirrored in the following discussion of arts in and as therapy within the secure setting.

2.4.1.2 Arts in and as therapy within the secure setting

This section explores arts in and as health within the secure setting, such as inpatient mental health units or inpatient FMH units. Salient research within the art in therapy and art as therapy categories are explored; thus, projects which primarily focus on the product and

projects that focus on the process. The first documentation of art being used as therapy was in the mid-19th century, where patients within an institutional asylum in Scotland were provided with art materials so that they could paint and draw (Rustin, 2008). As discussed in section 2.4.1.1, NICE (2014) guidelines recommend art in therapy, such as, art, drama, music, and dance for adults with a diagnosis of Psychosis or Schizophrenia. However, the value of art in therapy can extend beyond particular clinical diagnoses, for example, art making offered by a trained therapist has been suggested to facilitate building psychological safety and security (Banks, 2012). Furthermore, Teasdale (1997) explored the use of art in therapy with forensic patients with a diagnosis of personality disorder and suggests that approaches can be tailored to the client's needs.

The history of art as therapy approaches begins with the moral treatment movement. William Tuke, at the Retreat York in England, is suggested to be the pioneer of modern occupational therapy practice who adopted an approach in which patients were to undertake occupations, such as, arts and crafts, to promote a meaningful life (Charland, 2007). The notion that work is good in opposition to idleness underpinned practice in occupational therapy (Hagedorn, 1995). The role of occupational therapists within secure mental healthcare is further discussed in section 2.4.1.3.

Four themes were found to underpin the literature exploring art as and in therapy within the secure environment, these were: art in therapy as a communicative tool, art in and as therapy as social connection, arts as health in engaging groups, and the challenging environment. These are explored in turn.

2.4.1.2.1 Art in therapy as a communicative tool

Art in therapy has been argued to allow the individual to explore their inner world through externalising, symbolising and restructuring traumatic experiences (Batcup, 2013). Furthermore, kinaesthetic movement provided in dramatherapy has been suggested to allow compassionate distance from the personal experiences (Batcup,

2013). Research suggests that engaging in art therapy can provide an alternative way of communicating when words are hard to find (Havsteen-Franklin and Altamirano, 2015; Springham et al., 2012) and can lead to the expression of emotions by enabling this expression to be exhibited through the art medium (Banks, 2012; Lamont et al., 2009) or by the elicitation of emotional states through the process of art making (Van Den Broek et al., 2011). Creativity as a communication method can lead to communication with the self through self-realisation (Stott, 2018). Eudaimonic approaches to wellbeing promote such insight (Ryff, 2014). Whilst such realisations may be promoted through art therapy as a process of self-discovery, the analysing of art work can sometimes lead to frustrations as art can be misinterpreted by staff. For example, participants in the research conducted by Gilbert et al. (2008) found that the interpretation of artwork can lead to pathologised assumptions leading to frustration for the patient. Furthermore, Woods and Springham (2011) found that when a patient was at her most acute she felt unable to engage in art therapy and found the prospect of exploring their inner world daunting and thus avoided attending such sessions. However, art therapy methods have been argued to be able to create a sense of safety and can be built through more basic tasks, such as, copying images (Stott, 2018). Whilst art therapy may be perceived as daunting for the patient, the therapeutic value of engagement is supported by the literature.

2.4.1.2.2 Art in and as therapy as social connection

Art in therapy techniques tend to focus on the individual in therapy. This is due to the assumption that representations of the patient's inner world are revealed though the artwork, thus the focus is on the product and not process (Gray, 2015). However, art in therapy can range from supporting care to engaging groups in health services through arts engagement, as identified by the arts and health diamond (Macnaughton et al., 2005). Thus, whilst the arts in therapy focus is traditionally on the individual, Batcup (2013) suggests that engagement in dance movement psychotherapy can assist with

socialising and bonding with other individuals. Furthermore, Morris and Willis-Rauch (2014) found that by utilising a social action approach in art as therapy activities, within an inpatient FMH service, patients were able to develop an artist identity. Thus, engagement in art in therapy can promote identity development. In addition, the collaborative decision making facilitated prosocial behaviour amongst participants (Morris and Willis-Rauch, 2014). Therefore, art in therapy approaches can also promote social connection.

2.4.1.2.3 Arts as health in engaging groups

Art projects that aim to build communities for health promotion are referred to as engaging groups in the arts and health diamond (Macnaughton et al., 2005). Examples of projects with this aim are considered in this section. Allan et al. (2015) offered group art therapy sessions in the community for those within inpatient mental health care with the aim to work with such individuals during their transition to the community, thus promoting consistency in care. The art sessions were run in the community, which has implications for those on restriction orders under the MHA (1983/2007). However, this does not apply to all forensic patients and thus has some relevance to the population explored within this research. The aim of the project was to improve wellbeing and increase social inclusion and found that participants reported a sense of community and a reduction in feelings of social isolation (Allan et al., 2015). It is argued that this project promoted personal recovery through providing opportunities for social connectedness (Leamy et al., 2011), whilst also continuing to develop an artistic identity through creative engagement, which has also been suggested to promote recovery (Repper and Perkins, 2003). Furthermore, Mezey and Krljes (2015) aimed to challenge mental health stigma through building a community through choir singing, which included forensic patients, a community choir, and staff at a medium secure unit in the UK. The participants reported many benefits of engagement, such as, improvements in wellbeing, emotional connectedness, and increased confidence (Mezey et al., 2015). The engagement of staff, forensic

patients, and members from the community promoted social inclusion by breaking down barriers between the groups in which active participation in signing was exhibited by all members of the choir. This project extended group membership to include a range of individuals in order to challenge stigma through a joint mutual endeavour.

Some arts engagement projects aim to promote individual learning and development through a special interest group. For example, Cocking and Astill (2004) developed a creative literature group for forensic patients in a high secure hospital in the UK. The group selected poems or short stories were read and then discussed in the group. The sessions aimed to assist in emotional and personal development however, therapeutic benefits were observed, such as, a growth in confidence and ability to participate in group discussions. Whilst the group is defined as a leisure activity which has therapeutic outcomes (Cocking and Astill, 2004) it is argued that the aim of the group was to assist in literacy development and thus focus on individual development as supporting care. It is argued that defining categories for the arts and health literature can be problematic. For example, Fancourt (2017) argues that continua models, such as the arts and health diamond, which focuses on two core dimensions, ranging from the individual to the social, and arts to health, can assist with contextualising core techniques and aims of projects. However, "the complexities and diversity of the field of arts in health arguably go beyond just two continua", thus the overlap found within this chapter are suggested to be due to such complexity and diversity (Fancourt, 2017, p.71).

2.4.1.2.4 The challenging environment

The challenging emotive environment has been recognised as pertinent to the institutional environment (Woods and Springham, 2011), which has implications for creative practice engagement within such a context. For example, Teasdale (1997) discusses how there is a tension between art therapy and the forensic setting, for example, the therapy and containment versus empowerment and restriction.

This tension can make it difficult to achieve the empowerment aims of art in therapy when the life of the individual is contained and constrained by the routine of the correctional setting. More recently, research has found that there are tensions in the emotional environment and the probing nature of art therapy. For example Woods and Springham (2011) recognise the challenge of the usual routine provided by the institutional environment in which art therapy can sharply contrast and can lead to the art therapist to spend time waiting for the patient. The difficulties experienced by Woods and Springham (2011) in finding allocated space for art therapy within the institutional routine has implications for this research. For example, the situatedness of creative practices within the institutional timetable are importantly explored within this thesis.

2.4.1.3 Art and occupational therapy

Occupational therapists were largely situated within hospitals in the 1960s and their registration status as health care professionals affirmed their professional identity (Hagedorn, 1995). The client-centred approach to occupational therapy practice is rooted in the moral treatment movement in the 19th century (Duncan, 2002). The practice of art as a projective tool within occupational therapy soon developed with a focus on humanistic and psychodynamic approaches, which further prompted the use of creative activities in practice (Thompson and Blair, 1998). For example, occupational therapists explored the art created as diagnostic material for assessing a range of underlying psychodynamic processes, such as, self-image or understanding unconscious drives (Lloyd and Papas, 1999). Psychodynamic models influenced the use of arts in therapy from the 1950s to the 1970s however, due to its subjective focus, within the economic UK landscape which valued scientific and quantitative data to support funding for healthcare services, such practices began to decline (Thompson and Blair, 1998). Furthermore, Duncan (2002) argues that anti-positivist approaches to practice are unhelpful in times of austerity when interventions with efficacy are most valued. Thus, the decline in creative activities within

occupational therapy practice has been argued to be influenced by the positivist paradigm (Mullersdorf and Ivarsson, 2016; Thompson and Blair, 1998). However, techniques in the field developed to utilising art for communicative purposes and developing a therapeutic relationship, and thus the focus shifted towards process and away from valuing the product (Lloyd and Papas, 1999), advocating an art as therapy approach.

Within modern practice, occupational therapists are suggested to provide individualised care to a range of individuals, thus each intervention is tailored to the individual and can vary from patient to patient (Royeen, 2002). According to the Canadian Association of Occupational Therapy (2008, p.24) occupations include:

> everything that people do to occupy themselves, including looking after themselves (self-care), enjoying life (leisure), and contributing to the social and economic fabric of their communities.

Furthermore, it is suggested that occupational therapy practitioners "enable their clients to participate in meaningful activities using occupation as therapy" (Fortuna, 2018, p.1). Thus, occupations encompass both self-care and leisure activities in which individuals participate; such occupations include daily living and meaningful tasks that contribute in some way to their community. This definition of occupations and occupational therapy practice is linked to mental health as outlined by the WHO (2004). For example, WHO (2004, p.59) indicate that mental health includes a level of resilience and "is able to make a contribution to his or her community". Thus, contribution to the individual's local community is viewed as an aim of occupational therapy practice which is linked to mental health and wellbeing. The view that individuals should engage in occupations which contribute in some way to the individual and society is rooted in occupational therapy practice dating back to the 19th century (Hagedorn, 1995). Furthermore, meaningfulness is associated with

personal recovery (Leamy et al., 2011), wellbeing (Huta, 2017), and meaningful occupational engagement underpins occupational therapy theory and has been identified as a key predictor of quality of life for FMH inpatients (O' Flynn et al., 2018). Thus, arguably, meaningfulness underpins models of personal recovery, occupational therapy practice, and wellbeing.

As noted within this chapter, art in therapy approaches have been historically utilised within occupational therapy practice however, there has been a move towards utilising art as therapy techniques (Lloyd and Papas, 1999). This shift in focus in relation to art in and as therapy in underpinned by a traditional shift in occupational therapy practice in which a move from psychodynamic approaches, associated with art in therapy, shifted towards cognitive and behavioural approaches (Duncan, 2002). The move in focus in occupational therapy practice towards occupation-as-means, and thus valuing the process of activities, has been noted (Royeen, 2002).

Activity analysis is a concept utilised by occupational therapists which considers the skill required to achieve the outcomes of tasks (American Occupational Therapy Association, 2014), such approaches are underpinned by cognitive assumptions, including motor skills, and psychological approaches (Yoshikawa, 1993). The occupational therapist is then able to utilise low demand tasks to engage the patient into activity which can be adapted and applied within the setting for therapeutic purposes (Hagedorn, 1995). Furthermore, activities of daily living can be utilised as an occupational task, such as, shopping or activity based task, such as cooking, in which function can be assessed (American Occupational Therapy Association, 2014) and activity engagement can provide opportunities to develop functioning (Creek and Lougher, 2011). This approach is adopted within forensic inpatient care which is underpinned by the assumption that mental ill health inhibits the performance of tasks associated with daily living (Robinson and Avallone, 1990). The aim of occupational therapy then, is to improve functioning for individuals in order to promote independent living. Within the FMH setting, occupations can

promote both socially acceptable and independent living skills, in preparation for life in the community (Morris et al., 2016). The core elements of occupational therapy practice in acute mental health are "individual assessment, individual treatment, therapeutic groups, and discharge planning" (Lloyd and Lee Williams, 2010, p.436). Thus, occupational therapy practice work with forensic patients and focus on rehabilitation and independence (Cronin-Davis and Sainty, 2017) can work therapeutically with individuals to develop skills with the aim to develop independent living.

Whilst arts and craft practices within occupational therapy has been noted to decline, their use still remain, although debates exist around the role of such activities (Bathje, 2012). The activities therapy approach, which adopts an art as therapy approach, focuses on adaptive skills and provides a theoretical framework in which interventions can be structured around activities that promote the development of skills (Chacksfield, 2002). Such an approach has been suggested to be appropriate for inpatient FMH care as skill development has been associated with risk-reduction (Chacksfield, 2002). Practitioners assess activity skills and aim to understand performance issues and intervention strategies "from the perspective of practice theories" (Forsyth and Kielhofner, 2002, p.93). A commonly used practice theory within forensic occupational therapy in the UK is the model of human occupation (Connell, 2016). The model is underpinned by the assumption that humans are motivated to engage in occupations (Cronin-Davis and Sainty, 2017) and dysfunctional behaviour may be due to internal or external barriers (Forsyth and Kielhofner, 2002). Thus, an individual's engagement in occupations can be influenced by performance skills, habits, motivation, and environmental influences (Duncan, 2011). Furthermore, motivation and self-perceptions in relation to ability can be affected by an individual's mental health (Cronin-Davis and Sainty, 2017). Therefore, occupational therapists work with individuals to understand their motivations and environment, performance skills,

and self-perceptions in which interventions are tailored to the individual's need.

Occupational therapists utilise engagement with the arts within their practice. The types of activities utilised by occupational therapists is wide ranging however, a survey found painting, artwork, drawing, collage, glass painting, card-making, printing, sewing, embroidery, pottery, music, cooking, and woodwork were the most frequently reported by occupational therapists working with individuals with a mental health diagnosis (Griffiths and Corr, 2007).

Perspectives from forensic patients in relation to engagement with occupational therapy have been explored. For example, engagement in occupational therapy was reportedly used for self-development, and for intellectual or emotional stimulation, self-expression, and to relieve boredom (Kennedy and Fortune, 2014), and provide relief from the ward environment (Bryant et al., 2016). However, issues related to engagement within arts activities are reported in the literature. For example, whilst agency and choice is fundamental to occupational therapy practice (Royal College of Occupational Therapists, 2012) and has been found to promote increased engagement with individuals in a residential mental health facility (Lloyd and Papas, 1999), barriers to engagement have also been reported. For example, research has found the volatile nature of the FMH environment to be a barrier to participation. For example, a lack of engagement has been reported to be due to safety concerns, such as feeling unsafe to exhibit expression or lacking trust (Kennedy and Fortune, 2014).Thus, motivations to attend therapy sessions within the institutional environment are importantly explored within this thesis.

Whilst it has been noted that the situatedness of creative activities within the institutional timetable are importantly explored within this thesis, it is also, however, important to consider how time is spent outside of the timetabled activities within the institutional context. Sturidsson et al. (2007) found that patients spent, on average, less

than two hours per day in structured activities, such as, meetings and chores, and treatment, which included occupational therapy, within an inpatient forensic mental health unit in Sweden. Furthermore, Stewart and Craik (2007) found that 73% of patient's time was spent in activities that were initiated by themselves across two forensic mental health inpatient secure services in the UK. Thus, whilst it is important to explore scheduled activities within inpatient FMH care, time outside of structured activities is also salient to this research. Furthermore, Clarke (2017) found that everyday social encounters and time outside of structured therapy played an important role in facilitating change within two therapeutic communities in the UK. Therefore, an exploration of social encounters within both timetabled structured therapy and the time spent outside of therapy is an important pursuit within this research.

2.4.1.4 Creative practice

Thus far, art therapies and their relation to FMH practice have been explored, but there is a need to consider the nature of creative practices more generally within mental health. The aim is to identify the nature of creative practices for the purposes of this research as well as to explore the relationship with wellbeing and mutual recovery. A primary set of literature is that arising from the CPMR programme. The CPMR programme, of which this research is one part, introduced in chapter one, aimed to investigate how engagement with creative practices could foster and promote wellbeing for a range of individuals, such as carers, and mental health service users (Crawford et al., 2015). This section explores the creative practices utilised within these projects in order to understand the types of activities which promoted wellbeing, including how such activities were implemented within and across a range of communities. The key themes outlined in this section are as follows: embodied practice, multiparty endeavour, transcending boundaries, and barriers and facilitators to creative practice.

2.4.1.4.1 Embodied practice

Four of the projects adopted a creative practice which provided an embodied experience. For example, Vallejos et al. (2016) conducted a series of Kundalini yoga workshops with staff and residents in a residential care home for children. Jordan et al. (2018) conducted a series of capoeira workshops for self-selecting participants from a local community in England. Fancourt et al. (2016a) conducted a series of group drumming sessions with mental health patients and carers. One of the research projects explored an existing community project in which residents and staff at an inpatient mental health facility in the USA participated in a music session, which was described as music jamming (Callahan et al., 2017). Music making is an inherently embodied practice where some form of bodily movement is required in order to create sound. These embodied practices are suggested to promote wellbeing through an awareness of bodily sensations and enables individuals to engage in self-knowledge (Impett et al., 2006) and offer an alternative to conventional therapies (Vallejos et al., 2016). The studies reported benefits for the individual, such as, feeling more relaxed (Vallejos et al., 2016), egoism (Jordan et al., 2018), and improvements in depression, anxiety, and the anti-inflammatory immune system (Fancourt et al., 2016a). Furthermore, the drumming workshops enabled the participants to experience embodied learning where the body enacted the learning process of group drumming (Perkins et al., 2016). Therefore, the embodied creative practices were found to promote wellbeing for individuals.

2.4.1.4.2 Multiparty endeavour

Jordan et al. (2018) describe capoeira as a multiparty pursuit and that notions of community were salient in the data. Engaging in Capoeira requires the community to participate in a joint physical activity by moving together and reading each other's body language, thus capoeira is underpinned by social connection and collective action (Jordan et al., 2018). Furthermore, participants reported enjoyment in the community endeavour (Jordan et al., 2018). Yoga was also

conducted as a group activity for children in a residential care home and staff (Vallejos et al., 2016). Whilst the activity does not require an embodied experience beyond the individual actor, this is conducted as a group activity in which the instructor leads the group to participate in the activity together. The group drumming project was also a joint venture amongst participants where an instructor guided the group to engage in the group activity (Perkins et al., 2016). The research conducted by Callahan et al. (2017) explored a musical jamming session in which all attendees were invited to take part in the group session. These projects promoted a sense of community through their group-based focus and participants reported social benefits of engaging in such activities, for example, participants reported feeling more open to others (Vallejos et al., 2016).The group drumming was found to facilitate new social interactions and feelings of belonging and connection (Perkins et al., 2016); the group music jamming sessions were found to promote connectedness amongst attendees (Callahan et al., 2017), and group playfulness and mutuality were found amongst the group of capoeiristas (Jordan et al., 2018). Therefore, the promotion of a multiparty endeavour was facilitated through creative practices which were found to have social benefits for participants.

Some projects promoted individual craft work however, this was delivered in a group setting and was conducted with communities of people with similar experiences. For example, Winship and Barker (2016) conducted comedy workshops with individuals who had experience of substance misuse. No qualitative data exploring group cohesion of study participants was collected however, whilst the research found that the number of social connections had reduced for the individuals taking part in the study, the strength of their existing relationships increased for those who completed the course. Furthermore, projects explored birth experiences with mothers through participatory art workshops (Hogan, 2015) and clay workshops with individuals with experience of mental health service use, clinicians, artists, and those with mixed identities (Argyle and

Winship, 2015). Whilst these projects were individual creative pursuits, group cohesion, mutuality, and reciprocity was found amongst workshop participants through the shared experience (Argyle and Winship, 2015).

Two of the projects explored existing community creative practice workshops. For example, Saavedra et al. (2017a) conducted an evaluation of an existing arts group in Spain, which explored the experiences of attendees. Participants included service users from a range of mental health services, clinicians, artists, and researchers. The development of art pieces were conducted in groups and individuals worked on their own projects. The project found both individual benefits of participation, for example, the workshops enabled participants to elaborate personal meaning and promote recovery, and social benefits, such as, a reduction in stigma and social inclusion (Saavedra et al., 2017b). Furthermore, Lewis et al. (2016) explored a range of mental health arts participatory projects and adult community learning initiatives within the community and found that community arts practices facilitated relationship-building and social participation.

2.4.1.4.3 Flattened hierarchy

Attributes relating to the flattening of the social hierarchy was prevalent in a few of the studies. This was viewed to be assisted by the supportive nature of the group leader through their openness which was contrasted to more traditional therapeutic sessions and was also suggested to be promoted through the group's diverse membership (Argyle and Winship, 2015). Furthermore, the research conducted by Callahan et al. (2017) found that attendees at the group musical jamming session reported experiencing a non-hierarchical environment between the caregivers and residents, which contrasted with their typical care environment. It is proposed that this was promoted through the lack of defined roles during the sessions, as one caregiver notes: "we get to be together and there are no roles" (Callahan et al., 2017, p.8). Similarly, participants in the group

drumming project commented on the lack of hierarchy which was facilitated by the positioning of the group which was in a circle, indicating that all participants were equal and through the lack of revealing identities, such as mental health patient (Perkins et al., 2016). Within another project, a participant recognised the value of a fluid hierarchy for the development of the staff-patient relationship, which was assisted by the non-clinical environment in which the activity took place (Saavedra et al., 2017a, p.11):

> This place becomes a setting where the relationship with users completely changes due to the possibility to develop more horizontal relationships that allow a deeper understanding of one another.

Thus, the non-clinical setting promoted the flattening of the hierarchy between patients and clinicians. Moreover, Lewis et al. (2016) found that participants of the participatory arts and adult community learning workshops found that the shared art-making with individuals promoted an inclusive approach which was found to facilitate the breaking down of social hierarchies.

2.4.1.4.4 Transcending boundaries

Participants reported how engagement with creative practices promoted social connection through having something new to discuss with others. For example, the staff reported that they enjoyed having something new to discuss with fellow staff within the children's homes (Vallejos et al., 2016). Also, Jordan et al. (2018) found that the capoeira sessions transcended boundaries, with one participant indicating that they had something new to talk about at work. Identity work is also important here, with the notion that engagement in creative practices can manifest themselves beyond the temporal space of the session and transcend into the participants life beyond the creative practice workshop. Participants in the creative practice workshops in Spain had developed new social connections and spent time with fellow participants outside of the workshops (Saavedra et

al., 2017a), thus promoting the development of new social roles beyond the initial creative practice engagement. Whilst, engagement in the capoeira classes were also suggested to provide a "hedonistic diversion from the mundane" (Jordan et al., 2018, p.1), Saavedra et al. (2017a) found that the focus on the art process allowed the mind to free from obsessive thoughts. Thus, engagement in creative practices can provide escapism from the everyday routine and negative thoughts and also promote social connection and identity development.

The context in which the community groups met was found to be a facilitator in developing identity amongst marginalised groups. For example, Saavedra et al. (2017a, p.12) found that creative practice workshops conducted away from the clinical context, enhanced the quantity and quality of social activities for participants "that motivate, increase their self-esteem and can help re-elaborate their identity". The participants valued engaging in normalised social practices which expanded their social network and identity, thus providing opportunities for social capital.

2.4.1.4.5 Barriers to participation

Barriers to participation were experienced by Vallejos et al. (2016) who conducted yoga workshops in residential children's care home. It was reported that time constraints were an issue for staff, along with a lack of ownership over the sessions, where participants felt pressured to participate. Participants suggested that the yoga sessions could be conducted in a space away from the stressful residential environment. However, one of the children's home suggested that attendance could be improved by having the sessions located at the residential site. Thus, agency in relation to what was perceived to be obligatory participation were found to be barriers, furthermore, there were tensions in relation to a suitable location for the sessions. Whilst conducting sessions outside of residential clinical context may be challenging, it is argued that socialising outside of such contexts can be powerful for the development of mutuality

between clinician and patient relationships, as noted in section 2.4.1.4.3.

Another barrier to participation was the participant's perceptions of coping and distress. For example, Lewis et al. (2016) found that in the mental health setting, some participants expressed that they lacked the resources to cope with those exhibiting mental distress. Furthermore, funding pressures and the political landscape were seen to create uncertainty which were viewed to be detrimental to their goals and the wellbeing agenda (Lewis et al., 2016). Another barrier was found in relation to mutual recovery. For example, the distinct and defined roles between the art therapist and the participant with a mental health diagnosis was found to hinder notions of mutuality and Lewis et al. (2016, p.158) notes that the art therapist felt that they had to "maintain 'boundaries' so as to avoid becoming too emotionally involved". Thus, such perceptions in relation to the appropriate level of mutual engagement has implications for mutual recovery. Therefore, whilst some projects found that the shared creative practices promoted an egalitarian approach to community building, some limits were reported in relation to mutual recovery due to the client-centred approach to working. Within the FMH setting, the professional role of staff as carers also has the potential to be a barrier to mutual recovery.

2.4.1.4.6 Facilitators of participation

The location of the community-based arts projects were reported to be a facilitator to engagement, particularly for those who had become socially isolated due to health issues or older age (Lewis et al., 2016). The accessibility of some of the creative practices were positively regarded, for example, Argyle and Winship (2015) found that participants liked the accessibility of working with clay and reported that this medium was not viewed as daunting.

Some of the participants expressed the importance of the skills and knowledge base of the practitioners who ran the art workshops which

facilitated their learning experience (Lewis et al., 2016). It is important to note here that, where there was a facilitator, the sessions were run by experienced artists in their respective fields. For example, the capoeira teacher was recognised internationally as a capoeira professor (Jordan et al., 2018). Other projects also had experienced facilitators, for example, an experienced yoga teacher (Vallejos et al., 2016), a professional music facilitator (Perkins et al., 2016), a professional comedian (Winship and Barker, 2016), a registered art therapist (Hogan, 2015), artists (Argyle and Winship, 2015), an art facilitator (Saavedra et al., 2017a), and trained artists and art therapists (Lewis et al., 2016). Other community-based projects were more participatory in nature, for example, the musical jamming sessions had no defined leader (Callahan et al., 2017), and one of the community poetry groups was run by a service user led arts organisation (Lewis et al., 2016). Some groups appreciated the facilitators knowledge, whilst others enjoyed the lack of defined roles within the creative practice spaces.

2.4.2 Arts and health: Summary

Within the field of arts and health, it is recognised that wellbeing extends beyond the alleviation of symptoms and encompasses a more holistic approach (World Health Organization, 2005), one that encompasses eudaimonic wellbeing which relates to meaning, self-realisation and also functioning (Ryan and Deci, 2001; Tennant et al., 2007). The hedonistic perspective relates to the subjective understanding of happiness, life satisfaction, and pleasure (Ryan and Deci, 2001; Tennant et al., 2007) and the All-Party Parliamentary Group on Arts, Health & Wellbeing (2017) outlines the vast and diverse field of arts and health in the UK which are argued to contribute to hedonistic and eudaimonic approaches to wellbeing. Both perspectives of wellbeing are important to consider within the FMH context due to the potentially volatile nature of the ward environment (Quirk and Lelliott, 2004). Individuals may experience a loss of social roles within the institutional environment (Goffman, 1961) however, social connection can promote recovery (Wolfson,

2009), and provide meaning (Leamy et al., 2011). Furthermore, arts engagement promotes wellbeing (All-Party Parliamentary Group on Arts, Health & Wellbeing, 2017) and this thesis explores such contributions within the FMH context.

Whilst the All-Party Parliamentary Group on Arts, Health & Wellbeing (2017) outline a range of projects that are underpinned by different aims, such as, a focus on the social benefits and the art itself (Fancourt, 2017) which can promote social capital (Miles and Gibson, 2016), or focus on the individual and utilise art to promote wellbeing (Broadbent et al., 2018; Puig et al., 2006), it is proposed that creative practices that promote a shared mutual endeavour are more suited to facilitate mutual recovery. Within the secure setting, arts are utilised by occupational therapists as a way of promoting meaningful engagement (Fortuna, 2018) and skill development (Chacksfield, 2002; Creek and Lougher, 2011). However, it is important to note that over 70% of patient's time has been found to be spent in occupations initiated by the patient (Stewart and Craik, 2007) and everyday social encounters and time outside of structured therapy has been found to play an important role in facilitating change (Clarke, 2017), thus time outside of therapy is worthy of exploration.

The CPMR programme of research found that engaging in creative practices that promoted an embodied practice (Callahan et al., 2017; Fancourt et al., 2016a; Jordan et al., 2018; Vallejos et al., 2016), a multiparty endeavour and shared experience (Argyle and Winship, 2015; Callahan et al., 2017; Hogan, 2018; Jordan et al., 2018; Lewis et al., 2016; Perkins et al., 2016; Saavedra et al., 2017a; Vallejos et al., 2016; Winship and Barker, 2016) promoted wellbeing for the participants. Furthermore, such engagement promoted a sense of community (Vallejos et al., 2016) and facilitated the flattening of social hierarchies between a range of individuals (Argyle and Winship, 2015; Callahan et al., 2017; Lewis et al., 2016; Perkins et al., 2016). Crawford et al. (2013, p.55) explain that:

> creative practice could be a powerful tool for bringing together a range of social actors and communities and connect communities in a mutual or reciprocal fashion to enhance mental health and well-being.

The notion of connecting communities is central to this thesis and is argued to be particularly important within the FMH context, as such an environment has been found to be challenging for both staff and patients (see section 2.2.5).

Within this research creative practice encompasses creative activities which are utilised within art in therapy and art as therapy and covers the diverse fields of arts and humanities. This thesis explores creative practices within the FMH environment with the assumption that such engagement can promote wellbeing and connect communities. This view extends the field of everyday creativity to include music listening and thus a broader perspective of the field is proposed, one that extends beyond the idea of originality and considers the appreciation of the audience member. As discussed in section 2.4.1.1.2, this thesis recognises the geographies of creativity, in that the "local social contexts of arts production" are considered (DeNora, 2000, p.4) and a qualitative and interpretive inquiry is adopted which extends beyond the experimental manipulation (DeNora and Ansdell, 2014), which takes creativity out of the context of practices, situations, and people. Hawkins (2016, n.p.) argues that the "geography matters to understanding creativity" and creativity is and embodied social practice which is part of everyday life. Thus, the geography of arts engagement within this thesis will be considered and a broad holistic perspective of everyday creativity which considers individuals within their social context and the meaning of creative pursuits is explored.

2.5 Interaction ritual theory

This section introduces Interaction Ritual Theory (IRT), which is utilised within this thesis as a theoretical framework to explore creative practices within the inpatient FMH environment. A brief

introduction to the theory's historical roots is provided, followed by an introduction to the core tenants of the theory—rituals and emotions. Relevant literature which explores the application of IRT within research is also debated, as terms are introduced. Finally, IRT is explored in relation to the CPMR research projects, where the key features of creative practice engagement are highlighted and problematised proving a framework for exploring creative practice rituals observed at Westmarch Hospital.

Ritual theory asserts that rituals are "at the heart of all social dynamics" and form culture through a system of beliefs (Summers-Effler, 2006, p.135). Durkheim studied religious rituals to highlight the social production of religion, but intended the theory to be broadly applied to other social encounters through a model of interaction rituals (Collins, 2014). Goffman (1967) built upon the theory of interaction rituals by exploring everyday interactions and utilised his observational work of mental institutions to highlight his claims.

The exploration of social life through the examination of social interactions underpins microsociology (Hausmann et al., 2011). The microsociological approach is argued to provide an empirical exploration of macrosociological theories (Collins, 1981). Collins (1981, p.989) further explains that:

> [s]ocial patterns, institutions, and organizations are only abstractions from the behavior of individuals and summaries of the distribution of different microbehaviors in time and space

Therefore, it is argued that sociological theory can be empirically explored through a microsociological approach of understanding everyday interactions. Furthermore, rituals are suggested to represent the interactive space between cultural and social structures

and individual agents (Boyns and Luery, 2015; Clarke and Waring, 2018).

IRT explores the micro behaviours, such as, face to face interactions of individuals, with the analytic focus of exploring interactions before the individual. Goffman (1967, p.1) suggests that IRT is the "class of events which occurs during co-presence and by virtue of co-presence". These class of events are referred to as rituals which occur in the presence of two or more people. Such a focus is suggested to be fundamental in understanding social life, and the exploration of the individual within the social context importantly considers the actor as embedded within their social context.

Goffman (1967, p.55) suggests that in all societies behavioural rules of conduct underpin laws, morals, and ethics and are substantive rules and codes, "which guarantee that everyone acts appropriately". However, the code that underpins ceremonial expressions is known as etiquette, which Goffman (1967) explains is enacted through deference and demeanour. Deference is respect for the other and can be expressed through a recognition of the other. Demeanour is associated with interpretations of behaviour exhibited and Goffman (1967, p.77) explains that the demeaned individual is associated with "character traits associated with 'socialization'". Thus, the exploration of social interactions reveals the socialisation of an individual within their context.

2.5.1 Ritual ingredients and outcomes

Goffman (1967) argues that social situations are underpinned by a series of rules of proper conduct, we might refer to such rules or ideals as social conventions. These social conventions are theorised to underpin the ritualistic life of social interactions, thus "[a]ttachment to rules leads to a constancy and patterning of behaviour" (Goffman, 1967, p.49). Rituals are defined as:

> a mechanism of mutually focused emotion and attention producing a momentarily shared reality,

> which thereby generates solidarity and symbols of group membership. (Collins, 2014, p.7).

The ritual ingredients are outlined in figure 2.3 below, along with the ritual outcomes, as identified by Collins (2014).

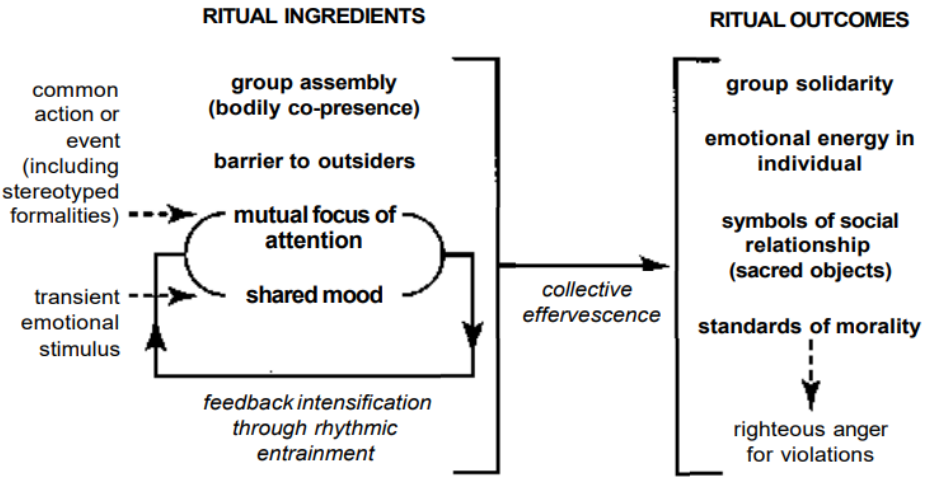


Figure 2.3: Ingredients of rituals and outcomes (Collins, 2014, p.49)

There are four key ingredients to rituals, which are: group assembly, barrier to outsiders, mutual focus, and shared mood – see figure 2.3. Rituals, therefore, involve:

> social actors interacting together within a shared spatial and temporal situation, where there is a boundary to legitimate participation, and where participants have a shared sense of purpose and emotional experience. (Clarke and Waring, 2018, p. 2).

The physical assembly of groups is underpinned both Durkheim's and Goffman's discussions (Collins, 2014). However, whilst Collins (2014) proposes that bodily co-presence enables an awareness of the other, it is also suggested that group assembly may not be a key ingredient to successful rituals. For example, online groups participate in rituals

and do not require bodily co-presence to achieve group solidarity (Collins, 2014). Thus, this ritual ingredient is not a necessity for achieving group solidarity however, some form of social connection is required, whether this be through online or face-to-face interactions.

A barrier to outsiders is defined by who is included and who is excluded; inclusion can be defined by the identity of group membership, such as, the patient status in mental healthcare (Clarke, 2017). Mutual focus of attention and shared mood are suggested by Collins (2014) as the key ingredients for ritual outcomes, which are reinforced by one another and intensified through emotional and rhythmic entrainment. The group are, therefore, required to be focussed on a mutually engaged activity or mutually focused on a common object and such focus is communicated verbally or through other cues, such as bodily cues (Clarke, 2017). As discussed in section 2.4.1.4, research has found that the shared experience of engaging in activities facilitated social connectedness and mutuality amongst participants (Argyle and Winship, 2015; Callahan et al., 2017; D Fancourt et al., 2016, 2016; Jordan et al., 2018; Lewis et al., 2016; Perkins et al., 2016; Saavedra et al., 2017a, 2017b; Vallejos et al., 2016; Wang et al., 2017; Winship and Barker, 2016), such research is further explored in the light of IRT in section 2.5.2. Collins (2014) suggests that as the shared attention on a common object or activity increases, a greater shared emotional experience is also generated.

Successful rituals generate four outcomes: collective effervescence is a momentary state shared amongst participants and can become embodied in individual Emotional Energy (EE), group solidarity, and symbols (Collins, 2014). Individual EE transcends the ritual but is different from the emotional mood experienced by the group during the ritual, which are momentarily experienced, such as, joy, pride, or anger (Clarke, 2017). The premise of IRT is that rituals equilibrate society through situational structure, which contribute to the social order of the context (Collins, 2014), such an assertion is apt for the exploration of a more formalised social environment, such as the secure inpatient context.

2.5.1.1 Emotional energy

The strength of the ritual ingredients influences the ritual outcomes, through the role of emotions, such as, the emotional experience shared by the group (Collins, 2014). Social interactions, therefore, have implications for individual Emotional Energy (EE) and thus wellbeing. According to IRT, EE can be gained, maintained or lost through rituals and individuals navigate market opportunities to gain EE (Collins, 1993). According to Collins (2014), individual EE is suggested to be positive even when there is a loss of EE. Successful rituals will lead to an increase in EE and create feelings of exhilaration, whilst failed rituals result in the loss of EE and are energy draining. However, such a proposition is argued to ignore intense negative emotions, which can lead to social connectedness. For example, Clarke and Waring (2018) found that patients within a therapeutic community would often experience emotionally challenging group therapy, however such experiences could lead to group solidarity. Boyns and Luery (2015) extend the theory to encompass the negative emotional experiences which represent affinity within the group. Throughout this chapter, positive EE (EE+) refers to the emotions of affinity towards group membership and negative EE (EE-) refers to emotions of enmity against group membership. Clarke and Waring's (2018) findings can, therefore, be explained by considering the negative emotional experiences, which generated low levels of EE+. However, the emotions were of affinity towards the social encounter, thus meaning group solidarity could be achieved through a negative emotional experience. For example, Clarke (2017, p.60) notes that:

> clients were understanding of each other's difficulties …. and were able to offer support to each other, thus building emotional entrainment.

Furthermore, Boyns and Luery (2015, pp.163–4) suggest that "[p]ositive emotional energy when stimulated by negative emotional

energy can become dramatically invigorating", concluding that EE- can be an important source of motivation. Therefore, positive or negative shared emotional experiences can lead to social connectedness, mutuality, and within the therapeutic relationship, mutual recovery, as outlined by the hierarchical model of therapeutic social capital, see section 2.3.4.1. It is argued that the research conducted by Clarke (2017) found moments of mutual recovery, but the conceptual model in relation to mutual recovery and group solidarity had not been developed. It is, then, the direction of shared emotions that are important, whether these are directed towards or against group membership and whether such emotional mood states are shared amongst group members.

Underpinning IRT is the premise that individuals aim to gain EE+ and protect their existing levels of EE, thus they navigate market opportunities to maximise their EE+, which "is by far the strongest of such motivations" (Collins, 1993, p.220). Furthermore, the EE outcome of an interaction influences an individual's disposition within everyday routines. According to IRT, past social encounters influences expectations for future social encounters (Summers-Effler, 2006). As discussed in section 2.2.5, the forensic patient has typically experienced a history of abuse and are often both perpetrators and victims (Mullen, 2000). Such traumatic experiences influence an individual's self-perception and the ways in which future relations are performed. Insecure attachments are common within the FMH population and can be intensified in threatening situations, such as, psychiatric admission, rendering the formation of new attachments as problematic within such environments (Adshead, 2004). Bowlby (1988, p.159) suggests that because of the:

> patient's adverse experiences in the past, the patient may not believe that the therapist is to be trusted to behave kindly or to understand ... [their] predicament.

Issues of trust, therefore, has implications for social connectedness amongst residents and staff. Trust is closely linked to social capital, in which this is a "close consequence" (Putnam, 2001, p.7). Furthermore, trust has been found to be an important feature of the patient experience and staff care for FMH patients (Gilburt et al., 2008), however forensic patients may be distrustful of authority (Barnao et al., 2016). Moreover, staff have been found to perceive forensic patients as distrustful when personal boundaries are crossed and was found to have implications for the process of depersonalisation (Johnson et al., 2016). Clarke and Waring (2018) also found that mental health patients were sometimes unsupportive of each other, which led to isolation and alienation. Therefore, social relationships can be complex within the mental health service environment, which are influenced by former negative experiences.

Clarke (2017, p.67) suggests that everyday social encounters have the potential to generate feelings of belonging and "are vital opportunities for client members to deconstruct and reconstruct their sense of self". Therefore, everyday social encounters influence individual's emotional states and self-perceptions, as such, social encounters within the FMH environment are important to consider as they can facilitate change and influence wellbeing.

Furthermore, within the context of power and status disparity different market opportunities for EE exist. According to IRT, those with power and/or status will gain EE+ during rituals that re-enforce such disparities and the subordinates will lose EE+. Such an assertion is problematic when considering the power disparity between staff and residents within the healthcare context and is further discussed in section 5.3.4.2. Research has found that social encounters, such as engagement with creative practices, which minimise power disparities between participants promote social connectedness (Lewis et al., 2016; Perkins et al., 2016). Therefore, engagement in creative practices has implications for promoting social connectedness between residents and staff within this research.

Everyday rituals can fail when an individual or individuals do not conform to social conventions. For example, Goffman (1967) suggests that social etiquette guide implicit rules which occur through obligations or expectations. However, it is argued that it is through the violation of societal values which define the forensic patient (Kelly and Wadey, 2012), as discussed in section 2.2.3, which are society's substantial codes (Goffman, 1967). Within the institution, the psychiatric patient is proposed to continue to diverge from expectations, for example, as Goffman (1967, p.68) explains patients:

> over-reach polite bounds and ask embarrassing questions of fellow-patients…or offer physical gestures of appreciated such as hugging…which are felt to be inappropriate.

But, however, the psychiatric patient also show commitment to their obligations and perform their patient role, by attending therapy or taking medication (Goffman, 1967). Such examples of behaving beyond social conventions within the social world of the institution, lead to low levels of collective effervescence and a lack of shared entrainment, which, according to Collins (2014), lead to failed rituals. Participants of failed rituals result in EE- (Boyns and Luery, 2015) and Collins (2014) suggests failed rituals can lead to a range of negative outcomes, which exist on a continuum, see figure 2.4.

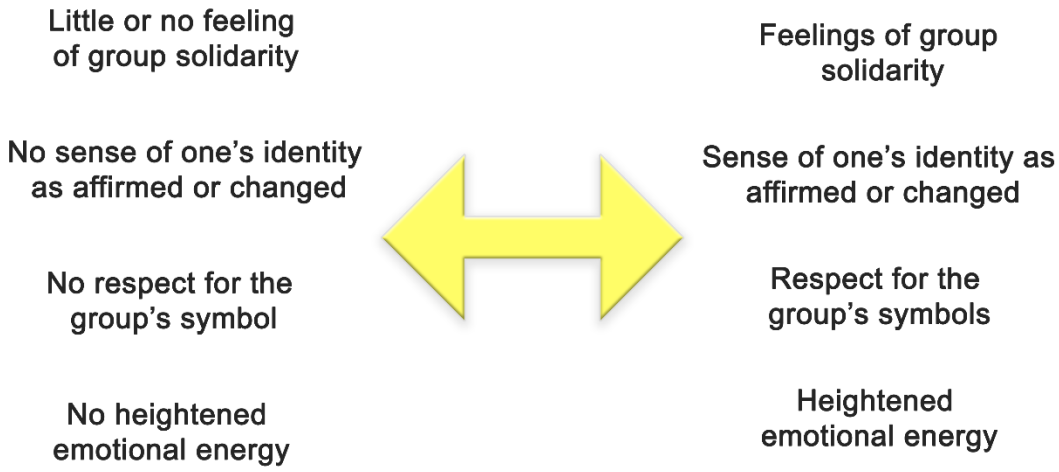


Figure 2.4: Interaction Ritual Outcomes Model (adapted from Collins 2014).

Everyday interaction rituals have been found to be therapeutic within the therapeutic community context (Clarke, 2017) and rituals can be an important source of EE+ and social outcomes, such as solidarity. However, failed rituals can lead to EE-. Whilst such a result may not be detrimental long term, which is a claim supported by the research conducted by Clarke (2017), continuous failed rituals may be problematic for the community of residents and staff in relation to wellbeing and recovery.

Emotions play a central role in delineating rituals from a mere routine. Whilst rituals and routines share common properties, such as, the presence of individuals and group interactions which are repeated (Clarke, 2017), it is the shared emotion and focused attention (Payr, 2010) which differentiates these social encounters. Routines lack meaning (Spagnola and Fiese, 2007) and offer "little cohesion as participants act as individuals rather than a group" (Clarke, 2017, p.55). Furthermore, the interruption of routines and rituals result in different emotional responses. For example Spagnola and Fiese (2007) suggest that when rituals are interrupted this can threaten the cohesion of the group whereas the interruption of routines can exhibit feelings of annoyance. Moreover, routines are not a source of motivation as group solidarity is an unlikely outcome however, rituals

are meaningful and promote solidarity for the group. The source of motivation then, is group solidarity. Collins (2014, p.148) purports that:

> [s]olidarity is a good; and individuals are motivated to maximize the amount of solidarity they can receive, relative to costs of producing it.

However, considerations of how residents navigate market opportunities within the confined social environment is an important consideration as opportunities for EE+ and therapeutic social capital may be restricted, particularly amongst the resident group if they are felt to be unsupportive.

2.5.2 Creative practice rituals

This section revisits the CPMR literature discussed in section 2.4.1.4, using the lens of IRT to explore its applicability as a critical analytic framework with this research. The creative practices evidenced in the CPMR research are theorised to be creative practice rituals in which the success of such rituals can influence wellbeing (EE+), group solidarity (i.e., social connectedness and mutuality), and mutual recovery. The ritual ingredients are explored in turn, these are: bodily co-presence, barrier to outsiders, mutual focus of attention, and shared mood. The outcomes of the creative practice rituals are also considered, in relation to the data and analysis provided by the authors.

2.5.2.1 Bodily co-presence

Attendance was a pre-requisite of participation within the projects, thus, bodily co-presence was prevalent in all but one of the studies in the CPMR research consortium, which was the sharing of stories on an online forum (Wilson, 2018). In circumstances where participants did not attend a certain amount of sessions, their results were omitted from the study (Fancourt et al., 2016a; Hogan, 2018; Vallejos et al., 2016) or utilised as baseline data. For example, Winship and Barker

(2016) analysed the pre and post data for those who conducted the final performance however, the pre-intervention data was utilised for comparison purposes.

2.5.2.2 Barrier to outsiders

A physical barrier to outsiders was often clearly defined. For example, Jordan et al. (2018) conducted the capoeira classes in a dance teaching venue and thus were conducted in a room allocated for the sessions. However, it is important to note that professional boundaries were found to be a barrier to participation (Lewis et al., 2016), as discussed in section 2.4.1.4.5. The emphasis on a client-centred approach, which places the client's needs first, is a potential barrier to an egalitarian approach to participation and has implications for mutuality. Furthermore, the other projects, excluding the online story sharing project (Wilson, 2018), were all conducted with participants who agreed to participate in the creative practice rituals. Thus, the barrier to outsiders was marked by their active participation creating a barrier to outsiders.

2.5.2.3 Mutual focus of attention

Collins (2014, p.48) suggests that individuals:

> focus their attention upon a common object or activity, and by communicating this focus to each other become mutually aware of each other's focus of attention.

Thus, the projects which utilised creative practices which were inherently multiparty, embodied, and a taught pursuit, such as, yoga, capoeira, and group drumming, are suggested to have promoted a high level of mutual focus of attention. The mutual focus can be communicated either verbally or through bodily cues (Clarke, 2017) and in these embodied circumstances, such communication will have been visible to all participants. These activities were run with a lead facilitator (yoga teacher, capoeira professor, or musician), but however, group attendees were shown techniques and were expected

to enact such techniques themselves. Thus, it is proposed that the projects conducted by Jordan et al. (2018), Vallejos et al. (2016), and Perkins et al. (2016) facilitated a high level of mutual focus of attention.

Furthermore, it is argued that the focus of all the projects were situated on a common goal, such as, participating within the creative practice ritual. The focus of attention within the CPMR projects is argued to be primarily focused on a common goal, which was reinforced through the voluntary participation within the sessions. The ways in which the attention was shown to be shared varied between and within projects, for example, some participants created individual artwork which explored their birth experience in which such experiences were expressed through their art work and also, at times, the experiences were verbally shared with the group (Hogan, 2015). Thus, the mutual focus of attention would have fluctuated depending on the task. Whilst it is proposed that embodied practices may lead to the identification of a shared mutual focus of attention more easily for group members, such shared experiences may still be exhibited by group members through more subtle gestures (i.e., bodily cues).

2.5.2.4 Shared mood

A shared mood was reported by the CPMR projects. For example, enjoyable group playfulness and hedonism were evidenced in the interview data from the capoeira project (Jordan et al., 2018). Furthermore, Saavedra et al. (2017a, p.8) found that the creative art workshops provided an opportunity for the participants to freely express themselves which was found to be enjoyable and was considered to be an "exceptional scenario which rarely can be enjoyed outside the workshops". Thus, these findings suggest that hedonistic wellbeing was provided by engagement in the creative practices. However, hedonistic wellbeing is transitory in nature (DeNora and Ansdell, 2014; Huta, 2017). Moreover, it is argued that the meaning of rituals extend beyond the temporality of the moment (Spagnola and Fiese, 2007). Thus, longer-lasting eudaimonic wellbeing may also

be provided by creative practice ritual engagement. Examples of eudaimonic wellbeing is provided in the outcomes section below.

2.5.2.5 Outcomes

Examples of eudaimonic wellbeing are now explored. For some participants, the artwork provided personal meaning and the appreciation exhibited by others in relation to their artwork was found to increase self-esteem (Saavedra et al., 2017a). Whilst, self-esteem is attributed to hedonistic wellbeing (Huta, 2017), it is proposed that self-esteem can be linked to identity reconstruction (Saavedra et al., 2017a). Thus, the creative art workshops provided the participants with moments of hedonistic wellbeing (i.e., increase in self-esteem) and potentially longer lasting eudaimonic wellbeing (i.e., providing meaning and identity development). However, it is important to note that personal identity in mental health can be promoted through the development of the individual's identity that situates the illness as part of their identity but does not define the person (Slade, 2009b). Thus, language use that theorises the individual as being the illness, such as a schizophrenic person (i.e., I am schizophrenic) contributes to the loss of personal identity beyond the illness. But however, the recovery literature proposes that personal identity and what is valued in association with this identity, is something that should be defined by the individual (Slade, 2009b). Therefore, the theoretical development of self-esteem to personal identity reconstruction is rooted in what is valued by the individual themselves. Moreover, participatory arts initiatives have been found to promote identity, connectedness, wellbeing, and facilitate recovery (Hui et al., 2019), thus creative practice engagement is theorised to promote eudaimonic wellbeing.

It is argued that therapeutic social capital was evidenced by the CPMR projects. For example, Argyle and Winship (2015) found that the shared experience of those engaging in an art activity facilitated mutuality, reciprocity and group cohesion amongst participants, such as, clinicians, artists, individuals with experience of mental health

service use, and those with mixed identities. Perkins et al. (2016) also found that the shared experience of group drumming promoted a sense of relatedness, which included users of mental health services and carers. Engaging in group creative practices, which promote a sense of shared activity, can therefore, facilitate connection between various groups, including service users, carers and clinicians. Moreover, creative practice rituals provide an opportunity for mutual recovery through social interaction—the fundamental requirement for mutual recovery (see figure 2.1 in section 2.3.4.1 for the hierarchical model of therapeutic social capital). Indeed, one of the projects describes the creative practice as a "mutual recovery approach", thus, recognising the opportunity that creative practice rituals can provide through social interaction (Vallejos et al., 2016).

2.5.3 Interaction ritual theory: Summary

IRT allows for the exploration of micro-behaviours within social interactions and explores the influence of social encounters on emotional wellbeing (Collins, 2014). Consideration is also provided for the influence on past social encounters (Summers-Effler, 2006), which is of particular relevance to the forensic patient who often has experienced abuse (Mann et al., 2014; Mullen, 2000). IRT also allows for the exploration of group solidary, which is theorised to involve social connectedness and mutuality, as outlined in the hierarchical model of therapeutic social capital in section 2.3.4.1. Due to the potentially volatile ward environment, the consideration of both positive emotions towards group membership, which represent affinity, and negative emotions towards group membership, which represent of enmity (Boyns and Luery, 2015), are of particular relevance to this research.

