# Exploring Stories of Occupational Engagement in a Regional Secure Unit


## Abstract:

This paper focuses on the occupational experiences of five men living within a forensic mental health unit over a year. This study used a descriptive qualitative case study methodology to explore the meaning and value placed on daily life (activities, occupations and routines), and how this changed over time. The men's stories showed a complex picture of their experiences of daily life. This study demonstrated the impact of the environment on the men and the ongoing challenge of the need to balance treatment/therapy with security demands and opportunities. Three interrelated themes were identified: 1. Power and Occupation; 2. Therapy or Punishment; 3. Occupational Opportunities within Restrictions. These findings serve as a reminder to clinical teams to reassess the value of occupations attributed by their patients and the impact of the secure environment, whist also acknowledging the potential for occupations to have a negative impact on wellbeing.

## Introduction:

Forensic mental health services are attempting to serve the needs of both the patient and society. These two 'masters' are at times in conflict. The two overarching aims of treatment are recovery from illness and maintenance of "good" mental health (patient focus), and the instilling of an ongoing desire to participate in socially acceptable behaviours (society focus) (Cronin-Davis *et al,* 2004; Bryman, 2012). This adds further complexity to person centred practice that is not present in other settings. There are unique power relationships between staff and patients and different staff groups with differing philosophies and responsibilities (Goffman, 1961/1991). It is inevitable that there are tensions associated with these issues.

On admission to a forensic unit, in addition to mental health issues, patients may have preferences for socially unacceptable occupations such as using illicit substances or criminal activities. Patients' attitudes and motivations towards their occupations are constantly being reviewed and assessed to try to establish their 'true' reasons for behaving as they are. In contrast, patients are trying to work out the best way to behave to receive privileges such as leave from the unit. Staff control the physical environment, access to the community and many aspects of the social environment; whilst patients are encouraged to work towards being independent, without challenging the staff power (Craik *et al,* 2010). Patients can exert power through refusing to attend sessions or through their attitude towards their content. As rehabilitation progresses, the patient learns or relearns both the behavioural expectations of society and how to live a fulfilling life within those restrictions.

'Negotiation centred' practice (Falardeau & Durand, 2002) and compromise are required to guide a path for intervention which meets the needs of both 'masters'. Additional skills are required by staff to successfully develop a rapport with patients. However, the

power inequality remains and reinforces the unevenness of the therapeutic relationship. There are clear boundaries about expected behaviour and consequences of not behaving in an appropriate way – reinforced by staff (Cronin-Davis *et al,* 2004; Tucker & Hughes, 2007). Patients are required to demonstrate socially acceptable behaviour and attitudes as part of their rehabilitation before discharge back to the community (Baumeister, 2013). Forensic services are responsible for carefully balancing the occupational preferences of patients with the behavioural demands of society. The experience of participating in occupations is the focus of this paper.

### *Occupational Therapy and Occupational Engagement:*

For this purposes of this paper, occupation is defined as a person taking part in a self-care, work or leisure activity (Creek 2003; Wilcock, 2006). It is not contested that occupation has value to people; however the evidence of how and why this occurs needs development and exploration (Kelly & McFarlane, 2007; Hammell, 2009; COT, 2012). We all participate in a number of different occupations during a week; each will have a value ascribed to it. There will also be perceived positive or negative consequences. It is important to remind ourselves as a clinical team of the unique impact of the secure hospital environment on people's occupations. Some occupations are discouraged by staff despite their perceived positive value by some patients, as they may be considered antisocial or not health promoting (Buckley *et al*, 2014), for example smoking. Other occupations are inhibited due to security and legal restrictions (Duncan, 2008), for example accessing the local leisure centre. It is acknowledged that the forensic setting can impede occupational engagement due to the conflict between security risk minimisation and therapeutic positive risk taking (Couldrick & Alred, 2003; Duncan, 2008).

