OCCUPATIONAL ENGAGEMENT IN FORENSIC SETTINGS – DETAILING WORK THAT HAS EXPLORED THE OCCUPATIONAL EXPERIENCES OF MEN LIVING WITHIN A FORENSIC MENTAL HEALTH UNIT

Abstract (200)

In my work I have found that environments, such as secure mental health units, add an additional layer of complexity for the occupational therapist who seeks to understand people's occupational experiences. I present this chapter in three parts: an introduction to secure mental health services in the United Kingdom; an outline of a framework which positions 'occupational engagement' in a framework of values and consequences; and finally with examples of how the framework could be used to help illuminate the dark side of occupations of men living in a forensic mental health unit.

Background and introduction

I intend for this chapter to illuminate how I explored occupational engagement for men living in a regional secure mental health unit in the United Kingdom (UK). First, I briefly outline forensic mental health services in the UK before exploring the development of a new framework to explore the concept of occupational engagement within this setting. I then explore the relationship between occupational engagement and the dark side of occupation for both residents and staff working in forensic settings.

This research formed my PhD studies (see Morris, 2012). The starting point for this was a nagging question – how do we, as occupational therapists, *know* that the activities we offer as part of our assessment and intervention have value and meaning to the people we work with, especially in long term settings? Other questions that are at the heart of the issues I explore within this chapter were:

- Just because something has value at the beginning of someone's stay in a unit, how often is this re-evaluated?
- What if the occupations that have most value to a person are not socially acceptable and therefore forbidden?
- What is the impact of this on occupational therapy practice within such settings?

Just as other contributors to this text have discussed and posed, at this point I would like to ask the reader to remind themselves of the difference between the 'dark side' and 'dark' occupations. The general dictionary definition of 'dark' as having little or no light aligns with Twinley's (2013) explanation of her concept that 'occupation is something that has aspects which are less acknowledged, less explored and less understood. It presents occupation as something which has aspects to it that have been left in the shadows' (p. 302). Then, there is the understanding of 'dark' or 'dark side' as something (or someone) who is mysterious or secret, evil or threatening. Considering this latter interpretation, there is no doubt that some of the occupations residents in secure units have experienced are 'dark', yet personal judgments about these need to be suspended to enable a full understanding of why people do the things they do – all occupations have illuminated and dark sides, whether socially acceptable or not.

The setting

Within a single chapter, it is not possible to explain all the intricacies of the UK forensic mental health system, but a very brief outline is hopefully useful to aide understanding if you are not familiar with this area. The UK has a community-focused mental health system with only about 6% of people admitted to hospital for treatment (CQC, 2009). Forensic mental health practitioners work within general mental health (inpatient, community and supported accommodation settings), secure mental health and prison services. Within the secure services, security levels are defined as high, medium, and low. In addition to this, there are specialist community teams and supported accommodation. There are around 6000 secure inpatient beds (approximately: 680 high; 2800 medium; 2500 low security [JCPMH, 2013]). Of these people, 8/10 are men, with an average stay of 5-10 years (Rutherford & Duggan, 2007). As far as possible, people are held at the lowest level of security required for safety. If you would like to find out more about UK mental health services, this link is a useful starting point: https://www.jcpmh.info/wp-content/uploads/jcpmh-forensic-guide.pdf.

Forensic mental health is a unique setting in that there are two clear purposes: 1) treating the person with mental illness, and 2) protection of society. The majority of residents are 'involuntary', being detained under the Mental Health Act 2007 (Great Britain, 2007). Another unique feature is that services do not have full autonomy with decisions; the Ministry of Justice can influence treatment as permission is often needed to change a person's security status, thereby impacting on their recovery journey, positive risk taking and movement within areas (Centre for Mental Health, 2011). Successful treatment is first measured by reduction of symptoms and public safety before personal wellbeing (JCPMH, 2013). In recent years, as in other mental health areas, there has been an active focus on implementing recovery-oriented principles through the implementation of 'My Shared Pathway' (Recovery & Outcomes, 2018; Livingston, 2018). This has highlighted the tensions, and potential for conflict, between the two 'masters' within forensic mental health services – the person and society. This is a significant culture shift which is beginning to be explored within the literature.