The exploration of creative practice rituals, as reported by the CPMR projects, allows for the consideration of the influence of the types of activities and their ingredients to promoting therapeutic social capital, such as, social connectedness and mutual recovery. A multiparty endeavour is theorised to promote a mutual focus of attention, which

is a key ingredient of successful rituals and theorised to be the most pertinent for the promotion of therapeutic social capital. Thus, IRT is utilised within this thesis as a theoretical framework to explore creative practices within the inpatient FMH environment.

2.6 Chapter two: Summary

Section 2.2 explored the history of mental health services, beginning from the deinstitutionalisation of mental health hospitals, followed by a discussion of the current frameworks underpinning FMH services in the UK, which are relevant to this thesis. The FMH hospital as a site for care and custody was debated, which highlighted tensions for the staff and forensic patient population and was found to have implications for wellbeing and recovery. Finally, this section considered the patient and staff experience of working and living within institutions, which was found to have implications for the therapeutic milieu.

Section 2.3 explored the current debates within mental health recovery, including inequalities experienced by those with a mental health diagnosis. Current debates regarding the application of recovery frameworks within FMH secure care were also considered, which highlighted the challenges of applying recovery principles within the secure environment (Drennan and Alred, 2012).

Section 2.4 introduced the field of arts and health and considered definitions in relation to health and wellbeing. Wellbeing is theorised to include both hedonistic and eudaimonic perspectives. Eudaimonic wellbeing relates to meaning, self-realisation and also functioning (Ryan and Deci, 2001; Tennant et al., 2007). The hedonistic perspective relates to the subjective understanding of happiness, life satisfaction, and pleasure (Ryan and Deci, 2001; Tennant et al., 2007). Whilst, individuals may experience a loss of social roles within the institutional environment (Goffman, 1961), social connection can promote recovery (Wolfson, 2009), and provide meaning (Leamy et al., 2011). Thus, engagement within creative practices and their

contribution to wellbeing for staff and patients is importantly considered within this thesis.

The CPMR programme of research found that engagement in creative practices can promote a sense of community (Vallejos et al., 2016), connect diverse group members (Jordan et al., 2018), and also facilitate the flattening of social hierarchies between a range of individuals (Argyle and Winship, 2015; Callahan et al., 2017; Lewis et al., 2016; Perkins et al., 2016). Thus, the notion that "creative practice could be a powerful tool for bringing together a range of social actors", such as staff and patients within the FMH environment, is central to this thesis (Crawford et al., 2013, p.55).

Section 2.5 introduced IRT and considered its contribution to exploring therapeutic social capital, as outlined in section 2.3.4.1. This section revisited the CPMR literature utilising the lens of IRT and explored its applicability as a critical analytic framework with this research. It is argued that IRT is a useful framework for exploring creative practice rituals within the FMH context, which importantly considers the role of emotions.

2.6.1 Implications and justifications for this thesis

The view that engagement in creative practices can have a positive therapeutic influence for forensic patients and staff is supported within the literature. The CPMR projects explored creative practices as interventions within the voluntary context. Thus, consideration of the voluntary nature of participation within creative practices within the FMH context is explored. This is of particular importance when the literature has noted that some forensic patients exhibit a level of performativity within the institutional environment (Gillard et al., 2012; Morris et al., 2016; Reynolds et al., 2014). Thus, agency in relation to participation within the scheduled creative practices, also known as formal creative practice rituals, is explored.

Forensic patients have been found to spend the majority of their time involved in occupations initiated by themselves (Stewart and Craik,

2007), thus, a consideration to how this time is spent outside of timetabled therapy and institutional regimes is explored. Social interaction is argued to be the fundamental basis in which mutual recovery can occur, as outlined in the hierarchical model of therapeutic social capital in section 2.3.4.1. Thus, the exploration of the institutional environment, such as the regimes, will be considered in relation to the opportunities provided for social interaction. Moreover, everyday social encounters and time outside of structured therapy has been found to play an important role in facilitating change (Clarke, 2017), thus time outside of therapy is worthy of exploration.

Finally, it is proposed that creative practices that promote a shared mutual endeavour are more suited to facilitate mutual recovery, thus a particular focus on the promotion of a multiparty endeavour during formal and informal creative practice rituals will be considered.

In conclusion, this research importantly explores the wellbeing of both staff and patients and considers the contribution of creative practice engagement to building reciprocal communities and enhance wellbeing for the community at the FMH field-study-site. Chapter three considers a suitable methodology that affords the opportunity to explore the micro-behaviours of social interactions and creative practice rituals.

Chapter Three: Research design and methods

3.1 Introduction

This doctoral study seeks to understand therapeutic social capital through engagement with creative practices within Forensic Mental Health (FMH) practice. This is the first research project to explore creative practices through mutual recovery within the FMH context. Specifically, the aims are to explore creative practice within one FMH residential site and consider:

- its relation to mental health and wellbeing for staff and residents
- the possibility of mutual recovery regarding wellbeing and mental health for staff and residents

The premise of this thesis is that social interaction centred on a shared experience can provide opportunities for therapeutic social capital. In section 2.3.4.1 it was noted that social interaction is the fundamental basis in which mutual recovery can occur, as outlined in the hierarchical model of therapeutic social capital in section 2.3.4.1. Research has found that engagement in creative practices can promote a sense of community (Vallejos et al., 2016), connect diverse group members (Jordan et al., 2018), and also facilitate the flattening of social hierarchies between a range of individuals (Argyle and Winship, 2015; Callahan et al., 2017; Lewis et al., 2016; Perkins et al., 2016). Thus, the notion that "creative practice could be a powerful tool for bringing together a range of social actors", such as staff and patients within the FMH environment, is central to this thesis (Crawford et al., 2013, p.55). It is argued that creative practices could be a powerful tool to build communities through the promotion of a shared experience. The research questions informed by this are:

- What formal and informal creative practices occur in the forensic mental health hospital?
- How do creative practices in the setting contribute to or negatively influence the mental health and wellbeing of both residents and staff?

- Do creative practices in the setting offer an opportunity for shared benefit or recovery among residents and staff?

Within this research a microsociological approach is adopted as this permits the exploration of social life through the examination of social interactions (Hausmann et al., 2011) as noted in section 2.5. This research is then positioned within an interactionist tradition (Collins, 2014) and, as such, adopts a qualitative methodological approach. Also, it was proposed in section 2.5.2 that Interaction Ritual Theory (IRT) is a suitable theory for the exploration of creative practice rituals, which need to be studied within their socio-cultural context. This is enabled by the adoption of ethnography as the methodology within this research as ethnography:

> is a holistic approach to the study of cultural systems [and is] … more than simply methods, but has ontological and epistemological properties. (Whitehead, 2004, p.5).

Social research is influenced by a variety of features, including the researcher's values, theory, epistemology, ontology, and practical considerations, which are inextricably linked (Bryman, 2004). These influences are also considered in this chapter.

3.2 Philosophical position

Epistemology and ontology are important philosophical positions which underpin research. Ontology, epistemology, and methodology are interlinked by assumptions about knowledge, for example, what knowledge is, what can be known, and how we can access such knowledge (Denzin and Lincoln, 2005). Ontology relates to the nature of knowledge, thus, concerns related to "what exists, what is real" is central to philosophical inquiry (Hughes and Sharrock, 2007, p.31). To briefly summarise a complex philosophical debate, there are two key contrasting ontological paradigms: objectivism and constructionism (Bryman, 2004). Positivism and interpretivism are the epistemological positions that are more commonly discussed.

Positivism is the adoption of natural science techniques within the social sciences (Hughes, Sharrock & Martin, 2003). The positivist ontology, also known as objectivism, is the view that there is one objective reality that exists outside of our perceptions therefore, there is a singular reality (Guba and Lincoln, 1985). The interpretivist ontology, also known as constructionism, is the view that social phenomena and their meanings are in a constant state of revision and are produced through social interaction (Bryman, 2004). As noted, assumptions about what is (ontology) and what can be known (epistemology) influence the methodology and the methods adopted by researchers. Within this thesis, the constructionist ontological position is adopted, and the premise of this research is, therefore, situated in the view that social phenomena are constructed (Bryman, 2004). An emic and etic approach to knowledge is also adopted within this doctoral research. For example, the emic approach to knowledge is adopted in order to understand the local interpretation (Berry, 1999) of creative practices within the FMH community. Thus, an approach to understanding "components of a cultural system from the perspective of the group being studied" is considered (Whitehead, 2004, p.16). An inductive approach to knowledge, therefore, underpins this research, in that the aim is to understand the cultural meaning of creative practice situated within the FMH context. An etic approach considers the researcher's theoretical ideas (Hammersley and Atkinson, 1995). Such an approach is adopted iteratively and the application of theory emerges over-time alongside data collection (Goldbart and Hustler, 2005). The nature of theory generation within this research is explored in section 3.8.2.

3.2.1 The researcher's values

It has been proposed that theory, the researcher's values, ontology, epistemology, and practical considerations all influence social research (see figure 3.2) (Bryman, 2004).

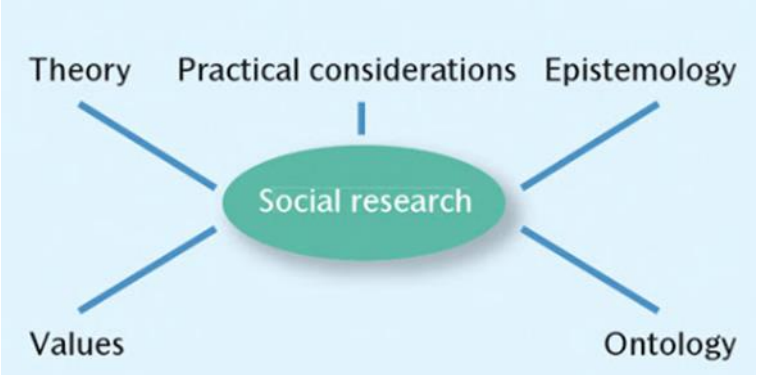


Figure 3.1: Influences on social research (Bryman, 2016, p.39)

The researcher's values are now considered. Section 1.2 briefly introduced the researcher as a middle-class, white female who has experienced a diagnosis of clinical depression. I felt dissatisfied with the quantitative measure assigned to my recovery, which led to the withdrawal of treatment from the NHS. Furthermore, a passion had been ignited from learning about alternative perspectives to the positivist paradigm associated with my undergraduate studies in 2010. These experiences have led me to be sympathetic to a more nuanced approach to conceptions of and research in the field of mental health, wellbeing, and recovery. Thus, such sympathies influenced my ontological and epistemological view and research topic (Bryman, 2004; Davies, 2008). The notion that wellbeing is subjective and transitionary is supported by the literature (DeNora and Ansdell, 2014; Huta, 2017), and the researcher's own experience, and it is argued that formal measures of wellbeing do not appropriately capture such a concept (DeNora and Ansdell, 2014). A constructionist approach to wellbeing is sympathetic to such a view and is considered appropriate for this doctoral research. From this viewpoint, the researcher's role in the research process is important to explore.

The methodological orientation of ethnography has adapted over time and is thus reported differently within the literature. For example, Tedlock (2005) describes the use of participant observation linking to three slightly differing epistemological positions: the scientific, the relativist and the personal relativist—these are not labelled as such by Tedlock (2005), but these labels have been applied by the author for clarity. The scientific position is adopted by those objectively observing the group under study—an approach traditionally adopted by anthropology. Malinowski's approach has been described as positivist and adopted a detached observer stance and aimed to undertake a scientific and objective approach to ethnography (O'reilly, 2005), thus this research was undertaken within the scientific tradition. The relativist position undertakes participant observation where the researcher is undertaking "the observation of participation" (Tedlock, 1991, p.78). An example of research undertaken within the relativist tradition was conducted by Schneider et al. (2010) who adopted the observation of participation as Healthcare Assistants across three wards run by the NHS. The researchers reported their findings which were gathered through personal experience of undertaking the role as Healthcare Assistants. The accounts from the researchers were personal, with the researchers describing their emotions during data collection (Schneider et al., 2010). Furthermore, the personal relativist approach explores society from within the group, as someone who has membership of the group and is the subject of the study within this personal relativist approach. The autoethnographer describes their personal experience of being a member of a group or society, for example, Albon (2012) describes the lived experience of being a nurse, mother, educator, and researcher diagnosed with Multiple Sclerosis.

Within this research, the personal relativist position was undertaken through the adoption of participant observation. Such an approach can adopt both the autobiographical and ethnographic impulse, in that personal accounts can be documented, which was an approach

adopted by Schneider et al. (2010). It is recognised that throughout the research, the phenomena described by the researcher will be bounded by the subjective experience of the researcher and that objectivity cannot be achieved (Crang and Cook, 2007) and thus will not be an aim of the research.

Research adopting an inductive approach often embraces an exploratory approach, and the ethnographer chooses what to observe and what information is salient to the research as the research progresses (Hammersley and Atkinson, 1995). Furthermore, Van Maanen (2011) suggests there are multiple ways that the ethnographer interprets the culture under study, one of the ways is through access to particular events and through authorship. As such, Van Maanen (2011, p.4) suggests that:

> [f]ieldworkers may present themselves as delicately lurking, working, and getting results, but the results they achieve are always experientially contingent and highly variable by setting and by person.

Furthermore, the "analysis of social life cannot be divorced from how we write about it", thus authorship has implications for what and how insights are documented (Hammersley and Atkinson, 1995, p.253). It is with this premise that my subjective experience of what I observed was explored reflexively and consideration is given to how I analysed such events within my fieldnotes, see section 3.4.2.

Reflexivity is suggested to be a key component of qualitative research which involves self-scrutiny (Mason, 2002). Ethnographers, then, "must seek to develop forms of research that fully acknowledge and utilize subjective experience and reflection on it as an intrinsic part of research" (Davies, 2008, p.5). A constructionist perspective aims to reveal and celebrate the inescapable interpretation of the researcher (Watson, 1987). The fieldnotes within this research also included

"intimate involvement" of the researcher so that emotion and meaning could be understood in the context of the study (Van Maanen, 2011, p.98). Furthermore, as noted, reflexivity was utilised as a way of understanding the position of the researcher in a way that celebrates the inevitable interpretation that occurred. Such interpretations are provided in the form of vignettes and reflections, which are further discussed as a method of presenting data in section 3.8.3.

Another key development was that of clinical supervision, which was provided by the University of Nottingham. Whilst the supervision differed to that of the clinical supervision provided to clinicians in the field, as discussed in section 2.2.5, the sessions provided valuable insight into my role as researcher and assisted with reflexivity. For example, at times, there were tensions which arose from adopting a participatory role, such as, the staff-helper role, in which I abided by the rules provided by staff. This role prompted a divide between me and the residents, as discussed in chapter four. I was able to explore my own projections through these supervisions, which enabled a deeper understanding of quite challenging events experienced in the field and to work towards resolving anxieties relating to these.

3.3 Methodology

Ethnography as a methodology has been adopted within the mental health service context (Clarke, 2017; Freestone, 2005; Goffman, 1961; Quirk et al., 2006). An ethnographic single site research design was adopted to explore embedded creative practices across three wards within one FMH hospital. In order to explore if engagement with creative practices facilitates therapeutic social capital between staff and residents and to understand the meaning of creative practice engagement, an exploratory and qualitative research design was adopted. The study was not an investigation of an organisation and the service which is run but more inquisitive by nature so that creative practices can be described, theorised and understood in relation to

the resident and staff community. Ethnography has been defined by Brewer (2000, p.6) as:

> the study of people in naturally occurring settings or 'field' by methods of data collection which capture their social meanings and ordinary activities, involving the researcher participating directly in the setting, if not also the activities, in order to collect data in a systematic manner.

Ethnography, as an approach to data collection, derived from the dissatisfaction of the scientific methodology associated with the positivist tradition for the exploration of social life (Crang and Cook, 2007; Hammersley, 2013) and its roots are situated within the field of anthropology (Crang and Cook, 2007; Hammersley and Atkinson, 1995). Ethnography is often referred to as the study of culture (Hammersley and Atkinson, 1995; Howitt, 2010) as the researcher explores social groups within their context.

Ethnography creates opportunity for the exploration of a range of phenomena, other more prescribed methods of data collection involve an:

> imposition of the researcher's assumptions about the social world and consequently reduces the chances of discovering evidence discrepant with those assumptions (Hammersley, 1992, p.11)

Therefore, within this area of research, a directed and bounded approach would restrict what can be discovered and only unveil what is already known about creative practice—that timetabled arts-based activity benefits the health and wellbeing of those who choose to take part, as discussed in chapter two. However, with this iterative approach to exploring the possible, comes the opportunity to discover and reveal creative practices that, until now, are under-researched

and allows for the exploration of creative practices in a way that is unbounded by guided theory or methods.

The ethnographic researcher situates themselves within the culture under study; it is the context of the field which is highly important within ethnographic research. As such, Hammersley and Atkinson (1995, p.X) suggest that "a particular virtue of ethnographic research is that it remains flexible and responsive to local circumstances". Ethnographic research has been described as "an art of the possible" (Hannerz, 2003, p.213) due to its flexible nature but bounded nature. For example, within organisational or institutional ethnographies in particular, what is possible is often negotiated by the researcher and the organisation. The art of the possible is therefore, the amount to which the researcher is creative and their ability to adapt to their surroundings. However, the adaptation must not be done in a haphazard manner whereby the researcher is "merely adjusting to events by taking 'the line of least resistance'" (Hammersley and Atkinson, 1995, p.21). It is, therefore, the relationships with key stakeholders and gatekeepers which becomes an important element of ethnographic research (Gobo and Molle, 2017). Once the ethnographer has entered the field, the researcher must work to build trust and rapport with the participants (Hammersley and Atkinson, 1995). The role of the researcher developed in a way that was flexible and responsive to local circumstances and adapted so that opportune moments could be explored, which served to facilitate the exploration of the research questions but also facilitated in building relationships with staff and residents, which is further discussed in section 3.4.1.

3.4 Methods

Traditionally ethnographers utilise observations, interviews, and the collection of documents as methods of data collection (Bryman, 2004). Observations, interviews, and interpretation of data is a cyclical process within ethnography (Whitehead, 2005). Therefore, the data collection and analysis stage of ethnography is often intertwined, and these are not distinct phases of the research process

(Coffey, 2018). Within ethnographic research, the analytic process begins as soon as the researcher enters the field.

Participant observation, informal and semi-structured interviews, were adopted as methods of data collection within this doctoral research. Furthermore, pertinent institutional documents were collected to inform the researcher of how creative practices form part of institutional life. The use and production of organisational documents have been argued to be "an integral part of everyday life" (Hammersley and Atkinson, 1995, p.166). The collection of institutional documents was included as a way of "gathering whatever data are available to throw light on the issues that are the emerging focus of inquiry" (Hammersley and Atkinson, 1995, p.3). Therefore, timetables which outlined the routine for the day, which included timetabled creative practices, were of interest to the study and thus were collected as data and included in the thesis' critical analysis.

3.4.1 Participation observation

There are two distinct activities related to ethnography, which includes getting to know the people in the social setting by developing relationships and the researcher documents the observations and experiences related to their time in the field (Emerson et al., 1995). This section focuses on the researcher's role within the data collection process.

Participant observation is both a methodology and a method in that participant observation is an approach to understanding the group under study and a way to collect data—through observing participants (Howitt, 2010). Participant observation is argued to facilitate the researcher in becoming an insider to the culture being studied (Whitehead, 2005) and social intercourse pertaining to everyday conversations has been suggested to be pertinent for the development of trust and is the basis of rapport (Hammersley and Atkinson, 1995). Engagement in everyday conversations is suggested to be the route to facilitating observations, events, and meaningful conversations (Davies, 2008). Overt participant observation was

adopted as a methodology and a method within this study in order to understand creative practices at the field-study-site.

Bryman (2004) identifies four types of participant observer, which range from complete participant to complete observer, see figure 3.2. The role of complete participant is adopted when the researcher's status is unknown and they are "a fully functioning member of the social setting" (Bryman, 2004, p.301). The participant-as-observer role is adopted when the researcher participates in the daily lives of the group being studied which involves regular interaction; the researcher's status is also known. The observer-as-participant is adopted when full participation is not possible and the researcher usually adopts the role of interviewer(Bryman, 2004). The complete observer role is adopted when the "researcher does not interact with people" (Bryman, 2004, p.301). The roles are suggested to be related to the degree of acceptance of the researcher in the social group (Davies, 2008).

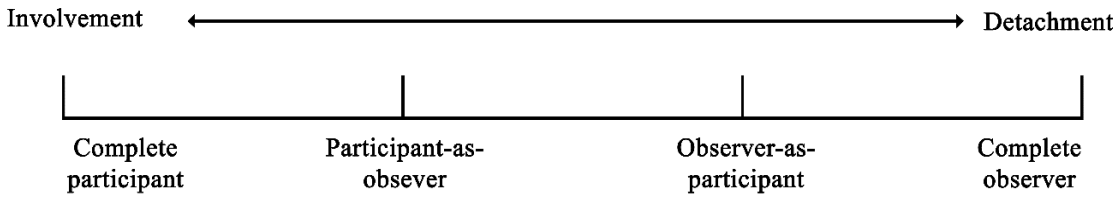


Figure 3.2: Gold's classification of participant observer roles, adapted from Bryman (2004)

My role within participant observation changed from being initially a complete observer to participant-as-observer during the research. The following explains the contextual factors and research priorities that influenced this. There were two distinct phases of data collection, these were:

- Phase one: the staff induction where the role of complete observer was predominantly adopted. However, the participant-as-observer role was also adopted, at times, when

the role of staff helper was undertaken. Tasks included making drinks for residents which was a known staff role. This phase facilitated my understanding of the ward environment. During phase one of the research, I aimed to become familiar with the context before explicitly exploring the research questions.

- Phase two: involved shadowing staff groups, such as the occupational therapy team, observations of meetings, involvement in morning meetings, and continuing to observe the ward environment. The shadowing role facilitated the researcher to become more heavily involved as a participant-as-observer and assisted with building rapport with the staff and residents. This phase facilitated with the understanding of the hospital environment through shadowing a range of staff groups and timetabled therapy offered by the psychology and occupational therapy team.

The staff helper role, along with the adoption of a staff dress code, assisted with creating a "front" so that access to the participant observer role could be gained (Bryman, 2004, p.299).

The participant observer role would often fluctuate from complete observer to participant-as-observer, which was influenced by the degree of acceptance; this developed over time through the building of relationships with staff and residents influencing the participation of researcher within every day encounters. Phase one of the research mostly comprised of the complete observer role; section 4.3 explores the researcher's experience during this phase of the research and serves as an introduction to the field-study-site. During this phase, I found that, whilst I was physically present, access to the social world was somewhat constrained. It has been noted that physical access to a social group may not provide access to relationships and the data required for the study (Bryman, 2004; Murphy and Dingwall, 2003). For example, Anspach (1997) found that access to key informants was achieved through continuous and delicate negotiations where physical access did not permit access to the data required for the

study. Within this doctoral research, continuous negotiations occurred. For example, whilst the occupational therapy staff permitted access for me to participate within their visits to the community, a resident who was a participant of the study refused access to a dog-walking trip. However, at another point in the research, this individual invited me to attend her Care Programme Approach meeting as a complete observer. Thus, access was continuously negotiated, and the role of participant observer fluctuated depending on the type of activity in which participation could occur. Furthermore, Whitehead (2005, p.4) notes that ethnography is "an intersubjective product constructed by the relationship between the researcher and the study population", thus the co-construction of creative practices as embedded within life at Westmarch Hospital was built through relationships and the researcher is the primary instrument for data collection and access is embedded within relationships (Curry et al., 2009). Access negotiations, then, "are not merely confined to the early stages of the ethnographic project" and development and maintenance of rapport need to be continually negotiated throughout fieldwork (Morgan-Trimmer and Wood, 2016, p.5).

During phase two of the research, I was adopting more of a participant-as-observer role, which was facilitated by the shadowing role. During this phase, I shadowed the maintenance team, reception, domestic staff, kitchen staff, the psychology department, and the occupational therapy team. I spent time in the administration office to understand how engagement in activities was monitored. I also continued to spend time on the wards, with different staff, such as medical doctors, healthcare assistants, and nursing staff. I was also present at formal clinical meetings, such as ward rounds, where a representative from the nursing, medical, psychology, occupational therapy, and psychiatry departments were present. This multidisciplinary meeting facilitated in my understanding of the relationship between the disciplines and how care was co-ordinated across the different disciplines. I ate lunch with residents on the ward

and I also ate lunch with non-ward staff and thus spent time in the staff dining area, sometimes observing and sometimes engaging with staff, such as hospital and clinical management. It has been noted that the alignment of the researcher's role with specific groups can lead to methodological issues. For example, building relationships with specific groups in the field may lead to limited contact with others (Hammersley and Atkinson, 1995). This was, potentially, the case for other staff groups, such as, nurses and health care assistants, at Westmarch Hospital where I could not gain access to individuals for interviews, which was likely influenced by a lack of rapport, which is further discussed in section 3.4.3.

Ethnographic observations often begin broadly and are collated through descriptive observation and then move towards more focused observations, in which there are three district phases (Spradley, 1980), see figure 3.3.

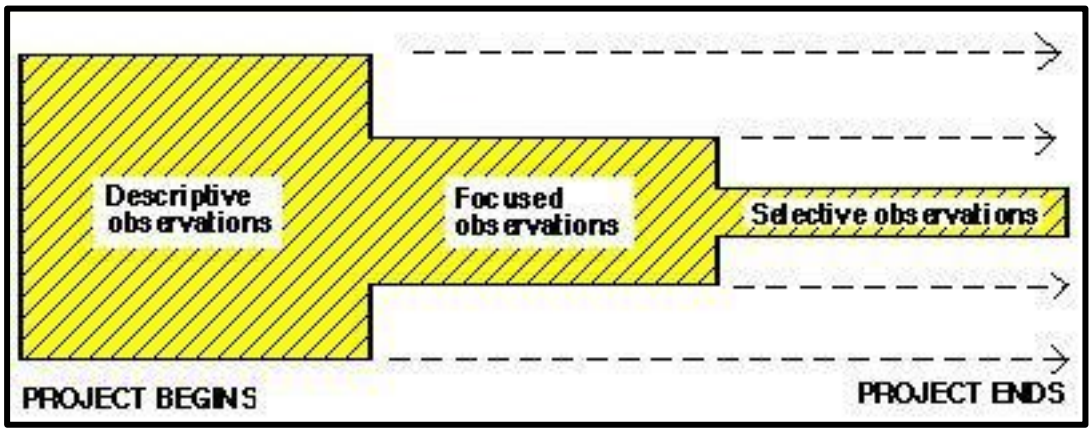


Figure 3.3: Journey of observational focus (Spradley, 1980)

Firstly, there is the descriptive observation stage in which the researcher notes as much contextual information as possible. Within this research such an approach was adopted. For example, phase one of the research facilitated in the descriptive observations which are presented as an introduction to the field-study-site in chapter four.

Secondly, there is a focused observations stage which considers the aspects related more specifically to the research questions. During

phase two of the research, I spent time visiting the research site during the evening and weekends and found limited opportunities for social interaction. This was because residents would often spend much of the time in their individual bedrooms. Thus, observational work became focussed on the key hours between 9:00 and 17:00.

The final stage of observations is when the researcher is seeking further information and thus, selective observations are sought. Therefore, as the data becomes more meaningfully understood in light of the research question, the researcher adopts a more selective and strategic approach to the final stages of data collection. However, it is important to note that the phases of observations, at times, overlapped. For example, the observations conducted whilst I was shadowing the occupational therapy staff involved some descriptive observations and were made alongside more focused observations relating to the research questions.

Observations are usually adopted in order to explore a range of dimensions in the social world for example, daily routines, active construction of documents, conversations, language, and behaviour (Mason, 2002). The aim of adopting observation as a method of data collection within this study facilitated the researcher to explore daily routines and the active construction of creative practice and the, often undocumented, interactions within the FMH setting relating to creative practice.

3.4.2 Fieldnotes

It has been noted that fieldnotes were kept by the researcher within this doctoral research. Fieldnotes are commonly used by the ethnographer as a way of recording observational data (Hammersley and Atkinson, 1995). Bryman (2004) identifies three types of fieldnotes, these are: mental notes, jotted notes, and full fieldnotes. Mental notes and jotted notes were primarily adopted during fieldwork, Madden (2010) refers to these notes as participatory fieldnotes, as these are taken within the field in which the research is

taking place. Such notes represented "shorthand reconstructions of events, observations, and conversations that took place in the field" (Van Maanen, 2011, p.123). These notes are translated into full fieldnotes, which Bryman (2004) advises should be conducted "as promptly and fully as possible" and "as soon as possible" and formed in to what Madden (2010, p.308) describes as consolidated notes. Within this research, this was conducted at the end of each day. At times, I attempted to formulate fuller sets of notes whilst in the field-study-site however, I often found that I was distracted by those around me. For example, conversations in the staff base were useful insights and ignoring these conversations felt like a missed opportunity to gain a fuller understanding of life. Thus, observations and conversations were formulated as jotted notes when conducted in the field. These jotted notes were of conversations and observations that I wanted to remember to expand upon later. The phases used could be described as "mnemonic devices" in which "bits of talk and action" serve as a reminder to what was observed and act as a prelude to the full written notes which were later expanded upon (Emerson et al., 1995, p.31).

Within this doctoral research, the self and the other is explored through the "autobiographical experience … [which is] used to relive and rework the material" (Okely, 1994, p.31). During phase one of the research, I found it particularly difficult to relive and re-tell what I had observed and experienced due to the emotionally challenging environment. Other researchers have noted that reliving traumatic events from time spent in the field can be difficult (Harris and Huntington, 2000; Pollard, 2009). I began to write what I termed critical incidents, which were shared during clinical supervision. This process formed the beginnings of what Maanen (2011, p.117) describes as a "long social process of coming to terms with a culture". Furthermore, it is argued that "to know the phenomenon about which they write and to be fully honest about how they came to their interpretation" (Gilbert, 2001, p.11). Thus, I endeavoured to include insights into my emotions in relation to observed events, as what is

learnt is argued to be inextricably linked to how I learnt about such insights (Emerson et al., 1995), and as such, this detail is included in the presentation of data in chapter four. These insights were used to develop themes and explore theory alongside other data, for example, interviews and further observations, during and after the research, which is further discussed in section 3.8.2.

Emerson et al. (1995) outlines two approaches to participation within the field, one that involves full participation which may restrict note-taking and an approach to participation which positions the researcher in events whilst trying to remember what is salient to the research, and thus the fieldnotes. Phase one more distinctly focused on participation in a way which restricted note-taking, this was because I spent intensive time on one of the wards and I was in constant view of staff and residents. Whilst, at times, I did conduct note-taking in the field, I wanted to restrict this activity until staff and residents had become familiar with my presence. As noted in section 3.4.1, I had aimed to become familiar with the context before explicitly exploring the research questions. Thus, whilst the complete observer role was primarily adopted during this phase, purposeful positioning in the field became more of a prominent feature during phase two of the research. Specifically, attending the timetabled creative practice events alongside the occupational therapists represents this purposeful positioning.

Fieldnotes have been suggested to be accounts which describe experiences and observations, such descriptions "involve issues of perception and interpretation" (Emerson et al., 1995, p.5) and such accounts are "rhetorical constructions" and an interpretation of events (Clifford, 1990, p.67). Section 3.8.3 discusses the presentation of data and returns to these issues.

3.4.3 Interviews

Unstructured ethnographic interviews were conducted during fieldwork. These are informal conversations where the researcher

asks questions in order to gain further insight in to an area of interest (Whitehead, 2005) and represent a natural conversation (Kelly, 2010). More formal interviews are often conducted later during fieldwork, once relationships have been developed in the field (Madden, 2010). Semi-structured interviews are adopted by ethnographers as a way to explore the research questions but are not restricted to predetermined questions. For example, interviewers often ask respondents to expand the points they've made (Davies, 2008). An interview schedule facilitates semi-structured interviews and may list a range of topics or specific questions that the researcher aims to cover (Whitehead, 2005). Probes were used to prompt the interviewee to expand upon their point, phases such as 'how interesting' and requesting for more information is an approach typically used within semi-structured interviews (Leech, 2002). The topic of exploring creative practices was chosen prior to entering the field-study-site, however, the interview schedule developed over time and thus questions regarding the occupational therapy timetable were chosen once knowledge of the sessions had been gained.

It was theorised in the research protocol that the semi-structured interviews would be undertaken after six months in the field. However, one participant was due to leave the field-study-site prior to then and thus one of the interviews took place during month four of the research. In total, eleven interviews were conducted with two occupational therapy staff, one education support worker, and seven residents. Two of the residents were situated on Mirkwood ward (female ward), two resided on Buckleberry ward (male ward), and four resided on Crickhollow ward (male ward).

The purpose of the interviews was to explore perceptions in relation to the timetabled creative practices and how time is spent outside of these sessions. Thus, the research schedule explored the creative practices which were timetabled as part of occupational therapy. The ward occupational therapy schedule was utilised as a resource within the interviews and the resident participants were prompted to explain

which sessions they most and least enjoyed along with examples of the types of activities that they engaged in. The staff also provided information on the types of activities which had taken place at the research site and the purposes of the sessions. How time was spent outside of therapy was explored with the residents and significant relationships were explored with staff and residents. Questions in relation to agency and choice were explored and the semi-structured nature of the interview meant that elaborations in relation to examples could be requested. Furthermore, residents often provided information in relation to barriers and facilitators, which formed part of the contextual detail discussed in chapter four.

It was noted in section 3.4.1 that building relationships with specific groups in the field may lead to limited contact with others (Hammersley and Atkinson, 1995). This was potentially an issue for conducting interviews with ward staff within this research as no interviews took place. However, professional busy-ness was also found to be limiting and "pragmatics of professional time" has been found to shape ethnography research (Bisaillon and Rankin, 2012, n.p.). This has also been noted to provide important insights in relation to the dynamics of an organisation (Bisaillon and Rankin, 2012). On several occasions, Julie, a social worker, informed me that she would be happy to undertake an interview with me and insisted that I emailed her, several emails were sent, with no reply. I had been informed by others that Julie often worked late and was very committed to her role, thus I had concluded that her busy-ness continued to be a barrier even though I felt we had built a good relationship, one in which she showed great enthusiasm for the research. Arguably, the occupational therapy team and the residents were key informants in the field for exploring formal creative practice engagement. Informal creative practices could be observed, nonetheless, between ward staff and residents and an emic understanding of such engagements was explored via interviews with residents. Therefore, the approach to undertaking the research by

aligning with the occupational therapists, is argued to be apt for exploring the research questions.

Conducting interviews with individuals who are currently engaged in their mental health therapeutic journey can be challenging. For example, I had scheduled an interview with James, a resident, and when I arrived, he was in his room. I knocked on the door and he informed me he wasn't in a great mood but explained that he would like to do the interview. I explained that we could conduct the interview another time and that this was not a problem to re-arrange. He insisted that we should continue, and indicated "let's do it now", so we headed down to one of the interview rooms. The next day I saw him on the ward, and he came up to me and asked if the interview was "alright?". He was concerned that the interview didn't go well. Research has found that interviewees possess a desire to perform well within the interview process (Jordan, 2012). Furthermore, it has been noted that the interviewee may provide socially desirable answers (Gobo and Molle, 2017). However, it is important to note that within this constructionist project, the interview is viewed as "a site where meaning is created and performed" (Denzin, 2001b, p.25). Thus, "the performative action of interview talk" is understood as a performative act between the interviewer and interviewee (Atkinson, 2015, p.99). The nature of knowledge within this research is viewed as constructed and extends to other data collection mediums, such as, observations.

It has been noted, then, that scheduling interviews in an environment where the wellbeing of the interviewee can fluctuate can be problematic. Another example, of the fluctuating moods of interviewees was the interview conducted with Jane. We began the interview at 4.15pm, Jane seemed to be in a good mood, and we were laughing during the interview, time soon passed, and food for the evening meal arrived on the ward. This interrupted our interview. We agreed to continue the next day. When I returned to the ward, Jane seemed unenthused by the interview, but she indicated that she would like to continue. However, during the interview, she fell asleep,

which was a behaviour that I commonly observed on the ward. We agreed to try again another time. The next day, I saw Jane and she asked, "you don't want to do the interview, do you?" I explained that I did and asked if she would like to, she declined.

Furthermore, care practices were also found to interrupt data collection. For example, during another interview, this was interrupted due to the arrival of the GP on Mirkwood ward. The resident had requested during the morning meeting that she wanted to see the GP and they had arrived once we had begun the interview. I sat and waited for approximately 15 minutes in one of the side rooms, where the interview took place, whilst she had her appointment with the GP. Thus, even when the interviews were planned, they were problematic.

3.5 Ethics

This section provides an overview of the research ethics review and details relating to capacity to consent and informed consent. Contentious issues related to entering the field, informed consent, and leaving the field are also considered.

3.5.1 Process

Formal ethical approval was sought from an NHS ethics board in the UK. The review board specialised in qualitative research and the Mental Capacity Act (2005). The research protocol was provided with a favourable opinion from the research ethics committee.

The Mental Capacity Act (2005) outlines that if an individual lacks capacity, then a nominated consultee should be sought for advice. However, an individual suitable to undertake the role of nominated consultee is usually a healthcare professional in the healthcare setting however, according to the Act, the consultee must not be involved within the research (Department of Health, 2008b). Within this research, staff were invited as participants. Thus, it was noted that a personal consultee would be sought if the responsible clinician

assessed a resident to lack capacity to consent to the research. It was noted in the research protocol that consent would be continually negotiated and if a resident or staff member had consented to take part in the study, such participants may not wish to engage with the researcher at all times. This also applied to those who lacked capacity to consent. Subsequently it was noted that the researcher will need to be "inviting of interaction without being intrusive and voyeuristic" (Phillips, 2012, p.68). As such, I endeavoured to be sensitive to participant's behaviour and thus may not engage a resident or staff member if they appear to be withdrawn. During the study, one resident was identified as a lacking capacity to consent. However, this individual presented as either hostile towards the researcher or was found to not interact otherwise. Therefore, the sensitive approach was undertaken where a personal consultee was not sought due to the resident's perceived wish to not engage with the researcher.

3.5.2 Ethical Issues: Entering the field—Self-doubt and researcher distress

During the research, I encountered intense emotions in relation to the research process and also as a witness to extreme emotional pain. It has been noted that:

> virtually all fieldworkers report experiencing emotional extremes, from great exaltation to serious feelings of inadequacy and self-doubt. (Davies, 1999, p.83).

Feelings of self-doubt were at their strongest during phase one of the research, at points when I began to question the strategy of observing the ward with little social interaction. Such feelings of discomfort were used as a reflexive tool to understand why I had feelings of self-doubt and what strategies could overcome this. Details relating to phase one and two of the research and the strategies employed are further explored in section 4.3 and 4.5.

The strong emotions evoked by witnessing emotional pain created a discomfort. It has been argued that "emotions are more than a by-product of ethnography but an integral part of the data gathering process" (Warden, 2013, p.14). The emotions experienced assisted with the development of understanding what life was like at Westmarch Hospital. Furthermore, these experiences informed chapter four and the key contextual features of life were utilised as themes in chapter five to frame the creative practice rituals. The aim of this research was to understand creative practices situated within the FMH environment, these themes are argued to facilitate this understanding as emotions can be a doorway into the emic perspectives of those being studied (Watts, 2008). It is also important to note the lens in which life at Westmarch Hospital was viewed and such a view was guided by the personal characteristics and experiences of the researcher. For example, Goffman (1961, p.8) warns the reader that:

> my view is probably too much that of a middle-class male; perhaps I suffered vicariously about conditions that lower-class patients handled with little pain.

My middle-class background has been noted as a key characteristic in the short biography provided in section 1.2, which has important implications when the researcher is the tool in which data is collected and understood. However, it is also important to note that such emotional disturbances were also observed from staff and residents at Westmarch Hospital. Thus, the emotions experienced by the researcher could be suggested to have, at times, partially reflected the experiences of staff and residents.

3.5.3 Informed consent, confidentiality, and anonymity

Informed consent has been argued to be complex within ethnography, particularly because the researcher spends considerable time with research participants who may indeed forget the individual is conducting research (Hammersley and Atkinson, 1995). Thus, whilst

overt ethnography informs the participants of the research at the beginning, such detail may be forgotten over a longer period of time (Hammersley and Atkinson, 1995). It has been argued that formal consent procedures outlined by ethics committees often follow a positivist approach to research, one in which the study procedures are outlined in advance (Atkinson, 2015; Fetterman, 2009). Such an approach has been argued to be inappropriate for ethnography (Librett and Perrone, 2010; Murphy and Dingwall, 2007) as consent is often continually negotiated and is a process (Davies, 2008). It was recognised within the research protocol that consent was to be continually negotiated and examples were provided to indicate how consent would be approached sensitively, as outlined in section 3.5.1. Section 3.4.1 provides an example of how the researcher's participation was continuously negotiated between the researcher and the participants.

For the observational element of the research, the formal procedure of reading and signing the study documents was found to facilitate but also hinder participation within the study. For example, one resident who spoke to me every day that I visited the ward would proceed to tell me about the activities he'd been engaged in. He was aware, however, that I could not use this information as data as he was not comfortable signing the consent form. This was due to his mental health which meant he was suspicious of formally signing a document. Other research has found participants were willing to engage in research but would not formally sign a consent form (Aguila et al., 2016) or the formalised process of signing a document lead to feeling of anxiety (Metro, 2014). I also encountered issues in the process of providing informed consent. One resident was interested in the research and requested that I read the participant information sheet to him. During the reading, he continued to slip in and out of sleep. Eventually we decided that we would try another time. In one instance, the rapport built through reading the participant information sheet, subsequently led to a participant joining the study.

Anonymity and confidentiality have been maintained through the adoption of pseudonyms and through careful consideration of the details shared within this thesis. The participant information sheet noted that confidentiality would be maintained unless future, planned illegal activity was shared with the researcher. Data has been presented in a way that is impressionistic of the research participants and do not include personal details which may reveal the identities of those at the field-study-site. Further discussion is provided on the presentation of data within this thesis in section 3.8.3.

3.5.4 Ethical issues: Leaving the field

Leaving the field can be both ethically and methodologically contentious for the ethnographer. This is often due to the close relationships built over time (Hammersley and Atkinson, 1995) and the iterative process of ethnography; a definitive end can be difficult to ascertain (Gobo, 2008). Methodologically, the researcher needs to assess when they have enough data (Gobo, 2008). Leaving the field site is often influenced by institutional requirements, such as, ethics boards that require to specify the end of the research (Iversen, 2009). Within this doctoral research, the end was noted to be no longer than nine-months or when theoretical saturation had been achieved. Section 3.7 details the decision to leave the field-study-site in more detail.

The avoidance of leaving too abruptly is offered as advice for the ethnographer (Coffey, 2018). My status as a researcher in the field-study-site meant that there were continual conversations of when I would leave. For participants, the option to receive a summary of the findings was a reminder that the research would come to an end and I would leave and not come back. Such a strategy has been suggested to be useful to indicate the benefit of participation (Gobo, 2008). During the final month I began to inform residents and staff that I would be leaving soon. Such reminders were often presented with an invitation to interview. However, whilst physically leaving the field-study-site marked the end of data collection, the reliving of

experiences and recounting memories continued during the write up. Thus, "the end of fieldwork may not really signify 'leaving the field'…[but] provide[s] physical and temporal separation" (Coffey, 2018, n.p.).

3.6 Study design

The iterative research design facilitated the exploration of creative practices within one FMH hospital and considered their contribution of therapeutic social capital. The study was not an investigation of an organisation and the service but more inquisitive by nature so that creative practices could be described, theorised and understood in relation to both FMH resident and staff populations. This section explores the access to the research site and the participants.

3.6.1 Access to the field-study-site

The selection of the field-study-site was based on a few reasons. One was that the hospital chosen was based upon the openness of the organisation. For example, the hospital was open to visitors and students regularly conducted training at the organisation. Thus, my presence was theorised to not be disruptive as the staff and residents would be accustomed to outsiders spending time at the hospital. The hospital had three wards, two male and one female, which was decided would be an opportune environment to explore creative practices across male and female wards; it was theorised that gender may play a role in the selection of activities. The three wards also meant that my presence may become less burdensome for those that lived there if I was to spend time visiting the three wards. Geographically, the hospital was within travelling distance and with the long-term access required for the ethnography, such a factor was inviting. The first meeting with the hospital manager suggested that the hospital was a fruitful environment to explore creative practices, as it was noted that the residents engaged in a range of activities, including those associated with creative practice as discussed in chapter two.

Following completion of phase one of the research, the staff induction, I took some time away from the field-study-site, in order to review the research strategy. However, my return to the field-site was delayed by four weeks, due to a resident with serious behavioural issues disrupting the timetabled activities. This is further explored in section 4.5. However, it is important to note that access to the field-study-site was problematic due to the nature of the individuals that resided at the hospital and access became restricted, at times.

3.6.2 Participants

The hospital manager informed staff at the hospital of the research. Subsequently, residents were informed of the research by a member of ward staff at the morning meetings on the three wards. However, informal conversations regarding the research had taken place on Mirkwood ward during the staff induction. Following the staff induction, the researcher provided staff and residents with the participant information sheets. The information was read to some residents, as requested and was described in section 3.5.1. Those who agreed to take part in the observational element of the research, signed a consent form. In total, twenty-eight participants provided consent to take part in the study and comprised fourteen residents and fourteen staff. The number of participants that I could observe fluctuated throughout the research. For example, two residents left the field-study-site during the research and I would sometimes enter the ward when residents were on leave.

Some of the staff that agreed to participate in the research were not seen again following the signing of the consent form. This may have been due to shift patterns. Whilst this limited opportunities for observational data, I also found that this limited opportunities for interviews. For example, I found that I did not see some participants during the time that I was conducting the interviews. The protocol outlined that staff and residents could be invited to interview if they had not participated in the observational element of the study. However, only the staff and residents who were already included in

the study agreed to participate in the interview. Details of the participants included in the interviews are provided in section 3.4.2. It has been noted in section 3.4.2 that no ward staff, such as nurses or healthcare assistants, were interviewed within the research. However, observational data was collected which included ward staff.

3.7 Research plan

As discussed in section 3.3, ethnography is a method which creates opportunity for the exploration of a range of phenomena and can be viewed as "an art of the possible" (Hannerz, 2003, p.213). Thus, the initial plans outlined by the researcher before entering the field-study-site were designed to be revised on the basis of new understandings of what was possible. The adaption of the researcher's role has been discussed in section 3.4.1 in which the researcher developed a shadowing role to facilitate everyday discussions to build rapport and to gain insight into the creative practices delivered by the occupational therapy team.

The initial fieldwork plan was to observe one ward per week. However, I soon learnt that such an approach impinged on my ability to build rapport with staff and residents. For example, on three occasions a staff member who I had conversations with, and who I had assisted with cleaning the kitchen, had forgotten that they had met me. Thus, I subsequently decided to spend more intensive time on the wards in sequence, for example, several weeks at a time, in order to build rapport.

As noted in section 3.4.3, one interview was also conducted earlier than was suggested in the research protocol. This was due to the resident leaving the field-study-site as part of his care pathway and eventual aim to return to living in the community. I began to conduct the subsequent interviews during month six of the fieldwork. During this time, I had begun to undertake selective observations across the three wards, during months six and nine, and during months seven and nine, I had arranged to shadow the maintenance, domestic, and

kitchen staff. It was noted in the protocol that the research would end when either theoretical saturation had been achieved or when the researcher had spent nine-months at the field-study-site. The two were achieved almost simultaneously. Theoretical saturation is achieved when no new information is being gathered, variation of the sampling has been explored, and the relationships between categories have been established (Bryman, 2004). However, theoretical saturation can also be viewed as data adequacy, which proposes that there is adequate data where no new information is theorised (Denzin and Lincoln, 2005). During the fieldwork the initial themes emerged however, the ways in which these were theoretically linked to one another developed after fieldwork. Hughes (1994, p.35) notes that "[c]entral issues…were raised at the end of the fieldwork period when I began to grapple, in a formal way, with making sense of my data". Hughes (1994) further expands on this point by noting that the initial literature review was found to be limiting in relation to the data collected and thus a broader perspective was actively sought by engaging with new literature. This new literature was then used as a framework to revisit the data. The process of returning to the data with a broader theoretical understanding was also adopted in this doctoral research. Section 3.8.2 describes this process in more detail.

3.8 Data analysis

This section describes the process of data collection, data analysis, and the development of theory, in more detail.

3.8.1 Data collection

More than 300 hours of participant observation was conducted over a period of 9-months. Phases one and two of the research were conducted during this time in which fieldnotes were produced from initial jottings which were undertaken during the fieldwork (see section 3.4.1 for more detail on these phases and section 3.4.2 for more detail in relation to the fieldnotes). A total of 14 staff and 14 residents participated in the observational element of the research. At times, I observed events in which no participants were present.

However, such observations were insightful and provided me with information regarding the types of activities that staff and residents engaged in and also provided valuable insights into community life. In these instances, broad descriptive fieldnotes were adopted. At times, in which I observed events with participants, I adopted more detailed descriptions within the fieldnotes, as such, quotes from participants. These were jotted fieldnotes, which were undertaken during fieldwork. These were expanded upon later that day, as described in section 3.4.2.

The interviews took place between month four and nine of the research and eleven interviews were conducted with two occupational therapy staff, one education support worker, and eight residents —this was outlined in section 3.4.3. Two of the residents were situated on Mirkwood ward (female ward), two resided on Buckleberry ward (male ward), and four resided on Crickhollow ward (male ward). The interviews were audio-recorded and ranged from two minutes to one hour forty mins. The broad range in time was influenced by issues relating to one participant falling asleep, as described in section 3.4.3, and the timing of the interview in relation to institutional routines. For example, only one of the interviews was undertaken with no interruptions from institutional regimes.

The interviews were transcribed verbatim. The fieldnotes also contained data related to the interviews, which included initial insights which served as theoretical codes and methodological insights, such as body language which revealed insights into what was said during the interview, which would not be captured via audio recordings. The behavioural descriptions inform some of the discussion in chapter five.

3.8.2 Data analysis

As noted in section 3.4, the data collection and analysis stage of ethnography are often intertwined, and these are not distinct phases of the research process (Coffey, 2018). Initial theoretical codes were

developed during the fieldwork, particularly during the writing of fieldnotes as this process often "heightens and focuses … [the] interpretive and analytic process" (Emerson et al., 1995, p.100). Emerging insights were sometimes added as additional headed sections following the write-up of observations and, at times, data was highlighted with accompanying theoretical codes or insights alongside the typed text. These initial theoretical codes were useful in developing the three contextual themes from my descriptive observations, which are discussed in section 4.8. I felt, however, that some of the theoretical codes weren't able to fully capture the moments observed in the research; the data was being divided into codes which related to specific detail, but it did not feel as though this was capturing the essence of some of the key moments observed in the research. I returned to the literature in search of a perspective that could provide a lens to theoretically link the initial theoretical codes. Interaction Ritual Theory (IRT) allowed for the exploration of interactions, which also framed emotions as central (see section 2.5 in the literature review for a discussion on this theory). As I began to revisit my data, the fieldnotes and the interviews, I was able to see how applying this framework more sensitively captured moments of interactions, which was central to the data and my understanding of the context. This framework was expanded upon so I could theoretically explore the contextual features of the environment and, thus, the interactions could be appropriately situated. A microsociological model, which theoretically links the contextual themes, and other themes in relation to the research questions, was developed following the fieldwork and thus the relationships between categories were more formally theorised after data collection had been completed (see figure 5.1).

3.8.3 Presentation of data

The fieldnotes in this doctoral research adopted a "thick description" approach to note-taking (Geertz, 1973, p.317) to provide a "detailed account" of the social setting (Bryman, 2004, p.590). Such accounts are "necessary for judgements of transferability" (Guba and Lincoln,

1985, p.359). However, it is important to note that such accounts are "rhetorical constructions" and an interpretation of events (Clifford, 1990, p.67). Thus, the accounts provided in this research aim to provide the reader with enough information to facilitate "the drawing of inferences by the reader which may apply in his or her own context or situation, alongside the interpretations by the researcher " (Guba and Lincoln, 1989, p.224). It is argued that the researcher is the primary instrument for data collection (Curry et al., 2009), and section 3.2.1 importantly provided insight into the researcher's values.