Occupational therapists have been recognised within policy as key members of the core forensic multi-professional team (Tucker & Hughes, 2007). Occupational therapists

offer a unique perspective and understanding of an individual's participation and engagement in occupation (Blank et al, 2015). Through this perspective, occupational therapists use occupation both as the means and outcome of their interventions (Creek, 2003). The occupational therapy role within forensic settings includes reducing the occupational risk factors and promoting health and wellbeing through occupation, as a person's daily life cannot be separated from the environment/society in which they live (Wilcock, 2006). This is achieved through a wide range of individual and group sessions utilising grading and adaptation of valued personal, work and leisure occupations. However, participation in occupation presents a dilemma within forensic settings. Despite being encouraged to engage in a full therapeutic, daily activity and leisure programme, the restrictions of the Mental Health Act 1983/2007 ((MHA); Great Britain, 1983/2007) impact on the occupational and environmental choices of many patients (Jobbins *et al,* 2007). Therefore, whilst this paper is not a detailed description of occupational therapy in forensic settings, it does describe the occupational aspects of participants' experiences of living within this setting and implications of this for the wider clinical team.

*Occupational engagement* has been described as both a process and a result of an occupational experience. In detailed narrative research exploring people's journeys of recovery from mental health problems, engagement was identified as a key theme and was described as "occur[ing] when the individual is ready and interested in taking part in an activity and the opportunity to do so presents itself" (Brown & Kandirikirara, 2007, p4). Using this definition, 'engagement' is seen to be a positive and rewarding concept, with more meaning and value ascribed to it than 'participation'. Activity, meaning, purpose and belonging were found to be central features of engagement. Both personal and external factors were seen to have an influence, some promoting and others inhibiting. Engagement was seen to be contributing to health and wellbeing, but also had a somewhat fragile nature for people with mental health issues (Blank et al, 2015). The College of Occupational Therapists (COT) have recently developed a National Institute of Health and Care

Excellence (NICE) accredited practice guideline for secure hospitals (COT 2012, 2014), the research discussed within this article formed part of the evidence. Previously very little research into identifying and monitoring the meaning of occupation over time had been published (for example Jonsson, 2008) and none in forensic mental health settings.

This study aimed to explore the experiences and personal values for participating and engaging in occupations over one year for men living in a regional secure mental health unit.

## Method:

A regional secure mental health unit (RSU; an NHS mental health unit with conditions of medium and low security) in the United Kingdom (UK) provided the environment for this research. Most patients (the term chosen by the unit's residents) in this setting were men and were charged with or convicted of a criminal offence as well as having a severe mental health issue (Rutherford & Duggan, 2007). This research used a descriptive qualitative case study methodology (Silverman, 2008) to explore the meaning and value placed on daily life (activities, occupations and routines), and how this changed over time, by five male patients living in the unit. Six patients were interested in participating; however one patient was unable to give informed consent.

### *Design:*

In order to allow the patients' voices to remain central to their stories, the research used a social constructionist methodology (Burr, 2003; Bryman, 2012). As an occupation based study, this fitted well with the philosophy of developing a shared understanding of the participants' worlds (Creek, 2003).

The inclusion criteria for the study were men who:

- had been sentenced by court and were expected to stay in the unit for at least 18 months.
- were deemed able to give informed consent (confirmed by their clinical team).

Men who had not yet attended court were excluded as their focus is usually their court case which would affect the findings and it was not known if they would return to the unit or for how long. "Into the Mainstream" (Great Britain. Department of Health, 2002), identified that women have different experiences of secure mental health services. These groups were therefore excluded from the research.

To initiate recruitment, posters were put up in the patient lounge areas to ensure all staff and patients were aware of the research. For each patient expressing an interest in participating in the research, the clinical team was approached to confirm that the patient met the inclusion criteria and that they were able to give informed consent. The intention was to recruit six patients (two patients a month over 3 months); this number was based on the demographics of the unit and the average length of stay. A short meeting was then arranged with the patient to explain the research and give them the information sheet. A follow up meeting was planned, to allow a cooling off period, when the patient indicated if they wished to participate in the study and sign the consent form. A time was then arranged for the first interview. These interviews were arranged at a time which was convenient for the participant and did not interfere with their therapeutic programme to minimise disruption.

A semi-structured interview guide, derived from the occupational therapy literature outlined above, was used for the initial interview with each patient. Interviews were audio recorded and transcribed. In addition to reading the transcriptions, the audio recordings were regularly listened to during the data collection and analysis phases of the research to enable immersion in the data. Mind maps were also used to capture reflections. A theme matrix was constructed through this process.