Forensic mental health is a growing area of practice for occupational therapy with active research contributions. This emerging evidence base has been used to develop NICE accredited practice guidelines (RCOT, 2017) to support therapists working with people living in secure hospitals. The impact of the additional restrictions from an occupational perspective are being explored, mainly through qualitative research (e.g. Cronin-Davis, 2010; Morris, 2012; Alred, 2018). This is ensuring that the voices of the people occupational therapists work with within these services remain strong. Additionally, the reflective nature of the methodologies used (e.g. action research, interpretative phenomenological analysis, social constructionism) are ensuring that researchers are also challenging the profession's long-held philosophical assumptions of the positive meaning of occupations to people (Hammell, 2009).

Exploring occupational engagement

My PhD research aimed to explore how the value of occupation changed over time for a small group of men living in a regional secure unit. Five men agreed to take part in the research and were interviewed four times over a year. In addition, I used participant observations and a review of their clinical notes to inform our conversations about how the value of their occupations changed during the year. I utilised a social constructionist methodology (Burr, 2003) and heuristic analysis (Moustakas, 1990). This approach enabled me to listen to the men's stories as a researcher, rather than a clinician, challenging my beliefs and understanding about the value and meaning of occupation in unexpected ways.

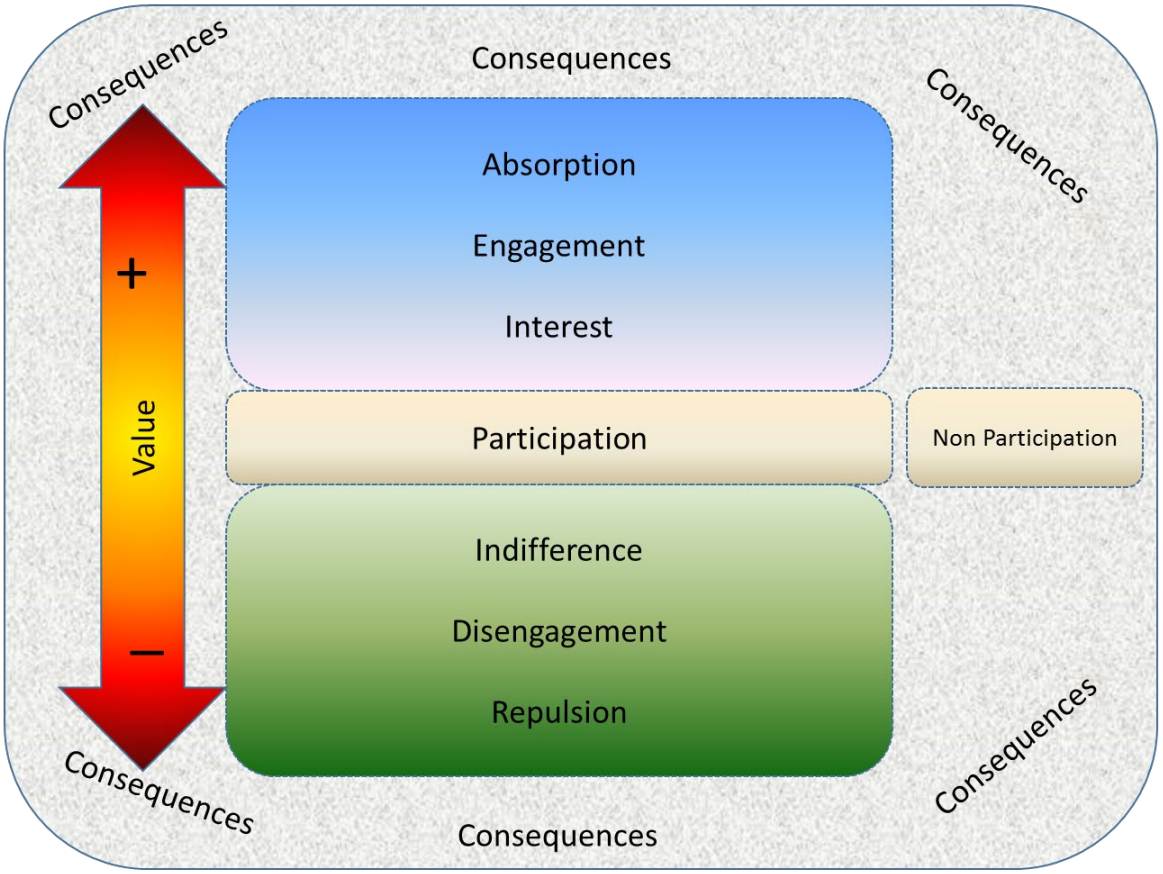
As already mentioned, within occupational therapy core texts, occupation traditionally has been assumed to be positive for health. For example, Duncan (2006, p. 30) said:

> "*Occupation has a central role in human life. It provides motive and meaning to life; lack of access to occupations may have a negative effect on health and quality of life; the use of occupation to address impacts on health or quality of life is the core of occupational therapy…Respect for the value of human life; The importance of individual empowerment and engagement in occupation; The integration of individuals into life through meaningful occupation*."

The term 'occupational engagement' has been frequently used within occupational therapy and occupational science literature, but without a consistent definition or use. Mary Reilly (1962) is often quoted as the source of the term, but it does not appear within the text cited. What she actually said was: "*That man, though the use of his hands, as they are energised by mind and will, can influence the state of his own health*" (p. 2) - often quoted as the occupational therapy philosophy - but she went on to say: "*This is the inherited occupational therapy* ***hypothesis passed on for proof*** *by the early founders*" (p. 2, emphasis added) and "*In our forty years of practice we have accumulated some* ***fascinating odds and ends of understanding*** *about the need to work*" (p. 4, emphasis added). So what is often quoted as a statement, is actually a challenge to the profession.

The 'creative synthesis' (Moustakas, 1990) of my research, rather than a simple definition of the term, was a new framework positioning occupational engagement within a range of positive and negative values and consequences (see figure below). During the development of the framework, I held only the traditional view of my profession and initially only focussed on the positive values of occupation. As the data analysis increased in depth, I was able to challenge this perspective and also explore the potential for negative value within occupations.

Figure: Framework to position Occupational Engagement (Morris, 2012; Morris & Cox, 2017)



As illustrated, the framework considers the values and consequences of an occupation. Occupation is defined as a unique, one off experience of an activity (Pierce, 2001). Occupational engagement is a fluctuating state influenced by complex and multiple factors. Occupational engagement is positioned within a framework of personal value and perceived consequences to participation. Every occupation has a level of personal value, but also has consequences in terms of feedback from physical, social, and cultural environments. 'Participation' is the anchor and entry point into the framework. Levels of value are represented as a continuum, from 'absorption' as the most positive level of value, to 'repulsion' as the most negative level. 'Absorption', 'Engagement' and 'Interest' represent graded levels of positive value. So, 'engaging' occupations require more involvement than those that just 'interest' the individual, but not as much as 'absorbing' occupations. On the other end of the scale, 'Indifference', 'Disengagement' and 'Repulsion' represent graded levels of negative value.

It should be noted that 'Non Participation' is not considered to be occupation, as the definition of 'occupation' used requires 'doing' (i.e. active participation). However, non-participation is important and must be remembered as it serves a purpose, for example, it may be the only way that individuals have of controlling their environment. As well as value, the person will perceive positive or negative consequences to participation which may change over time in response to feedback from their environment. An occupation with positive value for the individual can have negative consequences and vice versa. The aim of treatment within forensic settings is for people to participate in occupations with both

positive personal value and positive perceived consequences for both the individual and society.