Within this thesis, data excerpts have been selected because they "aptly illustrate recurring patterns of behaviour or typical situations in that setting" (Emerson et al., 1995, p.175). Chapter four presents a series of vignettes to illuminate typical moments within the context of the culture at the field-study-site with the inclusion of pseudonyms for staff and residents. A vignette "is a vivid portrayal of the conduct of an event of everyday life" (Erickson, 1986, p.149). The intention of the vignettes are to elicit "emotional identification and understanding" (Denzin, 2001a, p.141) and thus, such an approach facilitates "bring[ing] research to life" (Ellis, 1997, p.4). This approach has also been suggested to allow the reader "to sense some of the evocative power, embodiment, and understanding of life that comes through the concrete details of narrative" (Ellis, 1997, p.9). Such moments, whilst representative of typical moments within the field-study-site, also serve as a series of informative critical incidents for the researcher. For example, the vignettes presented in chapter four highlight moments in which the researcher gained understanding of the key contextual features of the environment. Thus, the vignettes are reflective of an "interpretive point the author intends [which]… are based on fieldnotes" (Erickson, 1985, p.150). The intention is to present a chronological account of the researcher's journey and the introduction to the emotive field. The vignettes are accompanied by information in relation to the day in which the observation was noted in relation to the time the researcher had spent in the field.

Furthermore, section 4.7 presents a vignette titled 'a day in the life of Joe', this representation elicits data that is "especially representative, meaningful data… [that has been] pulled together in a focused way for interim understanding" (Miles et al., 1994, p.81). Such an approach is adopted as a way to introduce the reader to context in which the doctoral research was undertaken.

The interview data are presented within chapters four and five, which is identified by double quotes. Interview data excerpts are accompanied by pseudonyms, and information in relation to whether this interview was conducted with a staff member or a resident, and the ward in which the resident resided at the time of the interview.

For those who had consented to take part in the research, accounts of events which involved such participants noted their involvement and provided detail of the event, if pertinent to the research. For those in the field-study-site who were present, but had not provided consent, the observational data would note their presence (i.e., how many individuals were present at the time), if pertinent to the research, but such accounts did not focus specifically on their role within the activity or provide direct quotes. All names within this thesis, including the field-study-site are pseudonyms.

3.9 Chapter three: Summary

This chapter has outlined how ethnography, as a methodology and a method, can be adopted within the constructionist paradigm. Participant observation has been noted to be central to this research in which a reflexive approach enabled the researcher to explore the research questions in a way that was sensitive to the context. It has been noted that the researcher's role as participant observer was continually negotiated and fluctuated from complete observer to participant-as-observer, throughout the research. I have noted the challenges of conducting and ethnography and interviews within the secure FMH environment, and the ethical considerations relating to informed consent. Furthermore, this chapter has provided an account of how I conducted data collection, analysis, and the presentation of

data, which forms the subsequent chapters. Chapter four introduces the field-study-site in which three contextual themes are argued to underpin life at the field-study-site. These contextual features influence creative practice and wellbeing, which are further explored in chapter five.

Chapter Four: Introduction to field-study-site

4.1 Setting-the-scene: Introduction

This chapter highlights the contextual environment in which this research is situated and provides a contextual lens for chapter five that serves to analyse and theorise the creative practice rituals observed during the research, see section 2.5.2 for the conceptualisation of creative practice rituals through Interaction Ritual Theory. The chapter provides, in section 4.2 to 4.7, an overview and an introductory analysis of the study site from the perspective of the researcher, utilising a thick descriptive approach, as discussed in chapter three. The chapter then explores in section 4.8, the key emergent contextual themes which are theoretically applied to a microsociological model of therapeutic social capital. Data from the interviews and observations are utilised to foreground the model, which provides the framework for exploring the rituals presented in chapters five and six.

As such, the aims are threefold in this chapter. First, to provide an overview of the social and physical environment, and to situate the field-study-site within its broader context of a secure Forensic Mental Health (FMH) hospital. Second, to provide rich data to highlight the context of the research, which is apt for ethnographic research, and of crucial importance to this research as the findings are contextually-bound. As concluded within the literature review, this contextual approach aligns with the research aim, which endeavours to explore the lived experience of creative practice within one FMH hospital. The culture of the FMH hospital environment is paramount to understanding how creative practice occurs within the field-study-site. This research thus contributes to the arts and health literature by exploring creative practice within a contextually-bound secure environment. Third, to introduce the microsociological model of therapeutic social capital which incorporates the contextual themes which emerge.

4.2 The organisational structure of Westmarch Hospital

The ethnographic work was conducted within Westmarch Hospital, which is an FMH hospital in the UK. The hospital was managed by the independent sector and the research was completed over a 9-month period, amounting to over 300 hours of observations with 28 participants (14 staff and 14 residents), and 11 interviews (3 staff and 8 residents). This section introduces the organisational features of Westmarch Hospital as they existed during the research.

The hospital comprised three wards:

- Mirkwood Ward: 16 bed low secure female personality disorder
- Crickhollow: 15 bed low secure male dual diagnosis
- Buckleberry Ward: 19 bed locked rehabilitation male ward, including a self-sufficient 3-bedroom residential ward, referred to as a court.

These wards were supported by various departments:

- Administration: Administration and management supported the three wards, which included the hospital manager, clinical manager, ward managers, clinical team manager, and administration staff (including a Mental Health Care Act team).
- Reception: The reception staff managed communications with all incoming calls to the main hospital telephone line and offered a switchboard service to the departments within the hospital. The reception was also responsible for the handing out of keys and safety alarms, the signing of the registration, informing visitors of contraband items, and allowing access into or out of the building.
- Maintenance and housekeeping: The maintenance and housekeeping team were often visible fixing doors and cleaning the hospital site.
- Kitchen: The kitchen staff supplied food for the residents, staff and visitors. Kitchen staff delivered the trolley of food to

each of the ward kitchens, with the meals chosen by the residents (one to two weeks in advance). Staff and visitors could choose a meal off the menu presented at reception by filling in a form (before 9am). Lunch was served to staff and visitors in the dining area, which was situated away from the wards, via a hatch from the hospital kitchen.

- Nursing and healthcare staff: This consisted of a team of mental health nurses, and health care assistants. These staff groups were allocated to wards for shift-work and were counted within the number of staff required for each ward, which also included the clinical team and ward manager.
- Consultants: These included a medical director, a psychiatrist, and a forensic psychiatrist.
- Social work: A team of social workers and an educational assistant provided support for patients.
- Therapy: Occupational therapists and psychology staff were situated in rooms along what was known as the 'therapy corridor'. Speech and language therapists visited the wards three times a week.

In the hospital, there were rooms that could be accessed by the different departments, such as: the staff dining room, meeting rooms, visitor rooms, a training room, and the gym. Visitors were also able to access the visitor room and meeting rooms. The occupational therapy team ran sessions with the residents in the Activities of Daily Living (ADL) kitchen, the gym, and the art room. Administration and management offices were situated along one corridor upstairs. There was a smoking shelter within the hospital area, for staff to use. However, this was removed during the research as a smoking ban was implemented; the ban removed the right for staff and residents to smoke on the hospital grounds. During the time of the research, the national implementation of the smoking ban across NHS sites in England, including inpatient hospitals, had begun. The aim for NHS England was to be smoke-free by 2018 (NHS England Board, 2016).

4.3 Phase one of the research

This section introduces the field-study-site via a narrative produced from my fieldwork data, beginning with the initial meeting with the hospital manager and subsequently moving on to the staff induction. Phase one of the research was conducted over a 10-day period, Monday-Friday between the hours of 9:00-17:30.

4.3.1 Meeting with the hospital manger

I had visited Westmarch Hospital prior to the data collection period to discuss the research with the hospital manager. This conversation took place in the manager's office, which was situated away from the wards. We discussed the activities that took place at the hospital and I was informed that there were many activities that occur that are creative, thus I was reassured this would be a suitable site for the research. The meeting also focused on the physical and verbal abuse risks that I would be undertaking when I spent time on site. I was told that a student hadn't been physically hit before, but that there was always a chance this could happen. This didn't come as a surprise to me and I could understand why this was being made clear to me before I began the research. However, the risk of physical harm loomed over me on every visit and I experienced aggression and, what could be perceived as intimidating sexual behaviour.

4.3.2 Staff induction

This section begins with a narrative of my first day of my induction at Westmarch Hospital that draws on data from my fieldnotes.

I began my two-week staff induction at Westmarch Hospital in May. I planned to spend the early part of this time familiarising myself with the hospital, including the staff and residents before formally introducing the research to them via participant information sheets. I dressed appropriately based on information I had received via email before my visit. I wore a loose-fitting pair of trousers that I had recently purchased, a high neck and loose-fitting shirt accompanied by a cardigan, a sturdy belt, lace-up shoes, and trousers with belt

loops. I had been informed that the dress code ensures a professional image is represented by staff and students. This was considered of the utmost importance as I would be representing the hospital to visitors—it would be presumed by others that I was a member of staff. I was informed that the lace-up shoes were for safety reasons; the shoes needed to be securely fastened so if I needed to move quickly at any point, my shoes would not impede me.

4.3.2.1 Fieldnotes: Phase one, day one

It is a pleasant Spring day as I arrive at Westmarch Hospital, which is situated on a main road, but the entrance is situated on a road which is shared by a business park. Although the small hospital car park is full, with several cars parked out on the road, I manage to find one of three allocated visitor spaces. I turn off my mobile phone and place it inside the glove-box, get out of my car and walk several yards to the reception area. As I do so, I notice that the site is not closed off completely from the local community. A woman passes by, walking her dog, using the car park as a cut through to the main road and its few local shops. The hospital building itself is modern, painted white with brown wood panelling. Part of the building has seven-foot concrete walls topped with three-foot barbed fencing enclosing its internal courtyards. As I approach the building, I notice a half-open, dark grey framed window and see a man dressed in chef's uniform—a white, buttoned outfit and a cap. I can hear the radio blaring out from the window which is covered by a dark grey meshed security panel. The only greenery I see is part of a tree reflected onto one of the glass panes. As I approach the reception entrance, I feel the gaze of the security cameras which line the building.

At the entrance, I feel both trepidation and a growing sense of curiosity. I had been informed via email that I would be undertaking the induction with other students and was now looking forward to this. I walk through the first set of automatic glass doors and onto a large brown, lightly speckled doormat which spans the area. As I

do so, the next set of doors open in quick succession and I find myself in a reception area, now standing on a second doormat displaying the company logo. I hear a soft sweeping noise behind me from the bristles at the bottom of the closing automatic door.

Once inside, I see to the left, a row of lockers, a locked disabled toilet, and a water dispenser with cone-shaped cups. Directly ahead of me, there are a few modern, navy blue, easy-to-wipe-down tub chairs, which remind me of the kind seen in banks. To the right there is a light-coloured heavy wooden door with a small rectangular pane of glass, leading to the hospital. I notice a hand sanitiser on the wall, situated to the right of the wooden door. I turn immediately right, about 90 degrees, to face the large glass window of reception. There are two female reception staff in the room behind it. The reception room is large, about 4 by 5 foot. I can see another window adjacent to the secure door, the window is small, approximately 1.5 x 2.5 foot. This small window looks onto a dimly lit enclosed space between the external secure door leading to the reception area and an inner secure door leading into the hospital – this was the hospital's main airlock. One of the reception staff is attending to some people who are handed keys through the small window. I wait at the main window for one of the other receptionists to attend to me, she is on the phone. As I wait, I notice it is warm in the reception area, a wave of heat is being blasted from above the automatic doors. The space has the air of a hospital or other formal building but is not overbearingly clinical. I look again at the tub chairs which are not typical of a hospital waiting room. I expected to see a row of lightly cushioned metal chairs bolted together.

I hear a light click and two males appear from the secure door, one is smartly dressed and is wearing a name badge, the other is casually dressed and quickly moves to one of the tub chairs to sit down. He begins to roll a cigarette. The smartly dressed male joins

him, sitting with his back to me. As I stand by the reception window, I continually set off the automatic doors with my movement and step to the left and further away from the sensor above the doors so that they close again.

I look back into the reception room, the receptionist turns her body to face me, as an indication that the telephone conversation is coming to an end, she put down the receiver of the telephone: "Hello, how can I help you?", she remarks in a spritely but also somewhat demanding or no-nonsense manner. She is pleasantly engaging but with a sense of urgency to her question. I explain that I am there for a staff induction with the hospital manager. There is a small gap under the large glass window for keys and alarms to be exchanged, the receptionist pushes through a piece of paper that lists the items that cannot be taken through to the hospital, the list is titled: '**CONTRABAND**'. The receptionist remarks: "Sign this please". I study the list, which includes items that I would expect to be considered contraband within this secure environment, such as mobile phones, cameras, sharp objects, batteries, etc. I sign the declaration and pass the piece of paper back under the small space of the partition window.

I am told to make my way through the secure door, I hear a soft click and push the door. I enter the small airlock, it is dark. I am handed a visitor badge through the small window between the airlock and the reception. The hospital manager appears and greets me. I am informed that the other students had already arrived and are reading through some documents. We walk through another door where another row of lockers are and head up some stairs. We enter a corridor and I am led to a seat in the hospital manager's office. I am handed a series of booklets. I am told to sit and study the documents prior to signing the declarations. The booklets cover the organisation's Codes of Conduct and Practices. I am then told to visit the administration office, where my photograph is taken

prior to issuing me an identification badge. I am asked what I am (i.e., what role I would be undertaking in the hospital) and this question causes some confusion. I am asked if I was a student nurse. I say that I am a student researcher. I am handed a badge that reads "student". I return to read the booklets in the office. After about an hour, the hospital manager collects me and the other two female students, who look to be in their 20's. "You're nursing students?", the hospital manager asks, they both nod their heads.

We are given a pouch to hold a heavy set of keys and fobs, which are to be worn on the belt. These are newly packaged; the manager unwraps each one and hands them out. It is explained that the pouches are often only provided to the female staff members as the lack of large pockets are often a design issue in female clothing—the male staff often use their trouser pockets to hold the heavy set of keys and fobs. I have a small notebook, which I had planned to use to make my fieldnotes and this fits neatly within the key pouch. I notice that the pouch also has a pen holder. I feel pleased that the pouch will be useful to carry around my notebook and a pen whilst at the hospital.

Next, we are shown how to wear our identification badges for the different wards at Westmarch Hospital. The lanyard, which has a safety break, was to be worn on the male wards, Buckleberry and Crickhollow, but not when visiting Mirkwood ward. It was explained that this is due to the residents potentially using such materials for ligatures and thus these items are viewed as a risk within that particular ward environment. Instead, magnets were used to keep the identification badge in place. I am then informed that I would be spending my induction on Mirkwood ward, the female ward. So, the hospital manager puts his hand out, gesturing for me to hand the lanyard over. I give it to him and he then places it in a box in his office.

We hover in the hallway of the administration and manager's offices, whilst the Hospital Manager inspects our outfits. One of the students is wearing slip-on style shoes. The Hospital Manager points to my shoes and advises the other student, "You'll need ones, like these". We all look down at my shoes, which are high ankle, flat-heeled boots with laces. Then we are shown down the stairs to the first security 'airlock'. The other students and I are introduced to security and safety features such as: the set of approximately 7 keys and what they are for, the locked doors and how to pass through them safely including the principal of 'ghosting'. I learn that ghosting is a method of escape which can be adopted by residents in secure settings. We are told that ghosting occurs when a resident remains close to a member of staff who is walking through doors; the aim of this is to create the impression that they are being escorted by this member of staff and so may not be challenged enabling them to make an unauthorised exit from the secure building. We are informed how to prevent ghosting and thus how to ensure that we do not contribute to a resident absconding. To do this we are to challenge any individual, including staff if their badge is not visible, and ask either who they are with or, if a staff member, for their identification.

All movement in and out of the hospital is documented on the register at reception. The movement of keys and alarm numbers are also recorded on this document. We are handed the set of keys and an alarm each and take turns to fill in the register, noting the key and alarm number that we have been handed. It becomes clear as I fix the heavy set of keys and the safety alarm to my belt, why we are asked to wear a sturdy belt and trousers with belt-loops. The alarm sits on my belt secured by a clip and fixed to one of my trouser belt loops; this proves to be a challenging task as I have to reach around my back with one hand to secure the clip to my belt-loop and it takes me a while to get used to the mechanism.

We are taken into the reception room and shown where the ward and department keys are kept, these are hung on the wall by several rows of hooks. Non-ward staff are provided a different set to that of ward staff. I learn that I could obtain the ward keys upon arrival by informing the reception staff the name of the ward I was visiting. We are also informed how to follow procedure if we discover that we have taken any items outside of the service, and where to store our belongings.

We are then escorted around the building and shown the staff kitchen, Activities of Daily Living (ADL) kitchen, the occupational therapy room, computer room, the gym, and the grounds, including the courtyard for Mirkwood ward, which can be viewed from an inside corridor. I make a mental note about the occupational therapy room, which the hospital manager says is used as an art room. By peering through the glass panel in the door I can see some paintings on the wall, presumably created by the residents. I feel thrilled and look forward to finding out more about opportunities to be creative in such a setting!

We are escorted along a corridor leading to the wards, the other students and I awkwardly shuffling along keeping up with the manager but trying not to get in the way or take the lead as we don't know our way around the hospital. We head up some stairs and stand outside a door, the hospital manager uses the hand sanitiser, which is fixed to the right of the door. The other students and I copy his behaviour. We enter Mirkwood ward, through an airlock, but before entering the communal area on the ward, we take a right into the ward kitchen. The manager begins to check the dates of the items in the fridge and states: "This is a hospital" as he throws away some food that's missing a date label. He remarks: "okay" to signal that we were done in the kitchen. We are escorted onto the ward and shown how to unlock the doors on the ward in an emergency situation should a door become barricaded by a

resident. We each take a turn to unlock one of the toilet doors with the barricade key which is kept in the staff base. The hospital manager seems proud of the design and indicates that the hospital was designed, and purpose built as a secure hospital. I am also impressed by the ergonomic design of the hospital and wonder how often this method is used to unlock doors. We are taken to the staff room, which is labelled with a metal rectangle sign stating 'staff base' on the door where I was introduced to the staff briefly. The two students leave at this point and I stay for the rest of my first day of induction on the ward. As I stand in the office, I notice the surveillance camera live feed display on a computer screen. The live feed looks as though it covers the areas of the ward, I can see corridors, and the sofa area, and a stairwell.

I am left sitting on the ward, alone. I am not that sure what to do on the ward. I find myself observing life on Mirkwood ward from a chair in the corner of the communal space on the ward.

Phase one, day one: Reflection

Upon entering Westmarch Hospital, I soon learnt that surveillance, security and risk governed much of the practices at the site. From the signing of keys, safety alarms, secure doors, the barricade key, dress code, and cameras. The induction, provided by the hospital manager, was focused on the security features of the hospital. I am committed to maintaining these features by following the procedures outlined.

I'm looking forward to finding out more about the facilities available to the residents, for example, the ADL kitchen, the gym, the art room, and the computer suite. However, I found the afternoon of day one to be a struggle emotionally and was unsure how to spend my time during the induction.

4.3.3 Phase one vignettes

This section presents a series of moments observed by the researcher, which convey the challenging and emotive environment

at Westmarch Hospital. The following vignettes are provided from my research fieldnotes, which highlight a series of moments which arose from phase one of the research—the staff induction.

4.3.3.1 Vignette A: Phase one, day one

The Emotive Environment
On my first day at Westmarch Hospital, I sat on Mirkwood ward with a resident and I attempted to distract her from 'intrusive thoughts' with a puzzle, as directed by a staff nurse. We were sat in the dining area of the ward; the chairs were hard and bolted to the floor in groups of four with a small circular table situated in the middle of the chairs. She sat with her head down, crying and periodically asking for her 'PRN'. I didn't know what this was. I would explain: "I'm sorry I don't know what that is, can you tell me what it is?". She didn't respond. She sat and glared at the puzzle, her whole body slumped in one of the chairs. At times she became agitated and moaned with frustration remarking: "I want my PRN!". I noticed that she was nearly three times the size of me, which I found unnerving. I felt that she was frustrated. I didn't understand her. It was the afternoon, the ward had become dull from the lack of natural light, there were no curtains but the cloud cover outside made it a gloomy afternoon. I could see another female resident in distress, she looked young, perhaps barely 20 years of age. She had tears flowing down her face. Each tear came in quick succession which she left to roll down her cheeks, eventually dropping onto her zipped hooded top. She shuffled around the common area. I looked to see if anyone else had noticed her discomfort, but the other staff member and residents seemed to be in their own worlds. At one point, the female shuffled near to where the other resident and I were sat. I tried to catch her attention with my eyes. But she just moved along, shuffling down to one of the bedroom corridors. The

resident next to me had begun to pull at one of her scabs on her arms, making it bleed.

Phase one, day one: Reflection

On the evening of my first day, I reflected on my experience at Westmarch Hospital:

My first day in the service was challenging. Witnessing the level of emotional pain was difficult. I'm also reminded that I knew that I would find the environment personally challenging. However, I didn't envisage that the staff induction would entail being sat on the ward for long periods of time with little to do, but I also reflected that this might be a good opportunity to be an observer for a period of time on one of the wards. I will try to find a role or some jobs that I can do to assist the staff in some way. I would like the opportunity to spend some time with staff so I can get to know them, the routines, and talk about my research. I wasn't quite sure how I would build rapport with residents who were in visible emotional pain. Perhaps this will develop with time. It was clear that I was an outsider on day one, which felt challenging. I was exhausted by today, but I'm keen to know more.

4.3.3.2 Vignette B: Phase one, day three

"They just don't understand"

I had almost completed my third day on Mirkwood ward when I overheard one of the residents comforting another resident. She was explaining that the staff are different. The view was that the staff didn't understand their emotional pain, they tried but "they just don't understand". I felt like this indicated a divide between the residents and the staff. Just a few moments later, an incident erupted on the ward, the alarms rang. Residents and staff watched as a resident was being restrained, she was on the floor, her legs partially on the ward with the rest of her body in one of the interview rooms. She was initially screaming but then appeared to become exhausted. This moment felt stark, a divide of two worlds colliding,

the staff and the residents, all of whom, at times, seemed to experience anguish. I left the ward moments later as it was the end of the day for me, the resident was still on the floor, the ward was silent.

Phase one, day three: Reflection

I felt saddened by the comment that one of the residents made, she clearly felt that there was a divide between staff and residents and that they couldn't understand the experiences of the residents. I had wondered if this was a common perception of staff from the point of view of the resident. The physical restraint seemed to symbolise the divide between the staff and the residents as the resident initially was resisting staff. The silence of the ward seemed to provide the restraint centre stage, with the screams drawing attention to the struggle.

4.3.3.3 Vignette C: Phase one, day four

"You're just trying to control me"

By day four, I was taking on more of a staff helper role and as part of this I was handing out food to the residents when requested. I began to wonder why the food was kept away from the residents and what the rules were relating to the handing out of food. I went to the staff base and asked the three female staff who were sat down. I asked if there are times at which it was not appropriate to hand out food from the kitchen. The staff informed me that I should persuade the residents not to snack before lunch or dinner time.

Earlier that day, an occupational therapist had been baking cakes with two of the residents and in the afternoon, whilst I was in the kitchen, I was asked through the kitchen hatch by one of the residents who had been baking if she could have some of her cakes. She pointed to where they were in the kitchen. I indicated that it was close to lunchtime (lunch was just under half an hour away). She insisted that she still wanted a cake. I informed her that I would need to check with a member of staff. This comment appeared to

anger the resident. I closed the kitchen hatch, which opened into the ward, and walked through to the staff base. I asked a member of staff if I could allow the resident to have a cake that she had baked. I was informed that I would need to ask the occupational therapists as it was their decision—I was also informed that this member of staff wasn't around. I went back to the kitchen and opened the hatch. I explained to the resident that I had been informed that it was up to the occupational therapist and, unfortunately, she wasn't around. This angered the resident. She looked at my badge and asked: "What are you training to be, a nurse?". I explained that I was a researcher. She talked over me and asked: "You like control, do you?" and stated: "You're just trying to control me".

We discussed this back and forth for a few minutes until a staff member, who was sat in the dining area and was undertaking the ward observations, remarked: "Leave her alone, she has done exactly what any one of us would have done. She did the right thing". The resident continued, who was visibly getting very animated and frustrated. The staff member interrupted once more, and the resident gave up and walked away. I looked around and I could see that no-one was waiting to be served. I shut the hatch and returned to the staff base to inform the staff what had happened in case this behaviour was important to note. One staff member reassured me by stating: "If they're unhappy with what you're doing, you're probably doing it right!".

Phase one, day seven: Reflection

I found this position uncomfortable, I was perceived to be holding the control but in this situation I felt powerless. I didn't feel like me or the resident had any power in this situation. I tried to explain this point of view—that it really wasn't my decision. I'm not sure how comforting it was to know, but I was motivated to explain the situation. The last thing I wanted the resident to think was that this

was about me exerting power. Although in some sense I was, as I withheld what she had requested.

This situation and the way that it evolved seemed to make complete sense to me. I felt upset at the idea that the resident thought I was trying to control her. I didn't much like the idea of any resident thinking this of a member of staff, but I also felt that I wasn't surprised that the resident held this view either, because I could imagine that it may feel like the staff are making the decisions to restrict what the residents want, which may seem unfair at times.

I felt uncomfortable that the debate got heated and continued for some time. I felt calm throughout, but the resident was visibly angered. I'm not sure how helpful such a conversation was. I felt like it was important to explain my position, but the conversation seemed to escalate regardless of any explanation.

I had feared that a moment like this might erupt, particularly as I was adopting a staff helper role, and was a person that carried keys and wore a name badge—I felt like these items symbolised a status of power within this environment as the identification badge gained me access in and out of the hospital. Furthermore, those who carried keys were able to gain access to non-resident areas in the hospital, for example, the staff base, which marked a divide between me and the residents.

I did feel comforted by what the staff member had said afterwards in the staff base, that I was doing the right thing. I had expected that I would be confronted by residents if I was restricting something that was requested. I accepted that I would likely be viewed as a staff member even if I was introduced as a researcher.

I wondered if different staff members followed different rules, blurring the lines for residents on the nature of rules. This later

became apparent when I saw a member of staff being asked to heat up a microwavable teddy. The resident had asked for "2 minutes in the microwave please", the staff member proceeded to read the label and check the microwave for its specifications. She chose 01:30 on the microwave and handed this back, explaining that this cannot be placed in the hospital microwave for 2 minutes. The resident complained and protested that this wasn't fair as other staff would do it for 2 minutes. The staff member told me that the other staff were not acting appropriately and that these things should be checked. The next day I observed different staff members heating the item up for 2 minutes.

On another occasion I had been asked to open the bedroom door of a resident who had room access. I was informed by a staff member who was on observations that I could do this. The resident informed me that she didn't know why her room was being locked as she was allowed in there. I stood whilst she grabbed an item from her room, and she instructed me to leave the door open and walked away. I proceeded to lock the door as earlier that day I had learnt that another resident had personally-restricted items in her room, in this case it was a razor, and the staff suspected that this had been taken from a resident's unlocked bedroom. I learnt that whilst some residents had room access, the rooms needed to be locked at all times so that restricted items weren't available to those that weren't allowed them, in order to minimise the self-harm risk prevalent on the ward.

4.3.4 Summary of phase one

During phase one, I was able to establish the staff helper role. Duties included collecting visitors or deliveries from reception, photocopying, answering the telephone, labelling purchased food items, assisting with the shop run, serving food, cleaning the kitchen, removing ligature risks from clothing, making drinks for the residents, clearing cupboards, spending time with the residents focusing on tasks, giving residents food items through the kitchen hatch, and documenting

liquid intake. The staff helper role developed over time and the boundaries of this role were regularly negotiated and essentially extended. The development of this role was discussed further in section 3.4.1.

Whilst I had begun to develop the staff helper role, the environment that I experienced at Westmarch Hospital was personally challenging. During the staff induction I felt locked in a world that I could only bear witness to and quickly felt uncomfortable with my role as a 'helpless witness'. I decided to take a break from the environment and began to develop a plan which focused on answering the research questions whilst also being mindful of my own emotional needs. I realised that spending extensive time in the field with little structure led me to sit on Mirkwood ward mostly in isolation and bearing witness felt like it had become my central role. I reflected that this role, whilst somewhat helpful for the research, needed to develop so that I could engage more purposefully in extended interactions. Understanding the personal challenges of my role, within the environment, unfolded during my time out of the field-site and during clinical supervision (see section 3.2.1 for a discussion of the role of clinical supervision). This thinking developed when I realised that the staff induction was not the experience that I had in mind and I began to question why that was and what I could do differently. I developed a plan which focused on shadowing different staff groups, I needed a way to spend time with staff because being physically there was not allowing me to participate in the culture and build rapport—the necessary components of a more developed ethnographic work (Hammersley and Atkinson, 1995). However, it is important to note that the role of helpless witness assisted with my understanding of the ward environment, one that was emotionally challenging. I obtained the contact details for the occupational team and began building a plan by studying the timetables of the three wards.

4.4 Phase two of the research

I planned to return to Westmarch Hospital following several sessions of clinical supervision which had been offered through the University of Nottingham to help with the emotional adjustment to the setting. This felt appropriate given that clinical staff at Westmarch Hospital had regular clinical supervisions so that they were supported in their role whilst working on the wards.

My return to the field-site was delayed by four weeks, due to a resident disrupting the timetabled activities through their challenging behaviour. It was suggested that this would not be a fruitful time for the research as the staff resources were focused on the process of transferring the individual to a different service and maintaining the safety of the ward. It was suggested that I return once the individual had been transferred to another service. Once I returned, I arranged meetings with the responsible clinician for each of the wards so that they could conduct individual assessments in relation to capacity to consent for the research. My first meeting was on the female ward. The responsible clinician, Mandy, informed me that all the women had capacity, but I would more likely experience issues with participation and that I "might need to catch them at the right time though!". We had arranged to meet on the ward between 13:00-13:30. An excerpt from my research fieldnotes is presented below to highlight my experience as a researcher and the initial impressions relating to creative practice, and the environment at Westmarch Hospital.

4.4.1 Fieldnotes: Phase two, day one

I arrive on a sunny day at 12:30pm. I struggle to find a car parking space and park on the road outside. Before my arrival, I had spent time printing off some patient information leaflets and consent forms. I sit for a few moments in the car gathering my thoughts as the air conditioning winds down before heading into the hospital grounds. The sun glints on the mirrored windows as I approach the entrance. Once inside, I ask the receptionist if I can use the visitor lockers and explain that I will be working between the three wards

that day. There is some confusion over this, marked by the question: "You want a visitor locker key?". This was followed by hesitation. Presumably this confusion was caused because staff with identification badges use the lockers situated beyond the main secure door to the hospital. However, I had learnt that when I visited Buckleberry ward, I would also be expected to swap the sets of keys which also had a locker key attached. I observed that the visitor lockers were not used by staff. I am handed a key to a locker. I ask what I should do with the key. "Oh, you keep it on your person", the receptionist informed me. I place the key in my pouch, wondering about the security of this as I know that keys are contraband items on the ward, if they are not fixed to the leather belt which is fixed to all sets of ward keys. The visitor locker key, however, is loose. I shove it underneath my notepad in my pouch that holds the keys, hoping this would add some extra security. Whilst I place my bag in the locker, two staff members (one I had met previously, one that I hadn't) are standing at the reception window. I wait behind them whilst they talk about how the smoking ban is a good thing. One of the male staff members looks at me and smiles. I can tell by his vacant look that he doesn't recognise me. The staff leave reception through the double sliding doors and head outside.

The usual piece of paper about the contraband list is shoved under the glass partition and I begin to sign the declaration but struggle to recall the date. I look to check with the receptionists, but both are busy. One of them has called a visitor over who is waiting with a pushchair. She is told that staff are held up and the person she is visiting is delayed. The visitor explains that she is supposed to be somewhere else soon. I mouth purposefully to the receptionist, saying quietly and apologetically: "Have you got the date?". The receptionist pauses and turns to me and says, "It's the 4th, but I've been writing the 3rd all morning!".

The receptionist takes the piece of paper and I shuffle a little to the left, moving closer to the first secure door to be ready for when the receptionist activates the release mechanism. I hear the click as the door unlocks and proceed through into the airlock. I turn to the small partition window between reception and the airlock and state the name of the ward for the keys: "Mirkwood ward please". The receptionist nods and I can hear the beeps of the safety alarm being tested. I begin to fill in the register when the receptionist asks if I have an alarm. I remark: "Yes an alarm but not a tally". I wasn't entirely sure what a tally was, but I knew that I didn't have one. I had learnt the script for the airlock interactions during my previous visits. The receptionist then asks if I had received key training and I confirm that I had. The receptionist passes a set of keys through the gap under the partition window. I study the key number and make a note on the register. I hook up the keys and the alarm to my belt.

I head through the second airlock, I'm alone. I walk down the long corridor, past the kitchen and meeting rooms. I can see the courtyard for Mirkwood ward to my right. The sun is still shining, and I wonder if they still use the outdoor space now that the smoking ban is in place. I pull the heavy fire door towards me and take a sharp left to the stairwell and head up the stairs. I hover by the airlock to Mirkwood ward, catching my breath and placing my documents on the radiator. They just about balance as I hover my left hand beneath the sanitiser. It is battery powered, squirting a small amount of sanitiser onto my hand with a distinct mechanical whirring sound. I rub my hands together and wave them a little to dry the solution. I take the set of keys out of my pouch and turn to pick up my papers. I peer through the pane of glass on the first airlock door, to check it is empty before holding the fob near the sensor to release the door lock. I enter the airlock and glance to my right to peer through the pane of glass of the ward kitchen door. The kitchen looks different. There are a series of tall stacked plastic

drawers that weren't there before. I peer through the second airlock door and notice that the ward looks busy, I head through. I stand by the airlock door as it shuts and push to check the door is locked, as instructed during induction, although I had noticed from my time on the unit that most of the staff did not do this check. I place the set of keys back in my pouch and see my notepad is safely in place, along with the locker key—I can see a glimpse of the turquoise key fob attached to my locker key. It was safe.

I scan the room of faces and say: 'Hi', to those that catch my eye. I recognise only some people. I see a familiar face of a resident smiling at me with wide eyes. She excitedly comes over to where I stood: "Hiya! Where have you been?". I say that I had spent some time away from University, but I was back now. I ask: "How are you?". She says: "Really well thanks, I'm moving to supported housing". I say: "That is amazing, congratulations, supported housing too, that's a big step, that's great! When did you hear? When are you going?". She replies: "I'm going in about two months, I was told last month". She then proceeds to walk away. She was so elated I thought perhaps that she'd heard the news just that morning.

I head off between some tubbed chairs and through the main carpeted area to the staff base door, and after a brief conversation with the ward manager I return to the main ward area to talk to the residents about the research and hand out information sheets. I introduce myself to the resident nearest to me sat on the radiator. She says: "It's dead cool that you are doing a PhD". I say: "Thanks". I leave an information sheet with her. I note Little Mix is playing on the TV, the music channel was often the chosen channel. I proceed to hand out more information sheets to the residents.

The ward is busy, there is lots of activity. There is a staff member and a resident sat talking on one of the sets of the bolted tables

and chairs in the dining area. Another staff member and a resident are playing pool. A staff member indicates that she hadn't seen the pool table being used until the last two weeks. We hadn't previously met. We talk about the smoking ban as it was day one of the non-smoking NHS site ban at Westmarch Hospital. I ask about the residents' smoking behaviour the night before and she tells me that one had 7 cigarettes in one sitting and another had 13! We laugh, I say: "It must have made them feel very sick". "One of them had been struggling", she chuckles.

Phase two, day one: Reflection

My return to the Westmarch Hospital felt positive, I was really pleased that one of the residents I had met previously was moving on to supported housing, and that she had excitedly shared this news with me. It was uplifting to hear of progress within this environment. It made me feel that there was much more to an individual's recovery journey than I had witnessed so far at Westmarch Hospital. I knew that my experience was limited to the two weeks of sitting on the ward for the staff induction, but this was a great reminder of successful recovery journeys. I felt positive.

4.4.1 Phase two vignettes

The following vignettes are salient and significant moments observed by the researcher, during phase two of the research. Phase two of the research was defined by the development of my role as a participant observer, in addition to the initial lone observer and staff helper roles. This role developed when I began to shadow the occupational therapy team and was introduced to the other wards: Buckleberry and Crickhollow. I began to observe the role of the occupational therapist, which broadened my understanding of creative activity at Westmarch Hospital. However, the challenging environment continued, and I found myself observing aggression and restraint.

4.4.1.1 Vignette D: Phase two, day three

Monitoring and Assessment
I'm shadowing Siobhan today, it's Wednesday. Siobhan was running a series of cooking sessions for residents on Crickhollow. We entered the ward and Siobhan indicated that we were going to see a resident down one of the bedroom corridors. His bedroom door was closed. Siobhan knocked and she began interacting with the resident through the closed door. It was difficult to understand what was being said on the other side. "Hi, it's Siobhan, are we going to go cook?". There was no obvious answer and she asked again: "Are we going to cook?". Then I heard a muffled voice reply and Siobhan shouted: "Okay". We began to walk away, Siobhan was disgruntled, she explained that she suspected that he would probably not participate. I asked what he had said, and she remarked, something like: "No, thanks". Siobhan was disappointed. We headed to the staff base, and she sat on a chair in front of one of the computers. She showed me a spreadsheet that was used to log the occupational therapy activity of each resident. There were a series of codes used; today she marked the resident as 'offered but refused'. Later that morning, the resident Siobhan had asked to join in with cooking passed by and asked her what she had said through the door that morning. He explained that he had misunderstood her and did not realise she was asking about the cooking session. He thought she was asking if he wanted a cup. Siobhan and the resident chuckled at the misunderstanding, but I sensed that the resident wanted to share with Siobhan that he had misunderstood, with the knowledge that his refusal would be noted. In the afternoon, I attended Mirkwood ward. I was sitting in the staff base when a staff member burst in and asked where the incident book was. The room became silent, whilst the staff eagerly awaited to hear what had happened. The female staff member

proceeded to explain a series of inappropriate comments, such as pet names or "love", made by a resident and an impromptu meeting began regarding the resident. The resident's review was to be held soon and the staff were reminded that all comments need to be recorded so that a representative picture was presented at the review.

Phase two, day three: Reflection

Siobhan was particularly welcoming of my presence and was keen to share her role with me. I felt positive about the ways in which the research was developing, as Siobhan shared valuable insights into the monitoring and assessment of residents' activity engagement with the occupational therapy team. I was learning about the monitoring and assessment of the residents' behaviour through occupational therapy activities. The occupational therapy coding system was clearly important, and I wondered who had access to the information kept there.

I learnt that staff were encouraged to make notes of conversations with residents and I got the impression that staff were keen to log any comments that were potentially offence related. I felt I had a lot to learn, and since I was at Westmarch for a long time period, I decided to read the patients' medical files to broaden my understanding.

4.4.1.2 Vignette E: Phase two, day forty-two

Racism and the Threat of Violence

This afternoon I attended the local pool hall with residents from Buckleberry ward as part of sports group. I had followed the residents and occupational therapy staff back to the ward. We entered the ward airlock and huddled together so that Kerry, one of the occupational therapists, could close the external door behind her. Kerry took a moment to thank everyone for their positive attitude and explained what a lovely outing it had been. One of the residents opened the door to the ward. The majority of residents

dispersed to their rooms, while others hovered by the staff base door to fill out their 'Section 17' form so that they could go for their usual last cigarette of the day (see section 4.6.3 'Section 17 Leave' for a description of this legislative section). Ian joked with me that he was: "going to check the fencing outside, to see how it's getting on", we both exchanged knowing looks and laughed—he was going to sit on the fence to smoke. I followed Kerry into the staff base, we chatted about how well the group went, she told me that I fitted in well. I felt pleased.

I headed back out onto the open ward area, just as a commotion developed between a resident and two staff members. I heard: "Fuck off you paki bastard!". I was alone at the other end of the ward. I looked over and the resident was sat down and glaring at the staff. I decided to head back to the safety of the staff base, where I found myself alone for a moment. Three members of staff then burst into the staff base; the more senior member of staff remarked in a stressed tone: "Oh my God!". She looked at me and apologised and then immediately looked back at the staff, swearing: "Oh my God, what the fuck!". She explained that the resident had a cup of boiling water, while another staff member added that he also put sugar in it. I was not sure of the meaning of this. They rushed back out onto the ward leaving me alone again in the staff base. Another member of staff appeared, visibly angry, glaring at me. I could see that he was thinking through his next move. Another staff member followed him in and advised him to leave it to the other staff, it wasn't necessary for him to get involved. He refused and went back out to the ward and over to the scene of the commotion.

Kerry appeared in the staff base and stated: "Shall we get you off the ward?". I hesitated and she asked again, and this time I answered: "Yes, okay, thank you". She led me out onto the ward, cautiously positioning herself in a protective manner to guard me

from the commotion taking place. She pressed the green door release and sent me through saying: “Thanks, Emma”.

I left the ward in a daze, handed the keys back into reception, sat in my car and sobbed. I suddenly felt overcome by the rush of adrenaline. In all the commotion I hadn't realised how scared I was. Witnessing the staff's fear meant that I was also fearful of my own safety, the resident, and also the staff’s.

Phase two, day forty-two: Reflection

Whilst I had been informed of the likelihood of aggressive and violent acts at the hospital, this felt as though this was the closest moment to witnessing violence. I had left at the end of my day and was due to visit Crickhollow ward the following day. I hadn’t witnessed the staff swearing in this manner and clearly the behaviour of the resident was visibly and seriously affecting the emotions of the staff.

I left the hospital after this incident very concerned and somewhat scared. I also felt lucky to be away from the ward and continue my day outside of the hospital. I wondered how things resolved on the ward. As travelled home, I became very aware that my role as researcher meant that I was dipping in and out of this locked world, whilst the staff and residents endured incidents like this, quite possibly on a daily basis. However, the staff and residents were bound to different roles and responsibilities. Whilst conducting the research, it was rare that I left before my planned shift was complete as I needed to take opportunities to explore creative practices, however the knowledge that I was able to leave, and request clinical supervision support, allowed me to feel more comfortable within this environment. I realised that this contrasted how I felt during the staff induction as I observed life on Mirkwood ward and, at times, felt trapped. I felt less autonomous during the staff induction than I did now. I wondered if staff ever felt like this, as they were assigned their working hours on the monthly rota. If

an incident erupted, it was part of their role to deescalate the situation and, for those trained, sometimes restrain residents.

4.4.1.3 Vignette F: Phase two, day fifty-five

Boundary Work

Harriet, one of the occupational therapists, had indicated to me that she had a dislike for the way in which boundaries were managed by a fellow staff member. She reported that she felt this was inappropriate and risky in relation to the maintenance of trust, which she viewed as highly important within the hospital environment.

Later in the afternoon we were attending a community visit, I was sat in the front of the taxi, with Harriet and two residents Ryan and Sam in the back. Ryan said: "I can't remember if we've talked about your boyfriend, Emma". I replied: "Oh, that's not something we have discussed". The conversation moved on.

After the visit, we arrived back at Westmarch Hospital. As I walked with Harriet to the occupational therapy office, she remarked: "You did really well in the taxi, that was good". I was surprised and not entirely sure what she was referring to, so I enquired. Harriet indicated that the question asked by Ryan was potentially contentious and boundary-probing but that I managed it in an appropriate way.

Phase two, day fifty-five: Reflection

As I spent more time shadowing staff, I learnt how much of their interactions with residents were purposeful and skilled. The staff constantly worked at maintaining appropriate boundaries whilst interacting with residents.

I also quickly felt less like an outsider and enjoyed spending time with the occupational therapy team and the residents. The research also exposed me to new experiences. For example, I visited a golf

driving range for the first time, which was fun! The residents prompted the staff to give it a go, and I was invited to join in by one of the residents. Shadowing the occupational therapy staff was assisting my researcher role of building rapport and being able to be a participant-as-observer across the community at Westmarch Hospital.

4.4.1.4 Vignette G: Phase two, day seventy

"Someone died last night"

I was placing my bag in one of the lockers in reception when Charlie, the music teacher, came through the double sliding doors. He was handing in the keys from Buckleberry ward. He asked if I was okay and then looked sternly and said: "I've been asked not to go to Mirkwood ward". He looked around checking we were the only people in the reception area. He said: "Someone died last night". He handed the keys in and signed the register. He then shuffled towards me and said: "Yeah, one of the women died last night, I thought you should know". I was shocked and felt a wave of sadness, standing quite still. The next thing I noticed was that Charlie had left.

When I entered Crickhollow ward and entered the staff base, I asked one of the nursing staff if there was anything I should know before I spent time on the ward. He repeated the news and informed me of her name. I was surprised by his delivery of the news as he said it very matter-of-factly. I indicated that I was aware.

I sat amongst the community at Crickhollow who did not know of the news. Crickhollow was situated below Mirkwood ward. As I sat below Mirkwood ward, I remained preoccupied and distracted by the news. I had decided to visit the Mirkwood ward occupational therapy lead and let her know that I was very sorry about the news. I asked her how she would like to proceed as I had planned to spend

time on Mirkwood ward that week. She requested that I give the women a few days to adjust and informed me that the therapy timetable was temporarily postposed because of the incident.

Phase two, day seventy: Reflection

As I left that day, I sat in my car and looked up at the windows of Mirkwood ward, still saddened by the news. As I looked at the building, I was reminded that Westmarch Hospital was a hospital for acutely ill residents and the community was subject to both tragedy in death as well as recovery. At this time, the building seemed darker in colour and grew somehow haunting. I wondered how the community on Mirkwood ward were managing, feeling sorry for the staff, and the family of the deceased resident that I had heard about during a ward round. I wondered about the impact that this would have on the wellbeing of everyone who knew her and what a sombre place the ward must be just now.

I realised that I hadn't thought that this might occur, perhaps naively, and over the weekend, I began to research the statistics of death rates in inpatient mental healthcare. I learnt that it wasn't quite as rare as I had thought. It was likely that many of the staff had experienced a similar tragedy during their working life.

As the days went by, I remembered the brief moments that I had shared together with the resident. In particular, I remembered very clearly her session in the ward round. It was a difficult meeting with lots of tears. I recalled the way that the clinician had spoken to her. She was incredibly fair, kind, and understanding, showing a great deal of compassion. I could see that the resident and the staff were divided in their views of her care. This was visibly distressing for the resident. Again, this divide between staff and residents was apparent. I was moved by these memories which led to my thoughts of her family and the loss that they were experiencing. I felt saddened.

4.5 Phase one and two of the Research: Emerging theoretical insights

Chapter three explored my role development from complete observer to participant-as-observer, which evolved during phase one and two of the research. These roles illuminated different aspects of the culture under study, as highlighted by the vignettes and my field-notes in sections 4.3 and 4.4.

The development of my role as participant-as-observer throughout phase one and two of the research, allowed me to gain insights into the community at Westmarch Hospital. In vignette C "You're just trying to control me", I was perceived to be representative of a student nurse within this environment. The confusion around my role as a researcher was prevalent throughout the research and formed part of the discussion outlined in section 3.4.1. Phase two of the research developed by adopting a shadowing role with the occupational therapy team, providing valuable insights into staff-resident interactions and the role of staff as monitors of engagement.

Surveillance, security, and risk were the pertinent aspects observed during phase one and two of the research and are highlighted by the fieldnotes from these phases. For example, vignette D Monitoring and Assessment highlights the monitoring of occupational therapy activities, indicating how resident engagement is documented for activities of leisure, skill development, social events, and creative practices. Surveillance, security, and risk is proposed to be a key contextual feature of life at Westmarch Hospital, which is further explored in section 4.8.1.

The critical incidents highlight the challenging environment that the staff work within and that the residents experience during their time at Westmarch Hospital. Phase one of the research, during the staff induction period, highlighted the challenging and emotive environment at Westmarch Hospital, as I observed the emotional pain

of the residents, highlighted by the vignettes and in particular vignette A The Emotive Environment. The emotive environment is proposed to be another key contextual feature of life at Westmarch Hospital, which is further explored in section 4.8.2. It was also found that the environment, at times, sharply contrasted notions of mutuality with the undertone of the division between staff and residents. For example, the patient-staff divide is most prominently highlighted in vignettes B "They just don't understand", C "You're just trying to control me", and E Racism and the Threat of Violence, however this theme underpins most of the critical incidents. It was a divide which was defined by their roles within moments of tension. This research was conducted in an emotionally challenging environment, which is important to consider when exploring the potential of mutual recovery through creative practices. Furthermore, the participant-as-observer role highlighted the importance of boundary work between the staff and the residents as captured in vignette F Boundary Work. Vignette E Racism and the Threat of Violence highlights the prevalence of the threat of violence and aggression that the staff and residents experience. Thus, boundaried relationships, which includes professional boundaries and the division between the staff and resident group, is proposed to be a key contextual feature of life at Westmarch Hospital, which is further explored in section 4.8.3.

The emerging contextual features of the environment are further discussed in section 4.8 of this chapter. The next section explores the scheduled life at Westmarch Hospital. These practices were observed and also documented in information provided to the researcher, such as the occupational therapy timetables.

4.6 Scheduled life at Westmarch Hospital

Much of life for those working and residing on the wards at Westmarch Hospital could be described as scheduled. Scheduled life is a typical feature of institutions, where groups of individuals can be managed by a scheduled system that is convenient and orderly. Indeed,

convenience is palpable. This section presents the schedules of life on the wards, which include meetings, meal times, smoking breaks, leave, and finally, the activities available to the residents, creative or otherwise.

4.6.1 Meetings

There were two community meetings that occurred on each of the wards on a regular basis. The morning meetings would take place at 9:00am Monday-Friday on each of the wards and the community meeting was scheduled bi-weekly but was not always held. In order to promote the balance of power relations and to build self-confidence, the morning meeting was chaired by a resident.

The ward round was held weekly for each resident, but the resident was only required to attend in person on alternate weeks. A representative from each department would be in attendance at the ward round and usually present were as follows: a doctor, mental health nurse, occupational therapist, psychologist, social worker, and a member of the administration team to take the minutes. On the weeks that the resident did not attend, the resident would sometimes provide a written letter to the consultant psychiatrist who chaired the meeting; this would be read aloud to those in attendance. The letter might include requests, which would be discussed, and a decision made. The ward round agenda would cover the care received over the previous week, an update on progress, and any decisions regarding changes to the resident's care plan formulated at the meeting. The Care Programme Approach meeting would be held on a 6-monthly basis and aimed to summarise the care received and key decisions regarding any future placements. The resident would be in attendance at this important meeting alongside representatives from each department, much like the ward round format.

4.6.2 Meal times

Meal times were scheduled on all three wards at 8:30 for breakfast, 12:00 for lunch, and 17:00 for dinner. The food trolley was delivered

by the kitchen porter and left in the ward kitchen. Two staff undertook the job of serving the food through the kitchen hatch. On Mirkwood ward, the cutlery was signed out by a member of staff and the ward would remain on 'lock down' (i.e., the residents' rooms could not be accessed, and residents could not leave the ward) until the sharps had been counted. Ward staff also ate the food prepared on site but waited until the residents had an opportunity to get their food first. The non-ward departments would collect their food at 12:00 from the hospital kitchen, which was served through a hatch to the staff lounge.

I learnt that the residents would often find the menu choices to be overly elaborate. For example, Imran, a resident, was a representative for Crickhollow ward and attended food group meetings to provide feedback to the kitchen staff and stated:

> "sometimes they [the kitchen staff] try a little bit too hard with the food over here, they complicate it, they really do, when they could just make simple food and it might keep everybody happy, they over-complicate the menu so they try too hard"
> *[Resident interview: Imran, Crickhollow ward]*

I learnt that the resident feedback upset the kitchen staff and they informed me that the residents just wanted "comfort food" but they tried to serve them great dishes that were underappreciated. The food group would review the menu choices periodically. Whilst, a representative from each ward would attend the meetings, it was the view of kitchen staff that the residents tended to make requests based on individual preferences rather than those of the ward community as a whole. The food group was set up to provide a more controlled feedback forum after the perceived failed attempts by kitchen staff to attend the ward meetings because the kitchen staff felt unfairly heckled by residents. The menus ran on a seasonal schedule and changed every three months.

4.6.3 Section 17 leave

Residents detained under the Mental Health Act (1983/2007) must be granted leave from the Ministry of Justice, and requests for leave can be recommended by the patient's Responsible Clinician. Those residing at Westmarch Hospital would have different restrictions to their leave, depending on their perceived level of risk. The most pertinent to the therapy timetable was that of escorted or unescorted leave. The occupational therapy staff would negotiate the number of staff required to attend a session in the community, based on the leave privileges of those residents who wished to attend a session. Some residents did not have any leave privileges and thus, could only attend the on-site and on-ward activities. Those who did not have leave privileges were often new residents to Westmarch Hospital and were under assessment for such privileges, typically during the first three months of their stay.

4.6.4 Smoking breaks

When I first arrived at Westmarch in Spring 2016, each ward had scheduled smoking breaks where staff escorted residents to the ward courtyard. Cigarettes, vapes, and lighters were stored in the staff base. On the day I returned for phase two of the research, the NHS smoking ban was in its first day of implementation. Procedures for smoking on section 17 leave were under constant review by the smoking cessation group. Initially, residents were allowed to smoke on escorted and unescorted leave, however smoking on escorted leave was considered contentious due to the health implications for staff who accompanied the residents on their leave. However, as noted by Imran (a resident), such restrictions would be difficult to enforce and noted: "What if somebody [a resident] on their escorted leave, goes to the shop, buys a packet of 20 cigarettes and wants to smoke and they're not breaking the law so you can't really stop them". He further noted that he had "seen a staff take patients out over the weekend, locally, and they'll be smoking together", this was against hospital policy. By the time I left Westmarch Hospital, smoking on escorted leave was under review.