Each participant was interviewed about their experiences of daily life four times over a one year period (20 interviews in total). This was supported with a review of their clinical notes to provide an overview of how they spent their time. This approach enabled greater depth of exploration over time and gave an insight into the ongoing changes to the patients' experiences of living in such a unit. The objective of re-interviewing participants over the year was to explore any changes in the personal values attributed to their daily occupations. The theme matrix was reviewed following each interview cycle and discussed with the wider research team.

***Data analysis:***

An analytical inductive process (Silverman, 2008; Denzin & Lincoln, 2000) was used to create a theme matrix, allowing common themes emerging from the men's stories to be identified. Full transcripts of interviews and audio recordings were reviewed and key themes identified. An iterative analysis was used throughout the interview cycles to identify key themes such as changes in personal values. These included participation in key occupations, influences on their engagement in those occupations and themes associated with participant's feelings about living in the unit over time. These themes were compared with information from clinical notes. Throughout the analysis of the data, any changes over the year were identified. Reflections were central and were used to help identify the themes. As themes emerged or were refined, these were considered, reflected on and challenged. This process enabled increasingly deep analysis.

***Ethical considerations:***

A favourable ethical opinion was obtained from the National Health Service (NHS) Local Research Ethics Committee (04/Q1801/5). An underpinning theme for all the ethical issues within this setting was that of power. Therefore, written informed consent was re-

confirmed before each interview to ensure capacity and informed choice to continue participation. Careful consideration was also given to confidentiality, disclosure and duty of care. All names were changed and no locations identified.

***Trustworthiness:***

Due to the qualitative, social constructionist nature of this research the findings are only one of many potential explanations (Burr, 2003; Bryman, 2012). The data gathered were carefully compared for similarities and differences and potential reasons and themes reflected upon. These reflections were discussed with the men during the next interview. This ensured the data's trustworthiness, authenticity and credibility through a shared building of data with participants.

## Findings:

Five male patients participated within the research over one year. The stories told within their interviews are the focus of this paper. The description of each patient was derived from the interview data. Limited information is given here about each participant to protect their identity. Patients ranged in age from 20 to 64 years. Three had been resident at the unit for five years or less and all had been resident for less than ten years. Two were admitted from other hospitals, three from prison settings. Quotations from the patients are used to illustrate the themes and give their words prominence. Each participant is briefly introduced below:

**Alan** had been living at the unit for a number of years, having previously lived in his own flat. He described himself as "part of the furniture" and being happy living at the unit, considering it to be his home. He greatly valued music, craft and creative activities where he enjoyed the role of "expert/enthusiast". Alan was also interested in sport.

**Bikram** described experiencing both mental and physical health issues for a number of years, exacerbated by alcohol abuse. Bikram was bilingual, having come to the UK as a young child. He said he had a traditional upbringing, his mother never learning much English as she did not need to as she did not go out to work.

**Charlie** discussed spending almost his entire adult life in institutions. He first saw a psychologist before he was 10 years old. Charlie felt close to his family. He grew up doing and enjoyed martial arts. Charlie started taking drugs as a young teenager. As an adult, he said his impulsive behaviour escalated eventually resulting in his getting into trouble with the police.

**Dave** described a disrupted upbringing. He had truanted from school and left as a young teenager when he started drinking and taking drugs. He described an extensive offending history dating back to his later teenage years, which had resulted in both hospital and prison admissions. Dave had a poor employment record and had had no significant intimate relationships.

**Ed** described a long history of mental illness dating back to his childhood when he talked about hearing voices. He became more unwell when he used illicit drugs or alcohol. Ed described a supportive family with whom he had regular contact. His long-term goal was to have his own house and car and attend a carpentry course so he could work as an apprentice within his family's business.

The men's stories showed a complex picture of their experiences of daily life within the unit over one year. This study demonstrated the impact of the environment on the men and the ongoing challenge of the need to balance between treatment/therapy with security demands and opportunities. Through the theme matrix (see Figure 1) three interrelated

themes were identified: 1. *Power and Occupation*; 2. *Therapy or Punishment*; 3. *Occupational Opportunities within Restrictions*.