Using this framework to help illuminate the dark side of occupations

The framework may be helpful to illuminate the dark side of occupations, and to understand motivations for participating in traditionally perceived 'dark' occupations. In this section we will explore some examples of how the framework outlined above could be useful.

Understanding someone's attitude and motivation to their occupations is carefully considered by staff working in forensic mental health. For example, Spruin, Canter, Youngs, and Coulston (2014) used narrative analysis to explore the criminal and personal narratives of seventy men living in secure units to increase understanding of their views of themselves and their crimes. They found that participants used four main narratives to explain their behaviour – hero, victim, professional, and revenger. The framework may support this exploration of why people do the things that they do (Morris, Cox & Ward, 2016). For instance, taking illegal drugs might stimulate occupational interest or engagement (so therefore positive value) but can result in getting arrested (and therefore negative social consequence). On the other hand, attending a drug awareness course might be accompanied by occupational indifference (classed as negative value), motivated by increasing leave out of a unit, but can result in increased ability to manage without drugs (and therefore assumed positive consequence for the individual and society). Another example came to light when a clinician used the framework to structure a conversation with a resident about their poor personal care (Morris & Ward, 2018). The resident's refusal to shower was assumed to be about poor personal care (a common feature of his illness), but in reality the water often went cold so showering was very unpleasant and no longer had positive consequences for him.

The emphasis within forensic mental health units is on relational and procedural security as much as physical security (JCPMH, 2013), but this does not fully alleviate the impact of restrictions. As in any setting, staff can quickly become desensitised to the impact of the work environment and the impact this can have on wellbeing. Health care professionals traditionally focus on the positive aspects of the impact of our interventions with an expectation of *'first, do no harm'*. As already discussed, attitude and motivation are closely examined. Residents may be required to attend certain therapeutic groups before being eligible for increased leave from the unit, or discharge. It can be incredibly hard for clinicians to really hear some of the messages that they are given by residents in secure units. For example, we can all appreciate that it is not nice to have our movements and activities restricted by others, but it is easier for clinicians to focus on the potential positive therapeutic benefits of the unit rather than dwelling too much on the potential negative impact of the secure environment; as one of my research participants, Dave, reinforced when he asked "*am I your only torture victim today*?". This was a man who hated living communally, but was not yet deemed 'well enough' to move to a quieter part of the unit – for him the 'therapeutic' environment within the unit had a dark side expressed as 'torture', only relieved with short periods of unescorted leave within the wider hospital grounds. This led Dave to be labelled as uncooperative when he expressed his frustrations (sometimes aggressively). Due to legal restrictions and the need to serve both masters (society as well as the individual), staff were unable to change the situation, sometimes leading to Dave feeling

not listened to. The framework above could be used to support conversations to both understand the impact of the unit on Dave, but also to help Dave explore the dark side of his own occupations on his therapeutic journey.

Summary and key points (200)

I echo Nastasi's (Chapter TBC) assertion that analysing the impact of the environment on a person's subjective experience of occupation is crucial; environments such as secure mental health units add an additional layer of complexity to the exploration of the dark side of occupations. Theory, including the framework I have discussed within this chapter, is emerging that enables practitioners to fully consider the negative values and/or consequences of someone's occupations. I believe that occupational therapists can use this framework to help illuminate the dark side of occupations in a number of ways, for example:

- Using the framework to help structure conversations exploring both positive and negative aspects of occupations, illuminating why people do the things that they do (or no longer do).
- Using the framework as a reflective supervision tool to illuminate and explore the complex nature of occupations used within therapeutic interventions.
- Using the framework to help illuminate the impact of physical, social and cultural environments on occupations.

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