4.6.5 Staff breaks

The shifts of ward staff were 12.5 hours with a 1.5-hour lunch break. Many of the staff went home during their lunch break, whilst some visited the on-site gym. Some staff would opt to finish their shift early without a lunch break; this was usually to accommodate the challenge in scheduling staff breaks mid-shift when escorted leave was in high demand from residents.

4.6.6 Activities

The occupational therapy team provided each ward with a therapy timetable based on the perceived needs of those on each ward. The timetable also included a selection of some of the institutional sessions, such as the morning meeting, the community meeting, and ward rounds. These timetables showcase the curriculum outlined by the occupational team, however there are other timetabled events which constitute institutional life, for example, breakfast, morning meeting, medication, an evening meal, psychology mindfulness sessions, educational support, and mental health advocate support. Appendix A highlights available activities at Westmarch Hospital (the original timetables have not been included to maintain anonymity). Residents were invited to make suggestions for activities during the ward community meeting, which was held every two weeks. Each day, during the morning meeting, a member of the occupational therapy team would attend and introduce the activities available. The therapy programmes were displayed on the community board of each ward and the activities for the day were printed and displayed in a frame which lent against the staff base window, facing the ward — on some occasions this was missing or had incorrect information displayed.

The therapy programmes were themed into three categories by the occupational therapy team: a. self-care; b. leisure; and c. vocational sessions. However, the assigned categories were found to be fluid between the wards, for example some sessions were considered to belong to different categories, depending on the ward. For the purposes of this research the timetabled sessions have been re-

defined into the following categories, which include sessions run by other departments, such as, psychology, and institutional regimes, such as meal times:

- Formal creative practices: The timetabled sessions which encompass creative activities which are utilised within art in therapy and art as therapy and covers the diverse fields of arts and humanities, as discussed in section 2.4.2
- Leisure activities: Activities that that are run by the occupational therapy team as part of their leisure skills sessions, such as, local visits to the community on on-ward leisure activities, such as, playing board games. IT sessions are also included in this category as the residents were observed to spend their time watching YouTube videos by their favourite artists
- Psychology: The timetabled psychology sessions, such as the departments' on-ward drop-in sessions, Dialectical Behavioural Therapy, and mindfulness sessions
- Institutional practices: This category includes meetings, such as morning meetings, ward-round, and community meetings
- Informal creative practices: These are sessions that are not timetabled and encompass creative activities from the diverse fields of arts and humanities. This thesis considers the "local social contexts of arts production" (DeNora, 2000, p. 4) and thus explores everyday creativity as "an embodied, material and social practice that produces both highly specialist cultural goods and is a part of everyday life" (Hawkins, 2016, n.p.). Thus, the geography of arts engagement within this thesis is considered and a broad holistic perspective of everyday creativity, which considers individuals within their social context and the meaning of creative pursuits is explored. Examples include, listening to music, as such an activity has been found to promote wellbeing (DeNora, 2016), as discussed in section 2.4.1.1.2.

4.6.6.1 Creative practice

Appendix A shows a selection of sessions that are considered to be creative practices and thus are potentially salient to the research. These are art, cooking, and music, which are further described in section 5.3. The consideration that such sessions have the potential to facilitate therapeutic social capital is explored in chapter five through observations from the fieldnotes and interview data. The creative practice sessions are introduced in the following section, which are: art, cooking, and the music sessions.

4.7 A day in the life of Joe

This section provides a constructed narrative example of a day for a resident called Joe at Westmarch Hospital. The writing collates information gathered during the data collection period via interviews, informal conversations, observations, and information provided in documents. The purpose of this writing is to give a sense of what a day is like from the perspective of a resident. Details also allude to the themes of the research project, such as, security features, routine, physical and social ambience. This writing further illuminates the context in which the research took place.

> Joe wakes up to the sounds of staff walking along the corridor, murmuring something about waking Simon up. Joe checks his phone for the time: it is 8:46am. His pillow is soaked once again from the continuous night-time dribbling, which is just one of many unpleasant side effects of his clozapine medication - the clonidine patch used to assist with this still isn't working. Joe can feel the left side of his face is sticky from the dribble. He sits up on his bed and wipes his face with a towel. Joe hears the rain outside and thinks: "at least our visit to play pool won't be cancelled today because of it". Joe heads out to the ward, the lights seem brighter today, the brightness contrasts

with the dark outside, even though all the curtains are open. The ward is quiet.

A new staff member, perhaps a student he thinks, is serving breakfast through the hatch. Joe requests some cereal and asks for the milk to pour for himself. At first, Rick, the staff member, is hesitant but then hands the milk over, whilst holding the lid. John is sat on a table, eating his cereal on his own. He doesn't want to be disturbed right now. Another resident is also sitting on a table on his own, eating cereal. Joe passes the bowl and spoon back through the kitchen hatch and heads to the campus room where five other residents are already waiting. Joe sits on one of the empty sofas and closes his eyes. He's tired after waking numerous times throughout the night because another resident, Jason, was struggling again with his night terrors. Jason always apologises, and Joe understands that it's hard for him. Zack was also up. Joe could hear his loud laugh as he made his way to the group room. Zack stood by the door, shifting his body nervously, he likes to keep an eye out on the ward. The staff are making drinks for one another and chatting about the fussiness of Katie and the way she likes her cup of tea.

The remainder of the staff shuffle into the group room accompanied by John, who fist bumps all the staff. The morning meeting begins. William, a resident, is running the meeting and asks who would like to see the chiropodist. Chris and Joe snigger along with Katie as William tries to spell chiropodist. Joe remarks: "Joe for IT please", and watches William as he makes a note, swiftly glancing up at Joe and then back down at the clipboard, signalling his request was heard. Siobhan tells the group: "We're playing pool this afternoon and there's an art

session on this morning, we are making Father's Day cards with one of the student occupational therapists".

Art group begins around 10:00. The student occupational therapist spends time in the staff base, searching how to make a card that has a collar and a tie. She comes over and apologises but explains that she gets it now. There's only Joe and Sean making cards and they look at the prototype the occupational therapist has made. Sean is a relatively new resident on the ward and appears nervous, he keeps his head down so his hair covers his face a little.

In the afternoon, Joe sits on one of the sofas in the communal area. The TV is on playing music videos. Two occupational therapists burst through the airlock and on to the ward, leaving the door to slam shut, they head straight to the staff base. John begins to shout just before the staff base door closes: "We're going to pool, yeah Siobhan? Pool, yeah?". Siobhan hovers, holding the door slightly ajar and replies: "Yes, we've just got to do the forms, John". The door closes noisily. Siobhan re-appears holding the section 17 forms and passes them around to those going to pool. Joe fills in the form, looking down at his clothes, and writes 'Blue t-shirt, black jeans, white and blue trainers' and hands the form back to Siobhan. We head out and wait in the reception area. The guys from Buckleberry ward are held up which causes some frustration to John. After about 5 minutes, Sharon appears saying: "Sorry guys, we're here".

Joe gets into one of the waiting taxis, along with John and Jacqui, the occupational therapist. It's a bit of a squeeze. At the pool hall bar, Joe orders a pint of coca cola. The occupational staff pay for the pool and take a seat in the pool hall, at a distance from the group. They sit and chat,

facing the group all the while. Joe teams up with Andy to play pool and they manage to play five games before the lights are turned on to indicate that time is up. One of the taxis has already arrived by the time that the pool cues and balls are handed back in at the bar.

Back on the ward, Joe completes the section 17 form and hands this back to Siobhan. It's almost dinner time so Joe sits on the sofas, watching the music channel on the communal TV. William is asleep on one of the sofas, Nadir is sat watching TV. John is walking around following staff, asking for fist bumps. Dinner is being served, Joe is informed that he had chosen option two on the menu the week before so it's courgette pasta. Nadir joins Joe on one of the bolted down chairs. They talk about Alien, the film they are planning on watching next week. It's almost 6:00pm, some of the windows are open on the ward, so that screams from Mirkwood ward can be heard. It's a piercing noise. Nadir and Joe head off to their bedrooms.

Joe is on 'self-meds' (patients on an advanced stage of self-administered medication) so takes his medication around 8:00pm and watches TV in his room. Joe can hear the night shift staff have arrived. Sarah is on again, laughing loudly. The sound travels down from the staff base along the deserted bedroom corridor. Joe falls asleep around 9:00pm.

4.8 Setting-the-scene: Theoretical insights

This chapter, so far, has explored the journey of the researcher through phases one and two of the data collection period and presented salient data excerpts. This has highlighted the key contextual features of life at Westmarch Hospital which are surveillance, security and risk; the emotive environment; and boundaried relationships. These are further discussed in this section

linking them to the microsociological approach adopted in this thesis. This model supports understanding of the everyday interactions, centred on creative practice, amongst the staff and residents through the exploration of the observational and interview data, which are discussed in chapters five and six.

As discussed in chapter two, rituals represent the interactive space between cultural and social structures and individual agents (Boyns and Luery, 2015; Clarke and Waring, 2018). A theoretical model is proposed (see figure 4.1), which is underpinned by a social constructionist perspective. Wellbeing (Seligman, 2011) and social connectedness (Hare-Duke et al., 2018) are considered to be subjective and thus relate to the perceptions of individuals. The view that individuals co-construct community life at Westmarch Hospital through interaction rituals is central to the model.

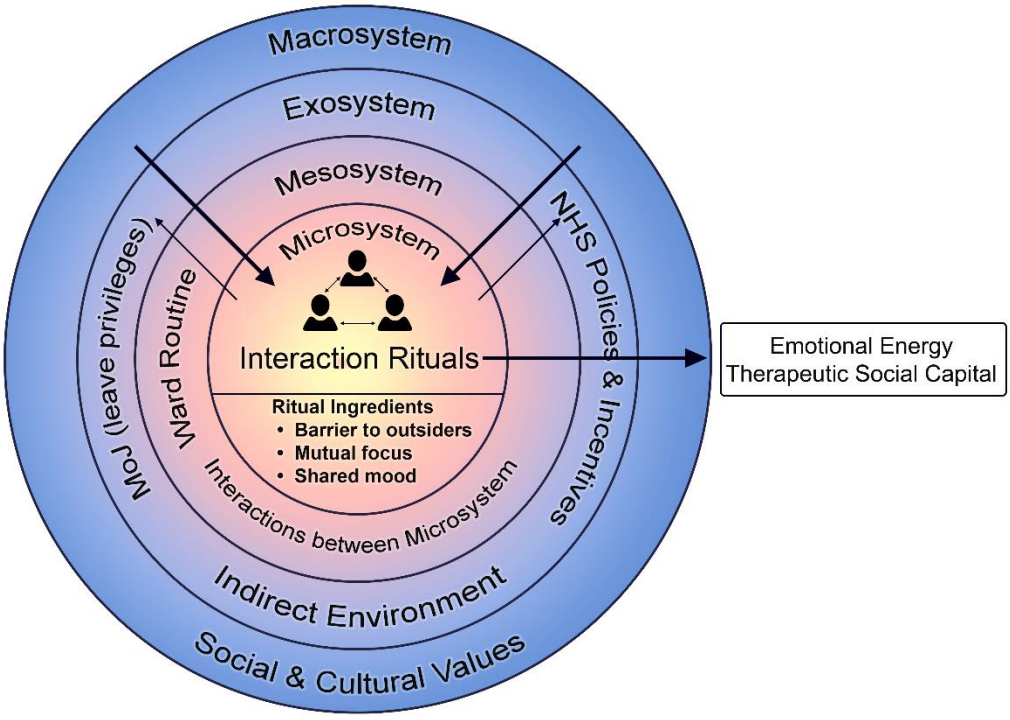


Figure 4.1: Microsociological model of therapeutic social capital

The premise of Interaction Ritual Theory (IRT) is that rituals equilibrate society through situational structure, which contribute to

the social order of the context (Collins, 2014). The situational structure is reinforced through the institutional structure of scheduled life and are argued to contribute to the social order at Westmarch Hospital. The preservation of the institutional structure is underpinned by the attachment to the situational rules of the institution and can be observed through "a constancy and patterning behaviour" (Goffman, 1967, p.49). Commitment to the institutional structure is impinged upon the individual directly through obligations and indirectly through expectations (Goffman, 1967). Such structure associated with institutional living has been described as "so painfully banal and repetitive", however is suggested to offer a much needed consistency (Woods and Springham, 2011, p.64) The structured life at Westmarch Hospital was typically adhered to by the staff and residents through a series of rituals. Such engagement links to Goffman's (1967) notion of obligations, where the patient and staff are committed to the ceremonial order within the institutional environment. It was observed that hospital regimes were typically conducted on time, for example, meal times were served at scheduled times across the hospital. According to IRT, rituals exist on a continuum ranging from formal and ceremonial to informal and natural. Scheduled life at Westmarch consists of formal rituals, such as, meal times, timetabled therapy, medication, ward rounds and life can also be spontaneous, with informal rituals occurring, such as game playing.

The microsociological model of therapeutic social capital explores creative practice rituals as small-scale interactions within a broader perspective to understand the influences on the nuances of life at Westmarch Hospital. In this way it accommodates the situated nature of the creative practice rituals within the institutional environment and supports analysis of the creative practice moments embedded within the Westmarch FMH Hospital context. Within this section, IRT is explored broadly in relation to the social environment and the three contextual themes, particularly in relation to the emotive

environment. Chapter five further explores IRT and the ritual ingredients through a series of observed creative practices.

The key features of the environment were introduced in this chapter as: surveillance, security, and risk; the emotive environment; and boundaried relationships. Some of these environmental features are externally influenced and are important to consider when exploring rituals within a community which is embedded within a series of political, legal, and social systems.

The three key contextual themes are now explored in turn along with the consideration of external influences. In section 2.5, it was noted that a society's behavioural rules of conduct underpin laws, morals, and ethics and are substantive rules and codes, "which guarantee that everyone acts appropriately" (Goffman, 1967, p.55). It is argued that the external influences, at the exo and macrosystem, are underpinned by substantive codes.

4.8.1 Surveillance, security and risk

The observations during phase one and two of the research highlighted the importance of surveillance, security, and risk, which was observed to govern much of life at Westmarch Hospital. I learnt that all movement in and out of the hospital was documented and that much of what each resident did or did not do was documented in some form, as highlighted in section 4.3.2 Staff Induction and section 4.4.1.1 Vignette D Monitoring and Assessment. For example, resident engagement in occupational sessions was coded, depending on the perceived or verbal response from the resident and according to the occupational therapist's understanding of this response. The coding system covered those who were offered therapy but refused to attend, engaged in therapy, or not offered therapy. The documentation of creative practice engagement is pertinent to this research.

Section 2.2.3 discussed policies which recommend 25 hours of structured therapy are available for inpatient forensic mental health services (Nicholls and Goossens, 2017) and thus such monitoring practices observed at Westmarch Hospital are influenced by directives at the mesosystem level. The health policy context is important to consider as this has implications for the ways in which life at Westmarch Hospital is influenced by the national mental health context. Sugarman and Dickens (2015, p.8) capture the current landscape of a payment by results culture, which highlights the continuous surveillance of care in mental health policy:

> In England, health policy is now focused on patient choice, provider diversity, outcomes and payment by results, to identify variations in performance and improve effectiveness… Adverse incidents are routinely reported to health purchasers, and payments linked to measures of quality are in place, including minimum volumes of weekly therapy, and standard risk, recovery and outcome tools.

Thus, the institution is governed and incentivised by a range of policy directives. The minimum number of weekly sessions is of particular importance to this thesis and underpins the monitoring and surveillance culture observed in this study. The surveillance of the forensic patient is suggested to reinforce the power disparity between staff and residents at Westmarch Hospital. For example, hospital regimes, such as, ward rounds can reinforce such a disparity (Woods and Springham, 2011). The patient-staff divide underpinned many of the critical incidents presented in chapter four, which has implications for agency and intentional social capital for the residents of inpatient care, as discussed in section 2.3.4.1. The arrows in figure 4.1 represent the influences on agency at Westmarch Hospital. Whilst some aspects of community life can be influenced by the actors within

it, the macrosystem influences (represented by the inward facing arrows) can be more pervasive in strength when underpinned by public protection duties, as discussed in chapter two. For example, residents at Westmarch Hospital were typically detained under section 37/41 of the Mental Health Act (1983/2007) with restrictions to the community, (i.e., leave outside of the hospital may not be granted or is restricted). Such restrictions can be re-assessed by staff at the hospital and a recommendation can be provided to the Ministry of Justice (MoJ), which is situated at the exosystem level. However, such decisions regarding leave from the hospital are ultimately granted by the MoJ. Requests to the MoJ also take time to process, and residents can experience delays. For example, at the time of the interview with Jim, he had been on Crickhollow ward for three months and he explained that the decision regarding his leave was:

> "up to them [MoJ] too, you know the doctor has to write to them and ask them and then it's up to what they say, and they might even say no… it's probably going to be about another three months before I can get [occupational therapy] OT leave, if I do get it!"
> *[Resident Interview: Jim, Crickhollow ward]*

Therefore, whilst the staff at Westmarch Hospital may recommend leave privileges and attempt to influence the resident experience, external influences, such as the MoJ, more heavily influence community life at Westmarch Hospital. This is particularly important when considering engagement in creative practices at Westmarch Hospital, when a substantial amount of the occupational therapy timetable requires leave permissions—such decisions influence activities at the microsystem. For example, 40% of the occupational therapy activities were conducted away from the hospital for Crickhollow ward, which could only be accessed by some of the residents who had leave permissions.

Vignette B, in section 4.3.3.2, highlighted the staff response to patient risk, in which a resident was restrained and it is argued that the risk-averse FMH environment often overrides patient autonomy (Adshead, 2000; Völlm et al., 2016). Risk management practices have been argued to be central to FMH care (Sugarman and Dickens, 2015; Slemon et al., 2017) and such practices are influenced by societal attitudes at the macrosystem and underpin policies at the exosystem level. For example, Warner (2007) argues that mental health policies are rooted in a perceived increase of risk of those with a mental health diagnosis and Stanford et al. (2017) argues that the measurement and prediction of risk is underpinned by public fear and assumptions relating to prevention. Section 2.2.2 further discussed the public concern in relation to those with a mental health diagnosis and their perceived risk. Moreover, debates exist in relation to the political nature and the accuracy of risk assessments (Markham, 2018; Morgan, 2013), as discussed in section 2.2.2 of this thesis. Thus, life at Westmarch Hospital is argued to be influenced by the macro, exo, meso, and microsystem, particularly in relation to risk and monitoring practices, and importantly influences the ways in which creative practices are situated within embedded practice, as explored in chapter five.

Whilst notions of risk practices are argued to be influenced by societal fears, some aspects of community life at Westmarch Hospital can be influenced by the resident community. For example, residents can influence ward and hospital procedures via community and hospital-wide meetings, for example the food group which met quarterly to provide feedback on menu choices, at the mesosystem level. Food choices have been argued to represent autonomy for the resident, for example, Freestone (2005, p.461) suggests that meal times "form a temporal social space in which patients are afforded some degree of control over their own bodies". Opportunities for the development of autonomy has been argued to be central to recovery (Drennan and Wooldridge, 2014). However, the balance between containment and autonomy can be challenging within the FMH environment (Robertson

et al., 2011), as discussed in section 2.2.2 of this thesis. James, a resident on Crickhollow ward, explained that he enjoyed the community meetings: "I do like community meetings, yeah, it's just a chance to give us that, patient's views on the ward and that and how things should be done better". When asked: "Do you find that things change as a result of things discussed?", he replied: "Yeah, it does, yeah". Therefore, whilst decisions in relation to treatment and discharge are influenced by third parties (Adshead, 2000), some aspects of life at Westmarch Hospital can be influenced by the forensic patient community, as depicted by the outward facing arrows in the microsociological model (see figure 4.1).

Staff can also influence community life at Westmarch Hospital at the mesosystem level. For example, staff can influence ward procedures through meetings, such as, community meetings and ward rounds. Staff can also implement sanctions when a resident's behaviour is viewed as not congruent with community rules, as such a social hierarchy is present. For example, a common sanction would be the temporary suspension of leave privileges following a violent (verbal or physical) incident. Life at Westmarch Hospital for the resident community can feel restrictive and, at times, contradictory. For example, the removal of leave privileges, sanctioned by staff, was viewed by one resident as contradicting his recovery by being "excluded from society". Ryan further explained that: "You can't do the normal things that normal people do in society" (Interview: Ryan, Buckleberry ward). Furthermore, Ian also commented on how it feels when he was not able to access leave when he wants to:

> "it feels like being a child, and like, we're adults and we're like, it's like being punished, so; which then makes people angry with the staff members, and it's like 'okay'. So, I try to tend to do what I've been asked to do really."
> *[Interview: Ian, Buckleberry ward]*

Ian's comments indicate tensions between the staff and resident group when sanctions are enforced. Ian's comments also allude to coercive practices, which are discussed in section 5.3.4. The hierarchy between staff and residents has implications for social connectedness, mutuality and thus mutual recovery, as highlighted within the CPMR programme and is discussed in section 2.4.1.4.3. For example, some of the projects found that the supportive nature of the group leader facilitated in the flattening of hierarchies (Argyle and Winship, 2015) and the purposeful non-hierarchical environment within music sessions was promoted by the lack of defined roles between staff and patients (Callahan et al., 2017). Therefore, engagement in creative practices has thus been found to facilitate the flattening of social hierarchies within the mental healthcare environment indicating that engagement in such practices can promote the building of communities within temporal spaces.

4.8.2 The emotive environment

During my time at Westmarch Hospital, I was often confronted with personally challenging moments and witnessed extreme emotional pain. I found myself unwillingly adopting the role of the helpless witness, which at times was almost unbearable. I witnessed disturbing scenes of self-harm (e.g. vignette A "The Emotive Environment"), and aggression and violence (e.g. vignette I "Racism and the Threat of Violence"). I witnessed staff losing their poised selves at times when they met their personal limits of tolerance and could no longer maintain a calm demeanour. I witnessed tears from both staff and residents. I learnt that the hospital site was, at times, a place where staff were unable to intervene when a resident planned their death (vignette K "Someone died last night"). I was also a listening ear to residents and sometimes staff would inform me of their distress—a role typically undertaken by staff.

I read the medical files of some of the residents which held the accounts of their abuse and neglect and also the abuse that they themselves had perpetrated. It was an emotionally demanding task.

I had expected to be moved by the stories that I heard. As the environment was wholly different to my own, I had expected and anticipated that I would be disturbed when I entered the field. I had expected that my life, during data collection and to some extent after, would be a little more challenging on a personal level, and it was.

The vignettes highlighted within this chapter illuminate the challenging environment that the staff work within and that the residents experience as part of community life at Westmarch Hospital. Research supports this finding, for example, chapter two highlights how the acute ward has been described as "an especially volatile and unpredictable place in which to live" (Quirk et al., 2004, p.2581). Furthermore, patients have described the inpatient mental health environment as a culture of violence with violence being exhibited by staff through restraint (Gillard et al., 2012) and patients through violent attacks (Gillard et al., 2012; Stenhouse, 2013). Other negative experiences have been reported by patients in inpatient care, such as, fear and embarrassment (Bonner et al., 2002), and feeling upset when other patients are in distress (Thibeault et al., 2010), which can negatively influence the therapeutic milieu, as discussed in section 2.2.3.

Additionally, the prevalence of staff burnout in FMH care is argued to be underpinned by the emotionally challenging role (Johnson et al., 2018; Nathan et al., 2007), which is further discussed in section 2.2.4. The witnessing of violence, including self-harm, is also suggested to be a common feature of secure FMH environments and can cause distress to those, such as, staff who witness these events (Tofthagen et al., 2014). Vignette A evidences the self-harm prevalent on Mirkwood ward and section 5.2 discusses the distress exhibited by staff during phases one and two of the research. As well as the evidence of the emotionally challenging environment for staff and residents at Westmarch Hospital, it was found that the residents typically had a history of abuse, which is common within the FMH patient population (Mullen, 2000), see section 2.2.1 for further

discussion on the patient experience within the FMH population. Such traumatic experiences influence the ways in which future relations are performed, as discussed in section 2.2.5. The role of emotions is central to Interaction Ritual Theory (IRT) (Clarke, 2017) and, thus, is considered an apt theory for exploring creative practice rituals at Westmarch Hospital. IRT is the central theory within the microsocialogical model (see figure 4.1).

Central to IRT is Emotional Energy (EE) which is suggested to be the source of motivation for social interactions (Collins, 2014). Underpinning IRT is the premise that individuals aim to gain EE+ and protect their existing levels of EE, thus they navigate market opportunities to maximise their EE+ (Collins, 1993). It is important to note that past events can influence expectations for future social encounters (Summers-Effler, 2004), thus a history of abuse or neglect can influence expectations for the forensic patient. Furthermore, within the highly emotive environment, opportunities for gaining EE+ can be diminished. As distressing events can influence expectations for future social encounters individuals may lack motivation to engage in social interactions. For example, Goffman (1967) suggests that individuals may engage in avoidance rituals in order to preserve the self. Thus, individuals may avoid one another out of a self-protective concern. Furthermore, Boyns and Luery (2015, p.160) state that:

> individuals may seek to reduce the amount of … [EE]– that they have acquired by avoiding interaction rituals that have a history of resulting in negative emotions.

Furthermore, interpersonal issues can influence motivation for avoidance rituals. For example, issues with trust were identified within two resident interviews. Ryan, a resident, discussed this as an issue relating to particular individuals on Buckleberry ward, he explained that: "erm not everyone's trusted on here. There are a

couple of people that are hard to trust". Another resident, Ian, had experienced an incident with a fellow resident which led him to lack trust in other residents, he shared: "Well at first after doing that, I felt cautious of other in-mates, well other patients, and it took me, after that, two years to trust people again". The emotions related to negative social experiences are theorised to diminish with time, thus an avoidance approach is suggested to rely "on the dissipation of … [EE]−" (Boyns and Luery, 2015, p.160). However, whilst Ian reports that it took two years to trust people again, he also explained how he doesn't trust some fellow residents to make a drink for him:

> "I never touch drinks off wards even if a patient comes up to me and says: 'Do you want coffee?' I say: 'No.' I'm quite wary of things like they're quite far [away at the] end [of the ward] and you don't know what they're doing. So, I don't take drinks off people."
> *[Resident interview: Ian, Buckleberry ward]*

Thus, Ian's avoidance techniques did not appear to be associated with the dissipation of EE− at the time of the interview. Issues of trust have implications for therapeutic social capital amongst residents. For example, if avoidance rituals are enacted, this reduces opportunities for social interaction and thus the possibility for social connectedness, mutuality, and thus mutual recovery are equally reduced. Trust has been found to be a common feature of the patient experience and staff care for FMH patients (Gilburt et al., 2008), furthermore, patients within the FMH context may be distrustful of authority (Barnao et al., 2016). This finding is also evident within the literature amongst the staff and patient group, where the staff perceive patients as distrustful when personal boundaries are crossed, this was found to have implications for the process of depersonalisation (Johnson et al., 2016), as discussed in section 2.2.5. Clarke and Waring (2018) also found that mental health patients were sometimes unsupportive of each other, which led to isolation and alienation. Thus,

opportunities for therapeutic social capital may be restricted within the FMH environment, amongst staff and forensic patients.

It is important to note that avoidance rituals may be enacted when the perceived social value attributed to an individual is low. For example, Goffman (1967, pp.69–70) suggests that individuals:

> may avoid an object so as not to be polluted or defiled by it … and avoids a person of lower status than one's own out of self-protective concern.

Thus, when social relationships are underpinned by distrust or negative social experiences, this can lead to avoidance behaviour, minimising opportunities for therapeutic social capital. Therefore, it is important to consider the complexities of relationships within the mental health service environment, which are influenced by former negative experiences and interpersonal issues. Furthermore, social encounters influence individual's emotional states and self-perceptions, as such, social encounters within the FMH environment are important to consider in the context of therapeutic social capital, including possibilities for mutual recovery. Section 5.3.5.2 further explores avoidance rituals in relation to creative practice rituals.

4.8.3 Boundaried relationships

The environmental, relational and procedural security features are an integral part of the FMH site, which is upheld by formal measures of surveillance and security. For example, the CCTV and the documentation of activity, but these features are also enacted via staff and resident interactions through boundary work, as introduced in vignette F "Boundary work". Boundaries in mental healthcare was discussed in section 2.2.5, and importantly underpin care within the FMH environment. It is argued that the introduction and maintenance of positive relationships within care hold an important therapeutic value (Marshall and Adams, 2018). However, mutuality within the

context of power disparity and mental health care is complex as such a concept has normative limits in the staff-patient relationship (Brown, 2015).

Furthermore, boundaried practices can influence opportunities for social interaction and thus mutual recovery. For example, the occupational therapy staff were observed to often remind residents of this when asked questions regarding their visit, whilst out in the community. The staff would prompt the resident to ask a fellow resident or an individual that worked in the establishment that they were visiting by making remarks such as: "Remember, act as though I'm not here". It was explained to me that this was to prepare the residents for life within the community, when the staff would not be there to support them.

Boundaried practices which promote independence has implications for therapeutic social capital amongst staff and residents. For example, social interaction is argued to be a pre-requisite of mutual recovery, as highlighted in the hierarchical model of therapeutic social capital, see section 2.3.4.1. Thus, opportunities for therapeutic social capital are minimised in the boundaried practices of occupational therapy. Furthermore, Imran, a resident, talks about staff who were perceived to not care about the patients as they would avoid spending time with patients by remaining in the staff base:

> "You notice which members of staff care about erm the patients because some members of staff, you'll see them, they come in, and they sort of stay in the office a lot and they just sort of tick all the boxes and then they go, they don't really interact with service users and they just do the obs[ervations] and sort of erm get by"
> [*Resident interview: Imran, Crickhollow ward]*

Such practices maintain a boundaried relationship, one that extends beyond professional boundaries and can be exhibited through avoidance rituals. For example, Peternelj-Taylor (2004) suggests that under involvement, such as, avoiding patients is also a form of boundary violation. Research has found that physical spaces, such as the nurses station, can further promote the divide between patients and staff (Kennedy and Fortune, 2014). Thus, over involvement and under involvement are suggested to be professional boundary violations and opportunities for therapeutic social capital are constrained if social interaction is minimised.

Research has found that engaging in creative practices can facilitate a flattened hierarchy and promote wellbeing amongst participants (Argyle and Winship, 2015; Callahan et al., 2017; Lewis et al., 2016). Whilst the structure of life within the community at Westmarch Hospital is underpinned by surveillance, security, and risk, opportunities for hierarchies to become fluid are suggested to be possible and engagement in creative practices could be a powerful tool for bringing communities together (Crawford et al., 2013). Joint engagement in creative practices, therefore, could promote a flattened hierarchy proving opportunities for therapeutic social capital and is explored further in chapter five.

4.9 Chapter four: Summary

This chapter has introduced the field-study-site and has highlighted the key contextual features of life at Westmarch Hospital. As discussed, life at Westmarch Hospital is embedded within a range of legal and policy frameworks, which are also influenced by societal attitudes. These frameworks influence the microsystem, as debated within this chapter. The microsociological model of therapeutic social capital was introduced as means of understanding the influences on the nuances of life at Westmarch Hospital and providing a situational framework for analysis of the creative practice rituals in relation to mutual recovery within the institutional environment. These formal

and informal creative practice rituals are analysed using the model as a framework in chapter five with chapter six covering mutuality.

Chapter Five: Formal and informal creative practice rituals at Westmarch Hospital

5.1 Introduction

Chapter four set the scene for daily life at Westmarch Hospital to provide an overview of the context in which the research was situated. Three contextual themes were identified: surveillance, security; the emotive environment; and boundaried relationships. This chapter explores six creative practice rituals observed over the nine-month period of data collection, which had the potential to foster therapeutic social capital amongst residents and staff.

The aims of this chapter are twofold. First, to explore the creative practice rituals observed during the fieldwork and theorise their contribution to therapeutic social capital through the theoretical framework of Interaction Ritual Theory (IRT) with a particular focus on ritual ingredients. Second, to analyse creative practice rituals within the context of Westmarch Hospital through the use of the microsociological model introduced in chapter four (see figure 4.1 this is repeated in this chapter as figure 5.1 to aid comprehension) and consider how these moments are situated within the key aspects of life as introduced in chapter four.

5.2 Therapeutic social capital through creative practice rituals

As discussed in section 2.4.1.4, the value of engaging in creative practices has been evidenced to contribute to wellbeing (Crawford et al., 2013). IRT explores social life by framing interactions through rituals; this thesis explores creative practice rituals, in a novel sense, and considers their contribution to social outcomes, such as social connectedness, mutuality, and mutual recovery amongst residents and staff at Westmarch Hospital, as outlined by the hierarchical model of therapeutic social capital, see section 2.3.4.1. The consideration of

social interactions and emotions through IR's is argued to contribute to the understanding of therapeutic social capital within this context.

Chapter three introduced IRT as a tool for micro analysis of everyday social interactions (Collins, 2014). The premise of IRT is that social interaction leads to social outcomes, such as group solidarity, and influences levels of individual Emotional Energy (EE). The strength of the ritual ingredients influences the ritual outcomes, through the role of emotions. The key ingredients of IRT are explored to illuminate the features of creative practice rituals and evaluate their potential to lead to therapeutic social capital amongst the community at Westmarch Hospital. The four key ingredients of rituals are: bodily co-presence, barrier to outsiders, mutual focus of attention, and shared mood. Within this thesis, bodily co-presence was present during the creative practice moments observed at Westmarch Hospital; the population of residents and staff were situated within a locked environment or a supervised environment within the community. Therefore, bodily co-presence is accepted within the Westmarch Hospital context and not explored, regarding the possible necessity of this ingredient to promote therapeutic social capital.

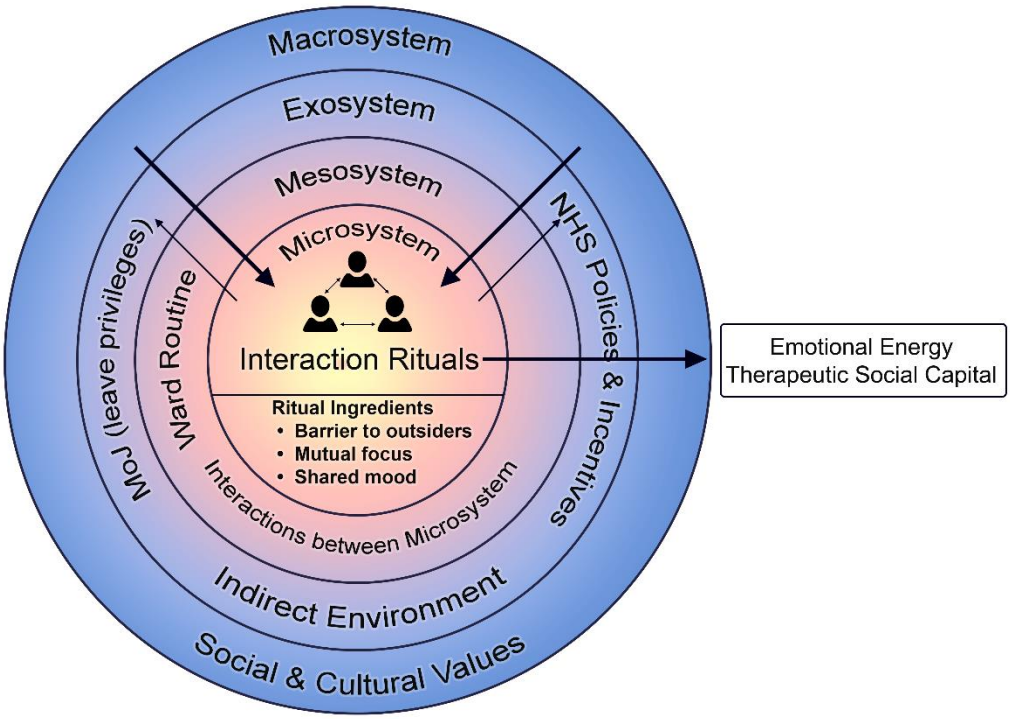


Figure 5.1: Microsociological model of therapeutic social capital (4.1 copied)

The micro is presented at the centre of the microsociological model of therapeutic social capital, which is the community at Westmarch Hospital, who interact through rituals. As discussed in chapter two, ritual engagement produces an EE outcome for individuals participating within the ritual, which is influenced by the ritual ingredients. Transient emotional states, such as joy or anger, if shared amongst the group may lead to a positive social outcome for those participating within the ritual. Social outcomes can be positive and represent affinity towards group membership (i.e., social connectedness, mutuality and mutual recovery within the therapeutic context of relationships (+)) or negative and represent enmity against group membership (i.e., social isolation (−)), which can be exhibited through avoidance rituals.

The formal interaction rituals at Westmarch Hospital are the institutional regimes, such as, timetabled therapy, and the informal interaction rituals typically occur outside of structured therapy and are spontaneous in nature. However, it is important to note that informal interaction rituals can occur during formal times. Three formal and three informal observed creative practice rituals are explored through IRT in sections 5.3 and 5.4. The analysis explores the successful and unsuccessful features of such rituals in relation to facilitating opportunities for therapeutic social capital within the institutional context.

5.3 Formal creative practice rituals

Chapter four introduced art, cooking and music as possible creative practice subjects to be explored as formal practices, which were timetabled and offered by the occupational therapy team at Westmarch Hospital. Creative practices are used within mental health

services due to their ability to meet a diverse range of interests (Griffiths and Corr, 2007). Creative practices are viewed by occupational therapists as a tool to achieve a diverse range of objectives, including: the enhancement of intrapersonal and relational skills, such as, self-confidence and to encourage interaction; the enhancement of functional performance, such as, manual skill development; and the facilitation of personal growth, such as, self-expression, motivation, and choice (Griffiths and Corr, 2007). The CPMR programme researched a series of timetabled, thus formal, creative practice sessions, such as, art and music, which were found to promote mutuality within a voluntary participatory context (Hogan, 2015; Lewis et al., 2016; Callahan et al., 2017; Perkins et al., 2016). This section introduces the art, cooking and music sessions as formal creative practice rituals at Westmarch Hospital through observational and interview data, with considerations of their influence on EE and therapeutic social capital for staff and residents.

5.3.1 Art

The art sessions were run on all three of the wards at Westmarch Hospital which were delivered by the occupational therapy team and were typically an on-ward activity. The occupational therapy staff would bring the materials required for the session to the ward. These sessions mostly comprised of colouring tasks, which I observed and experienced to facilitate discussion between the occupational therapy staff and the residents. An observed art session is introduced within this section in order to explore art as an interaction ritual and its possible contribution to therapeutic social capital. The excerpt below, from the fieldnotes, highlights one of the art sessions observed on Crickhollow ward.

> It was 10:00am on a Friday morning when I met Dave, a new resident, during the art session, we sat and coloured and introduced ourselves. The ward was relatively busy, with some residents watching TV on the sofas in the communal areas, whilst other residents were walking around the ward, either visiting their

bedrooms to get something or hovering around the staff base filling out forms. Two residents were making drinks near to us as we sat on the bolted down dining room chairs. There were approximately nine residents in the communal areas of the ward and four staff who moved between the staff base and other areas of the ward, for example, one staff member walked past the dining area to visit one of two bedroom corridors, which was situated at the end of the communal space. We were provided with colouring pencils and images to colour in, such as a butterfly or the outline of a camera. Another resident, Luke, came over to the tables and asked Siobhan, the occupational therapist, if this was 'art'. She explained it was. Luke sat and began colouring in one of the images, whilst his eyes flickered and followed the movement on the ward. He was visibly distracted. He asked Siobhan if she could make sure that his attendance was noted as his engagement in occupational therapist had been raised as an issue during his ward round session that week. She reassured him that this would be noted on his file. A few moments later, Luke asked for confirmation once more and Siobhan reassured him that his attendance to the art session would be noted. After approximately fifteen minutes, a male senior staff member spoke loudly and announced that it was known there was a lighter on the ward. He was stood approximately six metres away, leaning against the far wall of the communal area, facing the direction of the group in the art session. Whilst he was addressing all members on the ward, he was more visibly addressing the residents who were sat on the sofas in the communal area. He explained that the staff could smell smoke and were not stupid and were aware that this had been going on and therefore knew there was a lighter. He then explained

> that this was another amnesty opportunity, but when no-one came forward, the staff informed the residents that if the lighter was not found then there would need to be a systematic room search, this sparked great tension amongst those who were attending the art session who felt that this was unfair. I heard: "For fuck's sake! But I don't even smoke though!"—the colouring quickly subsided.
> *(Fieldnotes: Day 52)*

The art session was interrupted by an impromptu community meeting, which involved all residents on the ward. The smoking ban had recently been implemented on this NHS site and it was known to the staff that there was a lighter on the ward. A lighter posed a risk to the hospital's safety—the patient group on Buckleberry ward had arson-related convictions. A national smoking ban was being implemented at NHS sites which included inpatient hospitals (NHS England Board, 2016) and Westmarch Hospital had become smoke-free during the time of the research with staff undertaking new responsibilities in implementing rules related to the ban. For example, prior to the ban, staff escorted residents to the ward's courtyard for scheduled smoking breaks throughout the day. All residents had access to smoking breaks provided there had not been incidents (physical or verbal altercations). Smoking was, therefore, viewed as a privilege and was utilised as a sanction for those who smoked. Once the smoking ban was implemented, only those who had been granted leave from the hospital site were able to smoke. As discussed previously, such leave privileges were often decided by external agencies, such as, the MoJ at the exosystem level. Whilst smoking inside of the hospital had not been permitted prior to the ban, smoking incidents, inside of the hospital building, had increased significantly during the first few weeks of implementing the ban. The routine of handing residents their lighter along with their smoking materials (i.e., cigarettes or rolling tobacco) in preparation for smoking breaks, which were permitted on leave from the hospital had

remained consistent after the implementation of the ban and were to be handed to staff on return. However, lighters and smoking materials had begun to be brought onto the wards, this may have been via those who had unescorted leave and purchased such items on their visits to the community and kept them hidden during pat-downs (i.e., checking for concealed items on the body). Thus, whilst the policies relating to lighters and smoking items had not changed after the ban, smoking incidents had increased as those who wanted to smoke and had no leave privileges were no longer able to smoke; some smokers did not wish to quit so found ways to break the rules.

The staff member conducting the meeting was implementing the services' policies on risk management, which was deemed to take priority over any activities taking place on the ward, such as the art session. The staff member was then respecting the dominant symbols of the organisation and adopted a Goffmanian performative role, suggested by Collins (2014) as the role of the order-giver. The session, therefore, was interrupted by ward policies and procedures relating to risk at the microsystem level, which were influenced by new NHS policies on the smoking ban at the exosystem level. Incentives for the delivery of such policies are evident at the exosystem level, where rewards are granted for successful implementation, which is measured through a reduction in patients who smoke (see NHS England, 2017 for commissioning targets).

The impromptu meeting could be argued to have led to the failure of the ritual as the attention of the participants was quickly averted from the art session and towards the topic of the meeting, leading to a lack of mutual focus of attention—a key ingredient, according to Collins (2014). The meeting also created a new ritual with a new barrier, which included all those in the communal ward area. The meeting ritual was a power ritual, one which re-enforced the power disparity between the residents and staff. Power rituals are marked by a social interaction where there are order-takers and order-givers and a mutual focus of attention is centred on the activity (Collins, 2014). The meeting established the staff member as the order-giver and the

residents as order-takers and the staff member undertook the role of reinforcing the institution's policy on risk and as such showcased their commitment to the institutions symbol of a risk-averse culture.

The residents eventually complied with the order and a lighter was handed to the staff, evidencing a commitment to the symbols of community life at Westmarch Hospital and the institutional structure. Goffman (1967) suggests that obligations and expectations are often intertwined, and in this instance, it is suggested that the residents felt obligated to hand the lighter to the staff member and that this action aligned with the expectations of the staff member. The power ritual could be argued to have high levels of mutual focus of attention, as evidenced by the shared focus on the meeting by those in the ward area. All activities had diminished; the residents were quiet and listened to the staff member whilst they were given their orders. All those that spoke were focused on the meeting, thus indicating shared attention amongst the community—another key ingredient of rituals (Collins, 2004). However, this mutual focus of attention was one that was directed by staff, as professionals within the institution, and situated within a power ritual which was influenced by changes in exosystem policies (i.e., NHS smoking ban policy and associated incentives for successful implementation).

The intensity of the power ritual led to high levels of emotional expression, including that of anger for one individual. Whilst room checks and searches were part of life at Westmarch Hospital, Luke appeared to express anger at this possibility, particularly as he was a non-smoker. It could be argued that a few individuals within the community on Buckleberry ward had violated the symbols of their community by introducing a negative symbol—the lighter, a contraband item. Symbols represent shared meaning (Collins, 2014) and the violation of community symbols "provoke righteous indignation towards, and sanctions against, those guilty of transgression" (Baehr and Collins, 2005, p.2). Thus, this rebellion had been enacted by a few members of the resident community, which

could be argued to have been viewed by at least one resident and the staff as a violation of the community rules. Sanctions, on this occasion, meant a possible room search if the item was not handed in. Furthermore, there was an amnesty opportunity before any sanctions were enacted. But, indignation over the violation and the consequences for the resident who did not smoke was observed through verbal swearing. Luke, the resident who protested about the room search had remarked that he did not smoke, therefore questioned why he was to be treated the same as those who had violated community rules when he was a loyal retainer of the symbols of the community. This ritual created a divide between the community on Buckleberry ward. Power rituals and their implications for EE is further discussed in section 5.3.4.2.

The perceived value of the art session, according to ward staff, is questioned, as the commencement of the art session would have been visible to the member of staff who initiated the impromptu meeting. The occupational therapist, Siobhan, was a well-known member of staff on Buckleberry ward and Siobhan's presence would have indicated that therapy was likely taking place at the time. The member of staff running the meetings commented that the staff on Buckleberry had known about the lighter, suggesting that the discovery of the lighter was not new information in that moment. The timing of the meeting is therefore questionable. The daily schedule on Buckleberry ward creates opportunities for all the resident population to present on the ward at the same time, such as, meal times and morning meetings. Therefore, it is proposed that to time the meeting during the art session was viewed as unproblematic by the staff member who initiated the meeting, which has implications for the value attributed to occupational therapy.

Whilst the impromptu meeting interrupted the art session, it is important to consider the possibility for therapeutic social capital, and individual EE, without the interruption. The ritual ingredients: barrier to outsiders, mutual focus of attention, and shared mood are now explored in turn, which are at the centre of the microsociological

model, see figure 5.1. Residents were able to participate within these open sessions that took place on the ward. The location of the art sessions meant that residents could join in at any time however, this also meant that there could be distractions on the ward, as identified in the observation above. The sessions would take place on the bolted dining tables, which were typically occupied only by those participating within the group, creating a permeable barrier to those within the group and those outside of it — a necessary ingredient of rituals (Collins, 2014). The session began with one resident, Dave, who was handed some colouring materials; he began to participate in the session by colouring in one of the images provided. The task, whilst new to Dave within this environment, was one that he was familiar with.

According to IRT, group members:

> focus their attention upon a common object or activity, and by communicating this focus to each other become mutually aware of each other's focus of attention. (Collins, 2014, p.48).

When I first met Dave, we sat and coloured and used this opportunity to introduce ourselves as we both recognised that we had not previously met. We did not discuss the artwork that we were creating and focused on getting to know each other via an exchange of friendly talk. A few moments later, another resident, Luke, joined the art session however, their focus of attention was on an individually-focused level and lacked mutual awareness of each other's projects. Luke, who was interested in the documentation of his participation only made comments in reference to this interest and largely appeared to be disinterested in the colouring task, which was evident by a constant turning of his head to look around the ward. Dave, meanwhile, appeared shy and kept his head down, only momentarily looking into my eyes as we conversed.

The lack of shared experience amongst those participating within the art session is argued to hinder the possibility for social connectedness. Research exploring engagement in the arts and wellbeing promotes the notion of a community endeavour, whereby the participants are actively engaged in a multiparty pursuit, as discussed in section 2.4.1.4.2. A key component of these projects were that the participants engaged in a shared experience together within a supportive group. For example, the activities researched were shared group experiences either through the activity itself being explicitly a group activity, such as, capoeira (Jordan et al., 2018), yoga (Vallejos et al., 2016), and group drumming (Fancourt et al., 2016a; Fancourt et al., 2016b; Perkins et al., 2016), or a shared learning and exploration experience, such as, exploring personal birth stories through art with fellow mothers (Hogan, 2015), comedy workshops (Winship and Barker, 2016), or adult community learning workshops (Lewis et al., 2016). It is argued that the art task itself was unlikely to promote social connectedness amongst participants due to its individual focus. Payr (2010) suggests that the ingredients shared mood and attention distinguishes rituals from routines. It is, therefore argued that the activity did not promote a mutual focus of attention and the art session is synonymous with a routine. Within the occupational therapy literature, the parallel group structure in relation to tasks are characterised by "individual achievable tasks in the presence of others" and interaction is theorised to be minimal (Chacksfield, 2002, p.157). Such tasks require the lowest minimal group skill level and such groups can be organised into the structuring of group programmes, which are then progressive in focus to develop skills (Chacksfield, 2002). Thus, whilst the individual focus of the group activity does not promote interaction and thus has constraints for social connectedness, mutuality and thus mutual recovery—according to the hierarchical model of therapeutic social capital (see section 2.3.4.1), such an approach may be aimed at the most basic form of group type which is rooted in a developmental model of occupational therapy practice.

Furthermore, the group activity dynamic allowed for the development of rapport between me and Dave and is theorised to create similar opportunities for occupational therapists. Thus, such an approach can provide an opportunity for the enhancement of relational skills, as identified by Griffiths and Corr (2007). Therefore, the art session's therapeutic aims, from the occupational therapy perspective, could provide a structured opportunity for the enhancement of relational skills, however, the structure of the session diminished opportunities for social connectedness, mutuality, and mutual recovery. A consideration of the ways that group-level activities could provide opportunities for therapeutic social capital would be a useful addition to occupational practice.

In conclusion, exosystem policy changes relating to the smoking ban influenced life on Buckleberry ward, at the microsystems level. Procedural security enforcement is argued to have implications for the perceived value of occupational therapy on Buckleberry ward and in this circumstance, procedural security was viewed as more important than the relational security potentially offered by the art session. Relational, procedural, and environmental security is further discussed in section 5.3.5.1.2. Moreover, it is argued that the creative practice ritual lacked the mutual shared experience required for mutual recovery and, in the observed example, did not promote a shared group activity, thus minimising opportunities for therapeutic social capital.

5.3.2 Cooking

During my initial meeting with the occupational therapy team, I was informed that their cooking sessions were creative activities. Research has also found that engaging in group cooking activities has implications for social connectedness. For example, Farmer et al. (2018) found evidence of the psychosocial benefits of engaging in group cooking lessons, such as increased socialisation. The cooking sessions were for those residents that the occupational therapy staff identified as needing assessment and culinary support; as such, the residents who attended these sessions often lacked confidence in their

culinary skills. Research also suggests that engagement in cooking can increase self-esteem (Farmer et al., 2018). The occupational therapy staff would use this session as an opportunity to educate the residents on the safe handling of food (e.g., prompts for effective cooking timings and dietary information). Below is an excerpt from the fieldnotes.

> I had arranged to meet the occupational therapist, Stephanie, at 10:00 outside the ADL kitchen. At 10:10, Nicole, Jane and Stephanie arrived. Stephanie began to unlock the cupboards with a key and then proceeded to sit down and busily began to fill out paperwork in a folder which was waiting on the small round table as we arrived. Stephanie proceeded to initial the forms inside, whilst periodically turning pages and looking around the room before continuing to initial the boxes on the pages. Nicola and Jane had begun to open the cupboards and the fridge to obtain the ingredients for their meals. Jane made her way to one of the kitchen counters and picked up a white chopping board. Stephanie remarked: "so you have an onion, what coloured chopping board do you think you need?". Jane shrugged her shoulders and turned away and walked over to the drawers near the cooker. She stood still as she waited for Nicole to move out of her way. Nicole walked over to the fridge and Jane opened a drawer to retrieve a cutlery knife and returned to the counter with the chopping boards. Stephanie continued "well, brown is for vegetables, so that's the one you want". Jane swapped the white chopping board for the brown and began to chop the onion with the blunt knife. It looked challenging but she used her weight to assist with the chopping by leaning her body forward as she pushed the knife into the onion. Mine and Stephanie's alarms rang, I looked at the screen on the alarm, the words

> read “Mirkwood bedroom corridor”. Stephanie checked her alarm, which was situated by her left hip, and turned back to face forwards in her chair to continue with the paperwork.
>
> Nicole sighed and turned to Stephanie: “how do I turn the grill on?”. I noticed that there was no writing or pictures on the cooker to indicate which knob was linked to which function. Stephanie quickly stood up and began to investigate: “there you go, it’s this one here”. In the meantime, Jane had placed a pan on one of the hobs. Nicole then turned to face Stephanie, who had returned to one of the chairs, and said in a frustrated tone: "she's using the hob I want!" Stephanie turned to look at the cooker and asked if she could use a different one and adjust the heat to suit her needs. The mood was tense. The session involved little social interaction. Stephanie, at times, would attempt to engage with the residents by talking about food, but this was often to no avail.
> *(Fieldnotes: Day 41)*

The ritual ingredients: barrier to outsiders, mutual focus of attention, and shared mood are now explored in turn. The barrier to outsiders was marked by the location of the cooking sessions in the ADL kitchen. Prior to the sessions, the residents had planned individual meals and thus, the residents did not participate in a shared cooking activity. The staff member would sit, carry out paperwork, and observe the session, often prompting if the resident was perceived to be making a mistake, such as, incorrect food hygiene. The tasks conducted in the cooking sessions were conducted individually, with a lack of teamwork, even at times the washing up was completed separately. As such, there was a lack in mutual focus of attention for all those involved. A lack of a multiparty endeavour and shared experience was observed, much like the art session explored in

section 5.4.1. Furthermore, the individual focus of the session did not promote social connectedness through the engagement in the cooking task. There are similarities between the art session and the cooking session being planned individual tasks in a group setting. For example, both sessions were run with a parallel group structure with minimal social interaction. Whilst such an approach may be theoretically relevant to occupational therapy practice, as discussed in section 2.4.1.3, this minimises opportunities for therapeutic social capital—as identified by the hierarchical model of therapeutic social capital (see section 2.3.4.1).