*Insert Figure 1 here*

These themes acknowledged the unique nature of the forensic environment and illustrated how this restricted environment was experienced by the patients and influenced the value placed on their occupations. They are illustrated below using brief quotes from the men's narratives over the year. The number used for each quote indicates the chronology of the interview during the year.

***Theme 1: Power and occupation:***

With the exception of Alan, at times all participants felt disempowered, impacting on how they experienced and valued occupations. However, how they managed these feelings was very different. Charlie was reluctant to participate in compulsory treatment groups. He did so because of the potential positive consequences of gaining more leave away from the unit if successfully completed. He explained how he had changed his behaviour to comply with regimes, despite feeling frustrated by having to do so:

> "I was fighting the system…I thought I was doing the right thing…it doesn't work does it really…" (Charlie, interview 1)

> "You don't deal with it you just get on with it, that's all you can do really…No point in getting all **** stressed about it is there, 'cos that ain't gonna help" (Charlie, interview 4)

Throughout the year, Dave seemed to be in a constant fight with the system. Unlike Charlie, who accepted the 'game' he was required to play to make progress, Dave found this extremely difficult and this inhibited his ability to feel comfortable living in the unit. Feeling

disempowered and lacking autonomy distressed him. Throughout the year, he felt that the staff within the unit were trying to 'break' him and he complained angrily about this:

> "... I hate every aspect of it because they're writing down everything you're doing, looking at everything you're doing, judging everything you do..." (Dave, interview 1)

> "I don't take any notice of it to be honest, I ignore it, I act myself, I won't act differently because they threaten me [with] loss of leave" (Dave, interview 2)

However, the story told was not a simple one of feeling disempowered. There were also examples when the participants actively took control of situations. Who held the power was not always open or explicit. At times the men had more power than was apparent, positively increasing the value of their occupations. In the second interview, Ed spoke about gambling with his brother when playing pool during visits, smiling when I asked if this was allowed:

> "Err, sometimes when my brother comes up, like without the staff knowing, and he might say he wants a game for 50p a game...Bending the rules" (Ed, interview 2)

Some areas within the unit were less closely monitored by staff. In a later interview, Ed spoke about how patients sometimes used the smoking room to have conversations which they did not want to be overheard by staff:

> "It's just general chit chat about taking drugs and things like that" (Ed, interview 3)

Dave also spoke about using the smoking room for private conversations away from staff:

> "...I sit in the smoking room a lot as well...I don't smoke, but I sit in there with the lads...it's more sociable ain't it" (Dave, interview 1)

***Theme 2: Therapy or Punishment:***

The theme of *Therapy or Punishment* is closely linked to the previous theme of *Power and Occupation*. There was a range of perceptions from the participants and, for some, the perception of whether they felt that they were being '*treated'* or '*punished'* changed over the year. Both Charlie and Dave were generally negative and expressed their frustration at being forced to live in the unit by voicing an overall lack of autonomy and lack of interest in activities. Ed was negative about some aspects, and positive about others. The men who reported being happiest living in the unit were Alan and Bikram (see Figure 1); these two men were more compliant with the regime and had the fewest incidents of conflict with staff reported in their notes.

The patients generally credited the 'staff' as being accessible to discuss issues, over time developing positive and valued therapeutic relationships. The therapeutic gain of an occupation or therapy session was not always obvious, and was dependent on the interest and value ascribed to it by the person at that time. For example, Dave found sessions away from the unit therapeutic because of the sense of relief he got, but often described having little interest in the session topic:

> "Well I like getting away from this place I hate it here…Get away from people. I'm not used to living with people…" (Dave, interview 1)

Charlie attended therapy groups when required to or to alleviate boredom. However, he participated fully in sport as he enjoyed keeping fit. He discussed how security rules impacted on his ability to participate in his valued occupations:

> "...if there isn't an escort it can't go ahead which is a bit of a downer really…Sometimes I feel like I use more energy waiting to go to the gym waiting for the escort than I do when I'm actually there, you know what I mean, that's what it feels like any way" (Charlie, interview 2)

Patients were not allowed to use the local leisure centre during school holidays to maintain confidentiality about those patients who were deemed a potential risk to children.

Charlie discussed how he felt that he was being punished during this time. Charlie's relief in swimming again was clear when he spoke of the first session after the long summer break:

> "yeah I did I went on Monday, for the first time in ages...It was great yeah good...It's just good, good... it's just nice to, you know, swim and be in the water, exercise, just good you know, enjoy it" (Charlie, interview 3)

Alan also attended sport sessions, but to socialise with friends and mainly watched. He later decided to stop attending sport sessions, possibly as he had gained more leave and therefore freedom to meet his friends from other wards outside scheduled sessions:

> "I sort of sat down and chilled out and talked to people and watched the others play really." (Alan, interview 1)

> "I don't know I've sort of grown away from it" (Alan, interview 4)

***Theme 3: Occupational Opportunities within Restrictions*:**

Patients discussed how one occupation allowed them to participate in other valued occupations:

> "I like table tennis and all that, but to me, I'd rather, I like I enjoy physio...Because there, you do the exercise, you can go outside and have a smoke, come in have a cup of tea do a bit more exercise and then come back." (Bikram, interview 1)

In addition to treatment for mental health and offending issues, patients are given access to sessions which can help them live socially acceptable, independent lives in the community. Due to previously chaotic lifestyles, for some patients this was the first time they had had some of these opportunities. However, for Bikram living in an institution provided a sense of security:

> "I told them, I went to the doctor in my ward meeting, 'but I don't wanna go into supported accommodation, I want to go into residential care'" (Bikram, interview 4)

Every occupation has a level of personal value, but is also influenced by physical, social and cultural environments. This is illustrated by how Charlie described his coping mechanisms for living in the unit:

> "It's alright, the atmosphere's ok as these places go. You you've gotta remember it's got people with a lot of problems here so you can't open up too much you know what I mean…I've seen a lot of err people with a lot of problems… so I've learnt to just deal with those kind of things, you know..." (Charlie, interview 2)

Charlie discussed in a later interview how much changes to his physical environment affected him when he moved from rehabilitation to the less restricted pre-discharge area:

> "It's just being able to go out in fact I haven't seen the stars in in years, so that was really nice, going outside when its dark and seeing the stars…It's really good; it's like a normal environment you know, almost like a flat or something, it's good…Umm, I wouldn't go into how it made me feel, it wasn't like wooooooh!!! But it was nice you know, yer, just nice. Just to be able to like go out there and…Relax yeah... On occasions, yeah, I miss some of the people on Rehab but I am very happy to be where I am, yeah" (Charlie, interview 3)

The patients in this study were at differing stages of their recovery journey. Dave's story particularly demonstrated the powerful consequences of the struggle between a patient and staff when the patient is unwilling to accept the demands of socially acceptable behaviour. Charlie had decided to 'go with the flow' and avoid conflict with staff, but still did not agree with some of the restrictions. Ed discussed how he had decided to try to be more open with staff as trying to hide information about his mental health, particularly his voices, had not resulted in discharge. Bikram and Alan appeared to be more accepting of the demands of the unit and society.

## Discussion

During the analysis, the dual nature of serving both the needs of the men and of society became apparent and this tension was explored (Cronin-Davis et al, 2004; Martin, 2003). In common with the literature and policy frameworks, balancing the needs and

consequences of security and treatment/therapy was a dominant consideration within the findings (Duncan, 2008; Jobbins et al, 2007).

Forensic units provide many opportunities for their patients with a wide range of activities being available (Duncan 2008). In the interviews, the themes of Power and Occupation, Therapy or Punishment and Occupational Opportunities within Restrictions were dominant and provide a new understanding of the relationship between values ascribed to an occupation and the consequences of participation. In addition, this study has added a longitudinal perspective of the men's experiences of daily occupations over a year. It has indicated that the consideration of consequences of occupation can help clinicians understand motivations for participating in occupations and therapy sessions (Buckley et al, 2014; Neeson & Kelly, 2003). This needs to be considered fully by the clinical team member and the patient, both at the time of participation and when reviewing changes over time.