The residents often appeared uncomfortable during these sessions, evidencing low levels of EE− experienced by the resident, often representing enmity against the staff and fellow residents. For example, the residents were often observed to attend the shared cooking sessions, but often a lack of kinship between residents would indicate that any level of shared mood would be unlikely to contribute to social connectedness. The remark made by Nicole, regarding the hob was directed towards Stephanie, the occupational therapist, and not Jane. It is suggested that this interaction provides insight into the paternal relationship between residents and staff, but also the lack of community between the residents.

The aim of occupational therapy at Westmarch Hospital was to prepare the resident for community life, whether this was for skill development, such as cooking, or finding hobbies that could be continued when in the community. However, some of the teaching practices observed were not relatable to life outside of Westmarch Hospital. For example, within the cooking sessions, the residents were tested on their knowledge of the correct usage of coloured chopping boards. Strict hygiene practices are argued to not be a practice that is commonly utilised within the average home (Kennedy et al., 2011). Also, what were judged to be acceptable meals was directed by the occupational therapy team, with the view that food cooked should represent a balanced diet. However, it is proposed that the

healthiness of food intake is not something that is typically challenged by the average household, particularly for adults.

Furthermore, cooking interventions have been found to promote psychosocial benefits which are not directly attributable to nutritional value (Farmer et al., 2018). Exosystem level policies, however, indicate that care should include both physical and mental health, with a view to tackle obesity (see Nursing, Midwifery and Allied Health Professions Policy Unit, 2016). Integrative approaches to mental and physical health in UK care are underpinned by the evidence of inequalities of physical health associated with those with a mental health diagnosis (HMG/DoH, 2011). Therefore, according to UK policy, interventions within forensic practice should aim to promote a holistic approach to health, which includes physical health promotion.

The teaching of healthy lifestyles whilst individuals are under the care of services seems apt. However, when considering the power disparity between staff and residents, such practices further complicate the aim for empowerment associated with personal recovery, see section 2.2.3. Paternalistic models of care promote the treatment and management of mental health patients, which contrasts models of service user involvement offered by the recovery movement (Brown, 2016). Personal recovery within the FMH environment is challenging, whilst the Good Lives Model (GLM) appreciates the value of autonomy as a primary good, as discussed in section 2.3.1, traditional forensic rehabilitation approaches can undermine such values (Barnao et al., 2016). Thus, whilst the GLM promotes autonomy, national policies when implemented in practice, can conflict with such approaches to care through incentivising the lowering of BMI's for the FMH population.

In summary, the cooking session failed as a creative practice ritual due to the lack of shared focus of attention on a common object or goal. The parallel group structure did not promote social interaction, which is the fundamental basis for therapeutic social capital, see section 2.3.4.1.

5.3.3 Music

The music sessions were the liveliest and most well-attended sessions that I observed, across all three of the wards. Charlie, the music teacher, an art specialist, would teach and assist the residents to make music. The music sessions took place in one of the side rooms and the door would sometimes be left open as an invitation for others to join, or by a new person joining or leaving the room. The group members tended to fluctuate during the sessions on Crickhollow ward, often residents would come in and leave the room during the session, sometimes to mark the end of their one-to-one participation with Charlie, the music teacher, or to attempt to join the activity by entering the room and sitting down. Charlie would attend the three wards up to three times a week, making these sessions the most common occupational therapy activity in one week that was open to all residents on the ward. Charlie offered a range of musical support to the residents at Westmarch Hospital; he would support residents to create their own music by writing lyrics, recording the music played and the voices of those who wished to sing. Charlie would assist the residents to upload their music on the internet and burn CD's so that the residents could listen to their creations outside of the scheduled music sessions. Residents who had a desire to create their own music, outside of the music sessions, were observed to ask Charlie about the programmes he used and request advice on how to purchase these. This happened on two occasions with different residents. Charlie would then provide tutorial support during these sessions. For example, during the interview with James, he described how Charlie:

> "learns me how to navigate round the erm, programme, the music programme, and come up with better ideas on how to do stuff with the music programme"
> *[Resident interview: Crickhollow ward].*

Charlie thus offered practical support to residents, when requested, and supported the residents with their music creations during the sessions.

The residents across the wards spoke highly of Charlie; he was considered to be a well-respected musician. In the interview with Jane, she indicated that the music sessions were her favourite occupational therapy activity. She had recorded music with Charlie and enjoyed the opportunity to work with him. Jane respected Charlie's musical talent and thought he might become famous one day due to his musical abilities:

> "Charlie is such an amazingly talented person, he is nice person as well, and very friendly, very warm and friendly to talk to … It would be so nice, as somebody I actually know as well, to do well for himself … I would love to see him on TV or something, it would be wonderful"
> *[Resident interview: Jane, Mirkwood Ward]*

Charlie was supportive and offered a gentle teaching style, which was appreciated by the residents. The sessions were highly collaborative, and Charlie would often let the residents lead but would step-in and retake the lead when the resident was struggling. The excerpt below highlights a successful ritual which is an observed moment between Owen and Charlie. Owen had been learning to play the guitar with the assistance of Charlie—a mutual engagement between a respected musician and a resident.

> I entered Crickhollow just after 9:30am, Charlie was running the music session in the campus room. I could see as I entered the ward that this was a well-attended session; I could see a few people through the small windows of the campus room. The ward was quiet, two residents were sat watching TV.

> As I walked across the ward, I could hear music. I hesitated by the group room door, which was wide open, looking for somewhere to sit and not wanting to interrupt the session. Dave was sat on the floor, and a staff member was stood behind him, leaning against the window sill. Another staff member and a fellow resident were sat across the room on one of the sofas. We gestured: "Hello". I hadn't experienced staff members to be sat in the music session, this seemed unusual. The atmosphere in the room was relaxed.
>
> Owen and Charlie were playing guitar. They played a song I recognised. He'd [Owen] been learning the guitar for a few weeks. He'd really come along since the last time I heard him play. Charlie was pacing the notes to match the speed of Owen's playing and watching him all the while, giving prompts, such as 'yep, you had it there', 'that's it', 'nice', 'you've got it'.
> *(Fieldnotes: Day: Seventy-two)*

The ritual ingredients: barrier to outsiders, mutual focus of attention, and shared mood are now explored in turn. The barrier to outsiders was marked by their physical positioning—facing towards one another on chairs, just one foot apart and the activity—the playing of guitars. Charlie and Owen were creating music together and were the only individuals partaking within the creative pursuit. It is argued that there was a high level of mutual focus of attention between Charlie and Owen, marked by their concentration on the task and the direction of their gaze; they were both eagerly watching Owen's hands on the guitar strings whilst Charlie offered supportive prompts. Charlie and Owen were both highly engaged in playing a song together and their enjoyment was visible, particularly once they came to the end of the song when they both smiled at each other, indicative of a shared mood in this moment between Charlie and Owen. Whilst there were other people in the room, Charlie and Owen did not engage

with the audience members. Instead, Charlie and Owen interacted with one another through looking and talking to each other throughout the performance.

The verbal and physical bodily prompts evidence a mutual focus of attention on the shared task (Clarke, 2015). Rhythmic emotional entrainment is argued to be produced as collective effervescence builds (Chapple, 1982) and can be evidenced in synchronisation of bodily movements and verbal communication. Charlie and Owen's bodies were visibly in sync as they moved to the sounds of the music. Charlie's movements were to the beat of the song, which were timed with the notes that Owen played. Music playing has been suggested to entail communicative synchronising, and "facilitates intimate … forms of communicative coordination" and thus, "music provides … an intensive way of literally being together in time" (DeNora, 2016, n.p.). The movements exhibited by Owen were more exaggerated than Charlie's, as his attention was focused on playing the right note, but he would nod his head occasionally as he strummed the chords. Such rhythmic movements have been argued to promote the shared experience of group activities. For example, Perkins et al. (2016) found that the shared experience of group drumming facilitated opportunities for acceptance, identity building, and connectedness, within a learning environment that embraced mistakes and provided an embodied practice. The shared nature of capoeira play was also considered to be a key feature in the development of community, "whereby social actors form, and experience, a community in order to embrace capoeira play" (Jordan et al., 2018, p.12). Therefore, it is argued that the music sessions were a multiparty endeavour, which promoted acceptance, community, social connectedness, mutuality, and provided opportunities for therapeutic social capital.

Furthermore, identity development was also found to be promoted through new endeavours. For example, engagement in creative practices has been suggested to facilitate the development of personal identity beyond clinical symptoms through eudaimonic wellbeing, such as, challenges and growth (Saavedra et al., 2017a).

Hedonistic wellbeing is also argued to have been present in the excerpt above, which was exhibited by the smiles. Such wellbeing can be transient in nature, but eudaimonic wellbeing tends to be longer lasting (Huta, 2017). Moreover, it is argued that the meaning of rituals extend beyond the temporality of the moment (Spagnola and Fiese, 2007). Thus, longer-lasting eudaimonic wellbeing may also be provided by creative practice ritual engagement. Owen had not previously learnt how to play guitar, this was a new pursuit for him, and thus the music sessions are argued to have promoted Owen to develop his personal identity by choosing to learn something new. It is important to note that personal recovery can be promoted through the development of the individual's identity (Leamy et al., 2011; Slade, 2009b). Furthermore, the recovery literature proposes that personal identity and what is valued in association with this identity is something that should be defined by the individual (Slade, 2009b). Because Owen chose to learn to play the guitar, it is suggested that this was valued and assisted in the development of his personal identity, beyond his mental health diagnosis.

5.3.4 Formal rituals as forced rituals

This section considers the formal creative practice rituals as forced rituals. It considers the performativity of the community at Westmarch Hospital and power rituals, as proposed by Collins (2014). The section concludes by considering the hierarchy between Charlie and Owen in the music session in the light of therapeutic social capital.

5.3.4.1 Performativity

Participation in the occupational therapy timetable is enacted by staff and residents at Westmarch Hospital as a commitment to the ceremonial order of the institutional context. Residents do not need to attend all the sessions, but if their participation levels are considered to be lower than preferable, the staff will make this known to the resident officially during the resident's ward round, or unofficially on the ward, as highlighted in section 5.4.1. Research has

found that a lack of agency in creative practice engagement was found to be a barrier to participation (Vallejos et al., 2016). This has important implications for this research which is exploring creative practice within an environment where a lack of freedom (Gillard et al., 2012) and a loss of liberty (Davies, 2004; Norvoll and Pedersen, 2018) is often associated with life within an institution for the forensic patient.

It is argued that the obligations and expectations relating to attendance to the occupational therapy timetable highlights the social conventions which underpin behaviour at Westmarch Hospital. As such, the "[a]ttachment to [these] rules leads to a constancy and patterning of behaviour" observed in the study (Goffman, 1967, p.49). Furthermore, engagement within the occupational therapy timetable and commitment to the rules of the community were exhibited by the residents who handed in the lighter and the resident who attended the art session following requests for increased engagement with occupational therapy. It has been noted that patients project power onto staff and institutions are "based on a complicity of *both* groups…[and] [t]here is co-operation on all levels" (Hinshelwood, 2001, p.53), and the roles undertaken by those observed in Goffman's research were roles performed through a "dynamic, agentic team performance" and not a static structure of the asylum (Scott, 2010, p.215). It is argued, therefore, that such behaviours symbolise a commitment to community rules.

Moreover, the expectations for increased engagement were verbally expressed by staff which resulted in attendance to the art session for one of the residents, Luke. Thus, agency is central to the microsociological model of therapeutic social capital, see figure 5.1. As discussed in section 2.2.3, attendance to therapy is influenced by commissioning targets, at the exosystem. The resident's engagement with the art session is argued to be the result of forced ritual engagement. Luke was visibly distracted, evidenced by his behaviour in which he was focused upon the activity on the ward rather than the colouring task, yet he was noted as engaged in his medical notes.

Within the occupational therapy literature, it is suggested that "activity and participation should be the observable outcomes of the process of occupation" (Royeen, 2002, p.116). Siobhan, the occupational therapist, accepted Luke's performativity and his presence led him to be classified as the engaged resident. As discussed in section 2.2.3, research has found that patients perform their role as the patient by "playing the game" to avoid coercive treatment or to lead to release (Gillard et al., 2012, p.248; Reynolds et al., 2014, p.199). Furthermore, Morris et al. (2016) suggests that forensic patients are obliged to engage in therapy in order to progress in their treatment. For example, the author found that one forensic patient reported that they attended compulsory treatment in order to be compliant with staff even though they did not agree with their treatment plan (Morris et al., 2016). Thus, it is proposed that some residents in institutional care comply with treatment by adopting a performative role and co-operate in the expected role of the forensic patient.

Forced rituals are energy draining (Collins, 2014) and it is proposed that engagement in such rituals is likely to lead to a negative social outcome representing enmity against the staff group within the institutional context. According to IRT, the EE outcome of a ritual can determine commitment to the ritual and the community (Clarke and Waring, 2018). However, within the institutional context, residents can experience a lack of freedom (Gillard et al., 2012), a loss of liberty (Davies, 2004; Norvoll and Pedersen, 2018), and adopt a performative role in order to appease institutional expectations. Thus, it is argued that choice regarding participation in Westmarch Hospital rituals is further complicated by levels of agency. Furthermore, it is proposed that forced participation does not promote EE+ and minimises opportunities for therapeutic social capital. Thus, a novel finding of the research is that agency in creative practice ritual engagement has important implications for wellbeing, which is of particular relevance to the FMH context in which agency and choice may be constrained.

5.3.4.2 Power rituals

According to IRT, rituals become power rituals in the context of power disparity, which has implications for EE (Collins, 2014). Power rituals comprise of order-givers and order-takers (Boyns and Luery, 2015; Collins, 2014) and "[t]he amount of emotional energy gained or lost will be directly proportional to their relative power" (Boyns and Luery, 2015, p.151).Thus, the impromptu community meeting is argued to be a power ritual because the staff member was ordering the residents to hand the lighter in and had the authority to impose sanctions if his expectations were not met (i.e., room searches). Within power rituals, it is proposed that order-takers lose EE+ (Collins, 2014). However, developments in IRT theory suggest that EE− can be gained if the emotion is of enmity towards the order-giver (Boyns and Luery, 2015). It is proposed that the resident who protested the room search gained EE−, which was exhibited through the anger displayed.

Notions of gains and losses of EE are problematic when considering the power disparity between staff and residents within the healthcare context, where the staff's role is to assist with the mental health recovery of the residents and also to enforce rules. It would be difficult to assert that the staff feel good about reinforcing such a power dynamic, however it is deemed a necessary part of their role, particularly within the FMH context of care and custody, as discussed in section 2.2. It is also proposed that it is problematic to assert that the staff member gained EE+ through their order-giving role as such an assertion supposes that the individuals within the ritual perceive a relative gain or loss based on a tacit agreement on the power disparity between the staff group and the resident group. Within this thesis it is proposed that gains or losses of EE are influenced by individual perceptions and that such perceptions are central to rituals. However, Boyns and Luery (2015) do not make this claim. It is suggested that the indignation displayed by the resident who protested the room searches perceives the relative power and status of the staff member

and within this action also shows a commitment to the symbol of such power relations underpinning ritualistic life at Westmarch Hospital through the commitment of ceremonial order. The contribution of this thesis, then, is that perceptions are central to gains and losses of EE.

The cooking sessions would often evolve into power rituals, where staff adopted the role of order-giver and residents adopted the role of order-taker, leading to low levels of EE+ for the residents or a gain in EE−. It was clear within these sessions who the staff and the residents were, with defined roles and power relations being established and reinforced by the performed role of teacher and student. It has been argued that cooking can empower individuals as this activity enables an individual to feel in control of their treatment (McNeill and Bannigan, 2014). However, if such an activity is scrutinised by staff, feelings of empowerment may be challenging.

The cooking sessions were organised and directed by the occupational therapy staff, therefore who attended and when would be decided by the staff team. This is another example of a forced ritual with the mental health patient participating in hospital regimes. The residents lacked agency for participation within such sessions. However, the cooking sessions were sometimes avoided by mishearing the occupational therapy staff through bedroom doors, as evidenced in section 4.4.1.1, or sometimes by direct refusal to attend. Such responses would be marked on their individual file as 'offered but refused' and would also likely be discussed during ward round. Thus, some level of agency can be exercised within the institution however, the consequences of such agentic choices would be followed up at a later date.

5.3.4.3 Agentic rituals

Finally, it is important to consider those rituals in which residents exercised some level of agency. The example explored is that of Owen and learning to play the guitar. Owen was able to practice playing with the ward's guitar in his room, at his pleasure, as he had unlimited

room access; he also had plans to purchase a guitar which was permitted through his individual risk assessment. However not all residents at Westmarch Hospital were allowed to have unlimited or unsupervised access to a guitar, based on their risk. For example, the guitar that was available on Mirkwood ward was locked in the game's cupboard due to its ligature and self-harm risk to the female residents. Owen, therefore, had agency to spend time playing the guitar. It is important to note that levels of agency can fluctuate for the residents at Westmarch Hospital, depending on their perceived and assessed risk and residents had differing levels of access to materials (i.e., a guitar) and to the occupation therapy timetable (i.e., leave permissions). Therefore, the availability of creative practice instruments would differ between residents and would also fluctuate, depending on their perceived levels of risk.

Charlie was not a clinical member of staff and thus it is argued that hierarchy between Charlie and the residents was flattened within this context. Charlie did not have the ability to impose sanctions, potentially contributing to a lack of perceived power disparity between the residents and Charlie. If we consider the diminished power disparity in relation to IRT, this dynamic opens up the possibility for Charlie and the residents to maximise their EE+ through the market opportunity of the music session. Participants within the CPMR consortium found horizontal hierarchies facilitated social inclusion and the mutual experience, as discussed in section 2.4.1.4.3. For example, Perkins et al. (2016, p.13) found that the removal of labels, such as carer, musician, or patient, assisted with the removal of:

> hierarchies in order to share and co-construct 'interactional processes, based in social relationships and situational identities' with the aim of achieving recovery for all. (as cited in Crawford et al., 2013, p.57).

Respect and equality was also found to be promoted by the non-hierarchical experience of the patients and clinicians attending the music jamming sessions, in a study in the USA (Callahan et al., 2017). Furthermore, the sessions themselves reportedly assisted with the breaking down of such hierarchical barriers (Callahan et al., 2017). It is therefore, argued that the flattened hierarchy within the music sessions promoted a different space to that typically experienced on the ward, an atmosphere that promoted respect, equality, and wellbeing.

The supportive space created by Charlie was upheld by the residents during the music session thus creating a sense of community, and contributions to EE+ of affinity towards the group's participants. For example, the residents were observed to interact with one another in a different manner to that observed outside of the music sessions. It was observed that Nicole and Jane did not interact outside of the music sessions. However, within the sessions, they were observed to be pleasant and would wait patiently for their turn to make music with Charlie. There would be occasional smiles whilst Charlie and the other resident interacted; this was a small but noticeable engagement between the residents. Furthermore, I observed that Jane was livelier in character in these sessions compared to the times that I observed her outside of the music session. Jane would often be asleep on the ward or commonly in arguments with staff and/or residents; Jane was described by staff as often having an hostile demeanour. However, in the music sessions with Charlie, I felt that I had an opportunity to gain some insight into the breadth of Jane's personality—one that was warm and friendly. For example, during my observation of the first music session, I offered to print some lyrics for Jane and returned with some of what was requested, Jane quickly joked: "I'll let you off since you're new, but next time no excuses!". We all laughed. The social space within the music sessions could be argued to provide temporary relief where discussions other than mental health can take place, suggested to be valued by those within mental health services (Stickley and Hui, 2012).

5.3.4.4 Meaningfulness

Throughout this thesis, meaningfulness has been argued to be a facilitator of personal recovery (Leamy et al., 2011), as discussed in section 2.2.3. Meaningfulness is argued to be influenced by the forced nature of creative practice engagement in which forced participation can lead to levels of performativity, which can potentially hinder meaningful engagement. Performativity is argued to represent a commitment to the ceremonial order of community life and such engagement is unlikely to be meaningful beyond such a commitment. However, this section also considers the meaningfulness of the creative practice rituals, from the resident perspective.

The quality of the art session was found to hinder participation for residents at Westmarch Hospital. For example, during the interview, Jane explained that the quality of the art session meant that she did not participate within those sessions. According to Jane, the sessions lacked artistic authenticity and described the art sessions as:

> "[v]ery basic…it's too basic really ... You can't really feel like it's something a proper artist would do, because you know if you went to art college, you'd do still life…one would feel like being a proper artist doing it"
> *[Resident interview: Jane, Mirkwood ward]*

The art sessions were facilitated by an occupational therapist and the tasks observed would require a basic application of skill from the participants. Research has found that tasks that are considered menial may promote accessibility, however such tasks may reinforce feelings of loss and helplessness and thus have a detrimental effect on wellbeing (McCann, 2004). It is argued that the simplicity of the task has limitations for identity development and escapism within this context. Engaging in creative practices has the capacity to re-build identities (Crawford et al., 2013; Hui et al., 2019; Jordan et al., 2018; Lewis et al., 2016; Saavedra et al., 2017a). For example, the re-

development of identities was found amongst participants of adult community learning arts workshops; participants described feelings of pride, achievement and self-affirmation, facilitating a rebuilding of identity and sense of self (Lewis et al., 2016). Therefore, the sense of self was extended through a sense of achievement. Furthermore, Jordan et al. (2018) found that learning something new through engagement in a community capoeira project assisted with the development of self and identity. Thus, learning and mastery is suggested to promote meaningfulness and wellbeing.

It is argued that colouring, which is a well-known social practice to residents, lacks a sense of mastery and is unlikely to instil a sense of achievement. However, it may be the case that activities which promote more choice and are meaningful would further promote wellbeing and identity development beyond symptoms of illness. Furthermore, Jordan et al. (2018, p.1) also found that participation in capoeira classes facilitated escapism, "whereby new place and pursuit ... [was found to] facilitate hedonistic diversion from the mundane". Whilst colouring may provide a diversion from the mundane within the institutionalised context, particularly when the resident often experiences restrictions of liberty (Davies, 2004; Norvoll and Pedersen, 2018; Simpson and Penney, 2011), it is unlikely that engaging in such a task would be described as hedonistic.

Personal recovery involves the development of new meaning and purpose (Anthony, 1993) and engagement in meaningful occupations has been promoted by the Department of Health (2002). Gillard et al. (2012) reported that patients found life on an inpatient ward boring with little stimulation via activities and McKeown et al. (2016) found that keeping occupied, via meaningful activity, was viewed as central to patient's recovery. It is suggested that the art session lacked meaning for some residents and thus opportunities for the promotion of personal recovery were constrained by the nature of these activities.

According to Collins (2014), successful creative practice rituals can lead to symbols of social relationships. Clarke and Waring (2018,

p.1278) also proport that "symbolic meanings and norms are transmitted and reinforced, shared identities are fostered, and a sense of belonging promoted". In section 5.4.1, the lighter was theorised to be a symbol of community rules. It is suggested that within the art sessions the artwork could symbolise meaning at Westmarch Hospital. However, it was often observed that the images were discarded after the session. These were either left on the table or, on one occasion, they were turned into paper aeroplanes and it is argued that this symbolises a lack of meaning for the artwork created in the art sessions.

As discussed in section 2.5.1, routines lack meaning (Spagnola and Fiese, 2007) and offer "little cohesion as participants act as individuals rather than a group" (Clarke, 2017, p.55). Whilst rituals and routines share common properties, such as, the presence of individuals and group interactions which are repeated (Clarke, 2017), it is the shared emotion and focused attention (Payr, 2010), which differentiates these social encounters. It argued that the art session was a routine for some residents due to the lack of shared emotion and focus of attention, which offered little cohesion for the residents and staff engaging in the ritual. Routines, then, are unlikely to promote therapeutic social capital. Furthermore, it is proposed that those who engage in routines present an agentic team performance, as discussed in section 5.3.4.1. It is important to note that attendees to the music sessions were able to choose what creative practice activity they engaged in. Thus a novel finding of this research is that agency and choice in relation to creative practice engagement has implications for meaningfulness, identity, and personal recovery, and that routines lack meaningfulness, which limit opportunities for therapeutic social capital.

5.3.5 Formal creative practice rituals: Key contextual themes

This section revisits the key aspects of life, which have been suggested to influence creative practice rituals at Westmarch Hospital. Section 4.8 explored the themes: Surveillance, security, and

risk; emotive environment; and boundaried relationships, in relation to the microsociological model of therapeutic social capital. Chapter four explored the key contextual themes in relation to community life at Westmarch Hospital broadly, this section considers how these themes influenced the formal creative practice rituals at Westmarch Hospital and the development of therapeutic social capital.

5.3.5.1 Surveillance, security, and risk

5.3.5.1.1 Forced rituals

Section 5.3.4.1 explored the performative nature of participation in institutional regimes. Whilst research has found that forensic patients play a performative game of engagement (Gillard et al., 2012; Reynolds et al., 2014), the commitment to the community rules is suggested to be underpinned by co-operation of both staff and residents, in a "dynamic, agentic team performance" (Scott, 2010, p.215).

If a resident's engagement in therapy was considered to be low, this would be raised during their ward round where increased engagement was promoted. For one resident, the purpose of the institutional policy of engagement in the occupational therapy timetable was viewed as assessment-orientated and once the assessments were complete, participation was viewed as optional. For example, when James was asked why he doesn't engage in occupational therapy anymore, he replied:

> "Erm, it's just because there's nothing for me to show them anymore, it's like, it's all to do with, well when I was doing [occupational therapy] OT here to show that I've got the skills for the community, yeah? And I've showed them all that, so really [it's now] to do with like, getting unescorted leave and proving that I can actually, that I can take drugs and come back on time and that and like test with unescorted … but it's all

> voluntary now what I'm doing so I don't have to do much like with OT."
> *[Resident interview: James, Buckleberry ward]*

The occupational therapy sessions were viewed by James as an assessment and monitoring tool for staff. The purpose for which he had previously fulfilled. Participation within such sessions are suggested to be performed by the resident as part of their role within the institution at Westmarch Hospital. Participation within forced rituals may lead to lower levels of EE+ or the gaining of EE− (Boyns and Luery, 2015), thus potentially diminishing opportunities for therapeutic social capital between staff and residents. It has been noted that increased engagement is likely to lead to increased liberty however, Adshead (2000, p.303) questions "when does consent become mere assent?". The power disparity between the resident and staff group is apparent when participation within hospital regimes is dictated. Participation within the occupational therapy timetable is suggested to residents as such participation is presumed to assist with their mental health recovery pathway by preparing them for life in the community. If a resident does not participate within the institutional regimes, sanctions are imposed. Such sanctions would commonly include a loss of section 17 leave. These sanctions were found to negatively influence the therapeutic milieu by restricting meaningful engagement in the local community:

> "When it got to that point when they're taking leave, it does feel like they're restricting you and they're not aiding your recovery…But when they do take your leave, it's kind of like you're excluded from society and you don't get involved in the community as much so just doing normal things like walking to the shop; or drink, or going for a coffee, or going into town and buying a game; or going to a library to read a book. You can't do the normal things that normal people do

> in society because even though you've got the external community, you're kind of stuck in your own community bubble within the four walls"
> *[Resident Interview: Ryan, Buckleberry ward]*

Being excluded from society was viewed by Ryan as negatively influencing his recovery. It is suggested that opportunities for therapeutic social capital are restricted at times, for the FMH patient.

Section 4.8.1 discussed that the surveillance of the forensic patient is suggested to reinforce the power disparity between staff and residents at Westmarch Hospital. It is also proposed that the staff-resident interactions showcased within the cooking sessions also re-affirmed the power disparity between the two groups. Such interactions are rooted in a paternalistic view of individuals receiving mental healthcare. For example, it is argued that the treatment and management of mental health patients through containment is underpinned by paternalistic policies (Brown, 2016). Furthermore, engagement in the occupational therapy timetable was monitored by staff at Westmarch Hospital, as discussed in section 4.8.1. Yet, such sessions offered an opportunity for the residents and staff to spend time together, providing opportunities for social interaction and thus therapeutic social capital. Thus, whilst the activities themselves were observed to offer little opportunity for a multiparty and joint endeavour, the social interaction may provide opportunities for therapeutic social capital. The occupational therapy timetable also offered a structure to social engagement. The range of activities were also reported by Ryan as:

> "giv[ing] you something to do… or even it just keeps you busy and it keeps your mind focussed on other than what's going on day to day in life"
> *[Resident interview: Ryan, Buckleberry ward]*

Research supports this finding where patients reported that activities help to alleviate boredom (Chambers et al., 2014).

5.3.5.1.2 Procedural versus relational security

As discussed in section 2.2.2, procedural and relational security are key features of a therapeutic environment (Department of Health, 2010; Exworthy and Gunn, 2003). The art session had the potential to promote relational security, which was discussed in section 2.2.2, and is described as:

> the knowledge and understanding staff have of a patient and of the environment, and the translation of that information into appropriate responses and care. (Department of Health, 2010, p. 5).

However, the session was interrupted by procedural security, for example, the removal of the lighter which symbolised risk. Procedural security includes "policies and practices relating to patients which control access, communication, personal finances and possessions", examples include searches of personal items on return from leave from the institution or room searches (Kennedy, 2002, p. 434). It is recognised that the "balance between these three elements often shifts" (Department of Health, 2010, p. 4), but "any substantial recovery work must bridge concepts of therapy and security" (McKeown et al., 2016, p. 235). Often in practice priority is given to procedural security rather than relational security leading to restrictive practices (Mann et al., 2014). It is argued that the over application of procedural and physical security can undermine therapeutic work (Tomlin et al., 2018). Furthermore, it is important to note that security is compromised when one feature of security is ignored or neglected (Exworthy and Gunn, 2003). Thus, balancing the different types of security is highly important to create a suitably therapeutic environment, one which protects the public, and also cares for the forensic patient. In section 5.3.1 the timing of the impromptu community meeting that interrupted the art session is

questioned as the potential relational security offered by the art session was overridden by procedural security practices.

Risk assessments were found to restrict access to creative practice tools, for example, musical instruments, as discussed in section 5.3.5.1. Access to creative practice tools were more heavily restricted on Mirkwood ward due to the high prevalence of self-harm. Furthermore, risk assessments influenced activity selection for the occupational therapy timetable, however it was noted by Ryan, a resident, that:

> "Even if they do restrict sports or some sports, erm it's never, it's never got to the point where it can't be done, it just gets to the point that it can't be done at that time, erm because it all comes down to risk and you have to get it cleared through ward round, which takes time…everything gets done eventually"
> *[Resident interview: Ryan, Buckleberry ward]*

Whilst policies on risk and risk assessments are influenced by the exosystem level, staff at Westmarch Hospital conduct the assessments and so can influence the outcomes of such assessments based on their professional judgments.

5.3.5.1.3 Meaningfulness

The promotion of participation with meaningful therapeutic activities within national policy is underpinned by the assumption that such participation promotes recovery (Department of Health, 2002), section 2.2.3 provides support for this claim. It has been noted that basic measures of assessing participation within activities does not evaluate meaningfulness (Wenman, 2010). The practices of collating engagement information at Westmarch Hospital assessed participation by attendance to sessions only. As discussed throughout this thesis, participation within the timetabled occupational therapy sessions was monitored at Westmarch Hospital, according to national

policy. Within the market of the privatisation of the National Health Service (NHS), competitive targets are highly important for the continued contracts of health services, as discussed in section 4.8.1. It is suggested that surveillance, security and risk practices are influenced at an exosystem level, but such initiatives do not assess meaningfulness. Section 5.3.4.4 noted that meaningful engagement promotes personal recovery however, such meaningfulness is suggested to be something that is valued by the patient (Slade, 2009b). It is suggested that the art and cooking sessions observed did not likely promote meaningfulness for those attending and their participation was the result of a forced ritual.

5.3.5.2 Emotive environment

Interaction rituals are considered to be chains of events, which build over time and can lead to feelings of solidarity or a build-up of EE (Boyns and Luery, 2015). Thus, as noted by Boyns and Luery (2015, p.159):

> a single interaction ritual rarely stands alone [and] emotional energy in a given setting is the result of previous interactions and the catalyst for future encounters.

The art session and the impromptu community meeting, outlined in section 5.3.1, are now considered in the light of ritual chains and their implications for EE and therapeutic social capital.

It is theorised that the forced nature of participation within the art session and the lack of mutual focus of attention did not promote therapeutic social capital and levels of EE+ are likely to have remained unchanged or indeed levels of EE− may have increased through engagement with the creative practice ritual. Thus, participants within the art session are theorised to have not experienced an increase in wellbeing from engagement with this ritual. The impromptu community meeting disrupted the creative

practice ritual. This was a power ritual which is argued to have led to an increase in EE− for Luke and possibly other residents who were assigned the role of order-taker. It is also proposed that such rituals have implications for therapeutic social capital, as such rituals may diminish EE+ or the individual may gain EE−, as evidenced by the indignation displayed by one resident, thus minimising opportunities for social connectedness.

As discussed in sections 4.8.3 and 2.5.1.1, the EE outcome of an interaction influences an individual's disposition within everyday routines. According to IRT, past social encounters influence expectations for future social encounters (Summers-Effler, 2006) and:

> gains of … [EE]− create negative feelings that, through repeated unsuccessful interactions, will build upon negative feelings and ultimately solidify one's experience as an outsider. (Boyns and Luery, 2015, p.158).

Thus, the art and power ritual may have led to a decrease in wellbeing for the residents influencing their disposition for future social encounters.

It is important to consider the social environment and its influence on engagement with creative practice rituals, beyond the art and power rituals, at Westmarch Hospital and its implications for EE and therapeutic social capital. It was noted in section 4.8.3 that there were interpersonal issues amongst the resident community on Buckleberry ward. Furthermore, section 2.2.3, noted that the acute ward environment can be an "an especially volatile and unpredictable place in which to live" (Quirk et al., 2004, p.2581) and chapter four highlighted the changeable and challenging nature of the environment at Westmarch Hospital. Patients have also been found to describe the inpatient mental health environment as a culture of violence (Gillard

et al., 2012) and reported to have experienced fear, embarrassment (Bonner et al., 2002), and distress (Thibeault et al., 2010), which can negatively influence the therapeutic milieu. Distressing events can influence expectations for future social encounters and individuals may lack motivation to engage in social interactions, as discussed in section 2.5.1.1. Goffman (1967) suggests that negative events may lead to avoidance rituals in order to preserve the self. This research found some residents adopted this strategy. For example, Imran explained that he would watch TV in his room in order to avoid certain residents:

> "it depends 'cause like if it's quite busy or if it's, or if erm, depending on which erm patients, which patients are on the ward, erm because there are some of them that I avoid, I've had erm racial abuse off some of the patients, so I avoid them purposefully"
> *[Resident interview: Imran, Crickhollow ward]*

The avoidance of participating within community life on Crickhollow ward was influenced by negative experiences for Imran. As noted by Boyns and Luery (2015, p.156):

> [o]n the micro-level of interpersonal interaction, presentation rituals affirm the positive solidarity of the group while avoidance rituals establish the boundaries of negative solidarity.

Imran conducted avoidance rituals indicating a lack of therapeutic social capital with fellow residents on Crickhollow ward indicating the boundary of negative solidarity.

Adam, on the other hand, actively engaged in the occupational therapy timetable, yet I often observed that Adam was rejected by the residents on Crickhollow ward. The excerpt below highlights

Imran's feelings towards Adam, including his treatment by fellow residents.

> "I don't do as much [Occupational Therapy] OT as I used to, and that's to avoid Adam and he does a lot of OT, he does practically everything…so I avoid him, not because I don't like him, I think he's alright, but I, I don't have it in me, to put up with him and his mannerisms, for a whole week and like not even a little bit… So yeah, so I have snapped at him a few times and other people as well, but for different reasons."
> *[Resident interview: Imran, Crickhollow ward]*

Research has found that patients can be judgemental of others due to their challenging behaviour (Woods and Springham, 2011). Adam established close working relationships with the staff, particularly the occupational therapy team who were friendly towards him and he would often make them laugh. According to IRT, individuals aim to maximise their EE+ and gravitate towards social encounters that are likely to increase it (Boyns and Luery, 2015). As such, Adam enjoyed spending time with staff and thus participated in all the occupational therapy groups available. However, his presence led Imran to undertake avoidance rituals as interactions with him were considered unfavourable.

During the interview with one of the residents on Mirkwood ward, interpersonal conflicts also became apparent. During our conversation about the community on the ward, Charlotte, was hesitant to answer, and her eyes were fixed on a fellow resident who could be viewed through the window of the campus room; the resident was shouting. Charlotte then explained:

> "I try to spend as much of my time either doing activities or in my room and staff doesn't like it so much, being in my room, but I'm like 'I don't want to sit out

> there on the ward.' And they're like, 'Why you isolating yourself?' And it's like 'You try living on here, every week, and you would isolate yourself in your room'"
> *[Resident interview: Charlotte, Mirkwood Ward]*

Charlotte also engaged in avoidance rituals by participating in activities or spending time in her room, in order to steer clear of particular individuals on the ward. This was despite staff not encouraging such behaviour.

As discussed in section 4.8.2, individuals may avoid interactions if past experiences have led to diminished levels of EE+ (Boyns and Luery, 2015). Research in the inpatient mental health environment supports this notion, for example, Quirk et al. (2004) found that patients would use avoidance techniques in order to keep safe, such as retreating to their rooms and Woods and Springham (2011) also found that patients avoided art therapy due to the challenging nature of the work. However, it is important to consider that not all rituals can be avoided in the FMH environment, particularly when some rituals represent forced rituals.

If avoidance techniques cannot be enacted it is proposed that:

> a loss of … [EE]+ matched with a concomitant gain of … [EE]− is increasingly likely when this situation becomes overtly rife with conflict. (Boyns and Luery, 2015, p. 158).

Ryan indicates that he struggled when he first arrived at Westmarch Hospital:

> "I kind of went through a time of fighting the system. I didn't agree with the system, I didn't agree with rules, I didn't agree with policies, I lost leave on an almost frequent basis so there were a lot of groups that I

> couldn't actually engage in. I was having incidents every other day"
> *[Resident interview: Ryan, Buckleberry Ward]*

Other forensic patients report that they were "fighting the system" (Morris et al., 2016, p. 690). It was noted in section 5.3.5.1.1 that Ryan's behaviour meant that he did not have leave privileges, which also influenced how he perceived his time at the hospital, during this period, he noted that: "you're kind of stuck in your own community bubble within the four walls". The conflict he experienced with the community led him to be unable to participate in activities outside of the hospital grounds, which negatively influenced Ryan's perceptions relating to his wellbeing and recovery.

The challenging environment is suggested to have implications for EE+ and EE− and therapeutic social capital. Residents were found to adopt avoidance rituals in order to protect themselves from the upset caused by fellow residents, which influenced participation within the creative practice rituals and also minimised opportunities for social interaction. However, staff challenged residents when they retreated to their individual bedrooms. The requirement for the presence of residents in the communal ward area facilitates social interaction and thus the increased presence of residents on the ward, providing opportunities for therapeutic social capital.

As noted in section 5.3.3, the social environment within the music sessions was observed and felt to differ to the usual ward environment on the three wards at Westmarch Hospital. It is suggested that Charlie promoted a supportive environment and the hierarchies were more fluid within these sessions, due to his lack of clinical role. The group leader was described as supportive in the clay workshops, which was reported to assist in flattening the social hierarchy which was noted to contrast the traditional therapeutic sessions (Argyle and Winship, 2015). It is therefore, suggested that

Charlie promoted a supportive environment, which facilitated therapeutic social capital.

EE then was a source of motivation to either participate or avoid engagement in creative practice rituals. However, forced rituals are likely to lead to a build-up of EE− or a loss of EE+. Such a finding contributes to an understanding of how creative practices are embedded within practice and navigated by the forensic resident community within a highly emotive environment and provides insight into possibilities for therapeutic social capital, which is a novel finding and a contribution of this thesis.

5.3.5.3 Boundaried relationships

Section 4.8.3 noted that boundaried relationships were observed between staff and residents and are theorised to be underpinned by professional therapeutic working, as outlined in section 2.2.5. Mutuality is suggested to be challenging within the hierarchical relationship between staff and patients (Brown, 2016). This chapter extends the theme boundaried relationships to include practices that promote or maintain boundaries within or between groups, such as, staff-resident and resident-resident relationships.

Boundaried practices can influence opportunities for social interaction and thus mutual recovery. For example, the formal rituals delivered by the occupational therapy team were for the resident's participation only, except for the art sessions in which the staff were observed to occasionally participate in individual projects. However, during the interview with Siobhan, she indicated that when there were not enough residents in attendance to the sports group, she has, on a few occasions, participated in the activities.

> "I've done it a few times with different things, tennis as well, I've played tennis because there's no-one else to come and play so I've really liked the fact that we did that and that we knew that that was something that

they really enjoy doing and we continued to do each week"

[Staff interview: Siobhan, occupational therapist]

Therefore, on some occasions, low engagement levels led to a less formal approach to boundaried practices that were suggested to promote independence and skill development for independent living. The lack of shared experience and multiparty endeavour found within the art and cooking sessions observed are suggested to promote the continuation of a boundaried relationship between staff and residents and thus it is argued that the individually focused sessions provided limitations for therapeutic social capital. It is argued that creative practice engagement, which promotes a multiparty pursuit, could be a powerful tool for connecting communities (Crawford et al., 2013) through providing opportunities for therapeutic social capital, as evidenced in the music session in section 5.3.3. A novel finding and a contribution of this thesis is that such a finding contributes to an understanding of how creative practices can promote therapeutic social capital within the institutional FMH environment.

5.3.6 Summary of findings: Formal creative practice rituals

This thesis provides novel insights into the implications for institutional regimes in which the forensic patient must engage and therapeutic social capital. For example, forced rituals have implications for a performative role which uphold the ceremonial order of community life at Westmarch Hospital, but can constrain opportunities for therapeutic social capital. A lack of meaningfulness is also suggested to be present when engaged in a performance ritual. Thus, opportunities for authentic engagement can undermine opportunities for therapeutic social capital, when attendance to creative practice pursuits are monitored.

It is proposed that agentic rituals promote opportunities for personal recovery and can promote meaningfulness, as evidenced in section 5.3.3 and discussed in sections 5.3.4.4 and 5.3.5.1.3. Furthermore, it is suggested that engagement in creative practices can promote a

fluid or flattened hierarchy between those engaged in a shared mutual endeavour and research has also made this claim, as discussed in sections 2.4.1.4.3 and 5.3.4.3. The flattening of the hierarchy between residents and residents and staff is argued to provide opportunities for therapeutic social capital. Furthermore, such insights have implications for occupational therapy theory and practice, in that an understanding of the types of group work which can promote therapeutic social capital would have important implications for the promotion of wellbeing.

It has been theorised that EE is a source of motivation to either participate or avoid engagement in creative practice rituals. This thesis then contributes to an understanding of how creative practices are navigated by the forensic resident community within a highly emotive environment and provides insight into possibilities for therapeutic social capital, which is a novel finding and a contribution of this thesis.

5.4 Informal creative practice rituals

The performative nature of engagement in formal creative practice rituals is influenced by agency and the obligations related to engagement in the occupational therapy timetable. It was noted in section 2.4.1.3 that over 70% of patient's time has been found to be spent in occupations initiated by the patient (Stewart and Craik, 2007) and everyday social encounters and time outside of structured therapy has been found to play an important role in facilitating change (Clarke, 2017). Section 2.4.2 concluded that time outside of therapy within the institutional environment is worthy of exploration. This section considers moments which are spontaneous in nature. Various informal creative practice rituals were observed during my time at Westmarch Hospital. The residents would often engage in playing pool, ping-pong, games, cards, or watching films on the ward which would often be outside of the structured therapy time.

During my time at Westmarch Hospital, I was often invited to play cards, board games, pool, and ping-pong with the residents, particularly on Buckleberry and Crickhollow wards. The examples provided within this section of the thesis explore both successful and unsuccessful informal creative practice rituals which were initiated by staff and residents. These were rituals which were not formally scheduled by the institution and were not established formal rituals, such as meetings. These examples are explored utilising the microsociological model of therapeutic social capital, (see figure 5.1) to illuminate moments that had the potential to foster social connectedness between residents and staff and thus provided an opportunity for mutuality, and mutual recovery (see figure 2.1 in section 2.3.4.1 for a conceptual model of therapeutic social capital). An unsuccessful ritual is explored to further understand moments where informal creative practice rituals can negatively influence wellbeing and lead to exclusion. Research has found that patients in a Therapeutic Community were sometimes unsupportive of each other, which led to isolation and alienation (Clarke and Waring, 2018). A situational approach to creativity is adopted which considers the physically restrictive environment, as discussed in section 2.4.1.1.2. Activities, undertaken within such an environment, that utilise the social and physical space to engage with fellow residents and staff is considered creative. This conception considers innovation as a quality of creativity which considers the geography of such innovations.

The thesis thus far has been focused on activities which have primarily involved participation in creative practice rituals with residents and not staff, with the exception of the music session as evidenced in section 5.3.3. This is due to the lack of expected engagement of occupational staff in the activities delivered, which minimised opportunities for observing activities which were undertaken by staff and residents. This section explores a creative practice ritual which was shared between staff and residents.

5.4.1 Eye-spy

It was nearing the end of my time at Westmarch Hospital and I had become familiar to the residents. The extract below from my fieldnotes highlights a moment observed where an informal creative practice ritual was initiated by James, a resident on Crickhollow ward.

> I was sat on one of the sofas in the communal area, next to James. It was the afternoon, around 4.45pm. It was a nice day; the sun was out and the atmosphere on the ward felt relaxed. The ward was relatively quiet, with a few residents walking around, visiting rooms or preparing drinks and one resident was lying on the sofa, watching TV. There weren't any staff in the communal area as they were gathered in the office doing paperwork. James invited me to play a game, we settled on eye-spy. James began with the letter 's'. Adam appeared from one of the bedroom corridors and watched us for a minute, then began to offer guesses. After many guesses, with the help of Adam, we gave up. The answer was screws. James pointed to the TV box where the TV had been secured behind a Perspex screen and wooden case, for safety reasons. This was fixed with an array of screws. Next it was my turn. As we played, more residents joined in. Imran appeared from the other bedroom corridor and began to also offer guesses. Soon, Assim offered a guess. Eventually, Imran got it: "ahh is it pillar?". Indeed, it was. Next it was Imran's turn, he offered the letter A. A staff member appeared from the staff base and sat down on one of the sofas, he also began to offer guesses. Residents were appearing from their rooms and had begun to queue by the kitchen hatch behind us. One by one, the residents on the sofas left to join the queue for dinner. The game players soon dissipated.
> *(Fieldnotes: Day seventy)*

Whilst, the environment was not a particularly fruitful one for the game, this added to the challenge. The hospital environment was rather sparse, with the secure features most prominent, which featured heavily in the game; the residents chose items such as screws and alarms, which were unique to the secure environment. Eye-spy was a social practice that the residents and staff were familiar with. Once someone had guessed the answer correctly; they then took their turn to lead the game. Due to the game's familiarity with the residents and staff, they were able to join in at any time and take a guess. Those who joined in did not ask what we were playing; the language used by players clearly marked the game being played. The game name is announced each time a new round begins, for example, "I spy with my little eye, something beginning with...". Those who are guessing shout out the name of objects and the round leader indicates if the guesses are correct. The movements of those playing the game were synchronised; it was clear who was participating by the head movements of those searching for the answer indicating a mutual focus of attention. Each person guessing would be scanning the room for possible clues, mostly in silence until a guess was shared amongst the players. The attention of the players was towards a mutual goal—to guess the name of the object. Synchronisation through movements was therefore observed, both physically and verbally, evidencing the shared mutual focus of attention towards the object of the game. The game was a familiar social practice and there is no clear winner thus the pursuit is a relational game.

The shared nature of the game, which included unlimited group guesses and turn-taking, promoted a shared social experience — this was a momentary mutual and multiparty endeavour for the residents and staff on Crickhollow ward. The shared social experience has been evidenced within chapter two as an important feature of the CPMR programme and was found to promote social connectedness through a mutual pursuit. For example, Jordan et al. (2018) found that engaging in capoeira play as a multipart pursuit promoted a sense of

community amongst participants. The barrier to outsiders, in this instance, was of a permeable nature. However, the lack of a rigid barrier was an attribute to the level of social engagement observed; fellow residents and a staff member began to join in and play the game as time progressed. I observed that residents who didn't typically socialise during unstructured time were playing the game together. The game was interrupted by the lunch-time routine and the game quickly dissipated.

Meal times are institutional regimes which occurred at 8:30, 12:00, and 17:00, across the hospital. The meals were prepared by the kitchen staff in the hospital kitchen and delivered to the ward kitchens on a heated trolley. The staff would then serve the food to the residents through the kitchen hatch. Meal times would begin when the ward kitchen hatch was opened by the staff serving food; the staff would, therefore, decide what time the meal was served to residents. Residents would begin queuing by the hatch, often signalled by the presence of staff member in the kitchen; the time would vary from day to day but would typically be within a 20-minute window. Occasionally, the residents would inform the staff when the trolley had arrived, however this was often met with a response indicating that the staff were busy. The staff would serve the food when it was deemed convenient for them, and not for residents — it was observed that the staff did not typically observe or monitor the activities of the residents or delay serving food due to an observed activity. As such, social interactions would be interrupted to implement the institutional regime. Such regimes are referred to by Goffman (1961, p.17) as "batch living" where individuals are grouped together, "all of whom are treated alike and required to do the same things together". Meal times at Westmarch Hospital were "conducted in the same place and under the same single authority" (Goffman, 1961, p.17). The institutional regimes, such as meal times, indicate the lack of agency that residents have over basic daily activities. This lack of agency has been argued to contribute to the deprivation of autonomy associated with the pains of imprisonment (Shammas, 2017).

The ward had become busy because dinner was due to be served. Thus, residents began to appear from their individual bedrooms, or returning from leave, in time for the evening meal. The eye-spy game was initiated in an opportune moment in-between the structured activity. The structured timetable of scheduled life, thus, promotes the bringing together of residents, which can lead to social interaction. Therefore, whilst scheduled life can restrict opportunities for social interaction, timetabled events can also provide opportunities for social interaction, which has been identified as a fundamental ingredient for therapeutic social capital, as outlined in figure 2.1 in section 2.3.4.1.

A shared mood was observed by the faint smiles when a guess was provided, and the game leader announced if this was correct. Enjoyment was observed to be more intense when a guess was wrong when the game leader would often proudly announce that the individual had guessed incorrectly.

5.4.2 Singing

It is important to consider the nature of failed informal creative practice rituals to further understand the boundaries of successful creative practice rituals and the circumstances in which rituals can fail. The excerpt below highlights an example of a failed informal ritual between two residents, Adam and James.

> During a music session with Charlie on Buckleberry ward four residents and Charlie had taken part in a group music making session. Adam was given the task to sing; he was great at making up lyrics on the spot. The session had ended, and we headed back out to the ward. He began to sing on the ward. James suddenly became irritated and said: "Shut up Adam!". Adam continued to sing. James continued to shout at Adam: "Shut the fuck up Adam!". Eventually Adam stopped and walked off to his room.
> *(Fieldnotes: Day sixty-one)*

The creative practice ritual of performer and audience had failed to extend beyond the music session. Adam attempted to continue the ritual of the music session by applying his role informally outside of the structured session. However, James did not want to engage in this informal ritual and was not prepared to undertake the role of audience in this circumstance. James' focus of attention was on the object of ending the ritual by verbal demand. Adam's focus of attention was fixated on singing. There was no shared mutual focus of attention marking the failure of the informal ritual.