Power relationships are especially relevant within forensic settings (Baumeister, 2013). This was reflected in the stories told by the patients. The need for staff to control the physical and social environments to maintain security is acknowledged within the literature (for example Jobbins et al, 2007). Patients are required to be in a less powerful position, sometimes leading to expressions of frustration. However, empowerment is required to promote recovery, so the balance is a delicate one (Duncan, 2008). In order to progress, patients are obligated to engage in therapeutic sessions which address not only their health but also their offending behaviour (Buckley et al, 2014).

Goffman (1961/1991) argued that patients and staff have differing views of what they consider to be therapeutic value within the hospital setting. Traditionally, therapy requires participants to be motivated and feel empowered to engage with the process (Neeson & Kelly, 2003). Although working towards independence, the men had very little genuine control over their environment. Risk assessment and security rules resulted in tight control

of both physical and social environments (Jobbins et al, 2007). This led to both occupational risks and opportunities (Cronin-Davis et al, 2004).

Working within forensic services requires us to acknowledge the perceived negative values of some the occupations required when living in a RSU, for example attending compulsory treatment groups (Morris, 2012; Twinley & Morris, 2014). This aspect in forensic settings can be in conflict with the underlying belief of the positive value of interventions (Wilcock, 2006; Hammell, 2009). Occupational therapists within the clinical team, in particular, work with people to understand and minimise these negative aspects of required occupations and to work with people to develop occupations with positive value and positive consequences (Hammell, 2009; Morris, 2012). However, it is acknowledged that this will not be possible for all occupations as this is unrealistic; after all, we all have occupations that have negative value or consequences. This has not previously been described. For rehabilitation to be successful, the number of occupations with both positive value and consequences needs to increase, so the patient has a fulfilling life which is also acceptable to society (Eklund, Hermansson & Håkansson, 2012).

A focussed consideration of the patient's experiences in occupations assists understanding of the motivations for participation and allows the clinical team to fully consider the impact of the overall balance of occupations and their consequences. It also reminds the clinical team of the need to fully consider the impact of the forensic environment.

**Limitations:**

The qualitative social constructionist nature of the methodology means that the story told within this study is just one of many potential stories. It would be interesting to repeat the research with a larger group and also with women. This would increase the

trustworthiness and credibility of the findings and would enable development of larger scale quantitative research in this area.

## Implications for practice:

This study has contributed to the existing evidence base in forensic settings and there are emerging implications for practice. The starting point was to explore if and how the value attributed to occupations changes over time. The rich descriptions of the patients provided over the year enabled an exploration of the changing nature of their personal values and experiences of their occupations and has shown that;

- Full consideration of all the experiences of occupation in the RSU, not solely therapy sessions, provides a more holistic view of how patients spend their time. This helps to broaden ideas of what we mean by occupation.
- The clinical team needs to understand what really motivates patients and how they can accurately capture changes in the reason for engagement (Blank et al, 2015). For example a patient who used to engage in an activity as a means of avoidance but now engages in the same activity as it provides a sense of productivity and meaning.

Further research is currently being carried out to fully explore the potential for this research in practice. This is already identifying potential benefits:

- Discussions with patients have uncovered new information for the clinical team. Consequently this could promote accuracy in intervention planning.
- Patients had been enabled to learn something about their own occupations in a collaborative way. For some it prompted conversations about real life and the idea that “we all have to do some things that we don’t enjoy” because of the consequences.

## Conclusion:

This study aimed to explore the experiences and personal values for participating and engaging in occupations over one year for men living in a regional secure mental health unit. Five stories were gathered and analysed. The patient's stories powerfully illustrated their experiences of occupation and the impact of the forensic environment on their recovery journeys.

These findings serve as a reminder to clinical teams to reassess the value of occupations attributed by their patients, and acknowledge the potential for occupations to have a negative impact on wellbeing. Clinical teams must regularly re-examine the meaning of occupations to maximise therapeutic power, particularly when working in forensic settings. Finally, the findings highlight the need to listen to the voice of the patient, even though this may at times be difficult.

Word count: 4981

## References:


Baumeister, R. (2013), "Self-control, fluctuating willpower, and forensic practice", *Journal of Forensic Practice,* Vol. 15 No. 2, pp. 85-96.

Blank, AA., Harries, P. and Reynold, F. (2015), "'Without Occupation You Don't Exist': Occupational Engagement and Mental Illness", *Journal of Occupational Science*, Vol. 22, No. 2, pp. 197-209.

Brown, W. and Kandirikirara, N. (2007), *Recovering Mental Health in Scotland. Report on Narrative Investigation of Mental Health Recovery*, Scottish Recovery Network, Glasgow.

Bryman, A. (2012), *Social Research Methods*, 4th ed, Oxford University Press, Oxford.

Buckley, P., McGauley, G., Clarke, J., Moore, E., Nichita, E., Rogers, P. and Taylor, P. (2014), "Chapter 23: Principles of treatment for the mentally disordered offender", Gunn, J., & Taylor, P. (2014). *Forensic Psychiatry: Clinical, Legal and Ethical Issues,* 2nd ed, CRC Press, Boca Raton.

Burr, V. (2003), *Social Constructionism,* Routledge, London and New York.

College of Occupational Therapists (2012), *Occupational Therapists' Use of Occupation-focused Practice in Secure Hospitals: Practice Guideline,* College of Occupational Therapists, London.

College of Occupational Therapists (2014), *Occupation-focused Practice in Secure Hospitals: Occupational Therapy Evidence Factsheet,* College of Occupational Therapists, London.

Couldrick, L. and Alred, D. (2003), *Forensic Occupational Therapy,* Whurr Publishing, London and Philadelphia.

Craik, C., Bryant, W., Ryan, A., Barclay, S., Brooke, N., Mason, A. and Russell, P. (2010), "A qualitative study of service user experiences of occupation in forensic mental health", *Australian Occupational Therapy Journal, Vol.* 57, No. 5, pp. 339–344.

Creek, J. (2003), *Occupational Therapy Defined as a Complex Intervention,* College of Occupational Therapists, London.

Cronin-Davis, J., Lang, A. and Molineux, M. (2004) "Occupational science: The forensic challenge", Molineux, M., *Occupation for Occupational Therapists,* Blackwell, Oxford, pp. 169-179.

Denzin, N. and Lincoln, Y. (eds) (2000), *Handbook of Qualitative Research,* Sage Publications, Thousand Oaks.

Duncan, E. (2008), "Forensic occupational therapy", Creek, J. and Lougher, L., *Occupational Therapy and Mental Health,* Churchill Livingstone, Edinburgh, pp. 513-534.

Eklund, M., Hermansson, A. and Håkansson, C. (2012), "Meaning in life for people with schizophrenia: Does it include occupation?", *Journal of Occupational Science*, Vol. 19, No. 2, pp. 93-105.

Falardeau, M. and Durand, M. (2002), "Negotiation-centred verus client-centred: Which approach should be used?", *Canadian Journal of Occupational Therapy,* Vol. 69, No. 3, pp. 135-142.

Goffman, E. (1961/1991), *Asylums: Essays on the Social Situation of Mental Patients and Other Inmates,* Penguin, Harmondsworth.

Great Britain, *Mental Health Act 1983: Elizabeth II. Chapter 20* (1983), available at: http://www.legislation.gov.uk/ukpga/1983/20/contents (Accessed on 30th August 2011).

Great Britain, *Mental Health Act 2007: Elizabeth II. Chapter 12* (2007), available at: http://www.legislation.gov.uk/ukpga/2007/12/pdfs/ukpga_20070012_en.pdf (Accessed on 26th February 2015).

Great Britain, Department of Health (2002), *Into the Mainstream: Strategic Development of Mental Health Care for Women*, available at: http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4008046 (Accessed on 30th August 2011).

Hammell, K. (2009), "Sacred texts: a sceptical exploration of the assumptions underpinning theories of occupation", *Canadian Journal of Occupational Therapy,* Vol. 76, No. 1, pp. 6-22.

Jobbins, C., Abbott, B., Brammer, L., Doyle, M., McCann, G. and McLean, R. (2007), *Best Practice Guidance: Specification for Adult Medium-secure Services*, Department of Health London.

Jonsson, H. (2008), "A new direction in the conceptualization and categorization of occupation", *Journal of Occupational Science,* Vol.15, No. 1, pp. 3-8.

Kelly, G. and McFarlane, H. (2007), "Culture or cult? The mythological nature of occupational therapy", *Occupational Therapy International,* Vol. 14, No. 4, pp. 188-202.