According to IRT, individuals are motivated to repeat successful rituals (Collins, 2014). Prior to Adam singing in the communal area of Crickhollow ward, Adam and James had been engaged in a creative practice ritual in the music session. James was tasked with creating a beat for the group, Charlie played the guitar, and Adam sang. As discussed in section 5.3.5.2, interaction rituals are considered to be chains of events (Boyns and Luery, 2015). It is proposed that Adam's levels of EE+ is likely to have been elated following the music session. Research has found that group singing can promote wellbeing and social support and belonging (Plumb and Stickley, 2017). It is proposed that Adam was likely looking to repeat the successful ritual in order to maximise his EE+ by creating a new informal creative practice ritual with fellow residents on the ward. Adam adopted the performer role he had enacted in the music session. However, James did not want to participate as an audience member to Adam's performance, rendering the ritual unsuccessful. Adam's singing did not promote wellbeing for others outside of the formal music session.

5.4.3 Bingo pen

> Julie, a staff member, entered the busy ward on Mirkwood; she entered the room with a big smile. The airlock door slammed. Julie was popular amongst the residents on Mirkwood ward and so was met with smiles and waves. The bingo session had just ended. I was walking over to the staff base. During this time, Julie

> had grabbed a red bingo pen and begun to draw on the faces of other staff present, giggling as she was doing this. Her demeanour was jovial and almost child-like as she ran around the unit laughing and slightly hunched with her hands pulled in near to her chin with the bingo pen in hand. Because I was not a member of staff at the hospital and we did not know each other, I had assumed that I was safe. But as Julie passed me, she drew on my nose!
>
> I laughed and paused for a moment, looking around at the ward. This had caused quite a commotion. There was running and laughter as Julie chased staff, all the while, slightly hunched and holding her hands near her chin, giggling. The female residents sat laughing and watching the spectacle and the other staff members were relaxed and jovial—joining in whilst carrying out their normal duties.
> *(Fieldnotes: Day thirty-three)*

Julie undertook the role of performer and saw an opportunity to initiate a creative practice ritual. Julie would often provide entertainment by dancing with staff. Her performances were not always for the entertainment of the residents as these would take place off-ward, where it would be less likely that residents could undertake the role of audience member. Julie once grabbed me and another staff member and danced with us in the foyer. Her performances were often met with laughter and smiles. Within the example outlined above, the residents on Mirkwood ward were audience members to Julie's performance. The performance had captured the attention of the female residents and a mutual focus of attention on her performance was observed by the residents watching Julie as she ran around the ward. The staff, however, were busy carrying out job related tasks and stopped momentarily when their faces were drawn upon but would continue with the task at hand. The

female residents found Julie's performance humorous and expressed laughter at the spectacle and thus a shared mood was observed. Research has found that staff reported moments which involved humour and were described as:

> being able to laugh at each other and the situation, to show a more humane side of staff, and to dampen the experience of seriousness, as it is used as something positive to defuse situations (Gildberg et al., 2012, p.106).

Furthermore, Gildberg et al. (2012, p.106) argues that staff adopt humour with patients within the FMH environment and suggests this appears to be "without reference to the illness". Such engagements are suggested to promote the identity of individuals beyond their illness and are rooted in personal recovery (Slade, 2009b). In section 1.4.1, it was also noted within the arts and health literature that wellbeing considers the health of an individual beyond the illness (Stuckey and Nobel, 2010). Moments which extend beyond conversations or interactions centred on illness are suggested to be important for those in recovery, particularly for those who have been suggested to be doubly stigmatised, as discussed in section 2.2.3.

It is suggested that this moment has links to carnivalesque theory, which proposes that carnivals can be thought of in such ways as "turning the world upside down, of symbolically subverting the dominant, ruling hierarchies of social existence" (Crawford, 2002, pp.42–3). Furthermore, carnivalesque can be thought of as modes that:

> interrogate the borders between realms of the rational and irrational … the basis upon which cultural order rests, for it opens up, for a brief moment, on to disorder … that which is outside dominant value systems. (Jackson, 2013, p.4).

Thus, it is argued that Julie momentarily turned the hierarchical social structure upside down by ridiculing staff and drawing on their faces. This diversion could provide momentary relief from the usual cultural order of staff being the dominant group which hold certain levels of power and authority within the FMH environment. Much like engagement in music sessions can provide a social space providing temporary relief and conversations other than on the topic of illness (Stickley and Hui, 2012), moments which divert from the usual and mundane can entertain.

This creative practice was undertaken opportunistically, the bingo pens were available on Mirkwood ward momentarily as pen access was restricted and thus were only available whilst the bingo activity was taking place. As stated in section 2.4.1.1.2, "geography matters to understanding creativity" (Hawkins, 2016, n.p.). The secure FMH site was often sparse, few items were available on the ward which mostly comprised books, games were locked away in the 'game cupboard'. Julie created a short-lived alternative world, one in which the staff were ridiculed utilising a level of innovation, given the usual restrictions of the environment. Research has found that engagement in creative practices can provide a relief from the mundane and opportunities for escapism (Jordan et al., 2018). It is suggested that this informal creative practice also provided momentary escapism.

5.4.4 Informal creative practice rituals: Key contextual themes

This section revisits the key aspects of life, which have been suggested to influence creative practice rituals at Westmarch Hospital. Section 4.8 explored the themes: Surveillance, security, and risk; emotive environment; and boundaried relationships, in relation to the microsociological model of therapeutic social capital and sections 5.3.5 and 5.4.4 explored these themes in relation to creative practice rituals and the microsociological model of therapeutic social

capital. This section considers how these themes influenced the informal creative practice rituals at Westmarch Hospital.

5.4.4.1 Surveillance, security, and risk

It has been noted that the institutional regimes, such as meetings and meal times, can interrupt creative practice rituals, as evidenced in section 5.3.1 and 5.4.1. However, section 5.4.1 noted that "batch living" can provide opportunities for social interaction and therapeutic social capital (Goffman, 1961, p.17). For example, residents appeared in the communal area in time for the dinner time meal being served. The opportunity for social interaction was then increased by the increase in the number of residents in one area of the ward. The fundamental basis for therapeutic social capital is social interaction, as outlined in figure 2.1, in section 2.3.4.1. Section 5.3.5.2 further discussed the obligations of increased visibility of residents, for example, residents are prompted to spend time on the ward and not in their individual bedrooms. Whilst interpersonal issues were found to lead to avoidance rituals, the promotion of residents spending time in communal areas increase opportunities for therapeutic social capital. The notion that institutional regimes may, at times, hinder and, at times, provide opportunities for therapeutic social capital is a novel contribution of this thesis.

It has also been noted that pen access was restricted on Mirkwood ward. It is theorised that the restriction of items may impede opportunities for creative practice at Westmarch Hospital, particularly on Mirkwood ward, as discussed in section 5.3.4.3. For example, it was noted that one resident played the guitar, but this item was locked away in the 'game cupboard' and a staff member was required to monitor the use of such items in the ward area. Thus, the availability of staff can influence the availability of creative practice instruments. In section 5.3.3, it was noted that Owen, on Crickhollow ward, always had access to a guitar on the ward. This was because self-harm was not prevalent on Crickhollow ward and thus the guitar was not viewed as a risky item. Furthermore, informal creative

practices were found to be initiated within the restrictive environment. Thus, it is suggested that whilst procedural security may minimise some opportunities for creative practices, such engagements are possible and can be spontaneously initiated, as evidenced in section 5.4. This thesis provides insight into the geographies of creative practices within the FMH environment, which is a novel contribution of this thesis.

5.4.4.2 Emotive environment

Section 2.2.3 noted that the ward environment can be particularly volatile with the presence of violence and section 4.8.2 summarised the emotive environment as a key contextual feature of life at Westmarch Hospital. The informal creative practice ritual initiated by Adam was met with, what appeared to be, bullying behaviour exhibited by James. It is suggested that this social interaction was not of support and may have been perceived as emotionally challenging. As noted by Boyns and Luery (2015, p.157):

> [n]egative emotional energy is the product of the unsuccessful exchange of cultural capital and indicates a failure to create, or the defilement of, a secure social bond.

Subsequently, Adam retreated to his bedroom, signalling an avoidance ritual. This thesis provides new insights into the understanding of EE within the FMH environment and considers the implications of the emotive environment on wellbeing and therapeutic social capital. As discussed, patients within a Therapeutic Community were observed to be unsupportive of each other, at times, which led to isolation and alienation (Clarke and Waring, 2018). It has also been noted, however, that residents were observed to engage mutually with each other, tolerating and potentially enjoying each other's company, as evidenced in the eye-spy game discussed in section 5.4.1. However, it is important to consider that this creative practice ritual was initiated by James as he wished to engage in a joint pursuit

with me and invited me to play eye-spy. This invitation of engagement was not extended to others however, this naturally occurred, and James did not appear perturbed by this.

It is important to note that my status differed to the residents and is suggested to be evidenced by my popularity, particularly on Crickhollow ward. I would be warmly welcomed on Crickhollow ward by a range of residents. I was often invited to play games or pool. However, such invitations did not extend to other residents and when it was noted that I was spending time with one resident, others would retreat and explain that we could talk later. According to Boyns and Luery (2015, p.151):

> The greater the social, symbolic, or physical power of the group with which an individual has a successful ritual exchange the higher the levels of emotional energy gain will be for that individual.

Thus, it is theorised that my popularity on the ward may be due to the symbolic power attributed to me as an outsider. However, it is important to note that central to this proposition is perception—in that James would need to perceive a higher symbolic or social status in order to gain EE+, as discussed in section 5.4.4.2. In section 2.3.2 it was noted that social capital relates to the capital or resources available to an individual through their social networks, thus also relates to an individual's social positioning in society. Research has shown that participants benefited from engaging in new social and spatial environments to extend their personal and social identities (Saavedra et al., 2017a, 2017b). I was not a staff member, or a resident and I potentially offered opportunities for residents to engage in a network which expanded their social network and related capital.

5.4.4.3 Boundaried relationships

Boundaried relationships was introduced in section 4.8.3 as a key contextual feature of life at Westmarch Hospital. This section

discussed the boundaried relationship between staff and residents which was facilitated by professional boundary maintenance. As noted in section 5.3.5.3, this chapter extends the theme boundaried relationships to include practices that promote or maintain boundaries within or between groups, such as, staff-resident and resident-resident relationships.

Section 5.4.2 which explored the failed singing ritual noted the annoyance this caused to another resident, Jacob. It is proposed that this moment lacked social connectedness, and thus the social interaction did not progress according to the hierarchy of therapeutic social capital, as outlined in figure 2.1, in section 2.3.4.1. It is suggested that the relationship between Adam and Jacob remained boundaried and was underpinned by interpersonal issues between the residents, as discussed in sections 4.8.2 and 5.3.5.2. This thesis, then, considers the implications of interpersonal issues between residents and possibilities for mutual recovery through creative practice engagement.

Other moments of informal creative practices are suggested to promote the breaking down of social hierarchies, as evidenced in section 5.4.3. Julie presented a moment where she momentarily challenged the dominant social structure of community life on Mirkwood ward. It is proposed that informal creative practices can provide an opportunity for a temporary relief of the social hierarchy. Research has also found that engagement in creative practices can promote a flattened social hierarchy between clinicians and patients, as noted in section 2.4.1.4.3.

5.4.6 Summary of findings: Informal creative practice rituals

The institutional structure has been suggested to facilitate social interaction, a key requirement of therapeutic social capital as outlined in figure 2.1, in section 2.3.4.1. However, it is important to note that institutional regimes may also hinder opportunities for therapeutic social capital, as evidenced in the art session (see section 5.3.1) and

the eye-spy ritual (see section 5.4.1). The notion that institutional regimes may, at times, hinder and, at times, provide opportunities for therapeutic social capital is a novel contribution of this thesis.

This thesis considers the implications of interpersonal issues between residents and provides new insights into the understanding of EE within the FMH environment and considers the implications of the emotive environment on wellbeing and therapeutic social capital, as discussed in sections 5.4.4.2 and 5.4.4.3. Furthermore, the informal creative practice rituals provide insight into the geographies of creative practices within the FMH environment, which is a novel contribution of this thesis. It has been found that staff can provide momentary relief and entertainment through informal creative practices, as noted in section 5.4.3.

5.5 Revisiting the key ingredients: Formal and informal creative practice rituals

According to IRT, the strength of the key ingredients influences the strength of the ritual outcomes (Collins, 2014). This section re-visits the ritual ingredients of a barrier to outsiders, mutual focus of attention, and shared mood, and considers the prevalence of the ingredients within the formal and informal creative practice rituals presented in sections 5.3 and 5.4.

5.5.1 Barrier to outsiders

The physical barrier to outsiders was most prominent in the cooking and music formal creative practice rituals. The location of the art creative practice ritual meant that the activity was not within a protected space, unlike the cooking and music sessions. However, as noted within this chapter, the barrier to outsiders does not need to be provided by physical attributes and can be defined by group identity, such as the status of the patient identity (Clarke, 2017) or the inherent focus on the task, as exhibited by Charlie and Owen when they played guitar. The music activity then created a barrier to outsiders however, the mutual focus of attention is theorised to have

created a less permeable barrier than the art activity due to the joint focus of attention on the task. Physical barriers are proposed to assist with the barrier to outsiders, and was evidenced in the cooking and music sessions, in which a room was allocated to the activity.

The art session was interrupted by procedural security concerns, indicating a priority over the implementation of such protocols, the balance of procedural, physical, and relational security was discussed in section 2.2.2. Although it was not clear whether the member of staff who initiated the meeting had knowledge that the art session was taking place on the ward however, Siobhan was present and was a known occupational therapist. It has been argued that the time of the art session was not the most opportune moment for the impromptu meeting regarding the lighter, as discussed in section 5.3.1 and 5.3.5.1.2. Such examples of practice illuminate such statements as: "recovery seems antithetical to safe and secure forensic care" (Simpson and Penney, 2011, p.303). The interruption is theorised to have negative implications for EE, as discussed in section 5.3.4, which may undermine the therapeutic milieu.

The barrier to outsiders for the informal creative practice rituals were found to be permeable in nature. However, such permeability was found to positively influence participation within such activities, in particular the example of eye-spy. The permeability of the barrier to outsiders and the accessibility of the game, for example, the ease of joining in, is suggested to have facilitated the increased participation that was noted during the game and thus is viewed as a facilitator to therapeutic social capital and not a hindrance. Within the performance-related rituals created by Adam, in section 5.4.2 and Julie, in section 5.4.3 a barrier to outsiders was loosely defined by the presence of those in the communal area of the ward. The rituals were performance based where those who were in sight were assigned the role of audience member. The barrier to outsiders may assist in minimising interruptions however, a permeable barrier may also assist with increased engagement.

5.5.2 Mutual focus of attention

A mutual focus of attention is argued to be the most pertinent ingredient for providing opportunities for therapeutic social capital. The activities undertaken within the art and cooking session explored within this chapter were individually focused and did not facilitate a mutual focus of attention. For example, the art and cooking sessions did not afford the opportunity for the residents to engage in a mutual task thus decreasing the likelihood of a successful ritual. A parallel group task, in which the participants engage in individual tasks in the presence of a group, is rooted in occupational therapy theory and the parallel group structure of tasks is the most basic form of group work in which group adaptive skill can be developed (Chacksfield, 2002), as discussed in section 2.4.1.3. Research exploring engagement in the arts and wellbeing promotes the notion of a community endeavour, whereby the participants are actively engaged in a multiparty pursuit with a common group goal, such projects were further discussed in section 2.5.2. It is proposed that a shared group experience is facilitated by a common goal and can provide opportunities for therapeutic social capital. Thus, it is argued that the structure of these sessions did not provide opportunities for therapeutic social capital but may have provided the basis for group adaptive skill development.

The music session is argued to have facilitated a mutual focus of attention and the barrier to outsiders was created and maintained through the activity of playing the guitar and creating music together. The cooking and art examples explored within this chapter were found to be typical of other occupational therapy sessions suggesting that therapeutic social capital is limited within the formal rituals at Westmarch Hospital. However, spontaneous creative practice rituals may occur during the formal sessions, which may lead to therapeutic social capital. It is suggested that the formal occupational therapy sessions provide an opportunity for social interaction and thus therapeutic social capital, as outlined by the hierarchical model of therapeutic social capital, see section 2.3.4.1. Therefore, whilst the

activities themselves were found to constrain therapeutic social capital through a lack of joint endeavour, the time spent together provides an opportunity for staff and residents to develop social connectedness.

The informal creative practice rituals were found to involve some level of mutual focus of attention. However, Jacob was motivated to end the singing ritual initiated by James and thus the ritual failed. The eye-spy and bingo-pen ritual involved a mutual focus of attention and was provided through a focus on the performance (i.e., evidenced by the direction of the gaze of the female residents) or through active participation (i.e., evidenced by the looking around the ward space and the guesses presented by the participants).

5.5.3 Shared mood

Whilst shared mood is difficult to explore during observations, some behaviours gave potential insight into the general mood experienced by individuals. It is proposed that the bingo-pen ritual led to a shared mood and is evidenced by the laughing displayed by the residents and Julie. Furthermore, the action of laughter is suggested to have provided bodily-cues which can promote emotional entrainment. For example, as discussed in section 5.3.3, verbal and physical prompts communicate a mutual focus of attention on the shared task (Clarke, 2015). Rhythmic emotional entrainment is argued to be produced as collective effervescence builds (Chapple, 1982) and can be evidenced in synchronisation of bodily movements and verbal communication. Furthermore, it is also proposed that the smiles displayed by both Charlie and Owen indicated a shared mood, which was reinforced by the nods displayed along with the playing of the notes on the guitar. Thus, the bingo-pen and music creative practice rituals are suggested to have been successful rituals which promoted a shared mood and emotional entrainment, which were communicated with others through bodily-cues, such as laugher, and rhythmic nodding.

It is proposed that the mood shared by those participating in the eye-spy game was limited, whilst there were occasional smiles, it is

theorised that there was a lack of intensity offered by the ritual. Collins (2014, p.166) suggests that EE fluctuates "depending upon the intensity of the IRs". The mutual focus of attention, whilst present, is suggested to be limited with a game which, by its nature, does not require full participation of all residents. The apparent lack of strength of the mutual focus of attention is suggested to have influenced the intensity of EE and the overall success of the ritual. The eye-spy ritual, however, provided opportunities for building therapeutic social capital.

It is argued that the art and cooking sessions did not promote a shared mood, due to the individualistic focus of the tasks, which thus did not promote a shared experience. It was observed that within the cooking sessions, Nicole and Jane expressed annoyance, as noted in section 5.3.2. Whilst they might have shared a similar mood, it is proposed that such feelings were of enmity against each other and thus did not promote therapeutic social capital. The art and cooking rituals are theorised to have failed due to their lack of mutual focus of attention, which also lacked a shared mood and was observed to lead to EE− due to the enmity against the resident group membership.

As noted in chapter four, the role of emotions is central to this thesis, and thus a consideration of the emotional environment is briefly explored. The outcry of verbal swearing in the singing example and the interrupted art session are both suggested to evidence EE−. However, within the highly emotive environment, as identified in section 4.8.2, the role of emotions can be complex. IRT suggests that EE gained or lost from previous rituals influences emotions within current or future rituals (Summers-Effler, 2006). It is proposed that the community at Westmarch Hospital navigates such emotions within their daily rituals and look for opportunities to maximise or protect their EE+. Another level of emotional complexity is the proposition that those that have lower levels of EE and perceive that there are minimal opportunities for EE+ gain, tend to adopt defensive

strategies which are focused on protecting EE, rather than towards EE+ gain (Summers-Effler, 2004). Thus, moments for EE+ may be constrained for some individuals, depending on their emotional disposition at the time of the ritual. EE has implications for therapeutic social capital in that shared mood can lead to a mutual experience. However, it's important to note that shared emotion does not need to be positive, as evidenced by (Clarke, 2017), and discussed in section 2.5.1.1. Thus, building therapeutic social capital within the FMH environment is presented with emotional challenges and staff and residents navigate a complex emotional environment in order to gain or protect their EE+.

5.6 Chapter five: Summary

This chapter has utilised the microsociological model of therapeutic social capital (see figure 5.1) to explore creative practice rituals within the situated context of the FMH ward community. This model has been applied to a series of six creative practice rituals observed at Westmarch Hospital and reveals the key influences on the success of creative practice rituals within the FMH environment. Important insights have been foregrounded in relation to the approach of occupational therapy tasks, for example, the individualised approach has been found to limit opportunities for therapeutic social capital. However, institutional regimes, such as, formal therapy and ward routines, facilitates social interaction, which is required as a basis for therapeutic social capital. The music sessions provided opportunities for therapeutic social capital and were facilitated by agency, choice, meaningfulness, and a lack of hierarchical structure provided by a non-clinical member of staff. The three key contextual features of life at Westmarch Hospital, as outlined in section 4.8, illuminate the complexity of institutional life and therapeutic social capital. These were: surveillance, security, and risk, the emotive environment, and boundaried relationships. The nature of forced rituals was found to have implications for performativity of activity engagement and wellbeing. Procedural security practices were found to constrain activity engagement through the limitation of creative practice

instruments, or through the interruption of activities which had the potential to offer relational security. Chapter six explores mutuality at Westmarch Hospital and considers the microsociological model of therapeutic social capital in the context of daily life.

Chapter Six: Mutuality at Westmarch Hospital

6.1 Introduction

This chapter considers mutuality within everyday life at Westmarch Hospital through the lens of the microsociological model of therapeutic social capital, see fig 5.1, with a particular focus on boundaried relationships. Section 4.8.2 noted that boundaried relationships were observed between staff and residents and are theorised to be underpinned by professional therapeutic working, as outlined in section 2.2.5. Mutuality is suggested to be challenging within the hierarchical relationship between staff and patients (Brown, 2016). Chapters four and five considered relationships within practices that promoted or maintained boundaries within or between groups, such as, staff-resident and resident-resident relationships. This chapter begins by considering the resident-resident relationships in the light of the promotion and maintenance of boundaried relationships which re-introduces tensions between the resident community that impact on mutuality. This chapter also considers an example of divergence from professionally-boundaried practices within the therapeutic context between staff and residents at Westmarch Hospital.

The aims of this chapter are to understand daily life at Westmarch Hospital which expands the analysis to consider mutuality amongst residents and staff within the therapeutic context outside of creative practice rituals presenting a nuanced approach to exploring therapeutic social capital.

6.2 Mutuality at Westmarch Hospital

Within the context of surveillance, security and risk, the emotive environment, and boundaried relationships, moments of mutuality can be challenging. Throughout the interviews, the answers provided by the residents were individually focused and examples of mutuality or group solidarity were uncommon. During the interview with Ryan,

a resident, he reported that he had learnt to tolerate a range of different individuals, whilst being at Westmarch Hospital. He viewed this as a positive skill development, in preparation for community living:

> "I think the last couple of months there's been a real community spirit where even if we don't necessarily talk to people we tolerate them [residents]…but through life you can't get on with everybody and even if you don't necessarily get on with them [staff], [you] just tolerate them … everyone talks to everyone, erm not everyone's trusted on here. There are a couple of people that are hard to trust. But currently [we don't] exclude anyone from anything because even if we dislike them, we still tolerate them, and we still do groups with them"
>
> [Resident interviews: Ryan, Buckleberry ward]

Ryan indicates that some individuals are tolerated on Buckleberry ward, however tolerance does not describe a mutual and reciprocal relationship. Furthermore, Ryan also uses the term: "we" and not "I". It may be that Ryan identifies within an in-group of individuals on Buckleberry ward, such as a group of residents, or indeed the occupational therapists. However, this phrase was not questioned at the time of the interview.

Furthermore, issues in relation to trust were presented and debated in section 4.8.2. Section 2.2.5 noted that trusting others can be problematic for the forensic patient and is suggested to be underpinned by past neglect and abuse and childhood disruptions (Mann et al., 2014). Mutuality, then, between residents can be complex between those who experience interpersonal issues.

During my time at Westmarch Hospital I learnt of a few significant relationships between residents. Imran and a fellow resident on Crickhollow ward, found a mutual love of film and they would use their leave to attend a local cinema. The two residents' leave privileges enabled them to spend time together engaging in an activity that they enjoyed. On Buckleberry ward, I observed Simon

and Ryan to enjoy each other's company and they would often spend time together on the ward, laughing and joking. This was despite Ryan indicating that he enjoyed time to himself and thus would engage in creative activities in his room, such as, listening to music or playing games. It is suggested that the individually focused provision of care at Westmarch Hospital follows a dated zeitgeist within mental healthcare which is underpinned by the clinical recovery model, as discussed in section 2.3.

6.2.1 The "dark side" of mutuality

Boyns and Luery (2015, p.149) extend IRT by considering the "dark side" of emotional energy, and thus proposed emotions that are of enmity against a group. This section extends mutuality to consider a darker side, one that considers mutuality that is not considered positive for therapeutic social capital or more broadly, one that works against a more egalitarian society. Furthermore, Adlam et al. (2013) proposes that Goffman articulates the darker side of institutional life. This section also considers the darker side of institutional life in the context of mutuality.

The staff-resident relationships at Westmarch Hospital were found to be paternalistic in nature, which is underpinned by longstanding tradition in mental healthcare (Haines et al., 2018), as discussed in section 2.3.5.2. A paternalistic approach to care advocates practice in which staff utilise their knowledge and skills for the benefit of the patient and assumes responsibility for the care of the patient (Pelto-Piri et al., 2013). Professional power and expertise pervade mental healthcare (Shepherd et al., 2008). It is important to consider how social interaction within the paternalistic context can have socially negative consequences. The power dynamic between staff and residents at Westmarch Hospital reinforced a power disparity between the staff and patient groups and the staff were viewed as teachers and experts who modelled pro-social interactions with careful consideration of professional boundary maintenance. An observed moment at Westmarch Hospital between a male staff member, Barry,

and a male resident, Jacob is now explored in the light of paternalism and mutuality.

It had become known to me that the Jacob was behaving in a challenging way with female staff. I had experienced this myself when Jacob called me: "Woman!". This form of address was made in a joke-like manner that could arguably be defined as 'banter' by the resident. In addition to this, I had heard conversations between female staff about Jacob's behaviour being problematic. The excerpt below took place after seven months in the field, I had known Barry for seven months and Jacob for two.

> I was invited by Barry [staff] to accompany him on leave with Jacob [resident]. Jacob was approximately 20 years his junior. We crossed the road and stood in the doorway of an abandoned pub. Jacob lit his cigarette. He was looking down at his phone and swiping. After taking a long drag on his cigarette, he turned the screen to face Barry and continued to hold his breath before exhaling: "Look at her, what do you think?" Jacob asked. "Yeah, she's nice, she's pretty," Barry responded. Jacob remarked: "Yeah, you think?". "You want them pretty, but not too intelligent! That was the problem with my ex, she was really pretty and intelligent, it caused us problems," Barry responded. "Oh yeah?" Jacob remarked with a slight chuckle. "Yeah mate," Barry replied raising his eyebrows as a signal of the certainty of his statement. I stood a little distance away from Barry and Jacob, remaining silent. I felt ignored and overlooked as a bystander to this inappropriate kind of male locker room talk.
>
> *(Fieldnotes: Day fifty-four)*

I now explore the observed moment as an informal ritual. The barrier to outsiders was gendered. The conversation was from the male heterosexual perspective regarding desirable features of a female partner. I was not invited to comment and neither Barry nor Jacob looked in my direction. The mutual focus of attention was evident by the conversational flow on the topic chosen and reinforced by the back

and forth of the conversation. The activity involved reviewing the tinder profile of a female and discussing her potential as a partner for Jacob. A shared mood was observed through the laughter exhibited; the mood was jovial. The conversation was reciprocal and arguably contributed to a moment of connection and mutuality, a shared interest in women and dating.

Barry's comments are now examined following the micro, meso, macro levels of analysis. Firstly, on the micro level, these comments were inappropriate in my presence and also in the light of Jacob's problematic and challenging behaviour. Secondly, Buckleberry ward, where Jacob resided, and Barry typically worked, was a male ward with residents with a history of sexual offending. Thus, Jacob's recovery would be focussed on countering the kinds of behaviour and communication that supports or encourages offending behaviour.

On the meso level, the Good Lives Model (GLM) and clinical assessment tools associated with sex offending, such as the Structured Assessment of Risk and Need (SARN), guide practice at Westmarch Hospital. Within the criminology and therapeutic context of sex offenders, risk factors, such as, cognitive distortions, are viewed as dynamic, meaning that intervention can lead to a reduction of risk. "A view of heterosexual relationships where the male is seen as dominant and the female as submissive" is considered a risk factor that can lead to sexual offending (Craig et al., 2008, p.103). This statement is included in the SARN, which is utilised to assess risk factors for sex offenders in the UK. Barry's comments, therefore, are considered to be associated to the risk factor outlined above. The claim here, however, is not that Barry poses as a risk for offending behaviour, it is claimed that these comments can normalise already problematic views of heterosexual relationships held as cognitive distortions.

The GLM, which is adopted as a theoretical basis for clinical work at Westmarch Hospital, views all individuals as wishing to live a good life. However, it is recognised that some individuals utilise socially unacceptable or illegal behaviour to obtain primary goods, such as

intimacy. Thus, the GLM and sexual offending is based on the assumption that "sexual offending reflects socially unacceptable and often personally frustrating attempts to pursue primary human goods" (Ward et al., 2007, p.90). Of particular relevance to the field of sexual offending in the primary goods of relatedness, also known as relationships which include intimate, romantic and family relationships (Ward and Brown, 2004). In the sexual offending context, the primary good of intimacy may be obtained through violence or controlling behaviour (Ward and Brown, 2004). Another primary good related to sexual offending is mastery, in which "the offender may be pursuing a sense of personal power and mastery over the victim" (Whitehead et al., 2007, p.3). Offender rehabilitation work focuses on "assisting offenders to achieve their goals as well as managing their risk for reoffending" (Barnao et al., 2016, p.203). Thus, clinical work at Westmarch Hospital would then aim to challenge the views of those who use inappropriate methods of obtaining primary goods, for example, seeking intimacy through violence or controlling behaviour, or indeed aim to obtain dominance over another individual through sexual violence. Ward and Brown (2004) further explain how "[s]ome of these [risk] factors are causally related to offending behaviour in a fundamental way (for example, antisocial attitudes)". It is argued that Barry's comments exhibit an antisocial attitude towards women and such comments can be associated with sex offending behaviour, which have the potential to reinforce existent cognitive distortions for individuals who have a history of sexual offending. From a therapeutic perspective, the culture of Buckleberry ward would aim to challenge such distortions associated with the degrading of women (i.e., that women should not be intelligent).

Furthermore, at the mesosystem level: Within the context of paternalistic models of care, the guidance offered by Barry may be viewed by Jacob as 'expert' opinion from someone who is more knowledgeable on the topic of personal heterosexual relationships. However, such conversations do not form part of a professional role.

It might be argued within the context of boundaried working that such conversations are problematic. The sharing of information through "innocuous personal stories" has been found to assist in the creating of trust between forensic patients and staff (Marshall and Adams, 2018, p.755). In Barry's communication with Jacob, this is clearly not the case. Attempts at friendly or informal conversations should take into account the context in which these are shared, with whom, and by whom. The teacher-student respect and knowledge acceptance of the professional being the expert must be carefully considered within paternalistic models of care, when such claims about women are antisocial. This caution should also extend to the wider care environment, its processes and culture.

At Westmarch Hospital, quite aside from the unguarded and problematic conversation discussed above. I experienced the hospital as a gendered space. This has also been described by others, for example, research has described "the ward as male space … [which] promoted gendered inequality" (Mercer, 2013, p.15) in a high secure forensic mental health hospital in the UK. At Westmarch Hospital, women had 'pampering' and 'complimentary therapist' as timetabled occupational therapy sessions. I also received many comments, from residents and one staff member, about how I looked or was told on several occasions that I should be a model. Barry had taken me aside to inform me that I was "pretty" and "young" and advised me to be careful when engaging with one of the residents — I was indeed aware of the individual's index offence and related risks. However, it was suggested that being "pretty" and "young" was a risk factor.

According to the microsociological model of therapeutic social capital, see figure 5.1, societal values are situated at the macro level and can influence life at Westmarch community. Examples within this thesis have considered how a risk-averse society can influence attitudes and practice at Westmarch Hospital, see section 2.2.2 and 5.3.1 for further discussion. Societal influences have been argued to influence sex offending behaviour. For example, Marshall and Barbee (1990) describe sociocultural influences, such as, male dominance, negative

attitudes towards women, and acceptance of rape myths. One feminist perspective has suggested that rape has been theorised to be connected to everyday forms of heterosexuality (Gavey, 2005). Furthermore, sexual violence has been suggested to be underpinned by the normative roles of heterosexual relationships and thus:

> heterosexuality is imbued with the dominance-submission dynamic…where male aggression and female passivity are integral to the socially constructed roles, and where forms of coercion are normative. (Gavey, 2005, pp.33–4).

Whilst, I was surprised to hear these comments from Barry within the professional mental health and sexual offending context, the notion that these comments are more commonplace is supported by the literature. For example, that sexual harassment and banter on a University campus in the UK has "become normalised and routinized, in which the trivialisation and minimisation of such behaviours render them invisible" (Sundaram and Jackson, 2018, n.p.). Furthermore, the theory of the continuum of violence against women proposes that an individual act "which may seem innocuous in another context can be experienced very differently as part of a pattern of behaviour extending over decades" (Boyle, 2018, p.4). Thus, there are arguments which propose that gender roles and attitudes can become normalised in such a way which can support sexual violence and can exist on a continuum of violence against women.

A core debate within the sexual violence literature, however, is "whether rape is about sex or whether it is about violence or power" (Gavey, 2005, p.31). According to the GLM, sexual violence can be the result of one of two primary goods, mastery or relatedness. Relatedness as a motivation proposes that the individual is aiming to achieve intimacy, but the utilisation of controlling behaviour is unlikely to lead to a satisfying level of intimacy (Barnao et al., 2016; Ward and Brown, 2004). Moreover, mastery may be pursued by the gaining of personal power over a victim (Whitehead et al., 2007). Thus, in offender rehabilitation, some individuals may be motivated by intimacy, and thus sex, whilst others may be motivated by mastery

and thus power. Such a debate exists in the recent women's movement against sexual harassment, for example, the Me Too and Time's up movement, which have been argued to mark a major shift in gender equality (Janz, 2019). The Me Too movement promoted widespread attention to harassment in the workplace (White, 2018) and gained global attention through its social media platform (Wexler et al., n.d.). The Me Too movement has been argued to be underpinned by the political interest in the ways in which sex and power intersect (Gill and Orgad, 2018). The notion that the individuals committing sexual offences are the deviant few as represented by the media are argued to be unhelpful when gender inequality is pervasive and not limited to certain environments and it is further proposed that the "structural and systemic nature of gender inequality, and the ways this plays out in everyday actions and interactions…[should be] a starting point for prevention" (Sundaram and Jackson, 2018, n.p.). Thus, propositions such as the "nature of manhood is power, the nature of womanhood is subordination to power" circulate harassment and sexual violence debates.

The Care Quality Commission has called for national guidance to improve sexual safety on mental health wards, following reports of sexual harassment and violence in mental healthcare in the UK (Care Quality Commission (CQC), 2018). Such reports have been filed by staff and patients, which include both staff and patients as perpetrators. Thus, worryingly harassment and sexual violence is prevalent in modern mental healthcare.

In summary, the notion that mutuality should be explored as a valenced concept, one that has positive and potentially negative influences on a broader perspective of an egalitarian therapeutic social capital. The link between Barry's comments and sexual offending behaviour is not suggested to be causal. However, it is important to consider the everyday conversations that occur between staff and patients within the offending context and understand how such social interactions may represent a wider inegalitarian rhetoric, which may serve to normalise criminogenic attitudes and behaviour.

Thus, whilst therapeutic social capital may be facilitated by mutual engagement in informal rituals for staff and residents, gendered attitudes held by some staff, notably in the case of Barry, serve to undermine therapeutic practices.

6.3 Chapter six: Summary

This thesis, thus far, had uncritically explored mutuality as a positive attribute to relationships, which can promote wellbeing and therapeutic social capital. This chapter has extended the concept of mutuality within the therapeutic context to consider its darker side, which is a novel contribution of this thesis. Within this chapter, the microsociological model of therapeutic social capital has been utilised to illuminate its utility in exploring therapeutic social capital utilising a valenced approach. In the following chapter, the overall findings of the thesis in relation to the research questions are discussed in relation to the key literature. The chapter also presents the conclusions and recommendations for research, policy, and practice.

Chapter Seven: Discussion, conclusions and recommendations

7.1 Introduction

Chapters four, five, and six presented an analysis of the findings using a microsocial model for critically analysing therapeutic social capital within Forensic Mental Health (FMH) and provided an in-depth discussion of the research findings. This chapter revisits the research questions, discusses the key findings, and considers the academic value of the research including limitations, suggestions for future research and implications for practice.

7.2 Revisiting the research questions

This research innovatively contextualises creative practices within the FMH environment and takes a holistic approach to exploring creative practices as part of institutional care. As such, it presents the first in-depth exploration and description of creative practices within established FMH practice, and analyses these in relation to their contribution to wellbeing and therapeutic social capital (i.e., social connectedness, mutuality, and mutual recovery, see section 2.3.4.1 for the hierarchical model). Previous studies researched creative practices as new and novel short-term interventions (Argyle and Winship, 2015; Fancourt et al., 2016a, 2016b; Hogan, 2018; Jordan et al., 2018; Perkins et al., 2016; Vallejos et al., 2016; Wang et al., 2017; Wilson, 2018; Winship and Barker, 2016), with few exploring existing community creative practice workshops (Callahan et al., 2017; Lewis et al., 2016; Saavedra et al., 2017a, 2017b).

The research questions were:

RQ1: What formal and informal creative practices occur in the forensic mental health service?

RQ2: How do creative practices in the setting influence the mental health and wellbeing of both residents and staff?

RQ3: Do creative practices in the setting offer an opportunity for shared benefit or recovery among residents and staff?

7.3 Key findings

In this section I discuss the key findings, including information on the corresponding sections where these are critically addressed elsewhere in the thesis.

7.3.1 The microsociological model of therapeutic social capital

1. The microsociological model of therapeutic social capital illuminates the micro, meso, exo and macro influences on community life at Westmarch Hospital. At the centre of the model is the observable microsocial activities explored through Interaction Ritual Theory (IRT), such as creative practice rituals. This holistic approach to exploring creative practice allows for a deeper understanding of the contextual influences on the activity and considers the wellbeing of staff and residents as well as contributions to therapeutic social capital.

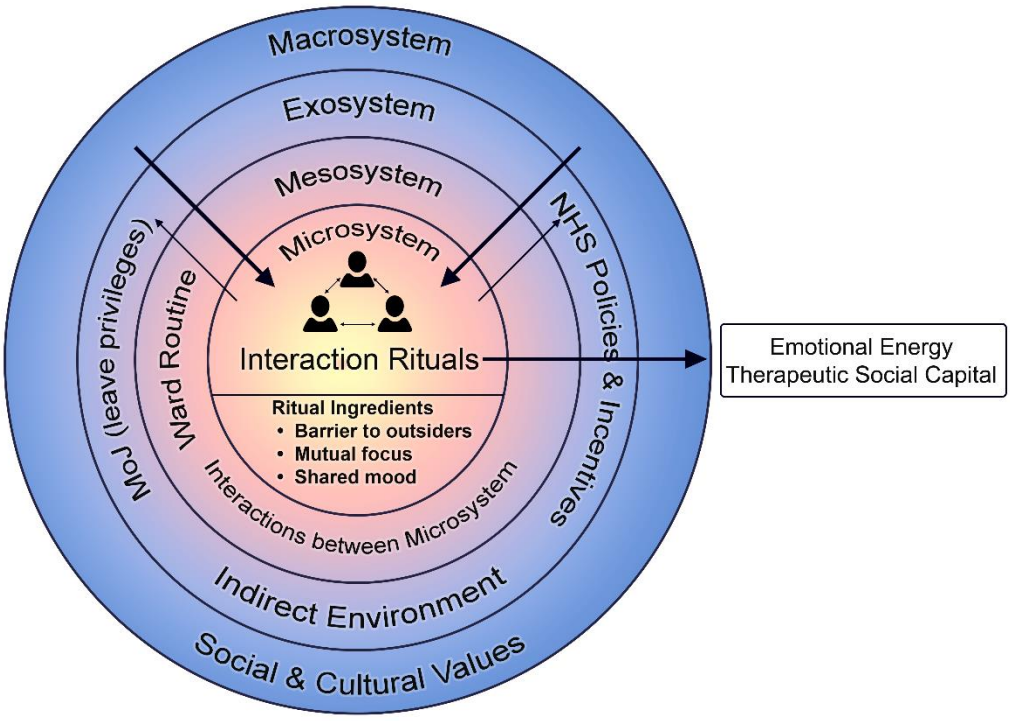


Figure 7.1: Microsociological model of therapeutic social capital (4.1 copied)

This thesis observes that formal creative practice rituals offered by the occupational therapy team often lack one of the key ingredients—a mutual focus of attention, which is argued to be the most pertinent in influencing therapeutic social capital within this environment, as discussed in section 2.5. Individualised models of care are argued to minimise opportunities for a mutual endeavour and thus therapeutic social capital. However, institutional regimes, such as, formal therapy and ward routines, facilitates social interaction, which is required as a basis for therapeutic social capital.

The music sessions, which were run by a non-clinical member of staff, were observed to include this key ingredient, which lead to opportunities for therapeutic social capital (see section 5.3.4.3). Importantly these sessions promoted agency, choice, and meaningfulness, which has been linked with personal recovery (see sections 2.3.3 and 5.3.4.4).

The informal creative practice rituals fostered opportunities for social connectedness through multiparty endeavours (see sections 5.4.1 and 5.4.3). However, not all informal creative practice rituals instigated were successful (see section 5.4.2); it is argued that the emotive environment creates a turbulent emotional landscape rendering informal attempts of engagement and social connectedness a challenge. As such, IRT importantly considers market opportunities and defensive practices in the context of emotional regulation (Summers-Effler, 2004).

Influences on creative practice engagement were identified at the exosystem (e.g., NHS incentives, see section 4.8.1, and leave privileges, see section 5.3.4) and macrosystem (e.g., societal influences on risk, see section 4.8.1). For example, the nature of forced rituals, which was influenced by NHS incentives, was found to have implications for performativity of activity engagement and wellbeing.

7.3.2 The three key contextual themes at Westmarch Hospital

2. Three key contextual themes emerged as fundamental to understanding life at Westmarch Hospital, outlined in section 4.8. These are:
    - Surveillance, security and risk;
    - The emotive environment;
    - Boundaried relationships.

These themes were observed to influence creative practices, wellbeing, social connectedness, and mutuality.

The aim of this thesis was to explore creative practices within the institutional context and ethnography was adopted as a methodology to understand the nuances of life underpinning the creative practice moments observed within this study.

A risk-averse culture is suggested to underpin FMH practices, as discussed in section 2.2.2. Surveillance, security and risk practices were observed at the micro level at Westmarch Hospital (see section 4.8.1), which were observed to influence the types of creative practices available to residents (see section 5.3.4.3). This theme was also observed to underpin practices related to the monitoring of engagement within the occupational therapy timetable and led to forced rituals, which had implications for wellbeing and therapeutic social capital (see section 5.3.4.1).

As noted in section 2.2.4, FMH services are emotionally challenging places to work (Johnson et al., 2018; Looff et al., 2019; Nathan et al., 2007; Tofthagen et al., 2014) and live (Bonner et al., 2002; Gillard et al., 2012; Quirk and Lelliott, 2004; Stenhouse, 2013), as discussed in section 2.2.3. The emotive environment was observed at the micro level at Westmarch Hospital, which was observed to influence and wellbeing for both staff and residents (see section 4.8.2) and limited opportunities for therapeutic social capital within formal creative practice rituals (see section 5.3.5.2) and informal

creative practice rituals (see section and 5.4.4.2). As noted in section 2.2.5, it is important for staff to maintain professional boundaries with their patients in healthcare, which is particularly important within FMH care (Adshead, 2012). Boundaried relationships were observed at the micro level at Westmarch Hospital (see section 4.8.3), and chapter five extended the theme to include practices that promote or maintain boundaries within or between groups, such as, staff-resident and resident-resident relationships which were observed to influence therapeutic social capital (see sections 5.3.5.3 and 5.4.4.3).

7.3.3 Formal and informal creative practices

3. This research noted art, cooking, and music, which were timetabled as part of occupational therapy, to be potential formal creative practices (RQ1). Staff and residents were observed to engage in informal creative practice rituals, such as, singing and game-playing (RQ1). However, the formal and informal creative practice rituals were influenced by the macro, exo, meso, and micro level highlighted by the microsociological model of therapeutic social capital.

The timetabled therapy included cooking and art sessions which were run by the occupational therapy team, which had the potential to be creative. Research has found that engaging in creative practices can promote identity development (Jordan et al., 2018; Saavedra et al., 2017a), and build individual (Lewis et al., 2016) and social identities (Winship and Barker, 2016), and strengthen social capital (Argyle and Winship, 2015). However, the art and cooking sessions (see section 5.3) were observed to minimise opportunities for identity development and are theorised to lack meaningfulness (see section 5.3.4.4), due to the forced nature of participation and power rituals observed (see section 5.3.4).

The music session, which was run by a non-clinical staff member (see section 5.3.3), was noted to provide opportunities for identity development and therapeutic social capital through joint activities,

agency over activity choice, the promotion of a mutual endeavour, and the flattened hierarchy between the music teacher and the residents (see sections 5.3.3 and 5.3.4.3). Other research has noted that a flattened hierarchy facilitated social connectedness amongst participants (Argyle and Winship, 2015; Callahan et al., 2017; Lewis et al., 2016; Perkins et al., 2016), as discussed in section 2.4.1.4.3.

Therapy timetabling was influenced as part of national directives to provide 25 hours of structured therapy (Nicholls and Goossens, 2017), as discussed in section 2.2.3. The microsociological model of therapeutic social capital (see figure 7.1) highlighted these exo-level influences and chapters four and five discussed how the occupational therapy sessions were utilised as monitoring and assessment tools, limiting their therapeutic social capital value to staff and residents.

Within FMH and mental healthcare, risk underpins much of practice (Mullen, 2000). Notions of risk are influenced at the exo-level, for example, risk assessments are the responsibility of mental health professionals across the UK and comprehensive guidance for clinicians is provided by the Department of Health (2009). Section 5.3.4.3 highlights examples where risk assessments influenced activity selection for the occupational therapy timetable.

Informal creative practices were initiated by staff and residents, these included singing, playing games, and carnivalesque performance (Crawford, 2002) (see section 5.4). The informal creative practices were influenced by institutional practices. For example, the institutional structure and practices, such as timetabled activities and the promotion of residents spending time in communal areas led to opportunities for social interaction, and thus therapeutic social capital. However, timetabled activities, such as hospital regimes, were also found to interrupt informal creative practices, as evidenced in section 5.4.1

7.3.4 Opportunities for wellbeing and therapeutic social capital through creative practices

4. On occasions engagement in creative practices were observed to contribute to the wellbeing of residents and staff and promote therapeutic social capital when hierarchies were flattened (RQ2 and RQ3).

IRT illuminated the key features of creative practice rituals, outlining their potential to influence wellbeing and therapeutic social capital for staff and residents. The microsociological model of therapeutic social capital (see figure 7.1) illuminated internal and external influences on community life at Westmarch Hospital. The music sessions offered an opportunity for the teacher and residents to engage in a mutually creative endeavour, which was observed to facilitate identity development and promote therapeutic social capital due to the flattened hierarchy (see sections 5.3.4.3 and 5.3.5.2). The creative practice activity itself could have promoted a lessened hierarchy however, admiration for the music teacher and his non-clinical role were also likely facilitators (evidenced in section 5.3.3). Within the art and cooking timetabled therapy sessions, opportunities for wellbeing were restricted through the types of creative practices on offer, for example, the lack of mastery or opportunities for identity development, see section 5.3.4.4.

Informal creative practice rituals were observed to provide opportunities for the promotion of wellbeing and therapeutic social capital (evidenced in sections 5.4.1 and 5.4.3). However, some informal creative practice rituals did not promote the wellbeing or therapeutic social capital of residents (evidenced in section 5.4.2). This was due to interpersonal issues between residents, which are argued to be a common feature of the FMH inpatient environment, as discussed in sections 4.8.2 and 5.3.5.2.

7.3.5 Mutuality at Westmarch Hospital

5. This research contributes to insights in relation to mutuality and forensic mental healthcare:
    a. *Mutuality between staff and residents, and amongst residents, was not promoted by observed models of practice within the FMH context (RQ3). However, staff sought opportunities to engage with residents during informal times.*

Individualistic and paternalistic approaches were observed to underpin practice at Westmarch Hospital. This extended to creative practices which were found to restrict opportunities for social connectedness and mutuality (see sections 5.3.4.2 and 5.3.5.3). Research has found that engaging in creative practices that promoted an embodied practice (Callahan et al., 2017; Fancourt et al., 2016a; Jordan et al., 2018; Vallejos et al., 2016), a multiparty endeavour and shared experience (Argyle and Winship, 2015; Callahan et al., 2017; Hogan, 2018; Jordan et al., 2018; Lewis et al., 2016; Perkins et al., 2016; Saavedra et al., 2017a; Vallejos et al., 2016; Winship and Barker, 2016) promoted wellbeing for the participants. Furthermore, such engagement promoted a sense of community (Vallejos et al., 2016) and facilitated the flattening of social hierarchies between a range of individuals (Argyle and Winship, 2015; Callahan et al., 2017; Lewis et al., 2016; Perkins et al., 2016). However, within this research, it was observed that the creative practices provided by the occupational therapy team did not promote a mutual endeavour and such approaches are influenced by individualistic models of care. Furthermore, paternalistic models of care led to the surveillance of residents which were noted to have implications for mutuality, as such forced rituals limit opportunities for promoting wellbeing (Collins, 2014) and reinforced the disparity between staff and residents (see section 5.3.4).

It was observed that some staff sought opportunities to challenge such hierarchical care during informal periods. Such practices were

observed at the micro level and is evidenced in section 5.4.3. It is argued that the flattening of social hierarchies can promote opportunities for mutuality.

b. Mutuality between residents is complex within a highly complex emotive environment.

Abuse and neglect are common experiences of those who are in contact with FMH services (Mann et al., 2014; Mullen, 2000), (see section 1.4 for further debate). Chapter four revealed the emotive environment as one of the key contextual themes of life at Westmarch community (see section 4.8.2). Such negative past experiences can lead to problems with forming new attachments later in life (Adshead, 2004), which can further complicate emotional states in the context of IRT (see section 4.8.2 for further discussion).

Other interpersonal issues, such as racism, were noted amongst residents at Westmarch Hospital, which is commonly reported within FMH environments (Cambridge: Norfolk, Suffolk, and Cambridgeshire Strategic Health Authority, 2003; Pilgrim, 1997). As such, the environment can be highly emotive for the community and notions of mutuality can be complex, and sometimes undesirable, amongst the patient group (evidenced in section 5.3.5.2).

c. This research considers the dark side to mutuality, extending research in this area.

Mutuality within mental healthcare is suggested to be challenging due to power relations (Adshead, 2012), institutional and professional boundaries (Brown, 2015), as discussed in section 2.3.4. Professional boundaries are argued to be important to maintain, particularly in FMH care (Adshead, 2012). Within the context of paternalistic models of care, where the staff are viewed as expert, mutuality can have negative implications if relationships are inappropriately managed. A moment highlighting the dark side to mutuality was evidenced and explored in section 6.2.1, indicating that not all moments of mutuality are prosocial.

7.3.6 Therapeutic social capital within the FMH context

6. Therapeutic social capital was observed to be constrained within the FMH inpatient context (RQ3).

Research question three explores the possibility for creative practices to offer shared benefit to staff and residents. It has been identified that the formal practices at Westmarch Hospital did not promote mutuality between staff and residents through models of professionalism (i.e., boundaried relationships) and individualistic approaches to care. However, this research highlights possibilities of therapeutic social capital, which are discussed in the implications section (see section 7.5).

7.3.7 Methodological insights

7. The research contributes towards methodological insights for institutional ethnographies within challenging environments, such as, FMH contexts.

This section has four sub-sections, which explore the development of the researcher role during fieldwork, potential limitations in relation to these developments, the value of clinical supervision, and the suitability of the research ethics protocol.

7.3.7.1 Developing the researcher role

Phase one of the research was characterised by a lack of socialisation, where everyday conversations were limited, due to a lack of defined role and a lack of opportunities for social interaction. Access negotiations "are not merely confined to the early stages of the ethnographic project" and development and maintenance of rapport need to be continually negotiated throughout fieldwork (Morgan-Trimmer and Wood, 2016, p.5), as discussed in section 3.4.1. Whilst I was given access by the hospital manager—the fundamental gatekeeper—this did not allow access to all contacts of the social group being observed.

Social intercourse pertaining everyday conversations has been suggested to be pertinent for the development of trust (Hammersley

and Atkinson, 1995). I learnt that the institution had a standard approach for student visitors, who would commonly spent time at Westmarch Hospital, through defined roles related to their training. For example, a student nurse would be assigned to a staff nurse mentor, assisting and learning about the nurse role within the institution. I, however, did not have a mentor or a discipline to shadow to assist with enculturation. It became apparent that I did not fit within the institution's defined roles and this was evidenced in the title assigned on my identification badge—"student" where all other staff and students had "nurse" or "student nurse" displayed. It has been noted within the literature that those within the field will seek to understand the ethnographer's role by locating them within their experiences (Hammersley and Atkinson, 1995). Often questions would occur which highlighted the tension of my role within the institution as a researcher and not a member of staff. For example, I was often asked to unlock doors by residents and one time I indicated that I could not do this, I was not staff. The resident replied "well, what's the point in you being here?". The lack of defined role during my induction meant that I had minimal opportunity to become an insider and access emic understandings of creative practices embedded within the institutional context, noted to be fundamental to ethnography research (Whitehead, 2005). However, the flexibility and creative nature of the iterative methodology (Whitehead, 2005) meant that I had an opportunity to explore ways to develop my role so that I could begin to engage in everyday conversations, suggested to be the basis of rapport (Hammersley and Atkinson, 1995) and the route to facilitating observations, events, and meaningful conversations (Davies, 2008). My choice to transition to a shadowing role in phase two of the research meant that I could develop my researcher role form being a complete observer to the participant-as-observer role. My participant observer role would often fluctuate from complete observer to participant-as-observer, which was influenced by the degree of acceptance; this developed over time through the building of relationships with staff and residents influencing the participation of researcher within every day encounters. Examples

and further discussion of the researcher role was provided in section 3.4.1.

7.3.7.2 Potential limitations with methodological developments

Section 3.4.1 discussed the challenges of conducting an ethnography within the institutional context where physical access was permitted however, access to social groups was restricted. Once the ethnographer has entered the field, the researcher must work to build trust and rapport with the participants (Hammersley and Atkinson, 1995). Whitehead (2005, p.4) notes that ethnography is "an intersubjective product constructed by the relationship between the researcher and the study population", thus the co-construction of creative practices as embedded within life at Westmarch Hospital was built through relationships and the researcher is the primary instrument for data collection and access is embedded within relationships (Curry et al., 2009). However, the groups in which the researcher aligns themselves to may have methodological implications for the research. For example, through building relationships with specific groups in the field may lead to limited contact with others (Hammersley and Atkinson, 1995). This was the case for other staff groups, such as, nurses and health care assistants, at Westmarch Hospital where I could not gain access to individuals for interviews, which was likely influenced by a lack of rapport. Section 7.4.2 further explores the limitations of this doctoral research.

7.3.7.3 Clinical supervision

Another key development was that of clinical supervision, which was provided by the University of Nottingham. Section 3.2.1 discussed how these sessions provided valuable insight into my role as researcher and assisted with reflexivity. For example, at times, there were tensions which arose from adopting a participatory role in which I abided by the rules provided by staff, but such a role prompted a

divide between me and the residents, as evidenced in vignette C: "You're just trying to control me" (see section 4.3.3.3). Furthermore, I was able to explore my own projections through these supervisions, which enabled a deeper understanding of quite challenging events experienced in the field and to work towards resolving anxieties relating to these.

7.3.7.4 The suitability of the research and ethics protocol

The consent form was found to be problematic within the FMH environment. Section 3.5.3 discussed an individual who was not comfortable with signing the consent form however, he would often spend time with me discussing his day and the activities he was engaged in. Other research has found participants were willing to engage in research but would not formally sign a consent form (Aguila et al., 2016) or the formalised process of signing a document lead to feeling of anxiety (Metro, 2014). Due to the iterative nature of ethnography, it has been argued that the requirement of consent forms is inappropriate (Fetterman, 2009). Furthermore, consent is often continually negotiated and is a process (Davies, 2008). Indeed, this was the case for this doctoral research. I was sensitive to the wellbeing of the residents and did not approach them if they appeared to not want to engage with me or if they looked visibly upset, as outlined by the research protocol, which was discussed in section 3.5.

7.4 Reflections on the ethnographic approach

7.4.1 Value of the approach

This is the first research project to explore creative practices through mutual recovery within the FMH context. An ethnographic approach was adopted and promoted the exploration of specific events by placing these within a "broader, more meaningful context" (Curry et al., 2009, p.1444). Thus, the research methodology allowed the exploration of current embedded practice related to creative practice engagement, which is argued to contribute to an understanding of the ways in which creative practice engagement is situated within

practice. Chapter three discussed the value of an ethnographic approach to exploring current practice, which was achieved by the researcher adopting strategies which promoted the researcher to be embedded within the culture under study, see section 3.4.

The ethnographic approach enabled the exploration of key contextual features of the environment in which creative practice rituals were situated, these are further discussed in section 4.8. Section 7.3.7.1 discussed insights gained in relation to using the ethnographic approach. However, although adopting this approach in the FMH setting was challenging, it did achieve the intention of "[b]eing in the field and coming to a thorough understanding of the daily lives of the group under study", as evidenced by the microsociological model of therapeutic social capital that highlights the importance of contextual influences on therapeutic practices and creative practice engagement (Whitehead, 2004, p.17).

7.4.2 Constraints

In spite of the value of the approach there are notable constraints related to exploration of interaction rituals and to the research sample. For example, interaction rituals are considered to be chains of events, which build over time and can lead to feelings of solidarity or a build-up of EE– (Boyns and Luery, 2015). Thus, as noted by Boyns and Luery (2015, p.159) "a single interaction ritual rarely stands alone [and] emotional energy in a given setting is the result of previous interactions and the catalyst for future encounters". This thesis has recognised the influence of past negative experiences on the forensic patient's self-perception and these have been argued to lead to difficulties in forming new relationships (Adshead, 2004). Whilst the theoretical application of such a chain of events has been recognised and the changeable emotional environment was noted in chapter four, the creative practice ritual data has limited sequenced observations and thus the notion of IR chains is not fully explored in all the observations provided. There are two exceptions. For example, the art session as a formal creative practice ritual was interrupted by

a new power ritual, the impromptu community meetings. Thus, this example provides an exploration of IR chains and considered the influence of such rituals on possibilities of therapeutic social capital and wellbeing. The other example of the ritual chains explored within this thesis is the informal creative practice ritual outlined in section 5.4.2. The formal creative practice ritual of the music session, which was a successful ritual where the residents and Charlie were engaged in a multiparty pursuit, prompted an informal creative practice ritual. However, the informal creative practice ritual was not successful and led to the annoyance of a fellow resident.

Furthermore, the self-selecting participant sample may be limited and may not be representative of low secure inpatient forensic mental health services.

Conducting interviews with individuals who are recovering from their mental health and have a mental health diagnosis can be challenging. Section 3.4.3 discussed the challenges with conducting interviews with individuals when their wellbeing would often fluctuate. Other challenges included fitting the interviews in between institutional and care regimes. Thus, even when the interviews were planned, they were problematic. Furthermore, the interviews and observations were partial and restricted, for example, on occasions I had to leave the ward, as evidenced in section 4.4.1.2.

Section 3.4.3 discussed professional busy-ness as a potential barrier to the research. Thus, professional busy-ness was also found to be limiting and "pragmatics of professional time" has been found to shape ethnography research (Bisaillon and Rankin, 2012, n.p.). It was also noted in section 7.3.7.2 that the groups in which the researcher aligns themselves to, may have methodological implications for the research. For example, through building relationships with specific groups in the field may lead to limited contact with others (Hammersley and Atkinson, 1995). Arguably, however, the occupational therapy team and the residents were key informants in

the field for exploring formal creative practice engagement and informal creative practices could be observed outside of structured therapy, nonetheless, and emic understandings could be explored via interviews with residents.

7.5 Novel contribution of thesis to knowledge

Research has explored creative practices as new, novel pursuits, within the community context to explore mutual recovery through creative practices, as discussed in section 2.4.1.4 (Argyle and Winship, 2015; Callahan et al., 2017; Fancourt et al., 2016a, 2016b; Hogan, 2018; Jordan et al., 2018; Lewis et al., 2016; Perkins et al., 2016; Vallejos et al., 2016; Winship and Barker, 2016). This thesis importantly explores the creative practices embedded within the institutional FMH context and is the first consideration of such practice within this context. Section 7.4.1. considered the value of adopting an ethnographic approach to explore creative practices within the embedded institutional context. Such an approach led to the understanding of the contextual environment. For example, three key contextual features of the FMH environment were found to influence creative practice engagement and therapeutic social capital, these were:

- Surveillance, security, and risk;
- The emotive environment;
- Boundaried relationships.

The theme surveillance, security and risk, was found to influence authentic creative practice engagement and lead to the performativity of resident engagement. The emotive environment and boundaried relationships were found to influence therapeutic social capital, see section 7.3.2.

This research adopts IRT to explore mutual recovery through creative practice, which is utilised in a novel way and is the first project to utilise this theory to explore creative practices and their contribution to therapeutic social capital, see section 7.3.4. The key features of successful creative practices in promoting therapeutic social capital is

identified by the microsociological model of therapeutic social capital (see figure 7.1). The model considers micro and macro level influences on the success of such engagement in promoting therapeutic social capital and thus contributes to the understanding of how creative practice engagement can lead to therapeutic social capital within the FMH context.

The research has provided conceptual development of therapeutic social capital, which considers the importance of relationships to wellbeing, see section 2.3.4.1. Thus, this research explored an holistic approach to wellbeing which considers the influence of staff-resident and resident-resident relationships to wellbeing within the FMH context. This holistic sociological approach to wellbeing contributes to the recovery literature by extending the focus beyond the individual within the recovery journey and considers the wellbeing of others.

Furthermore, this thesis considers how the forensic patient spends their time outside of structured therapy and considers informal creative practice engagement. It has been noted that everyday social encounters and time outside of structured therapy has been found to play an important role in facilitating change (Clarke, 2017). Thus, this research contributes to an understanding of how time outside of structured therapy is spent within the FMH environment in relation to creative practice engagement.

7.6 Doctoral work publications and future plans

7.6.1 Current involvement in publications

I am lead author on a collaborative chapter for Crawford et al., *The Companion to Health Humanities* (forthcoming 2019), entitled 'Health Humanities in Challenging places'. Insights from this doctoral work has resulted in the publication of this chapter. The chapter explores the challenges for creative practices within inpatient FMH contexts. The observation provided in section 5.3.1 is utilised to highlight the tensions of creative practice pursuits within an environment governed

by surveillance, security, and risk. This chapter concludes by highlighting the lack of literature exploring mutually beneficial creative practice engagement for staff and patients. Future research exploring such multiparty pursuits through the microsociological model of therapeutic social capital (see figure 7.1), has been suggested within this thesis. Such research would contribute to this lack of focus within the literature as highlighted within the forthcoming published chapter.

7.6.2 Planned future publications

I am planning three additional peer-reviewed articles.

First, chapter two will form the basis for a research paper for *The Journal of Recovery in Mental Health*. This publication will present the hierarchical model of therapeutic social capital, provided in section 2.3.4.1 and will add to the literature exploring, social interactions, social connectedness, mutuality, group solidarity, and mutual recovery by providing a theoretical structure to such concepts within the therapeutic context. Chapter five presents the microsociological model of therapeutic social capital which was utilised to explore and analyse the creative practice rituals at Westmarch Hospital and consider the micro, meso, exo, and macro level influences on the success of such rituals in facilitating therapeutic social capital. This first publication will present the model by situating this within the IRT literature and will build upon the theory by considering the hierarchical model of therapeutic social capital, and thus provide a theoretical development to the findings of rituals by expanding upon group solidarity and its relation to social interaction, social connectedness, and mutual recovery.

A second paper will explore the nature of negative emotions in the therapeutic context and consider how these experiences can be transformed into therapeutic social capital.

A third paper will explore the findings of the CPMR programme of research and consider the contribution of creative practice

engagement to therapeutic social capital. Chapter three will contribute towards this paper, exploring the methodology adopted and consider the contribution of such an approach within the FMH context. The paper will also focus on the research methods and ethics of adopting ethnography within an inpatient secure FMH hospital.

7.7 Professional gains

During my time as a doctoral researcher at the University of Nottingham I have been engaged in a range of research and networking groups. For example, in 2013 I became an active member of both the Centre for Social Futures (SoFu) which is a Centre of Excellence at the Institute of Mental Health, The University of Nottingham, and Nottingham Health Humanities (NHH) Research Priority Area (RPA). I joined as deputy lead of the Therapeutic Environments, Integrated Research Group (IRG) in 2014. From 2014-2019, I co-led the Nottingham Health Humanities (NHH) Research Priority Area (RPA) Early Bird Researcher (EBR) group, which has over 60 members across various schools and departments at UoN, highlighting the cross-disciplinary field of Health Humanities. The EBR group aims to bring together like-minded early career researchers and established academics from the NHH RPA.

I have as been involved as a researcher on the following projects:

- Community and Capoeira Research Group
- What is Home?
- Hungry for Words

Which has resulted in two publications:

Jordan, M., Wright, E.J., Purser, A., Grundy, A., Joyes, E., Wright, N., Crawford, P. and Manning, N., 2018. Capoeira for beginners: self-benefit for, and community action by, new capoeiristas. *Sport, Education and Society*, 1–14.

Vallejos, E.P., Baker, C., McGarry, J., Joyes, E., Carletti, L., Bartel, H., Jacobs, R., Gale-Feeny, A. and Higginbottom, R., 2017. What is home? An art-based workshop to explore the physical, relational and wellbeing properties of Home. *Journal of Applied Arts & Health*, 8(3), 341–355.

Engagement in these various activities has led to an increased understanding of the value of collaborative working and the promotion of sharing research and practice through engagement activities, such as, meetings, seminars, international conferences, and published findings in peer-reviewed journals.

7.8 Conclusions

Mutual recovery through creative practice is constrained within the FMH environment. Surveillance, security, and risk practices can hinder authentic engagement within creative practices and serve to undermine the relational security that creative practice engagement can offer. A highly emotive environment is challenging for staff and resident wellbeing which also poses challenges for therapeutic social capital. Furthermore, an individualised model of care restricts opportunities for therapeutic social capital through professional boundaried working between staff and residents. Residents were also observed to avoid engagement with fellow residents due to interpersonal issues. It is argued, however, that creative practices which promote a mutual endeavour for both staff and residents could provide opportunities for social connectedness and promote personal recovery. It is important to note that a dark side of mutuality exists and careful consideration of interactions that promote prosocial attitudes is advocated.

7.9 Implications for research, policy and practice

This section considers future research and provides recommendations for policy and practice, informed by this doctoral research.

7.9.1 Research

The microsociological model of therapeutic social capital (see figure 7.1) revealed the key ritual ingredients for successful creative practice rituals. Prerequisites for mutual recovery through creative practice in the FMH context were identified as: a barrier to outsiders and a mutual focus of attention which can be facilitated by a

multiparty pursuit and shared mood. Section 7.3.1 notes that within this research it was observed that the creative practices provided by the occupational therapy team did not promote a mutual endeavour thus, limiting opportunities for a mutual focus of attention and social interaction—identified as fundamental for therapeutic social capital, see section 2.3.4.1.

The research found that there were a few examples of successful creative practice rituals, which had the potential to facilitate therapeutic social capital (section 5.5 for a summary of the creative practice ritual ingredients). However, the environment was often constrained by the key contextual features of the life at Westmarch Hospital, such as: surveillance, security, and risk (see sections 5.3.5.1 and 5.4.4.1). For example, the art session was interrupted due to the staff implementing the hospital's policies on contraband items. Furthermore, the timetabled occupational therapy sessions followed an individualised model of care in which the activities were rarely undertaken as a multiparty pursuit. The exploration of the microsociological model of therapeutic social capital (see figure 7.1) in a creative-practice-rich environment would assist in understanding the utility and applicability of the model. Furthermore, a context in which a more fluid hierarchical structure to care is theorised to provide further insights into the utility of the model. For example, a service which authentically promotes patient involvement, such as, a Therapeutic Community, is theorised to be an apt environment, which may provide opportunities to explore creative practice pursuits promoting a shared experience.

It is important to note that there are temporalities associated with ethnographic research (Hannerz, 2003), the research was undertaken during a specific period of time. A new initiative was being implemented at Westmarch Hospital, during the end of the research. This was the introduction of the recovery college and the occupational therapy art room had been allocated for such activities. Recovery college initiatives were being supported nationally through

commissioning targets (NHS England, 2016). The introduction of the recovery college is theorised to have likely led to an expansion of creative practices at Westmarch Hospital, which, because of the time that the research was undertaken, were not explored. Thus, the introduction of such practices may provide further opportunities to explore creative practices within the FMH environment.

The microsociological model of therapeutic social capital (see figure 7.1) can be utilised to identify potential study sites by considering the key ingredients theorised to promote mutual recovery through creative practice. For example, joint participation of staff and residents within creative practice pursuits would indicate a suitable site for exploration. Future research, then, would explore the possibility of mutual recovery through creative practice within other FMH contexts and understand the ways in which the micro, meso, exo, and macro level influences are managed to promote therapeutic social capital through creative practice engagement.

Within this doctoral research, creative practices were explored as specific events situated within the institutional context. However, the permeability of secure care has been noted (Quirk et al., 2006) and, within this research, it was found that some residents had access to mobile phones and the internet, which was used to contact individuals outside of the institution. Thus, whilst the methodology and thus the participant observation role suited the aims of the research, including the research questions, the methods adopted within the research limited questions related to social networks outside of the hospital. Eco-mapping has been utilised within research to explore relationships over time, finding that during the individual's recovery journey, their social networks decreased in size but existing relationships were found to be more mutual (Winship and Barker, 2016). Future research could adopt social mapping methods to explore the strength of relationships within the institutional environment, which could also include key relationships outside of the institution. The notion that new social and spatial environments could

promote recovery is supported within the literature (Clarke et al., 2016; Saavedra et al., 2017a, 2017b). Such methods, then, would assist with the development of therapeutic social capital in relation to the institutionalised individual in care and their extending networks outside of secure FMH care. Such research would explore therapeutic social capital more broadly and consider the social permeability of FMH environments.

7.9.2 Policy

National policies reflect the dominant interest and values of those who have governmental power (Miles and Gibson, 2016) and poor implementation strategies can lead to disappointing results (Head, 2010). The emphasis on quantitative measures of policy implementation are argued to be driven by policy maker's interest in immediate demonstrations of successful implementation, which can distract the focus from what is relevant (Wond and Macaulay, 2010). Furthermore, Head (2010, p.80) notes that:

> policy managers and political leaders often insist that measurable results be available in a short time-frame, leading to greater focus on visible activities rather building the foundations for sustainable benefits.

Resident engagement in therapy was monitored by the hospital. Section 2.2.3 introduced the 25 hours of therapeutic activity outlined by the Royal College of Psychiatrists and sections 5.3.1 explored how such recommendations influenced practice. A payment by results policy has driven practice in the sector. The evaluation strategies used to assess the 25 hours of therapeutic activities, such as quantitative data relating to attendance, is argued to have undermined the aim of promoting engagement in activities for the residents at Westmarch Hospital.

Furthermore, mental health policy outlines the importance of therapeutic relationships and engagement. For example, the

Department of Health (2002, p.13) published a report outlining an implementation guide for mental health policy within adult acute mental health care provision which states:

> Many inpatient services are inadequately structured or resourced to allow effective therapeutic engagement of service users. Inpatient nursing and related care depends primarily on relationships; staff need to have the time to talk with and listen to service users and carers. Ward arrangements need to be organised and structured to foster a milieu and culture of engagement and to maximise the time that staff spend therapeutically engaged with service users. Activities that detract from therapeutic time should be reviewed.

The promotion of shared time between staff and patients in therapeutically engaged tasks is recognised by the Department of Health (2002). Moreover, the nursing literature has been found to promote mutuality between patients and staff (Brown, 2015, 2016) and there is growing literature which expands the field of arts and health which goes beyond an individualised approach to health by considering a holistic approach to wellbeing. For example research has found that engagement in creative practices can promote a sense of community (Vallejos et al., 2016), connect diverse group members (Jordan et al., 2018), and also facilitate the flattening of social hierarchies between a range of individuals (Argyle and Winship, 2015; Callahan et al., 2017; Lewis et al., 2016; Perkins et al., 2016). Thus, the contribution of creative practices as a powerful tool for promoting therapeutic social capital could be recognised. However, it is argued that evaluation strategies of policy implementation should promote a holistic understanding of the effectiveness of such implementations, and both quantitative and qualitative measures would more sensitively evaluate meaningful results (Wond and Macaulay, 2010).

7.9.3 Practice

It is argued in section 7.9.2 that there needs to be move from policy that values engagement, which is measured through attendance, to meaningful engagement in therapeutic activities. It is proposed that current measures of engagement can negatively influence wellbeing and constrain opportunities for therapeutic social capital. Furthermore, such a focus on attendance as engagement can lead to a performative role being undertaken by patients, as evidenced in section 5.3.1, such a role has also been reported by other research (Gillard et al., 2012; Morris et al., 2016). Thus, the ways in which practice can promote meaningful engagement is explored within this section.

It is argued that meaningful therapeutic activities can be promoted through the adoption of authentic service user involvement. Agency and choice for the patient has been noted to be fundamental to occupational therapy practice (College of Occupational Therapists, 2012) and thus consideration should be given to the application of such principles in practice. Furthermore, it has been noted that the overarching aim of the recovery movement is "to afford people with serious mental illnesses the rights, opportunities and resources needed to lead meaningful and productive lives" (Davidson, Rakfeldt & Strauss, 2010, p.3). Thus, the aims of personal recovery and occupational therapy practice is argued to be complimentary. The Quality Network for Forensic Mental Health services (Dzikunoo et al., 2017) note the importance of the patient recognising the connection between the activity and the therapeutic benefit provided. Thus, involving the patient in decisions about the care in relation to meaningful occupation should be promoted in practice.

Interpersonal issues between residents are commonly observed or reported within inpatient FMH environments (Nathan et al., 2007; Woods and Springham, 2011) and were noted to act as a barrier to mutuality within this doctoral research (see section 6.2).

Furthermore, within the institutional context, opportunities to maximise Emotional Energy (EE) are theorised to be limited. However, research has shown that participants benefited from engaging in new social and spatial environments to extend their personal and social identities (Saavedra et al., 2017a, 2017b). It is, therefore, proposed that wider community creative practice engagement could promote social connectedness and identity development amongst residents by extending opportunities for social capital. This research observed that paternalistic models of care were a barrier to mutuality between staff and residents, and thus engagement in a mutual endeavour which facilitates identity development beyond the role of patient and staff could extend the social and thus recovery capital for staff and residents.

An implication from the research for practice is that consideration to the careful monitoring of conduct that could be detrimental to therapeutic social capital should be explored as noted within the literature. Section 6.2.1 discussed a boundary violation exhibited by a staff member. Whilst, boundary crossing is common within practice, regular training is suggested to assist with the identification of appropriate professional relationships (Kelly and Wadey, 2012).

7.10 Personal gains

In this section I highlight the insight gained into creative practice engagement in my personal life. The example presented is representative of the therapeutic nature of mutual recovery at a personal level.

Polymer clay miniatures: A multiparty creative practice ritual

Whilst completing my thesis I have been drawn into a creative practice experience at a personal level through a friend of mine who spends some of their spare time creating miniatures out of polymer clay. For example, a miniature burger (see image below).



We have agreed that I will join her to engage in this creative practice together, once I have submitted my thesis. My friend has informed me to select the item which would bring me the most joy to create—one that provokes laughter during the creation process. The joy is based on the perceived lack of utility of the object; an object which seems inane. We have spent time looking through a book of possible creations and have talked on many occasions about spending time together in order to make them. I have chosen to make a bathroom sink (see image below). These conversations have already prompted laugher and joy.



Whilst the object itself will lack purpose, the creation will symbolise our friendship and will mark the end of my long PhD journey. This artwork will sit on my desk and I can imagine that it will make me chuckle and will remind me of the PhD journey exploring creative practices through mutual recovery and of our friendship.

References

Adlam, J., Gill, I., Glackin, S.N., et al. (2013) Perspectives on Erving Goffman's "Asylums" fifty years on. *Medicine, Health Care, and Philosophy*, 16 (3): 605–613. doi:10.1007/s11019-012-9410-z.

Adshead, G. (2000) Care or custody? Ethical dilemmas in forensic psychiatry. *Journal of Medical Ethics*, 26 (5): 302–304. doi:10.1136/jme.26.5.302.

Adshead, G. (2004) "Three degrees of security: Attachment and forensic institutions." In Pfafflin, F. and Adshead, G. (eds.) *A matter of security: The application of attachment theory to forensic security and psychotherapy*. London: Jessica Kingsley Publishers. pp. 147–61.

Adshead, G. (2012) What the eye doesn't see: Relationships, boundaries and forensic mental health. *Professional and therapeutic boundaries in forensic mental health practice*, pp. 13–35.

Aguila, E., Weidmer, B.A., Illingworth, A., R., et al. (2016) Culturally competent informed-consent process to evaluate a social policy for older persons with low literacy: The mexican case. *SAGE Open*, 6 (3): 1–11. doi:10.1177/2158244016665886.

Aiyegbusi, A. (2009a) "The nurse-patient relationship with offenders: Containing the unthinkable to promote recovery." In Aiyegbusi, A. and Clarke-Moore, J. (eds.) *Therapeutic relationships with offenders: An introduction to the psychodynamics of forensic mental health nursing*. London: Jessica Kingsley Publishers. pp. 15–32.

Aiyegbusi, A. (2009b) The psychodynamics of forensic mental health nursing. *International Forum of Psychoanalysis*, 18 (1): 30–36. doi:10.1080/08037060802450720.

Allan, J., Barford, H., Horwood, F., et al. (2015) ATIC: Developing a recovery-based art therapy practice. *International Journal of Art Therapy*, 20 (1): 14–27. doi:10.1080/17454832.2014.968597.

All-Party Parliamentary Group on Arts, Health & Wellbeing (2017) *Creative health: The arts for health and wellbeing: Inquiry report*. All-Party Parliamentary Group on Arts, Health and Wellbeing.

American Occupational Therapy Association (2014) Occupational therapy practice framework: Domain and process (3rd Edition). *American Journal of Occupational Therapy*, 68 (1): 1–48. doi:10.5014/ajot.2014.682006.

Ander, E.E., Thomson, L.J., Blair, K., et al. (2013) Using museum objects to improve wellbeing in mental health service users and neurological rehabilitation clients. *British Journal of Occupational Therapy*, 76 (5): 208–216. doi:10.4276/030802213X13679275042645.

Andrews, D.A., Bonta, J. and Wormith, J.S. (2011) The risk-need-responsivity (RNR) model: Does adding the good lives model contribute to effective crime prevention? *Criminal Justice and Behavior*, 38 (7): 735–755. doi:10.1177/0093854811406356.

Anspach, R.R. (1997) *Deciding who lives: Fateful choices in the intensive-care nursery*. California: University of California Press.

Anthony, W.A. (1993) Recovery from mental illness: The guiding vision of the mental health service system in the 1990s. *Psychosocial Rehabilitation Journal*, 16 (4): 11–23. doi:10.1037/h0095655.

Argyle, E. and Winship, G. (2015) Creative practice in a group setting. *Mental Health and Social Inclusion*, 19 (3): 141–147.

Arts Council England (2010) *Adult participatory arts: Thinking it through. A review commissioned from 509 Arts*. London: Arts Council England.

Atkinson, P. (2015) *For Ethnography*. London: SAGE Publications. Available at: https://books.google.co.uk/books?id=bejroAEACAAJ.

Baehr, W.P. and Collins, R. (2005) *Review forum: The sociology of almost everything: Four questions to Randall Collins about interaction ritual chains*.

Banks, L. (2012) Free to talk about violence: A description of art therapy with a male service user in a low secure unit. *International Journal of Art Therapy*, 17 (1): 13–24. doi:10.1080/17454832.2012.658578.

Barnao, M., Ward, T. and Robertson, P. (2016) The Good Lives Model: A New Paradigm for Forensic Mental Health. *Psychiatry, Psychology and Law*, 23 (2): 288–301. doi:10.1080/13218719.2015.1054923.

Barton, R. (1966) *Institutional Neurosis*. 2nd ed. Bristol: John Wright & Sons Ltd.

Batcup, D.C. (2013) A discussion of the dance movement psychotherapy literature relative to prisons and medium secure units. *Body, Movement and Dance in Psychotherapy*, 8 (1): 5–16. doi:10.1080/17432979.2012.693895.

Bathje, M. (2012) Art in occupational therapy: An introduction to occupation and the artist. *The open journal of Occupational Therapy*, 1 (1).

Bernstein, D., Keulen-de Vos, M., Jonkers, P., et al. (2015) "Schema therapy in forensic settings." In Van Vreeswijk, M., Broersen, J. and Nadort, M. (eds.) *The Wiley-Blackwell handbook of schema therapy: Theory, research, and practice*. Oxford: John Wiley & Sons Ltd. pp. 425–438.

Best, D. and Laudet, A. (2010) *The potential of recovery capital*. London: RSA Projects.

Bisaillon, L. and Rankin, J. (2012) Navigating the politics of fieldwork using institutional ethnography: Strategies for practice. *Forum: Qualitative Social Research*, 14 (1). doi:10.17169/fqs-14.1.1829.

Blackburn, R. (2004) "What works" with mentally disordered offenders. *Psychology, Crime & Law*, 10 (3): 297–308. doi:10.1080/10683160410001662780.

Blofeld, J., Sallah, D., Sashidharan, S., et al. (2003) *Independent inquiry into the death of David Bennett*. Norfolk: Suffolk and Cambridgeshire Strategic Health Authority.

Boardman, J. (2011) Social exclusion and mental health – how people with mental health problems are disadvantaged: an overview. *Mental Health and Social Inclusion*, 15 (3): 112–121. doi:10.1108/20428301111165690.

Bonner, G., Lowe, T., Rawcliffe, D., et al. (2002) Trauma for all: a pilot study of the subjective experience of physical restraint for mental health inpatients and staff in the UK. *Journal of Psychiatric and Mental Health Nursing*, 9 (4): 465–473. doi:10.1046/j.1365-2850.2002.00504.x.

Bonney, S. and Stickley, T. (2008) Recovery and mental health_ a review of the British Literature. *Journal of Psychiatric and Mental Health Nursing*, 15 (2): 140–53. doi:10.1111/j.1365-2850.2007.01185.x.

Borg, M. and Davidson, L. (2008) The nature of recovery as lived in everyday experience. *Journal of Mental Health*, 17 (2): 129–140. doi:10.1080/09638230701498382.

Borg, M. and Kristiansen, K. (2004) *Recovery-oriented professionals: Helping relationships in mental health services*., 13 (5): 493–505.

Bowlby, J. (1988) *A secure base: Parent-child attachment and healthy human development*. Oxon: Routledge.

Boyle, K. (2018) What's in a name? Theorising the inter-relationships of gender and violence. *Feminist Theory*, 0 (0): 1–18. doi:10.1177/1464700118754957.

Boyns, D. and Luery, S. (2015) Negative emotional energy: A theory of the "dark-side" of interaction ritual chains. *Social Sciences*, 4 (1): 148–170. doi:10.3390/socsci4010148.

Bredewold, F., Hermus, M. and Trappenburg, M. (2018) 'Living in the community' the pros and cons: A systematic literature review of the impact of deinstitutionalisation on people with intellectual and psychiatric disabilities. *Journal of Social Work*, 0 (0): 1–34. doi:10.1177/1468017318793620.

Brewer, J.D. (2000) *Ethnography: Understanding social research*. Buckingham: Open University Press.

Broadbent, E., Schoones, J.W., Tiemensma, J., et al. (2018) A systematic review of patients' drawing of illness: implications for research using the common sense model. *Health Psychology Review*, 0 (0): 1–21. doi:10.1080/17437199.2018.1558088.

Broderick, S. (2011) Arts practices in unreasonable doubt? Reflections on understandings of arts practices in healthcare contexts. *Arts & Health*, 3 (2): 95–109. doi:10.1080/17533015.2010.551716.

Brown, B. (2015) Towards a critical understanding of mutuality in mental healthcare: relationships, power and social capital: Mutuality in mental healthcare. *Journal of Psychiatric and Mental Health Nursing*, 22 (10): 829–835. doi:10.1111/jpm.12269.

Brown, B. and Baker, S. (2018) The social capitals of recovery in mental health. *Health*, 00 (0): 1– 19. doi:10.1177/1363459318800160.

Brown, B. and Manning, N. (2018) Genealogies of recovery: the framing of therapeutic ambitions. *Nursing Philosophy*, 19 (2): 1–9. doi:10.1111/nup.12195.

Brown, B.J. (2016) Mutuality in health care: review, concept analysis and ways forward. *Journal of Clinical Nursing*, 25 (9–10): 1464–75. doi:10.1111/jocn.13180.

Browne, D. (2009) "Black communities, mental health and the criminal justice system." In Reynolds, J., Muston, R., Heller, T., et al. (eds.) *Mental Health Still Matters*. London: Macmillan Education UK. pp. 167–173. doi:10.1007/978-1-349-92322-9_23.

Bryant, W., Cordingley, K., Sims, K., et al. (2016) Collaborative research exploring mental health service user perspectives on acute inpatient occupational therapy. *British Journal of Occupational Therapy*, 79 (10): 607–613. doi:10.1177/0308022616650899.

Bryman, A. (2004) *Social research methods*. 2nd ed. Oxford: Oxford University Press.

Bryman, A. (2016) *Social research methods*. 5th ed. Oxford: Oxford University Press.

Bungay, H., Clift, S. and Skingley, A. (2010) *The Silver Song Club Project: A sense of well-being through participatory singing*., 15 (3): 135–40.

Callahan, K., Schlozman, S., Beresin, E., et al. (2017) The use of music in mutual recovery: A qualitative pilot study. *Journal of Applied Arts & Health*, 8 (1): 103–114.

Cambridge: Norfolk, Suffolk, and Cambridgeshire Strategic Health Authority (2003) *Independent inquiry into the death of David Bennett*. Norfolk: Cambridge: Norfolk, Suffolk, and Cambridgeshire Strategic Health Authority.

Campling, P. (2004) "A psychoanalytical understanding of what goes wrong: the importance of projection." In Campling, P., Davies, S. and Farquharson, G. (eds.) *From Toxic Institutions to Therapeutic Environments: Residential Settings in Mental Health Services*. London: Royal College of Psychiatrists. pp. 32–44.

Care Quality Commission (CQC) (2011) *Care Quality Commission looks ahead as last Count Me In census is published*. London: Care Quality Commission.

Care Quality Commission (CQC) (2018) *Mental Health Act: The rise in the use of the MHA to detain people in England*. London: Care Quality Commission.

Care Quality Commission (CQC) (2018) *Sexual safety on mental health wards*. CQC-421-092018. Newcastle upon Tyne: Care Quality Commission.

Castora-Binkley, M., Noelker, L., Prohaska, T., et al. (2010) Impact of arts participation on health outcomes for older adults. *Journal of Aging, Humanities, and the Arts*, 4: 352–367.

Chacksfield, J. (2002) "Activities therapy: a recapitulation of ontogenesis." In Duncan, E.A. (ed.) *Foundations for practice in occupational therapy*. 4th ed. London: Elsevier Ltd. pp. 143–160.

Chambers, M., Gallagher, A., Borschmann, R., et al. (2014) The experiences of detained mental health service users: issues of dignity in care. *BMC Medical Ethics*, 15: 50. doi:10.1186/1472-6939-15-50.

Chapple, E.D. (1982) "Movement and sound: The musical language of body rhythms in interaction." In Davis, M. (ed.) *Interaction rhythms: Periodicity in communicative behaviour*. New York: Human Sciences Press. pp. 31–52.

Charland, L.C. (2007) Benevolent theory: moral treatment at the York Retreat. *Hist Psychiatry*, 18 (1): 61–80. doi:10.1177/0957154X07070320.

Chisnell, C. and Mitchell, Gordon.J. (2013) "The legal and ethical landscape." In Hall, A., Wren, M. and Kirby, S. (eds.) *Care planning in mental health: Promoting recovery*. 2nd ed. Chichester: John Wiley & Sons. pp. 117–129.

Chow, W.S. and Priebe, S. (2013) Understanding psychiatric institutionalization: a conceptual review. *BMC psychiatry*, 13 (1): 169.

Clarke, C., Lumbard, D., Sambrook, S., et al. (2016) What does recovery mean to a forensic mental health patient? A systematic review and narrative synthesis of the qualitative literature. *The Journal of Forensic Psychiatry & Psychology*, 27 (1): 38–54. doi:10.1080/14789949.2015.1102311.

Clarke, J. (2015) *Where the change is: Everyday interaction rituals of therapeutic communities*. Doctor of Philosophy. University of Nottingham: Nottingham.

Clarke, J. (2017) "The role of everyday interaction rituals within therapeutic communities." In Middleton, H. and Jordan, M. (eds.) *Mental Health Uncertainty and Inevitability: Rejuvenating the relationship between social science and psychiatry*. Cham: Springer International Publishing. pp. 47–72.

Clarke, Jenelle.M. and Waring, J. (2018) *The transformative role of interaction rituals within therapeutic communities*. doi:10.1111/1467-9566.12773.

Clifford, J. (1990) "Notes on (Field)notes." In Sanjek, R. (ed.) *Fieldnotes: The makings of anthropology*. Cornell: University Press. pp. 47–70.

Clift, S., Camic, P.M., Chapman, B., et al. (2009) The state of arts and health in England. *Arts & Health*, 1 (1): 6–35. doi:10.1080/17533010802528017.

Cocking, A. and Astill, J. (2004) Using literature as a therapeutic tool with people with moderate and borderline learning disabilities in a forensic setting. *British Journal of Learning Disabilities*, 32 (1): 16–23. doi:10.1111/j.1354-4187.2003.00266.x.

Coffey, A. (2018) *Doing Ethnography*. 2nd ed. Flick, U. (ed.). Sage Publications Ltd.

Collins, R. (1981) On the microfoundations of macrosociology. *American journal of sociology*, 86 (5): 984–1014.

Collins, R. (1993) Emotional energy as the common denominator of rational action. *Rationality and Society*, 5 (2): 203–230. doi:10.1177/1043463193005002005.

Collins, R. (2004) *Interaction ritual chains*. Princeton: Princeton University Press.

Collins, R. (2014) *Interaction ritual chains*. Princeton: Princeton University Press.

Connell, C. (2016) Forensic occupational therapy to reduce risk of reoffending: a survey of practice in the United Kingdom. *The Journal of Forensic Psychiatry & Psychology*, 27 (6): 907–928. doi:10.1080/14789949.2016.1237535.

Corrigan, P. (2004) How stigma interferes with mental health care. *American Psychologist*, 59 (7): 614–625. doi:10.1037/0003-066X.59.7.614.

Craig, L.A., Browne, K.D. and Beech, A.R. (2008) *Assessing risk in sex offenders: A practitioner's guide*. Chichester: John Wiley & Sons Ltd. (Google-Books-ID: Ey6wg5PieSsC).

Craig, L.A., Gannon, T.A. and Dixon, L. (2013) *What works in offender rehabilitation: An evidence-based approach to assessment and treatment*. Chichester: Wiley-Blackwell.

Crang, M. and Cook, I. (2007) *Doing ethnographies*. London: Sage Publications Ltd.

Crawford, P. (2002) *Politics and history in William Golding: The world turned upside down*. London: University of Missouri Press.

Crawford, P., Brown, B., Baker, C., et al. (2015) "Health Humanities." In Crawford, P., Brown, B., Baker, C., et al. (eds.) *Health Humanities*. London: Palgrave Macmillan UK. pp. 1–19.

Crawford, P., Lewis, L., Brown, B., et al. (2013) Creative practice as mutual recovery in mental health. *Mental Health Review Journal*, 18 (2): 55–64. doi:10.1108/mhrj-11-2012-0031.

Creek, J. and Lougher, L. (2011) *Occupational therapy and mental health*. Philadelphia: Elsevier Ltd.

Crichton, J.H.M. (2009) Defining high, medium, and low security in forensic mental healthcare: the development of the matrix of security in scotland. *The Journal of Forensic Psychiatry & Psychology*, 20 (3): 333–353. doi:10.1080/14789940802542808.

Cronin-Davis, J. and Sainty, M. (2017) *Occupational therapists' use of occupation-focused practice in secure hospitals: practice guideline*. College of Occupational Therapists.

Curry, L.A., Nembhard, I.M. and Bradley, E.H. (2009) Qualitative and mixed methods provide unique contributions to outcomes research. *Circulation*, 119 (10): 1442–1452. doi:10.1161/CIRCULATIONAHA.107.742775.

Davidson, L., Rakfeldt, J. and Strauss, J. (2010) *The Roots of the Recovery Movement in Psychiatry: Lessons Learned*. Chichester: John Wiley & Sons Ltd.

Davidson, L. and Roe, D. (2007) Recovery from versus recovery in serious mental illness: One strategy for lessening confusion plaguing recovery. *Journal of Mental Health*, 16 (4): 459–470. doi:10.1080/09638230701482394.

Davies, C.A. (1999) *Reflexive ethnography: A guide to researching selves and others*. London, UK: Routledge.

Davies, C.A. (2008) *Reflexive Ethnography: a guide to researching selves and others*. Oxon: Routledge.

Davies, S. (2004) "Toxic institutions." In Campling, P., Davies, S. and Farquharson, G. (eds.) *From toxic institutions to therapeutic environments: Residential settings in mental health services*. London: Royal College of Psychiatrists. pp. 20–31.

Deegan, P. (2001) *Recovery as a journey of the heart*. In Massachusetts State House, 2001. PhD & Associates, LLC. Available at: http://doi.apa.org/getdoi.cfm?doi=10.1037/h0101301 (Accessed: 12 November 2018).

Deegan, P.E. (1997) Recovery and empowerment for people with psychiatric disabilities. *Social Work in Health Care*, 25 (3): 11–24. doi:10.1300/J010v25n03_02.

DeNora, T. (2000) *Music in everyday life*. Cambridge: Cambridge University Press.

DeNora, T. (2016) *Music asylums: wellbeing through music in everyday life*. Oxon: Routledge.

DeNora, T. and Ansdell, G. (2014) What can't music do? *Psychology of Well-Being*, 4 (1). doi:10.1186/s13612-014-0023-6.

Denzin, N.K. (2001a) *Interpretive Interactionism*. 2nd ed. London: SAGE Publications Ltd.

Denzin, N.K. (2001b) The reflexive interview and a performative social science. *Qualitative Research*, 1 (1): 23–46. doi:10.1177/146879410100100102.

Denzin, N.K. and Lincoln, Y.S. (eds.) (2005) *The Sage handbook of qualitative research*. 3rd ed. California: Sage Publications Inc.

Department of Health (2000) *Reforming the mental health act*. (Cmnd 5016-1-11). London: HMSO.

Department of Health (2002) *Mental health policy implementation guide: adult acute inpatient care provision*. Department of Health.

Department of Health (2003) *Inside outside: improving mental health services for black and minority ethnic communities in england*. Leeds, UK: National Institute for Mental Health in England.

Department of Health (2008a) *Code of Practice: Mental Health Act 1983*. Norwich: The Stationary Office.

Department of Health (2008b) *Guidance on nominating a consultee for research involving adults who lack capacity to consent*. London: Department of Health.

Department of Health (2010) *See, think, act: your guide to relational security*. Department of Health London.

Department of Health and Home Office (1992) *Review of health and social services for mentally disordered offenders and others requiring similar services. (command paper 2088)*. Volume 2. Service Needs (Reed Report). HMSO.

Department of Health and Social Security (1975) *Report of the committee on mentally disordered offenders (butler report)*. (Cmnd 6244): London, HMSO.

Department of Health, National Risk Management Programme (2009) *Best practice in managing risk: principles and evidence for best practice in the assessment and management of risk to self and others in mental health services*. London: Department of Health.

Dixon, J. (2015) Treatment, deterrence or labelling: mentally disordered offenders' perspectives on social control. *Sociology of Health & Illness*, 37 (8): 1299–1313. doi:10.1111/1467-9566.12313.

Doyle, M. and Dolan, M. (2008) "Understanding and managing risk." In Soothill, K., Rogers, P. and Dolan, M. (eds.) *Handbook of forensic mental health*. Devon: Willan Publishing. pp. 244–266.

Drennan, G. and Alred, D. (2012) "Recovery in forensic mental health settings: from alienation to integration." In Drennan, G. and Alred, D. (eds.) *Secure recovery: approaches to recovery in forensic mental health settings*. Oxon: Routledge. pp. 1–22.

Drennan, G. and Wooldridge, J. (2014) *Making recovery a reality in forensic settings*. London: Centre for Mental Health and Mental Health Network, NHS Confederation.

Duncan, E.A. (2002) "Theoretical Foundations for Occupational Therapy: External influences." In Duncan, E.A. (ed.) *Foundations for Practice in Occupational Therapy*. 4th ed. London: Elsevier Ltd. pp. 11–24.

Duncan, E.A. (2011) *Foundations for practice in occupational therapy-E-BOOK*. Elsevier Health Sciences.

Dvoskin, J.A., Radomski, S.J., Bennett, C., et al. (2002) Architectural design of a secure forensic state psychiatric hospital. *Behavioral Sciences & the Law*, 20 (5): 481–493. doi:10.1002/bsl.506.

Dye, S., Smyth, L. and Pereira, S. (2016) "Locked rehabilitation": a need for clarification. *BJPsych Bulletin*, 40 (1): 1–4. doi:10.1192/pb.bp.114.049726.

Dzikunoo, D., Chandra, A., Parketny, J., et al. (2017) *Quality network for forensic mental health services annual report LSU Cycle 5 2016-2017*. CCQI277. London: Quality Network for Forensic Mental Health Services.

Edwards, D. (2014) *Art Therapy*. 2nd ed. London: Sage Publications Ltd.

Edworthy, R., Sampson, S. and Völlm, B. (2016) Inpatient forensic-psychiatric care: legal frameworks and service provision in three European countries. *International Journal of Law and Psychiatry*, 47: 18–27.

Elliott, I. (2016) Poverty and mental health: a review to inform the Joseph Rowntree Foundation's Anti-Poverty Strategy. *London: Mental Health Foundation*, pp. 1–110.

Ellis, C. (1997) An autoethnographic response. *Paper presented at the Annual Meeting of the National Communication Association (83rd, Chicago, IL, November 19-23, 1997)*, p. 12.

Emerson, R.M., Fretz, R.I. and Shaw, L.L. (1995) *Writing ethnographic fieldnotes*. Chicago: University of Chicago Press.

Erickson, F. (1985) *Qualitative methods in research on teaching*. New York: Macmillan.

Erickson, F. (1986) "Qualitative Methods in Research on Teaching." In Witrock, M.C. (ed.) *Handbook of research on teaching*. 3rd ed. New York: Macmillan. pp. 119–161.

Exworthy, T. and Gunn, J. (2003) Taking another tilt at high secure hospitals: The Tilt Report and its consequences for secure psychiatric services. *The British Journal of Psychiatry*, 182 (6): 469–471.

Fancourt, D. (2017) *Arts in Health: Designing and researching interventions*. Oxford University Press.

Fancourt, D. and Perkins, R. (2018) Effect of singing interventions on symptoms of postnatal depression: three-arm randomised controlled trial. *The British Journal of Psychiatry*, 212 (02): 119–121. doi:10.1192/bjp.2017.29.

Fancourt, D., Perkins, R., Ascenso, S., et al. (2016a) Effects of group drumming interventions on anxiety, depression, social resilience and inflammatory immune response among mental health service users. *PLoS One*, 11 (3): 1–16.

Fancourt, D., Perkins, R., Ascenso, S., et al. (2016b) Group drumming modulates cytokine response in mental health services users: a preliminary study. *Psychotherapy and Psychosomatics*, 85 (1): 53–55.

Farmer, N., Touchton-Leonard, K. and Ross, A. (2018) Psychosocial benefits of cooking interventions: a systematic review. *Health Education & Behavior*, 45 (2): 167–180. doi:10.1177/1090198117736352.

Felton, A., Wright, N. and Stacey, G. (2017) Therapeutic risk-taking: A justifiable choice. *BJPsych Advances*, 23 (2): 81–88. doi:10.1192/apt.bp.115.015701.

Fernando, S. (2000) "Imperialism, racism and psychiatry." In Barker, P. and Stevenson, C. (eds.) *The construction of power and authority in psychiatry*. Oxford: Butterworth-Heinemann. pp. 81–93.

Fetterman, D.M. (2009) *Ethnography: Step-by-step*. 3rd ed. London: Sage Publications Ltd.

Fisher, W.H., Geller, J.L. and McMannus, D.L. (2016) "Same problem, different century: Issues in recreating the functions of public psychiatric hospitals in community-based settings." In Perry, B.L. (ed.) *50 years after deinstitutionalization: mental illness in contemporary communities*. Bingley: Emerald Group Publishing Limited. pp. 3–25.

Forsyth, K. and Kielhofner, G. (2002) "The model of human occupation: integrating theory into practice and practice into theory." In Duncan, E.A. (ed.) *Foundations for practice in occupational therapy*. 4th ed. London: Elsevier Ltd. pp. 69–108.

Fortuna, J. (2018) The art and science of occupation as therapy. *The Open Journal of Occupational Therapy*, 6 (1). doi:10.15453/2168-6408.1476.

Freestone, M. (2005) *Overview of an ethnographic study of the UK DSPD Pilot Units*., 26 (4): 449–464.

Gavey, N. (2005) *Just sex?: The cultural scaffolding of rape*. Hove: Routledge.

Geertz, C. (1973) "Thick Description: Toward an Interpretive Theory of Culture." In *The Interpretation of Cultures*. New York: Basic Books Hachette Book Group.

Gilbert, K. (2001) "Introduction: why are we interested in emotions?" In Gilbert, K. (ed.) *The emotional nature of qualitative research*. Washington D.C.: CRC Press. pp. 3–16.

Gilbody, S., Cahill, J., Barkham, M., et al. (2006) Can we improve the morale of staff working in psychiatric units? A systematic review. *Journal of Mental Health*, 15 (1): 7–17. doi:10.1080/09638230500512482.

Gilburt, H., Rose, D. and Slade, M. (2008) The importance of relationships in mental health care: A qualitative study of service users' experiences of psychiatric hospital admission in the UK. *BMC Health Serv Res*, 8 (1): 92.

Gildberg, F.A., Bradley, S.K., Fristed, P., et al. (2012) Reconstructing normality: Characteristics of staff interactions with forensic mental health inpatients. *International Journal of Mental Health Nursing*, 21 (2): 103–113. doi:10.1111/j.1447-0349.2011.00786.x.

Gill, R. and Orgad, S. (2018) The shifting terrain of sex and power: From the 'sexualization of culture' to # MeToo. *Sexualities*, 21 (8): 1313–1324. doi:10.1177/1363460718794647.

Gillard, S., Borschmann, R., Turner, K., et al. (2012) Producing different analytical narratives, coproducing integrated

analytical narrative: a qualitative study of UK detained mental health patient experience involving service user researchers. *International Journal of Social Research Methodology*, 15 (3): 239–254. doi:10.1080/13645579.2011.572673.

Glasby, J. and Tew, J. (2015) *Mental health policy and practice*. 3rd ed. London: Palgrave Macmillan.

Gobo, G. (2008) *Doing ethnography*. London: SAGE Publications Ltd.

Gobo, G. and Molle, A. (2017) *Doing ethnography*. 2nd ed. London: SAGE Publications Ltd.

Goffman, E. (1961) *Asylums: Essays on the social situation of mental patients and other inmates*. New York: Doubleday & Co.

Goffman, E. (1967) *Interaction ritual: essays on face-to-face interaction.* New York: Pantheon Books.

Goldbart, J. and Hustler, D. (2005) "Ethnography." In Somekh, B. and Lewin, C. (eds.) *Research methods in the social sciences*. London: Sage Publications Ltd. pp. 16–23.

Gordon-Nesbitt, R. (2015) *Exploring the longitudinal relationship*. Manchester: Arts for Health.

Gray, R. (2015) The art of healing and healing in art therapy. *InPsych: The Bulletin of the Australian Psychological Society Ltd*, 37 (3): 16.

Greenall, P. (2006) The barriers to patient-driven treatment in mental health: why patients may choose to follow their own path. *International Journal of Health Care Quality Assurance Incorporating Leadership in Health Services*, 19 (1): xi–xxv.

Griffiths, S. and Corr, S. (2007) The use of creative activities with people with mental health problems: A survey of occupational therapists. *British Journal of Occupational Therapy*, 70 (3): 107–114.

Guba, E.G. and Lincoln, Y.S. (1985) *Naturalistic inquiry*. California: Sage Publications Inc.

Guba, E.G. and Lincoln, Y.S. (1989) *Fourth generation evaluation*. California: Sage Publications Inc.