Martin, M. (2003), "The foundation of good practice", Couldrick, L. and Alred, D., *Forensic Occupational Therapy,* Whurr Publishers, London and Philadelphia, pp. 22-29.

Morris, K. (2012), "Occupational Engagement in a Regional Secure Unit", *Unpublished PhD Thesis*, Lancaster University, Lancaster.

Neeson, A. and Kelly, R. (2003), "Security issues for occupational therapists working in a medium secure setting", Couldrick, L. and Alred, D., *Forensic Occupational Therapy,* Whurr Publishers, London and Philadelphia, pp.126-138.

Rutherford, M. and Duggan, S. (2007), *"Forensic Mental health Services: Facts and Figures on Current Provision*", Forensic Factfile 2007, The Sainsbury Centre for Mental Health, London.

Silverman, D. (2008), *Doing Qualitative Research,* 3rd ed, Sage Publications, London.

Tucker, S. and Hughes, T. (eds) (2007), *Standards for Medium Secure Units: Quality Network for Medium Secure Units*, Royal College of Psychiatrists, London.

Twinley, R. and Morris, K. (2014), "Are we achieving occupation-focused practice?", *The British Journal of Occupational Therapy*, Vol. 77, No. 6, pp. 275.

Wilcock, A. (2006), *An Occupational Perspective on Health,* 2nd ed, Slack Incorporated Thorofare, New Jersey.

**Figure 1: Theme Matrix for Men's Stories**

| | Power and occupation | | | | | | | | Therapy or punishment | | | | | | | Occupational opportunities within restrictions | | | | | Feelings about unit | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | disempowered | compliance | wanting to please | taking control | trapped | irritated by rules | staff communication | escorts | punishment | need therapy | settled | can't wait to get out | impact of tiredness | impact of mental health | impact of physical health | opportunity | restriction | freedom | waiting | boredom | positive | neutral | negative |
| Alan | | | | ✓ | ✓ | | | ✓ | | ✓ | ✓ | | ✓ | ✓ | | ✓ | ✓ | ✓ | | ✓ | ✓ | | |
| Bikram | ✓ | ✓ | ✓ | | ✓ | | | ✓ | | ✓ | ✓ | | | | ✓ | ✓ | ✓ | ✓ | | | ✓ | | |
| Charlie | ✓ | ✓ | | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | | | ✓ | ✓ | | | ✓ | ✓ | ✓ | ✓ | ✓ | | ✓ | ✓ |
| Dave | ✓ | | | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | | | ✓ | ✓ | | | | ✓ | | | ✓ | | | ✓ |
| Ed | ✓ | | | ✓ | ✓ | | ✓ | ✓ | ✓ | ✓ | | ✓ | ✓ | ✓ | | | ✓ | | ✓ | ✓ | | ✓ | ✓ |

**Figure 1: Theme Matrix for Men's Stories**

| | Power and occupation | | | | | | | | Therapy or punishment | | | | | | | Occupational opportunities within restrictions | | | | | Feelings about unit | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | disempowered | compliance | wanting to please | taking control | trapped | irritated by rules | staff communication | escorts | punishment | need therapy | settled | can't wait to get out | impact of tiredness | impact of mental health | impact of physical health | opportunity | restriction | freedom | waiting | boredom | positive | neutral | negative |
| Alan | | | | ✓ | ✓ | | | ✓ | | ✓ | ✓ | | ✓ | ✓ | | ✓ | ✓ | ✓ | | ✓ | ✓ | | |
| Bikram | ✓ | ✓ | ✓ | | ✓ | | | ✓ | | ✓ | ✓ | | | | ✓ | ✓ | ✓ | ✓ | | | ✓ | | |
| Charlie | ✓ | ✓ | | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | | | ✓ | ✓ | | | ✓ | ✓ | ✓ | ✓ | ✓ | | ✓ | ✓ |
| Dave | ✓ | | | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | | | ✓ | ✓ | | | | ✓ | | | ✓ | | | ✓ |
| Ed | ✓ | | | ✓ | ✓ | | ✓ | ✓ | ✓ | ✓ | | ✓ | ✓ | ✓ | | | ✓ | | ✓ | ✓ | | ✓ | ✓ |