Gudjonsson, G.H., Webster, G. and Green, T. (2010) The recovery approach to care in psychiatric services: staff attitudes before and after training. *The Psychiatrist*, 34 (8): 326–329. doi:10.1192/pb.bp.109.028076.

Hagedorn, R. (1995) *Occupational therapy: perspectives and processes*. London: Churchill Livingstone.

Haines, A., Perkins, E., Evans, E.A., et al. (2018) Multidisciplinary team functioning and decision making within forensic mental health. *Mental Health Review Journal*, 23 (3): 185–196. doi:10.1108/MHRJ-01-2018-0001.

Hammersley, M. (1992) *What's wrong with ethnography?* London: Routledge.

Hammersley, M. (2013) "On practitioner ethnography." In *What's wrong with ethnography?* Hoboken: Taylor & Francis.

Hammersley, M. and Atkinson, P. (1995) *Ethnography: Principles in practice*. 2nd ed. Oxon: Routledge.

Hannerz, U. (2003) Being there . . . and there . . . and there! Reflections on multi-site ethnography. *Ethnography*, 4 (2): 201–216.

Hare-Duke, L., Dening, T., De Oliveira, D., et al. (2018) Conceptual framework for social connectedness in mental disorders: systematic review and narrative synthesis. *Journal of affective disorders*, 245: 188–199. doi:10.1016/j.jad.2018.10.359.

Harris, J. and Huntington, A. (2000) "Emotions as analytic tools: qualitative research, feelings, and psychotherapeutic insight." In Gilbert, K. (ed.) *The emotional nature of qualitative research*. Boca Raton: Taylor & Francis Group. pp. 129–146.

Hausmann, C., Jonason, A. and Summers-Effler, E. (2011) Interaction ritual theory and structural symbolic interactionism. *Symbolic Interaction*, 34 (3): 319–329.

Havsteen-Franklin, D. and Altamirano, J.C. (2015) Containing the uncontainable: Responsive art making in art therapy as a method to facilitate mentalization. *International Journal of Art Therapy*, 20 (2): 54–65. doi:10.1080/17454832.2015.1023322.

Hawkins, H. (2016) *Creativity*. London: Routledge.

Head, B.W. (2010) Reconsidering evidence-based policy: Key issues and challenges. *Policy and Society*, 29 (2): 77–94. doi:10.1016/j.polsoc.2010.03.001.

Hinshelwood, R.D. (2001) *Thinking about institutions: milieux and madness.* London: Jessica Kingsley Publishers.

HMG/DoH (2011) *No Health Without Mental Health: A cross-Government mental health outcomes strategy for people of all ages Analysis of the Impact on Equality (AIE)*. London: Department of Health.

Hogan, S. (2015) *Mothers make art: using participatory art to explore the transition to motherhood*., 6 (1): 23–32. doi:10.1386/jaah.6.1.23_1.

Hogan, S. (2018) *The birth project: using the arts to explore birth. final research report*. Derby: University of Derby.

Howard, T. (2004) "The physical environment and use of space." In Campling, P., Davies, S. and Farquharson, G. (eds.) *From toxic institutions to therapeutic environments: residential settings in mental health services*. London: Royal College of Psychiatrists. pp. 69–78.

Howitt, D. (2010) *Introduction to qualitative methods in psychology*. 2nd ed. Harlow: Pearson Education Limited.

Hughes, C. (1994) "From field notes to dissertation: analyzing the stepfamily." In Bryman, A. and Burgess, R.G. (eds.) *Analysing qaultitative data*. Oxton: Routledge. pp. 35–46.

Hughes, J.A. and Sharrock, W.W. (2007) *Theory and methods in sociology: An introduction to sociological thinking and practice*. New York: Palgrave Macmillan.

Hui, A., Stickley, T., Stubley, M., et al. (2019) Project earth: participatory arts and mental health recovery, a qualitative study. *Perspect Public Health*. doi:10.1177/1757913918817575.

Humphreys, N. and Bree, A. (2004) "Difficulties with attachment and separation: Joining and leaving a therapeutic community." In Campling, P., Davies, S. and Farquharson, G. (eds.) *From Toxic Institutions to Therapeutic Environments: Residential Settings in Mental Health Services.* London: The Royal College of Psychiatrists. pp. 55–66.

Hunter, D.J. (2008) Health needs more than health care: the need for a new paradigm. *European Journal of Public Health*, 18 (3): 217–219. doi:10.1093/eurpub/ckn039.

Huta, V. (2017) *An overview of hedonic and eudaimonic well-being concepts*. In Reinecke, L. and Oliver, Mary.B. (eds.) New York: Routledge. p. n.p.

Impett, E.A., Daubenmier, J.J. and Hirschman, A.L. (2006) Minding the body: Yoga, embodiment, and well-being. *Sexuality Research and Social Policy*, 3 (4): 39–48. doi:10.1525/srsp.2006.3.4.39.

Iversen, R.R. (2009) `Getting Out' in Ethnography: A Seldom-told Story. *Qualitative Social Work: Research and Practice*, 8 (1): 9–26. doi:10.1177/1473325008100423.

Jackson, R. (2013) *Fantasy: the literature of subversion*. London: Taylor & Francis Group.

Jacob, J.D., Gagnon, M. and Holmes, D. (2009) Nursing so-called monsters: On the importance of abjection and fear in forensic psychiatric nursing. *Journal of Forensic Nursing*, 5 (3): 153–161. doi:10.1111/j.1939-3938.2009.01048.x.

Janz, T. (2019) *International women: how we #pressforprogress: international women's day 2018*. Available at: http://link.galegroup.com/apps/doc/A538762218/AONE?sid (Accessed: 10 March 2019).

Johnson, H., Worthington, R., Gredecki, N., et al. (2016) The relationship between trust in work colleagues, impact of boundary violations and burnout among staff within a forensic psychiatric service. *The Journal of Forensic Practice*, 18 (1): 64–75. doi:10.1108/JFP-03-2015-0024.

Johnson, J., Hall, L.H., Berzins, K., et al. (2018) Mental healthcare staff well-being and burnout: A narrative review of trends, causes, implications, and recommendations for future interventions. *International Journal of Mental Health Nursing*, 27 (1): 20–32. doi:10.1111/inm.12416.

Joint Commissioning Panel for Mental Health (2013) *Guidance for commissioners of forensic mental health services*. New York: Centre for Mental Health.

Jones, K. (2004) "The historical context of therapeutic environments." In Campling, P., Davies, S. and Farquharson, G. (eds.) *From toxic institutions to therapeutic environments: residential settings in mental health services*. London: Royal College of Psychiatrists. pp. 3–11.

Jordan, M. (2012) Patients'/prisoners' perspectives regarding the National Health Service mental healthcare provided in one Her Majesty's Prison Service establishment. *Journal of Forensic Psychiatry & Psychology*, 23 (5–6): 722–739. doi:10.1080/14789949.2012.733722.

Jordan, M., Wright, E.J., Purser, A., et al. (2018) Capoeira for beginners: self-benefit for, and community action by, new capoeiristas. *Sport, Education and Society*, pp. 1–14. doi:10.1080/13573322.2018.1441145.

Kawachi, I. and Berkman, L.F. (2001) Social ties and mental health. *Journal of Urban Health : Bulletin of the New York Academy of Medicine*, 78 (3): 458–467. doi:10.1093/jurban/78.3.458.

Kelly, G. and Wadey, E. (2012) "Boundaries in forensic mental health nursing: set in stone or shifting sands?" In Aiyegbusi, A. and Kelly, G. (eds.) *Professional and Therapeutic Boundaries in*

Forensic Mental Health Practice. London: Jessica Kingsley Publishers. pp. 113–123.

Kelly, S., E. (2010) "Qualitative interviewing techniques and styles." In Bourgeault, I., Dingwall, R. and De Vries, R. (eds.) *The SAGE handbook of qualitative methods in health research*. London: Sage Publications.

Kennedy, H.G. (2002) Therapeutic uses of security: mapping forensic mental health services by stratifying risk. *Advances in Psychiatric Treatment*, 8 (6): 433–443. doi:10.1192/apt.8.6.433.

Kennedy, J. and Fortune, T. (2014) Women's experiences of being in an acute psychiatric unit: an occupational perspective. *British Journal of Occupational Therapy*, 77 (6): 296–303. doi:10.4276/030802214X14018723138048.

Kennedy, J., Gibney, S., Nolan, A., et al. (2011) Identification of critical points during domestic food preparation: an observational study. *British Food Journal*, 113 (6): 766–783. doi:10.1108/00070701111140106.

Killaspy, H. (2006) From the asylum to community care: learning from experience. *Br Med Bull*, 79–80: 245–58. doi:10.1093/bmb/ldl017.

Killaspy, H., Fitch, C., Meier, R., et al. (2012) *Guidance for commissioners of rehabilitation services for people with complex mental health needs*. Joint Commissioning Panel for Mental Health.

Kim, D.-Y. (2016) Psychiatric deinstitutionalization and prison population growth: a critical literature review and its implications. *Criminal Justice Policy Review*, 27 (1): 3–21. doi:10.1177/0887403414547043.

Kingdon, D. (1994) Care programme approach: Recent government policy and legislation. *Psychiatric Bulletin*, 18: 68–70.

Kingdon, D. (n.d.) Care programme approach – time to move beyond? *BJPsych Bulletin*, pp. 1–3. doi:10.1192/bjb.2018.73.

Knowles, L.J. and Haigh, R. (1998) Care Programme Approach. *Psychiatric Bulletin*, 22 (3): 188–188. doi:10.1192/pb.22.3.188-a.

Kurtz, A. (2002) A psychoanalytic view of two forensic mental health services. *Criminal Behaviour and Mental Health*, 12 (2): S68–S80. doi:10.1002/cbm.2200120608.

Lamont, S., Sutton, D. and Brunero, S. (2009) A brief report of art therapy in an inpatient mental health unit; consumer support

and experience. *Australia and New Zealand Journal of Art Therapy*, 41 (1): 68–74.

Leamy, M., Bird, V., Le Boutillier, C., et al. (2011) Conceptual framework for personal recovery in mental health: systematic review and narrative synthesis. *The British Journal of Psychiatry*, 199 (6): 445–452.

Leech, B.L. (2002) Asking questions: techniques for semistructured interviews. *Political Science & Politics*, 35 (04): 665–668. doi:10.1017/S1049096502001129.

Leigslation.gov.uk (2007) *Mental Health Act 2007*.

Lewis, L., Spandler, H., Tew, J., et al. (2016) Mutuality, wellbeing and mental health recovery: Exploring the roles of creative arts adult community learning and participatory arts initiatives. *Connected Communities. London: Arts and Humanities Research Council*.

Librett, M. and Perrone, D. (2010) Apples and oranges: ethnography and the IRB. *Qualitative Research*, 10 (6): 729–747. doi:10.1177/1468794110380548.

Livingston, J.D., Nijdam-Jones, A. and Brink, J. (2012) A tale of two cultures: examining patient-centered care in a forensic mental health hospital. *Journal of Forensic Psychiatry & Psychology*, 23 (3): 345–360. doi:10.1080/14789949.2012.668214.

Lloyd, C. and Lee Williams, P. (2010) Occupational therapy in the modern adult acute mental health setting: a review of current practice. *International Journal of Therapy and Rehabilitation*, 17 (9): 483–493. doi:10.12968/ijtr.2010.17.9.78038.

Lloyd, C. and Papas, V. (1999) Art as therapy within occupational therapy in mental health settings: A review of the literature. *British Journal of Occupational Therapy*, 62 (1): 31–35. doi:10.1177/030802269906200109.

Looff, P. de, Didden, R., Embregts, P., et al. (2019) Burnout symptoms in forensic mental health nurses: Results from a longitudinal study. *International Journal of Mental Health Nursing*, 28 (1): 306–317. doi:10.1111/inm.12536.

Looff, P. de, Nijman, H., Didden, R., et al. (2018) Burnout symptoms in forensic psychiatric nurses and their associations with personality, emotional intelligence and client aggression: A cross-sectional study. *Journal of Psychiatric and Mental Health Nursing*, 25 (8): 506–516. doi:10.1111/jpm.12496.

Lubkin, I.M. and Larsen, P.D. (2009) *Chronic illness: Impact and interventions*. 7th ed. Boston: Jones & Bartlett Learning.

Macnaughton, J., White, M. and Stacy, R. (2005) Researching the benefits of arts in health. *Health Education*, 105 (5): 332–339. doi:10.1108/09654280510617169.

Madden, R. (2010) *Being ethnographic: A guide to the theory and practice of ethnography*. London: Sage Publications Ltd.

Mann, B., Matias, E. and Allen, J. (2014) Recovery in forensic services: facing the challenge. *Advances in psychiatric treatment*, 20 (2): 125–131.

Manning, N. (2010) Therapeutic communities: a problem or a solution for psychiatry? a sociological view. *British Journal of Psychotherapy*, 26 (4): 434–443. doi:10.1111/j.1752-0118.2010.01203.x.

Markham, S. (2018) Red-teaming the panopticon (mobilising adaptive change in secure and forensic settings). *The Journal of Forensic Psychiatry & Psychology*, 29 (1): 16–36. doi:10.1080/14789949.2017.1335761.

Marshall, L.A. and Adams, E.A. (2018) Building from the ground up: exploring forensic mental health staff's relationships with patients. *The Journal of Forensic Psychiatry & Psychology*, 29 (5): 744–761. doi:10.1080/14789949.2018.1508486.

Marshall, W.L. and Barbaree, H.E. (1990) "An Integrated Theory of the Etiology of Sexual Offending." In Marshall, W.L., Laws, D.R. and Barbaree, H.E. (eds.) *Handbook of Sexual Assault*. Boston, MA: Springer US. pp. 257–275.

Mason, J. (2002) *Qualitative Researching*. 2nd ed. London: SAGE Publications.

McCann, J. (2004) "What users want." In Campling, P., Davies, S. and Farquharson, G. (eds.) *From toxic institutions to therapeutic environments: Residential settings in mental health services*. London: The Royal College of Psychiatrists. pp. 159–165.

McDonald, R., Kristensen, S.R., Zaidi, S., et al. (2013) Evaluation of the commissioning for quality and innovation framework final report. *University of Nottingham*.

McKeown, M., Jones, F., Foy, P., et al. (2016) Looking back, looking forward: Recovery journeys in a high secure hospital: Recovery Journeys. *International Journal of Mental Health Nursing*, 25 (3): 234–242. doi:10.1111/inm.12204.

McNeill, S. and Bannigan, K. (2014) Forensic and prison services. *Creek's Occupational Therapy and Mental Health*, pp. 424–438.

McNelis, D. (2018) Reflections on the challenges of psychiatry in the uk and beyond: a psychiatrists' chronicle from deinstitutionalization to community care. *Journal of Mental Health Research in Intellectual Disabilities*, 11 (2): 180–182. doi:10.1080/19315864.2018.1424977.

Mercer, D. (2013) Girly mags and girly jobs: Pornography and gendered inequality in forensic practice. *International Journal of Mental Health Nursing*, 22 (1): 15–23. doi:10.1111/j.1447-0349.2012.00837.x.

Metro, R. (2014) From the form to the face to face: IRBs, ethnographic researchers, and human subjects translate consent. *Anthropology & Education Quarterly*, 45 (2): 167–184. doi:10.1111/aeq.12057.

Mezey, G., Durkin, C. and Krljes, S. (2015) Finding a voice – the feasibility and impact of setting up a community choir in a forensic secure setting. *The Journal of Forensic Psychiatry & Psychology*, 26 (6): 781–797. doi:10.1080/14789949.2015.1069881.

Mezey, G.C., Kavuma, M., Turton, P., et al. (2010) Perceptions, experiences and meanings of recovery in forensic psychiatric patients. *The Journal of Forensic Psychiatry & Psychology*, 21 (5): 683–696. doi:10.1080/14789949.2010.489953.

Middleton, H. (2017) More focused attention upon relationship; another call for paradigm shift in psychiatry. *European Journal of Psychotherapy & Counselling*, 19 (3): 252–266. doi:10.1080/13642537.2017.1348374.

Mik-Meyer, N. and Obling, A.R. (2012) The negotiation of the sick role: general practitioners' classification of patients with medically unexplained symptoms. *Sociology of Health & Illness*, 34 (7): 1025–1038. doi:10.1111/j.1467-9566.2011.01448.x.

Miles, A. and Gibson, L. (2016) Everyday participation and cultural value. *Cultural Trends*, 25 (3): 151–157. doi:10.1080/09548963.2016.1204043.

Miles, H. (2016) 'You need to meet with the psychologist before you can have any leave': reflections on 'coercion' in a secure forensic setting. *Australia and New Zealand Journal of Art Therapy*, 4 (1): 68–74.

Miles, M.B., Huberman, A.M., Huberman, M.A., et al. (1994) *Qualitative data analysis: an expanded sourcebook*. 2nd ed. Thousand Oaks: Sage Publications Inc.

Moore, E. (2012) Personality disorder: Its impact on staff and the role of supervision. *Advances in psychiatric treatment*, 18 (1): 44–55.

Morant, N., Azam, K., Johnson, S., et al. (2018) The least worst option: user experiences of antipsychotic medication and lack of involvement in medication decisions in a UK community sample. *Journal of Mental Health*, 27 (4): 322–328. doi:10.1080/09638237.2017.1370637.

Morgan, J.F. (2013) Does the emphasis on risk in psychiatry serve the interests of patients or the public? *BMJ*, 346: 20–21.

Morgan, S. and Rees, S. (2018) An evaluation of recovery in a forensic mental health service. *Mental Health Practice*, 21 (10). doi:10.7748/mhp.2018.e1316.

Morgan-Trimmer, S. and Wood, F. (2016) Ethnographic methods for process evaluations of complex health behaviour interventions. *Trials*, 17. doi:10.1186/s13063-016-1340-2.

Morris, F.J. and Willis-Rauch, M. (2014) Join the art club: exploring social empowerment in art therapy. *Art Therapy*, 31 (1): 28–36. doi:10.1080/07421656.2014.873694.

Morris, K., Cox, D.L. and Ward, K. (2016) Exploring stories of occupational engagement in a regional secure unit. *The Journal of Forensic Psychiatry & Psychology*, 27 (5): 684–697. doi:10.1080/14789949.2016.1187759.

Mullen, P.E. (2000) Forensic mental health. *The British Journal of Psychiatry*, 176 (4): 307–311. doi:10.1192/bjp.176.4.307.

Mullersdorf, M. and Ivarsson, A.-B. (2016) What, why, how - creative activities in occupational therapy practice in sweden. *Occupational Therapy International*, 23 (4): 369–378. doi:10.1002/oti.1438.

Murphy, E. and Dingwall, R. (2003) *Qualitative methods and health policy research*. New York: Walter De Gruyter, Inc.

Murphy, E. and Dingwall, R. (2007) Informed consent, anticipatory regulation and ethnographic practice. *Social Science & Medicine*, 65 (11): 2223–2234.

Nathan, R., Brown, A., Redhead, K., et al. (2007) Staff responses to the therapeutic environment: A prospective study comparing burnout among nurses working on male and female wards in a medium secure unit. *The Journal of Forensic Psychiatry & Psychology*, 18 (3): 342–352. doi:10.1080/14789940701441136.

National Institute for Health and Care Excellence (NICE) (2011) *Service user experience in adult mental health: improving the experience of care for people using adult NHS mental health services*. London: NICE.

National Institute for Health and Care Excellence (NICE) (2014) *Schizophrenia in Adults: the NICE guideline on treatment and management, updated edition*. London: NICE.

NHS Commissioning Board (2012) *2012.13 NHS Standard Contract for Acute, Ambulance and Mental Health and Learning Disability Services: Section B Part 1 Service Specification*. C2a Forensic/Secure CRG. NHS Commissioning Board.

NHS England (2014) *Five year forward view*. London: NHS England.

NHS England (2016) *MH2 Recovery Colleges for Medium and Low Secure Patients*. London: NHS England.

NHS England (2017) *Commissioning CQUIN Indicator Specification Information on CQUIN 2017/18-2018/19*. London: NHS England.

NHS England Board (2016) *Report of the Mental Health Task Force: The Mental Health Five Year Forward View*.

Nicholls, T.L. and Goossens, I. (2017) "Guidelines for improving forensic mental health in inpatient psychiatric settings." In Roesch, R. and Cook, A.N. (eds.) *Handbook of forensic mental health services*. Taylor & Francis. p. np.

Noice, T., Noice, H. and Kramer, A.F. (2014) Participatory arts for older adults: a review of benefits and challenges. *The Gerontologist*, 54 (5): 741–753. doi:10.1093/geront/gnt138.

Norvoll, R. and Pedersen, R. (2018) Patients' moral views on coercion in mental healthcare. *Nursing Ethics*, 25 (6): 796–807. doi:10.1177/0969733016674768.

Nursing, Midwifery and Allied Health Professions Policy Unit (2016) *Improving the physical health of people with mental health problems: Actions for mental health nurses*. Department of Health.

O' Flynn, P., O' Regan, R., O' Reilly, K., et al. (2018) Predictors of quality of life among inpatients in forensic mental health: implications for occupational therapists. *BMC Psychiatry*, 18. doi:10.1186/s12888-018-1605-2.

Okely, J. (1994) "Thinking through fieldwork." In Bryman, A. and Burgess, R.G. (eds.) *Analysing qualitative data*. London: Routledge.

O'reilly, K. (2005) *Ethnographic methods*. Oxon: Routledge.

Papadopoulos, C., Ross, J., Stewart, D., et al. (2012) The antecedents of violence and aggression within psychiatric in-patient settings: Antecedents of violence and aggression. *Acta Psychiatrica Scandinavica*, 125 (6): 425–439. doi:10.1111/j.1600-0447.2012.01827.x.

Payr, S. (2010) "Ritual or routine: communication in long-term relationships with companions." In Trapple, R. (ed.) *European meetings on cybernetics and systems research EMCSR 2010.* Vienna, Austria: na. pp. 559–564.

Pelto-Piri, V., Engström, K. and Engström, I. (2013) Paternalism, autonomy and reciprocity: ethical perspectives in encounters with patients in psychiatric in-patient care. *BMC Medical Ethics*, 14 (1): 49. doi:10.1186/1472-6939-14-49.

Perkins, R., Ascenso, S., Atkins, L., et al. (2016) Making music for mental health: how group drumming mediates recovery. *Psychology of well-being*, 6 (1): 11.

Peternelj-Taylor, C. (2004) *An exploration of othering in forensic psychiatric and correctional nursing*., 36 (4): 16.

Phillips, C. (2012) *The multicultural prison: ethnicity, masculinity, and social relations among prisoners*. Oxford: Oxford University Press.

Pilgrim, D. (1997) *Psychotherapy and society*. London: Sage Publications Ltd.

Pilgrim, D. (2008) `Recovery' and current mental health policy. *Chronic Illness*, 4 (4): 295–304. doi:10.1177/1742395308097863.

Plumb, L. and Stickley, T. (2017) Singing to promote mental health and well-being. *Mental Health Practice*, 20 (8). doi:10.7748/mhp.2017.e1182.

Pollard, A. (2009) Field of screams: difficulty and ethnographic fieldwork. *Athropology Matters Journal*, 11 (2): 1–24.

Prince, M., Patel, V., Saxena, S., et al. (2007) Global Mental Health 1 No health without mental health. *The Lancet*, 370 (8): 859–77.

Prins, H. (2010) *Offenders, deviants or patients? explorations in clinical criminology*. 4th ed. Hove: Routledge.

Public Health England (2017) *Chapter 6: social determinants of health*. Available at: https://www.gov.uk/government/publications/health-profile-

for-england/chapter-6-social-determinants-of-health (Accessed: 19 February 2019).

Puig, A., Lee, S.M., Goodwin, L., et al. (2006) The efficacy of creative arts therapies to enhance emotional expression, spirituality, and psychological well-being of newly diagnosed Stage I and Stage II breast cancer patients: A preliminary study. *The Arts in Psychotherapy*, 33 (3): 218–228. doi:10.1016/j.aip.2006.02.004.

Putnam, R. (2001) Social capital: Measurement and consequences. *Canadian journal of policy research*, 2 (1): 41–51.

Quirk, A. and Lelliott, P. (2004) "Users' experience of in-patient services." In Campling, P., Davies, S. and Farquharson, G. (eds.) *From toxic institutions to therapeutic environments: Residential settings in mental health services*. London: The Royal College of Psychiatrists. pp. 45–54.

Quirk, A., Lelliott, P. and Seale, C. (2004) Service users' strategies for managing risk in the volatile environment of an acute psychiatric ward. *Social Science & Medicine*, 59 (12): 2573–2583. doi:10.1016/j.socscimed.2004.04.005.

Quirk, A., Lelliott, P. and Seale, C. (2006) The permeable institution: an ethnographic study of three acute psychiatric wards in London. *Soc Sci Med*, 63 (8): 2105–2117.

Ramon, S. (2008) Neoliberalism and its implications for mental health in the UK. *International Journal of Law and Psychiatry*, 31 (2): 116–125. doi:10.1016/j.ijlp.2008.02.006.

Ramon, S. (2018) The place of social recovery in mental health and related services. *Int J Environ Res Public Health*, 15 (6): 1052.

Ramsden, E. and Moore, E. (2012) "Groupwork for offence perpetrators with a history of boundary violation in the hospital setting." In Aiyegbusi, A. and Gillian, K. (eds.) *Professional and Therapeutic Boundaries in Forensic Mental Health Practice*. London: Jessica Kingsley Publishers. pp. 63–77.

Repper, J. and Perkins, R. (2003) *Social inclusion and recovery: a model for mental health practice*. Philadelphia: Elsevier Ltd.

Reynolds, L.M., Jones, J.C., Davies, J.P., et al. (2014) Playing the game: service users' management of risk status in a UK medium secure forensic mental health service. *Health, Risk & Society*, 16 (3): 199–209. doi:10.1080/13698575.2014.911820.

Richards, R. (2007) Everyday Creativity and the Arts. *World Futures*, 63 (7): 500–525. doi:10.1080/02604020701572707.

Roberton, T., Daffern, M., Thomas, S., et al. (2012) De-escalation and limit-setting in forensic mental health units. *Journal of Forensic Nursing*, 8 (2): 94–101. doi:10.1111/j.1939-3938.2011.01125.x.

Robertson, P., Barnao, M. and Ward, T. (2011) Rehabilitation frameworks in forensic mental health. *Aggression and Violent Behavior*, 16 (6): 472–484. doi:10.1016/j.avb.2011.03.003.

Robinson, A. (2018) Social prescribing: coffee mornings, singing groups, and dance lessons on the NHS. *BMJ*. doi:10.1136/bmj.k4857.

Robinson, A.M. and Avallone, J. (1990) Occupational therapy in acute inpatient psychiatry: An activities health approach. *The American Journal of Occupational Therapy*, 44 (9): 809–814.

Rogers, A. and Pilgrim, D. (2014) *A sociology of mental health and illness*. 5th ed. Maidenhead: Open University Press.

Rogers, P. and Soothill, K. (2008) "Understanding forensic mental health and the variety of professional voices." In Soothill, K., Rogers, P. and Dolan, M. (eds.) *Handbook of Forensic Mental Health*. Devon: Willan Publishing. pp. 3–18.

Royal College of Occupational Therapists (2012) *Occupational therapists' use of occupation-focused practice in secure hospitals: practice guideline*. 2nd ed. Royal College of Occupational Therapists.

Royeen, C.B. (2002) Occupation reconsidered. *Occupational Therapy International*, 9 (2): 111–120. doi:10.1002/oti.159.

Rustin, T.A.R. (2008) Using artwork to understand the experience of mental illness: mainstream artists and outsider artists. *GMS Psycho-Social-Medicine*, 5: 1–14.

Rutherford, M. (2010) *Blurring the boundaries: convergence of mental health and criminal justice policy, legislation, systems and practice*. London: Sainsbury Centre for Mental Health.

Ryan, R.M. and Deci, E.L. (2001) On happiness and human potentials: a review of research on hedonic and eudaimonic well-being. *Annual Review of Psychology*, 52: 141–166. doi:10.1146/annurev.psych.52.1.141.

Ryff, C.D. (2014) Self realization and meaning making in the face of adversity: a Eudaimonic approach to human resilience. *Journal of psychology in Africa*, 24 (1): 1–12. doi:10.1080/14330237.2014.904098.

Saavedra, J., Arias, S., Crawford, P., et al. (2017a) Impact of creative workshops for people with severe mental health

problems: art as a means of recovery. *Arts & Health*, pp. 1–16.

Saavedra, J., Pérez, E., Crawford, P., et al. (2017b) Recovery and creative practices in people with severe mental illness: evaluating well-being and social inclusion. *Disabil Rehabil*, pp. 1–10. doi:10.1080/09638288.2017.1278797.

Samele, C., Forrester, A. and Bertram, M. (2018) An evaluation of an employment pilot to support forensic mental health service users into work and vocational activities. *Journal of Mental Health*, 27 (1): 45–51. doi:10.1080/09638237.2016.1276527.

Schneider, J., Carpenter, J. and Brandon, T. (1999) Operation and organisation of services for people with severe mental illness in the UK: A survey of the Care Programme Approach. *The British Journal of Psychiatry*, 175 (5): 422–425. doi:10.1192/bjp.175.5.422.

Schneider, J., Scales, K., Bailey, S., et al. (2010) *Challenging care: the role of healthcare assistants in dementia wards*. SDO.

Scott, S. (2010) Revisiting the total institution: performative regulation in the reinventive institution. *Sociology*, 44 (2): 213–231. doi:10.1177/0038038509357198.

Seligman, M.E. (2011) *Flourish: a visionary new understanding of happiness and well-being*. New York: Free Press.

Shattell, M.M., Andes, M. and Thomas, S.P. (2008) How patients and nurses experience the acute care psychiatric environment. *Nursing Inquiry*, 15 (3): 242–250. doi:10.1111/j.1440-1800.2008.00397.x.

Shea, M., Wong, Y.J., Nguyen, K.K., et al. (2017) College women's subjective femininity stress, gender solidarity, and psychological help-seeking intentions. *The Counseling Psychologist*, 45 (3): 438–461. doi:10.1177/0011000017701820.

Shepherd, G., Boardman, J. and Slade, M. (2008) *Making recovery a reality*. London: Sainsbury Centre for Mental Health.

Simpson, A., Miller, C. and Bowers, L. (2003) The history of the Care Programme Approach in England: Where did it go wrong? *Journal of Mental Health*, 12 (5): 489–504. doi:10.1080/09638230310001603555.

Simpson, A.I. and Penney, S.R. (2011) The recovery paradigm in forensic mental health services. *Crim Behav Ment Health*, 21 (5): 299–306. doi:10.1002/cbm.823.

Sine, D.M. (2008) The architecture of madness and the good of paternalism. *Psychiatric Services*, 59 (9): 1060–1062. doi:10.1176/ps.2008.59.9.1060.

Singh, S.P. and Burns, T. (2006) Race and mental health: there is more to race than racism. *BMJ: British Medical Journal*, 333 (7569): 648–651. doi:10.1136/bmj.38930.501516.BE.

Singh, S.P., Greenwood, N., White, S., et al. (2007) Ethnicity and the Mental Health Act 1983. *The British Journal of Psychiatry*, 191 (2): 99–105. doi:10.1192/bjp.bp.106.030346.

Slade, M. (2009a) *100 ways to support recovery - A guide for mental health professionals*. Rethink recovery series 1. London: Rethink.

Slade, M. (2009b) *Personal Recovery and Mental Illness: A Guide for Mental Health Professionals*. Cambridge University Press.

Slade, M. (2009c) The contribution of mental health services to recovery. *Journal of Mental Health*, 18 (5): 367–371. doi:10.3109/09638230903191256.

Slade, M. (2010) Mental illness and well-being: the central importance of positive psychology and recovery approaches. *BMC Health Serv Res*, 10 (26): 1–14. doi:10.1186/1472-6963-10-26.

Slade, M., Amering, M., Farkas, M., et al. (2014) Uses and abuses of recovery: implementing recovery-oriented practices in mental health systems. *World Psychiatry*, 13 (1): 12–20. doi:10.1002/wps.20084.

Slade, M., Bird, V., Clarke, E., et al. (2015) Supporting recovery in patients with psychosis using adult mental health teams (REFOCUS): a multi-site cluster randomised controlled trial. *The Lancet Psychiatry*, 2 (6): 503–514.

Slemon, A., Jenkins, E. and Bungay, V. (2017) Safety in psychiatric inpatient care: The impact of risk management culture on mental health nursing practice. *Nursing Inquiry*, 24 (4): 1–10. doi:10.1111/nin.12199.

South London and Maudsley NHS Foundation Trust and South West London (2010) *Recovery is for all. hope agency and opportunity in psychiatry. a position statement by consultant psychiatrists*. London: South London and Maudsley NHS Foundation Trust and South West London.

Spagnola, M. and Fiese, B.H. (2007) Family routines and rituals: a context for development in the lives of young children. *Infants & Young Children*, 20 (4): 284–299. doi:10.1097/01.IYC.0000290352.32170.5a.

Spradley, J.P. (1980) *Participant observation*. Belmont, CA: Thomson Learning.

Springham, N., Findlay, D., Woods, A., et al. (2012) How can art therapy contribute to mentalization in borderline personality disorder? *International Journal of Art Therapy*, 17 (3): 115–129. doi:10.1080/17454832.2012.734835.

Stacey, G., Felton, A., Morgan, A., et al. (2016) A critical narrative analysis of shared decision-making in acute inpatient mental health care. *Journal of Interprofessional Care*, 30 (1): 35–41. doi:10.3109/13561820.2015.1064878.

Stanford, S., Sharland, E., Heller, N.R., et al. (2017) *Beyond the risk paradigm in mental health policy and practice*. London: Palgrave Macmillan.

Stenhouse, R.C. (2013) 'Safe enough in here?': patients' expectations and experiences of feeling safe in an acute psychiatric inpatient ward. *Journal of Clinical Nursing*, 22 (21–22): 3109–3119. doi:10.1111/jocn.12111.

Stern, J. (2012) "37 - Psychotherapy – individual, family and group." In Wright, P., Stern, J. and Phelan, M. (eds.) *Core Psychiatry (Third Edition)*. Oxford: W.B. Saunders. pp. 545–567. doi:10.1016/B978-0-7020-3397-1.00037-9.

Stevenson, M. and Orr, K. (2013) Art therapy: stimulating non-verbal communication. *Nursing and Residential Care*, 15 (6): 443–445. doi:10.12968/nrec.2013.15.6.443.

Stewart, P. and Craik, C. (2007) Occupation, mental illness and medium security: exploring time-use in forensic regional secure units. *British Journal of Occupational Therapy*, 70 (10): 416–425. doi:10.1177/030802260707001002.

Stickley, T. (2012) *Qualitative research in arts and mental health: context, meanings, and evidence*. Herefordshire: PCCS Books Ltd.

Stickley, T. and Hui, A. (2012) Arts In-Reach: taking "bricks off shoulders" in adult mental health inpatient care. *J Psychiatr Ment Health Nurs*, 19 (5): 402–9. doi:10.1111/j.1365-2850.2011.01811.x.

Stickley, T. and Wright, N. (2011a) The British research evidence for recovery, papers published between 2006 and 2009 (inclusive). Part One: a review of the peer-reviewed literature using a systematic approach. *J Psychiatr Ment Health Nurs*, 18 (3): 247–56. doi:10.1111/j.1365-2850.2010.01662.x.

Stickley, T. and Wright, N. (2011b) The British research evidence for recovery, papers published between 2006 and 2009

(inclusive). Part two: a review of the grey literature including book chapters and policy documents. *J Psychiatr Ment Health Nurs*, 18 (4): 297–307. doi:10.1111/j.1365-2850.2010.01663.x.

Stickley, T., Wright, N. and Slade, M. (2017) The art of recovery: outcomes from participatory arts activities for people using mental health services. *Journal of Mental Health*, 27 (4): 367–373.

Stott, S. (2018) Copying and attunement: the search for creativity in a secure setting. *International Journal of Art Therapy*, 23 (1): 45–51. doi:10.1080/17454832.2017.1415364.

Stuart, S.R., Tansey, L. and Quayle, E. (2017) What we talk about when we talk about recovery: a systematic review and best-fit framework synthesis of qualitative literature. *Journal of Mental Health*, 26 (3): 291–304. doi:10.1080/09638237.2016.1222056.

Stuckey, H.L. and Nobel, J. (2010) The connection between art, healing, and public health: A review of current literature. *American journal of public health*, 100 (2): 254–263.

Sturidsson, K., Turtell, I., Tengström, A., et al. (2007) Time use in forensic psychiatry: an exploratory study of patients' time use at a swedish forensic psychiatric clinic. *International Journal of Forensic Mental Health*, 6 (1): 79–86. doi:10.1080/14999013.2007.10471251.

Sugarman, P.A. and Dickens, G.L. (2015) "The evolution of secure and forensic mental healthcare." In Dickens, G.L., Philip, S., A. and Macro, P.M. (eds.) *Handbook of Secure Care*. Royal College of Psychiatrists. pp. 1–14.

Sullivan, M.O., Boulter, S. and Black, G. (2013) Lived experiences of recalled mentally disordered offenders with dual diagnosis: a qualitative phenomenological study. *The Journal of Forensic Psychiatry & Psychology*, 24 (3): 403–420. doi:10.1080/14789949.2013.795238.

Summers-Effler, E. (2004) "Defensive strategies: the formation and social implications of patterned self-destructive behavior." In *Advances in Group Processes*. Bingley: Emerald (MCB UP). pp. 309–325. Available at: https://www.emeraldinsight.com/10.1016/S0882-6145(04)21012-8 (Downloaded: 16 October 2018).

Summers-Effler, E. (2006) "Ritual theory." In Stets, J.E. and Turner, J.H. (eds.) *Handbook of the Sociology of Emotions*. Boston, MA: Springer US. pp. 135–154. doi:10.1007/978-0-387-30715-2_7.

Sundaram, V. and Jackson, C. (2018) 'Monstrous men' and 'sex scandals': the myth of exceptional deviance in sexual harassment and violence in education. *Palgrave Communications*, 4 (1): 147. doi:10.1057/s41599-018-0202-9.

Sustere, E. and Tarpey, E. (2019) Least restrictive practice: its role in patient independence and recovery. *The Journal of Forensic Psychiatry & Psychology*, 0 (0): 1–16. doi:10.1080/14789949.2019.1566489.

Szmukler, G. and Weich, S. (2017) Has the Mental Health Act had its day? *BMJ*, 359. doi:10.1136/bmj.j5248.

Teasdale, C. (1997) Art therapy as a shared forensic investigation. *Inscape*, 2 (2): 32–40. doi:10.1080/17454839708413045.

Tedlock, B. (1991) From participant observation to the observation of participation: the emergence of narrative ethnography. *Journal of Anthropological Research*, 47 (1): 69–94.

Tedlock, B. (2005) "The observation of participation and the emergence of public ethnography." In Denzin, N.K. and Lincoln, Y.S. (eds.) *The Sage Handbook of Qualitative Research*. 3rd ed. California: Sage Publications, Inc. pp. 467–482.

Tennant, R., Hiller, L., Fishwick, R., et al. (2007) The Warwick-Edinburgh Mental Well-being Scale (WEMWBS): development and UK validation. *Health Qual Life Outcomes*, 5: 63. doi:10.1186/1477-7525-5-63.

Tew, J., Ramon, S., Slade, M., et al. (2012) Social factors and recovery from mental health difficulties: a review of the evidence. *British Journal of Social Work*, 42 (3): 443–460. doi:10.1093/bjsw/bcr076.

The Canadian Association of Occupational Therapists (2008) *CAOT position statement: occupations and health*. The Canadian Association of Occupational Therapists.

The King's Fund (2016) *Bringing together physical and mental health: A new frontier for integrated care*. London: The Kings Fund.

Thibeault, C.A., Trudeau, K., d'Entremont, M., et al. (2010) Understanding the milieu experiences of patients on an acute inpatient psychiatric unit. *Archives of Psychiatric Nursing*, 24 (4): 216–226. doi:10.1016/j.apnu.2009.07.002.

Thompson, M. and Blair, S.E.E. (1998) Creative arts in occupational therapy: ancient history or contemporary practise?

Occupational Therapy International, 5 (1): 48–64. doi:10.1002/oti.67.

Thomson, L. (2008) "The forensic mental health system in the United Kingdom." In Soothill, K., Rogers, P. and Dolan, M. (eds.) *Handbook of forensic mental health*. Devon: Willan Publishing. pp. 19–63.

Thornicroft, G. (2006) Actions speak louder: Tackling discrimination against people with mental health problems. *London: Mental Health Foundation*.

Tofthagen, R., Talseth, A.-G. and Fagerström, L. (2014) Mental Health Nurses' Experiences of Caring for Patients Suffering from Self-Harm. *Nursing Research and Practice*. doi:10.1155/2014/905741.

Tomlin, J., Bartlett, P. and Völlm, B. (2018) Experiences of restrictiveness in forensic psychiatric care: Systematic review and concept analysis. *International Journal of Law and Psychiatry*, 57: 31–41.

Towl, G. (2005) Risk assessment. *Evidence-Based Mental Health*, 8 (4): 91–93. doi:10.1136/ebmh.8.4.91.

Turner, J., Hayward, R., Angel, K., et al. (2015) The History of Mental Health Services in Modern England: Practitioner Memories and the Direction of Future Research. *Medical History*, 59 (04): 599–624. doi:10.1017/mdh.2015.48.

Turner, T. (2004) The history of deinstitutionalization and reinstitutionalization. *Psychiatry*, 3 (9): 1–4. doi:10.1383/psyt.3.9.1.50257.

Vallejos, E.P., Ball, M.J., Brown, P., et al. (2016) Kundalini yoga as mutual recovery: a feasibility study including children in care and their carers. *Journal of Children's Services*, 11 (4): 261–282.

Van Den Broek, E., Keulen-de Vos, M. and Bernstein, D.P. (2011) Arts therapies and Schema Focused therapy: A pilot study. *The Arts in Psychotherapy*, 38 (5): 325–332. doi:10.1016/j.aip.2011.09.005.

Van Maanen, J. (2011) *Tales of the field: on writing ethnography*. 2nd ed. Chicago: The University of Chicago Press.

Vella-Burrows, T., Ewbank, N., Mills, S., et al. (2014) *Cultural value and social capital: investigating social capital, health and wellbeing impacts in three coastal towns undergoing culture-let regeneration: report*. Kent: Sidney De Haan Research Centre for Arts and Health.

Völlm, B., Bartlett, P. and McDonald, R. (2016) Ethical issues of long-term forensic psychiatric care. *Ethics, Medicine and Public Health*, 2 (1): 36–44. doi:10.1016/j.jemep.2016.01.005.

Wade, D.T. and Halligan, P.W. (2004) Do biomedical models of illness make for good healthcare systems? *BMJ: British Medical Journal*, 329 (7479): 1398–1401.

Wang, C., Hua, Y., Fu, H., et al. (2017) Effects of a mutual recovery intervention on mental health in depressed elderly community-dwelling adults: a pilot study. *BMC Public Health*, 17 (1): 4. doi:10.1186/s12889-016-3930-z.

Ward, T. and Brown, M. (2004) The good lives model and conceptual issues in offender rehabilitation. *Psychology, Crime & Law*, 10 (3): 243–257. doi:10.1080/10683160410001662744.

Ward, T. and Gannon, T.A. (2006) Rehabilitation, etiology, and self-regulation: The comprehensive good lives model of treatment for sexual offenders. *Aggression and Violent Behavior*, 11 (1): 77–94. doi:10.1016/j.avb.2005.06.001.

Ward, T., Mann, R.E. and Gannon, T.A. (2007) The good lives model of offender rehabilitation: Clinical implications. *Aggression and Violent Behavior*, 12 (1): 87–107. doi:10.1016/j.avb.2006.03.004.

Warden, T. (2013) Feet of clay: confronting emotional challenges in ethnographic experience. *Journal of Organizational Ethnography*, 2 (2): 150–172.

Warner, J. (2007) "Structural stigma, institutional trust and the risk agenda in mental health policy." In Clarke, K., Maltby, T. and Kennett, P. (eds.) *Social Policy Review 19: Analysis and Debate in Social Policy 2007*. Bristol: England: The Policy Press. pp. 201–220.

Watts, D. and Morgan, G. (1994) Malignant alienation: dangers for patients who are hard to like. *The British Journal of Psychiatry*, 164 (1): 11–15.

Watts, J.H. (2008) Emotion, empathy and exit: reflections on doing ethnographic qualitative research on sensitive topics. *Medical Sociology Online*, 3 (2): 3–14.

Wenman, J. (2010) *Quality Network for Forensic Mental Health Services*. Quality Network for Forensic Mental Health Services.

Wexler, L., Robbennolt, J. and Murphy, C. (n.d.) #Metoo, time's up, and theories of justice. *SSRN Electronic Journal*. doi:10.2139/ssrn.3135442.

White, M. (2009) *Arts development in community health: a social tonic*. Oxford: Radcliffe Publishing.

White, R. (2018) Title VII and the# metoo movement. *Emory Law Journal Online*, 68: 1014–1033.

Whitehead, Paul.R., Ward, T. and Collie, R. (2007) *Time for a Change: Applying the Good Lives Model of Rehabilitation to a High-Risk Violent Offender*., 51: 1–21. doi:10.1177/0306624X06296236.

Whitehead, T.L. (2004) What is ethnography? Methodological, ontological, and epistemological attributes. *Ethnographically Informed Community and Cultural Assessment Research Systems (EICCARS) Working Paper Series, University of Maryland. College Park, MD*.

Whitehead, T.L. (2005) Basic classical ethnographic research methods: secondary data analysis, fieldwork, observation/participant observation, and informal and semi-structured interviewing. *CEHC*.

Wilson, M. (2018) Some thoughts on storytelling, science and dealing with a post-truth world. *Storytelling, Self, Society*.

Wilson, R.J. and Yates, P.M. (2009) Effective interventions and the Good Lives Model: Maximizing treatment gains for sexual offenders. *Aggression and Violent Behavior*, 14 (3): 157–161. doi:10.1016/j.avb.2009.01.007.

Winship, G. (2000) "The construction of power and authority in psychiatry." In *The birth of the new asylum?*. The construction of power and authority in psychiatry. Oxford; Boston: Butterworth-Heinemann. pp. 165–180.

Winship, G. (2016) A meta-recovery framework: positioning the 'new recovery' movement and other recovery approaches. *Journal of Psychiatric and Mental Health Nursing*, 23 (1): 66–73. doi:10.1111/jpm.12266.

Winship, G. and Barker, A.B. (2016) Recovery is no laughing matter – or is it? *Mental Health and Social Inclusion*, 20 (3): 167–173. doi:10.1108/MHSI-02-2016-0006.

Wolfson, P. (2009) *Enabling recovery for people with complex mental health needs: a template for rehabilitation services*. Faculty report FR/RS/1. Royal College of Psychiatrists.

Wond, T. and Macaulay, M. (2010) Evaluating local implementation: An evidence-based approach. *Policy and Society*, 29 (2): 161–169. doi:10.1016/j.polsoc.2010.03.008.

Woods, A. and Springham, N. (2011) On learning from being the in-patient. *International Journal of Art Therapy*, 16 (2): 60–68. doi:10.1080/17454832.2011.603697.

World Health Organization (1995) *Constitution of the world health organization*. World Health Organization.

World Health Organization (2004) *Promoting Mental Health.* Geneva: World Health Organization. Available at: http://public.eblib.com/choice/publicfullrecord.aspx?p=4978588 (Accessed: 21 February 2019).

World Health Organization (ed.) (2005) *Mental health: facing the challenges, building solutions: report from the WHO European Ministerial Conference*. Copenhagen, Denmark: World Health Organization, Regional Office for Europe.

World Health Organization (2010) *Action on the social determinants of health: learning from previous experiences.* Geneva: World Health Organization. Available at: http://www.who.int/social_determinants/corner/SDHDP1.pdf (Downloaded: 19 February 2019).

Wright, N., Bartlett, P. and Callaghan, P. (2008) A review of the literature on the historical development of community mental health services in the United Kingdom. *Journal of Psychiatric and Mental Health Nursing*, 15 (3): 229–237. doi:10.1111/j.1365-2850.2007.01218.x.

Wright, N., Rowley, E., Chopra, A., et al. (2016) From admission to discharge in mental health services: a qualitative analysis of service user involvement. *Health Expectations*, 19 (2): 367–376. doi:10.1111/hex.12361.

Wright, N. and Stickley, T. (2013) Concepts of social inclusion, exclusion and mental health: a review of the international literature: Concepts of social inclusion/exclusion and mental health. *Journal of Psychiatric and Mental Health Nursing*, 20 (1): 71–81. doi:10.1111/j.1365-2850.2012.01889.x.

Yanos, P.T., Roe, D. and Lysaker, P.H. (2010) The impact of illness identity on recovery from severe mental illness. *American Journal of Psychiatric Rehabilitation*, 13 (2): 73–93. doi:10.1080/15487761003756860.

Yoshikawa, H. (1993) *The Use of Activity Analysis by Occupational Therapists in Treatment Decisions*. Western Michigan University: Master's Thesis.

Word count

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Appendix A: Activities available at Westmarch Hospital

Formal creative practices	
Art	The art sessions were available on all three wards. This session typically consisted of colouring in or crafts.
Music	Charlie (music teacher) would attend the three wards up to three times a week to make music with the residents.
Cooking session	The cooking sessions are for those residents that the occupational therapy staff identify as needing assessment and support.
Creative skills *(Buckleberry)*	The occupational therapy staff had a box full of different creative activities. The box had items for making loom bands, draw by numbers, knitting materials, colouring books *etc.*
Informal creative practices	
Playing pool, table football, table tennis	There was a pool table available on each of the wards. Buckleberry had a table tennis table. Crickhollow had a table tennis table along with table football.
card games, board games	Cards and board games were available on all three wards however, these were only accessible on Buckleberry and Crickhollow wards, these items were locked in a cupboard on Mirkwood.
basketball, football	All the wards had access to a courtyard where sports could be played. A basketball net was only available on Crickhollow. A football was not available on Mirkwood ward.
watching films	All three wards had televisions and a DVD player. Films were watched by residents. On one occasion it was observed that a group of residents put on a film and watched this in one of the side rooms on Crickhollow ward.
singing, dancing,	Staff were observed to dance as they walked through the communal ward space. On Mirkwood ward, it was observed that staff and residents would sing along to television adverts.
joke-telling and verbal games, such as eye-spy.	Residents and staff would often be observed telling jokes or stories to one another. Staff would often utilise stories as a way to engage residents during informal times. A game of eye-spy was initiated by a resident on Crickhollow ward.
Social sessions	
Rambling group	The group would attend a local park or drive to a nearby location to walk.
Social coffee morning	The OT staff would provide an array of different beverages, including fruit teas, hot chocolate, and coffees. All staff and residents were welcome to search the box of sachets and sit with the group.
Dog walking	The residents would visit a local kennels to walk the dogs. This activity was weather dependant.
Community sports	This was conducted on-ward and out in the community. A pool competition, including Buckleberry and Crickhollow, was conducted during this time.
Lunch group	This took place off-site in the local community, typically at a local public house. Residents would purchase their own meals.
Skill development	

Shop to cook	Shop to cook is undertaken off-site at a local supermarket. Those residents that have unescorted and escorted leave are assigned to attend these sessions in preparation for the cooking sessions.
Community skills	The community skills sessions typically comprised of visits to nearby cities or landmarks.
OT Drop in	These sessions were an opportunity to residents to interact with the occupational therapy staff. Staff would typically sit at the dining area and would often offer to play games, including board games and cards.
Kitchen skills *(Buckleberry)*	This session is used to provide additional support to those residing in the service who may need cooking support and skills training.
Leisure activities	
IT	The IT sessions were an opportunity for the residents to attend the IT suite, which is shared with all three wards. It was observed that these sessions were used to go on social media sites and YouTube in which artist music videos would be watched.
Leisure skills	Activities that that are run by the occupational therapy team as part of their leisure skills sessions, such as, local visits to the community on on-ward leisure activities, such as, playing board games. IT sessions are also included in this category as the residents were observed to spend their time watching YouTube videos by their favourite artists.
Psychology	
DBT	Group Dialectical Behavioural Therapy
Psychology drop in	This session was available for those who wanted to talk to the psychology team, they had crafts to assist with conversations.
Institutional practices	
Morning meeting	The morning meeting is at 9:00am on all three wards. One of the residents runs this meeting, this is usually the same individual that has been on the ward for some time. All staff on shift will be present, along with a member of the occupational therapy team, and sometimes staff from maintenance. The format is the same on all three of the wards; the resident chairing the meeting will say good morning to each of the residents and staff, and in turn, ask if they have anything to raise. The meetings are usually very short, under ten minutes. Some of the residents would often look sleepy and would be in their pyjamas.
Community meeting	The community meeting is run bi-weekly, all residents on the ward at the time are encouraged to attend along with staff. This meeting is an opportunity for the residents and staff to share any concerns or put forward new ideas for community living.
Ward round	Ward round takes place in one of the meeting rooms, which is off-ward. A representative from various departments is present at this meeting